Learning in practice

Revalidation: the purpose needs to be clear
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From 1 January 2005 every UK doctor will need a licence to practise. Most doctors will be able to secure revalidation of their licence by annual appraisal and by showing that they are compliant with local clinical governance requirements and free of any serious unresolved concerns about their fitness to practise.

In May 2001, the General Medical Council confirmed that all doctors would have to show regularly that they remained up to date and fit to practise in their chosen field. This process was termed revalidation, and its introduction was said to be a landmark in the history of self regulation of the medical profession.

The decision was made against a background of high profile cases of medical malpractice and coincided with the first term of a new government which had a mandate to modernise the health service. Indeed the years since the 1997 election have been characterised by a range of policy developments affecting the regulation of doctors in the NHS (see table A on bmj.com). These have included the contractual need to participate in annual appraisal and the professional obligation to undergo revalidation.

Recent guidance indicates that revalidation may be achieved through participating in annual appraisal. What then is the purpose of revalidation?

The emerging role of revalidation
In late 2001 I did research to analyse the development of policy between May 1997 (the election of the new government) and July 2001 (the publication of the report of the Bristol Inquiry) with particular respect to the revalidation of general practitioners. The overall aim of the study was to examine the emerging role of revalidation in relation to other changes in professional and contractual regulation.

The three key stakeholders (with political power) directly involved in negotiating the emergent policy were the profession, the government, and the General Medical Council (the profession’s regulator). The main focus of my research was on their contribution to policy development, and I used three principal sources of data:

- Stakeholders’ key policy documents—those which affected or potentially affected the professional or contractual regulation of general practitioners
- A sample of the responses to the Royal College of General Practitioners’ consultation exercise on revalidation.
- In-depth interviews with 18 key opinion leaders and policy makers (box).

Beyond the immediate antecedent of the Bristol case, I concluded that revalidation stemmed from various causes. Firstly, failure—failure of the systems, which were meant to assure the public that the care they received was satisfactory; and failure of the prevailing medical culture to change with the times. The government largely attributed these failings to their predecessor’s internal market. However, by 1998 they were also referring directly to the series of well publicised lapses, which they said had dented public confidence.

These were then developed into the more general theme of unacceptable variations in practice, and by 1999 the government was being specific in its concern about poorly performing doctors.

A second antecedent, that revalidation was part of a progressive development of the profession by the profession, was a view particularly emanating from the regulator and the profession. Conversely a number of the opinion leaders saw revalidation as part of a complex political readjustment between the main stakeholders.

In terms of the purpose of revalidation there were three over-riding themes: securing public trust, promoting continuing professional development, and detecting poor performance, with recognition that the

Summary points
Revalidation is a watershed in medical self regulation in the United Kingdom
Stakeholders agreed on the policy in principle but disagreed on its operation
Confusion and unease exist about whether revalidation is intended to detect poor performers and its overt link with appraisal
Ultimately separating revalidation from appraisal may be sensible; doctors can do this by following the “independent route” rather than the “appraisal route” to revalidation

Table A summarising the documents affecting relevant policy developments is on bmj.com

[Box:TDVZ]
A consensus on revalidation?

At one level consensus was reached on the policy throughout, and revalidation was referenced appropriately in policy documents. And the consultation exercise also showed that most general practitioner responders (1569 out of 1946; 81%) were “broadly in support.” Many adverse comments were, however, given even in the supportive responses, including objections in principle; anxiety about the process, its funding and its effect on general practice; and apprehension about how general practitioners could be expected to meet the requirements of revalidation given the constraints of the health service.

None of the opinion leaders voiced any substantial objection to revalidation. Concerns were expressed, however, about the process and whether it would deliver the desired outcomes. In particular, would revalidation redress unacceptable variation in practice or prevent high profile medical failure?

The future regulation of doctors

Stakeholders also expressed disquiet about the implications for the regulation of doctors in the future. Among the comments to the consultation exercise, in which respondents forecasted future consequences, two themes were evident—general pessimism about the effect on individual doctors and concern about political interference nationally and locally. The opinion leaders saw potential advantages in terms of guaranteed quality of the medical workforce. The main disadvantages were the costs of what was seen as a highly bureaucratic process and the possible negative impact on doctors themselves.

The stakeholders accepted that at some point a recently revalidated doctor would be found in breach but had different views on the likely consequences of this. One opinion leader thought that sensitivity and reliability tests would come, whereas another saw the potential for a huge loss of credibility. Expectations had been built up high, and each time there had been a reiteration of the problems of poor practice, the General Medical Council was said to have come out and stated, “Don’t worry, revalidation’s coming.”

