Revalidation

Revalidation in the United Kingdom: general principles based on experience in general practice

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Editorial by Buckley

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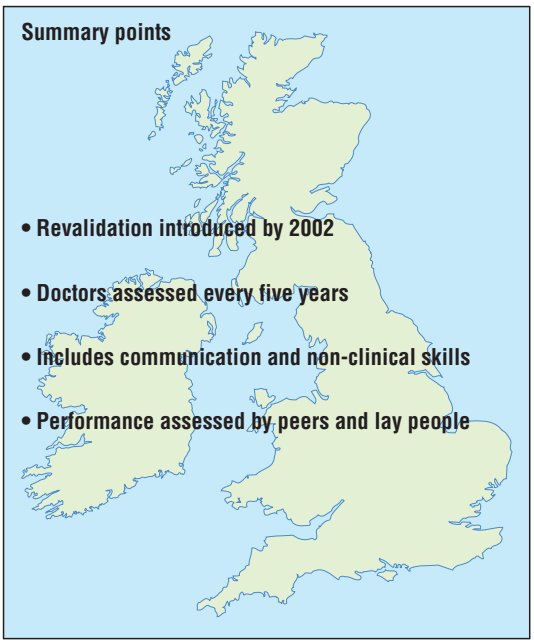
BMJ 1999;319:1180–3

Professional self regulation is at the heart of the organisation and philosophy of medical care in the United Kingdom. However, demands are growing for increasing transparency and accountability to patients in systems for ensuring doctors' standards. In response to this, the General Medical Council (GMC) has made a commitment to introduce periodic revalidation for all doctors on the medical register after 2002. Every five years all doctors will have to submit evidence that they are practising in accordance with clearly defined guidelines. There is debate about what methods of professional assessment are most closely linked with professional performance. In this article we describe an approach to establishing revalidation in the United Kingdom, highlighting areas of uncertainty and using examples of work in progress in general practice.



Methods

This article is based on our work in developing the performance procedures for general practitioners. The proposals are based on international guidelines for good practice in devising assessment programmes which emphasise the importance of using methods relevant to the purpose and content of the assessment.[1 2]

Content of revalidation

Revalidation will be a proactive, inclusive programme, designed to demonstrate that the performance of doctors is acceptable. It will apply to all doctors on the register, be conducted locally by peers and lay people, be monitored nationally by the GMC, and must be implemented with a "light touch" if it is to succeed.

It is essential that an assessment programme assesses what it purports to assess.[1] Revalidation should therefore seek evidence of a safe standard of practice for all areas in which a doctor works, both clinical and managerial. This presents particular problems for specialist practice. There are professional debates about core competencies for specialists (for example, in diabetes or breast surgery) who are on call as generalists for patients being admitted to busy hospitals all over the United Kingdom.[2] They will need to be revalidated—albeit at the level of basic competency—for all these activities. If, as a response, these doctors were to work only in their specialty there would be a severe workforce crisis throughout the NHS. Such issues must be openly aired, with the public and the funders of health care, as revalidation is implemented.

Actual practice has two components. The first is generic to all doctors and is expressed in the GMC's guidance document *Good Medical Practice*.[3] This document proposes a wide definition of competence, including relationships with patients, teamwork, participation in continuing professional development, and a commitment to maintaining performance alongside the traditional competencies in diagnosis, management, and practical skills that make up good clinical care.

In any discipline the generic attributes will be manifest within specific elements common to all of its practitioners. It is on this basis that several royal colleges have begun to elaborate *Good Medical Practice* for their members. The Royal College of General Practitioners' *Good Medical Practice for General Practitioners*[4] contains a definition of the excellent and the unacceptable general practitioner in relation to all areas covered in *Good Medical Practice* (box).

The second component of actual practice comprises the clinical problems which face the doctor. The

Examples of criteria for the unacceptable general practitioner[4]

Clinical care
Does not listen to patients and frequently interrupts
Fails to elicit important parts of the history
Is unable to discuss sensitive and personal matters with patients
Fails to use the medical records as a source of further information about past events
Fails to examine patients when needed
Undertakes inappropriate, cursory, or inadequate examinations
Does not explain clearly what he or she is going to do or why
Does not possess or fails to use diagnostic and treatment equipment
Undertakes irrelevant investigations
Shows no evidence of a coherent or rational approach to diagnosis
Reaches illogical conclusions drawn from the information available
Gives treatments that are not based on best practice or evidence
Has limited competence, and is unaware of where limits of competence lie

Keeping records and keeping colleagues informed
Keeps records which are incomplete, illegible, or contain inaccurate data
Does not keep records confidential
Does not take account of colleagues' need for information
Keeps records which are not in date order
Consistently consults without records

generic attributes should be assessed in relation to common and important problems with which the doctor will be faced. This has implications for the type and range of evidence that must be supplied to support revalidation.

One possible model for revalidation is to focus assessment on a few key areas in *Good Medical Practice* that are relevant to a specialty with briefer coverage of the remaining standards in the guidance for registration. The box lists the areas which the Royal College of General Practitioners has suggested should be assessed in revalidation.

The importance of this approach is that revalidation maps back directly to the national guidance for all doctors on the GMC register. It illustrates that for revalidation to be implemented locally for all doctors, the detailed work of defining content must be done by peers.[5] Participation and leadership from the royal colleges, specialist associations, and other professional groups will be essential.[6] The input of lay people is also critical to ensure coverage of areas to do with communication and attitudes to patients.

Assessment methods

Assessment of performance in practice has high validity, but the reliability of the evidence depends on sampling doctors' work systematically and training peers and lay people as assessors. This must be balanced against the resources available to the profession and the effect on service delivery. The process of collecting evidence must easily be incorporated into doctors' daily work, and the evidence must be valid and reliable, stem from an approved source, withstand public scrutiny, inform and improve standards of health care, and be capable of supporting local assessment for revalidation.

Determining the content of doctors' practice

One of the primary tasks in establishing revalidation will be to develop a template for an "extended curriculum vitae" which will enable doctors to present themselves, their education and experience, and their clinical practice to the assessors. This document should have a common structure for the whole profession. It will enable the content for revalidation to be established and allow identification of the appropriate peer group to evaluate the evidence submitted by the doctor.

Some doctors have unusual patterns of practice, and how evidence will be collected and evaluated in these circumstances remains unresolved. It is not an option to review only a section of an individual's practice; patients expect more.

Professional values

Professional values can be self reported, perhaps within the extended curriculum vitae, and countersigned by a colleague. But they may be best assessed through peer review. The system adopted by the American Board of Internal Medicine and the Royal Australian College of Physicians, in which doctors ask 15 colleagues to report on their performance,[7 8] has proved reliable and might be useful in the United Kingdom, particularly as the data could be collected and analysed nationally. This would make it cost effective, remove it from local influences, and provide an opportunity for feedback to the doctor.

Professional relationships with patients

Maintaining trust within relationships with patients is part of professional performance and therefore part of revalidation. Communication skills must form part of the assessment of all doctors' fitness to practice. They might be assessed through a survey of patient views[9 10] or through another doctor assessing consultations.

Aspects of good medical practice for general practitioners that could form basis for revalidation

Professional values:
  Overall standards in *Good Medical Practice*
Professional relationships with patients—maintaining trust:
  Communication
Keeping up to date and maintaining your performance:
  Reflection
  Education
  Changes in practice when appropriate
If things go wrong:
  Complaints procedures and complaints
Good clinical care
Medical record keeping and informing colleagues
Access and availability
Working with colleagues and working in teams
Effective use of resources

Assessment of communication skills will be an integral part of revalidation

In future data will be available from the annual national survey of user and patient experiences, which will be carried out as part of the national framework for assessing performance.[11] Coordination between government and the profession could avoid duplication and ensure the collection of relevant information. However, identifying the performance of individuals within the performance of large organisations will pose difficulties.

Keeping up to date and maintaining your performance[12]

With the move from continuing medical education to continuing professional development[13] doctors will be expected to show how their educational needs are identified and then met. When appropriate, this should be mapped through into changes in services and patient care.

To assess their educational needs, doctors should reflect on their practice. They will also wish to take part in the audit of groups of patients and case reviews. These include confidential inquiries, case based discussions, significant event auditing, critical incident analysis, and monitoring of adverse events. All of these activities will be recorded in the extended curriculum vitae as evidence for revalidation, with further evidence available should the local peer group require it.

If things go wrong

Every doctor will be expected to show appropriate responses to comments or complaints from patients and to discuss patients that experience poor care outcomes openly with colleagues. Cooperation with effective complaints procedures will be expected, and each doctor could document this aspect of practice within the extended curriculum vitae.

Further areas of evidence

For most doctors working in the NHS, evidence about their performance will be collected as a result of the establishment of clinical governance. Much of the evidence will be about process, with some proxies for outcome.[14] When outcomes are readily available, as in mortality after surgery, they will be used. But outcomes are unlikely to form the main evidence of performance until there is confidence that they truly reflect performance and are sensitive to context.[15] This, of all the evidence to support revalidation, requires the most work and greatest cooperation between stakeholders.