Nevertheless the opinion leaders thought that professional self regulation would endure for the foreseeable future, though its importance might wane. Equally though the profession and its regulator had to deliver.

Where does revalidation sit now?

The historian AJP Taylor commented that the greatest decisions are nearly always the ones most difficult to explain simply. So it is with revalidation. For although the main stakeholders agreed in principle on the policy, they reached only partial consensus on the reasons for revalidation, its purpose, its place among other mechanisms, and its likely effects. Given this background and the recent guidance which overtly links revalidation with appraisal, what might be the implications for the future?

Clearly the chief protagonists have seen value in revalidation, but it has had its critics. Some have argued that the purpose is not clear, and needs to be so that doctors and patients know what to expect; others that...
the process is not fit for purpose. In particular there is confusion about whether revalidation is intended to detect poor performance, and if so, whether the process will suffice. Formative appraisal and summative revalidation are seen as uneasy bedfellows.

For most doctors the process will entail participation in an appraisal system, which must be aligned with the headings in Good Medical Practice and quality assured to the satisfaction of the General Medical Council. The Council states that such participation will be “a powerful indicator of a doctor’s current fitness to practise,” but makes no claim that the process will be sensitive (identify poor performance), specific (identify educational needs), valid (reflect actual clinical practice), or reliable (be consistently across cohorts of doctors). Where there is any doubt doctors will be invited to submit more information and may be subjected to the performance procedures.

Conclusion

It is difficult to escape the conclusion that the purpose of revalidation is as a form of professional regulatory enforcer to ensure the NHS implements appraisal in a designated manner. This may be enough to encourage doctors to develop and to seek help early in case of difficulty. Alternatively, doctors relying for their revalidation on five appraisals might be tempted to set easily achievable objectives in their personal development plans, rather than risking failure to meet a challenging target. The problems with this dual purpose have long been recognised.

In Pringle’s view, the most likely outcome is the worst of all worlds, where the developmental and formative nature of appraisal is lost, and where revalidation fails to identify poor performers. Whether patients and the government will be satisfied remains to be seen, particularly if (and predictably when) a recently revalidated doctor is found to have been a poor performer. Ultimately it may be more sensible to separate revalidation from appraisal. Doctors themselves could choose the independent route to revalidation, by submitting other evidence of minimal fitness to practice—appropriate tools are being developed. Or we could move wholesale to such a model (as in Canada), where a screening tool provides feedback on performance to all while identifying the minority of doctors at risk of being poor performers. These doctors are then investigated in more depth.

Patients and others might be more convinced by this.

Finally, the impact on doctors and patients should not be underestimated. In just over a decade, the NHS has moved from being an organisation based on high trust relationships to one where explicit written down standards, which are monitored, have become the norm for individuals and institutions. Revalidation is part of this increased bureaucratic control being applied to professional self regulation. It may increase apparent accountability, but may not foster a culture which increases patients’ trust and doctors’ professionalism.

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Corrections and clarifications

Decrease in mortality, AIDS, and hospital admissions in perinatally HIV-1 infected children in the United Kingdom and Ireland

Mis-reading of the alignment in table 3 of this paper (table 2 in the abridged version) by D M Gibbs and colleagues led us to print the hazard ratios for death and AIDS/death incorrectly for “How the child was identified” (BMJ 2003;327:1019-23). The hazard ratios for “prospectively from birth” and “after birth” should be inverted: the values for children identified after birth such as therefore 1, and for children identified prospectively from birth 0.90 (95% confidence interval 0.31 to 0.78) and 0.44 (0.30 to 0.64).

ABC of smoking cessation: Nicotine replacement therapy

The table showing the formulations and availability of nicotine replacement products in this article by Andrew Molyneux contained an error (21 February, pp 434-6). Nicorette nasal spray is licensed as a Pharmacy (P) medicine and is available over the counter at pharmacies; it is not a prescription-only product, as stated in the table.

Effects of low dose ramipril on cardiovascular and renal outcomes in patients with type 2 diabetes and raised excretion of urinary albumin: randomised, double blind, placebo controlled trial (the DIABHYCAR study)

A wrong reference number persisted to publication of the full version of this article by Michel Marre and colleagues (28 February, pp 495-9). In the fifth paragraph of the Discussion, in the sentence starting “Conversely, only 30% of the diabetic patients...” the reference for the HOPE and MICRO-HOPE studies should be reference 9 (not 11, as stated). The references in the abridged version are correct.