Other routes to revalidation

Some doctors may wish to submit evidence of a higher standard of practice than that required for revalidation. Many general practitioners, for example, are planning to take part in peer review programmes such as fellowship by assessment (FBA) or membership by assessment of performance (MAP). These programmes are congruent with *Good Medical Practice,* and it seems sensible that such activities should be acceptable for revalidation of registration.

Making the assessment

The judgment on revalidation will be made by a trained and accredited panel which will include lay people as well as senior professionals. Trained lay assessors are vital for the credibility of revalidation and can assess all aspects of a doctor's performance except technical competency.

The revalidation judgments must be made and documented against predetermined standards. Doctors must clearly understand what is expected of them and have access to support and mentoring when preparing their evidence. When a doctor does not seem to meet the initial requirements further assessments should be made. Support and education should be provided to enable the standards to be met.

Exceptionally, a doctor may not respond to professional support or may be underperforming too severely. In these cases, the GMC will be informed. This referral may result in an assessment under one of the GMC's fitness to practice processes. Only the GMC can decide to remove a doctor's name from its registr.

Organisation of revalidation

We visualise several regional revalidation groups for each discipline, although smaller specialties may require only one. Such groups will need to be identified, trained, and monitored by national professional organisations, usually the royal colleges. In turn these national professional organisations will be recognised by the GMC. Each local revalidation group will represent the interests of the specialty concerned, the local professional organisations, the public, and doctors in health services management.

A doctor will apply to the local group for revalidation, offering the evidence agreed by that discipline. It is likely that the evidence will be assembled by each doctor over five years, and as the organisation of revalidation becomes clearer, mechanisms to support this process will develop. For most doctors the local group will recommend revalidation direct to the GMC. The work of the local group will be monitored and quality assured by the appropriate college.

This means that the evidence for revalidation must be in a standardised form so that a national standard can be guaranteed for the public. Although the GMC may receive only a single sheet of paper, the audit trail must lead back to individual components that support

the statement. There will need to be equivalence across specialties, area, and settings, whether in the NHS or the private sector.

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Recertification in the United States

John J Norcini

From the creation of the first board (in ophthalmology) in 1917 to the late 1960s, the specialty boards in the United States focused exclusively on initial certification. With its inception in 1969, however, the American Board of Family Practice limited the validity of its certificates to seven years, and since then other boards have followed suit, some after attempting voluntary processes that ultimately failed. Of the 24 boards that are members of the American Board of Medical Specialties all have limited, or plan to limit, the duration of validity of their certificates to seven to 10 years.[1]

According to Benson, the goals of recertification are to improve the care of patients, to set standards for the practice of medicine, to encourage continued learning, and to reassure patients and the public that doctors remain competent throughout their careers.[2] To meet these goals, an ideal programme for recertification should have three components for evaluation.[3–5] Firstly, to ensure that doctors are providing good care in practice an assessment of patient outcomes is needed. Secondly, to ensure that doctors are aware of recent advances in medicine and have the potential to treat the broad range of less frequent but medically important problems an evaluation of medical knowledge and judgment is needed. Thirdly, to ensure that doctors exhibit professionalism a review of credentials (for example, a valid licence and attestation of competence from the hospital or other local authorities) and the judgments of peers and patients are needed.

Patient outcomes

The assessment of patient outcomes is the most important component of a recertification programme. It directly reassures the public that doctors are performing well, and it is tailored to practice so it offers evaluation of what doctors actually do, rather than what they do in an artificial testing situation.

Summary points

- Periodic recertification
- Trend to computer based testing
- Some assessment of practice performance
- Focus on processes of care
- One board includes patient satisfaction and peer assessment

In the United States, outcomes assessment has become a reality of practice. Many healthcare systems give doctors a "report card" detailing their performance in areas such as screening, prescribing, and patient satisfaction.[6–8] However, outcomes assessment for a national recertification programme faces significant technical obstacles in data collection and in the number of cases that need to be sampled to have confidence in the results.[9] Moreover, there are difficulties in evaluating the outcomes themselves, including attribution, complexity, and case mix.[10] Treatment is often provided by healthcare teams, so it is difficult to attribute a particular patient outcome to a single doctor. In addition, patients with the same condition often vary in complexity for a variety of reasons including the severity of the disease, comorbid conditions, and patient compliance. Furthermore, there is considerable variation in the patient mix from one doctor to another. Although there are partial solutions to these problems, a rigorous and fair evaluation based on patient outcomes is not yet possible.[10]

This inability to do adequate assessment in a setting where so much is at stake for patients and doctors has created a conundrum for the boards. In response they

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BMJ 1999;319:1183–5

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