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Revalidation for relicensing

Reflections on the proposed British model

Background

In the United Kingdom, the General Medical Council aims to introduce revalidation for all medical doctors from 2012, in response to public and government pressure. Doctors will submit evidence to support their fitness to practise medicine every 5 years in relation to the four domains and 12 attributes of good medical practice.

Objective

This article reviews the argument for revalidation, the proposed process and some of the findings of a pilot carried out with general practitioners.

Discussion

A revalidation process is being piloted in several parts of the United Kingdom with a view to implementation in 2012. However, there is a lack of evidence internationally that revalidation or relicensure identifies doctors who are performing poorly. The medical profession in Australia needs to reflect on whether this model is one it wishes to consider.

Keywords

accreditation; clinical competence/standards; Great Britain; quality assurance

culminating in self regulation. However, following a series of high profile incidents and public inquiries, including the Bristol paediatric cardiac surgery cases,³ the GMC decided in 2002 that doctors should undergo regular review of their performance to reassure the public and the government that they remained fit to practise across their professional lifetime.

Initial plans for what would be called revalidation (synonymous with relicensure) involved professional self regulation including participation in formative annual quality assured peer appraisal, provision of evidence of compliance with local clinical governance requirements and demonstration of being free from any ongoing significant complaints or probity issues.⁴ However in 2003, in response to public and government pressure, the GMC moved from professional self regulation to regulation by decision making panels including medical and lay members.

In 2005, the introduction of this system of revalidation was shelved on the recommendation of Dame Janet Smith, chair of the Shipman Inquiry (general practitioner, Harold Shipman, was convicted of murdering 15 patients by intravenous opiates, though it is likely he killed about 300 patients over 24 years).⁵ Dame Janet's conclusion in the Shipman enquiry was that historically the GMC had acted more to support the interests of doctors than their patients. She further argued that the suggested revalidation format lacked objectivity and scientific standards and would not be capable of detecting poor performance in doctors.⁵ The inquiry's fifth report called for increased monitoring of GPs' practice, including prescribing, and enhanced control of death certification. Subsequently the then Labour government told the medical profession that it needed to develop a more robust procedure.

After this directive from the government a new

'The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practice'.¹

The United Kingdom General Medical Council (GMC) is responsible for accrediting the training and registration of doctors and monitoring their fitness to practise medicine in the United Kingdom. Until 1999, once doctors were GMC registered this was for life, unless they were removed for unprofessional behaviour, including criminal misconduct, following a complaint. This meant that the GMC was reactive rather than proactive, encouraging a culture of secrecy about doctors' personal conduct and their clinical performance. Sir Donald Irvine (GMC past president), suggested that this was a profession used to seeing patients' interests through its own eyes and on its own terms,² a process

revalidation process was suggested. Importantly, during the development of this process, while one of the aims was to improve standards by identifying poorly performing doctors, the other aim of preventing another Shipman scenario seemed to take precedence. Common feedback from UK GPs is that the proposed revalidation process alone is unlikely to detect such behaviour; Shipman would probably have been able to revalidate if he sorted out the correct paperwork.⁶ However, improvements in the monitoring of death certificates (which is a separate process) may have raised suspicions if they had been in place during the Shipman era.

A refined revalidation process is being piloted in several parts of the UK with a view to implementation in 2012 (the timing has been pushed back several times). While the overall premise is the same for all specialties, each royal college has developed its own procedures, subject to GMC ratification, which map onto the four domains and 12 attributes of good medical practice (*Table 1*).⁷ The Royal College of General Practitioners (RCGP) is overseeing revalidation for GPs. Building on the familiar formative annual peer appraisal process, GP revalidation involves an enhanced appraisal, which is largely summative. Doctors will submit evidence supporting their provision of patient centred clinical care and areas of extended practice in an ePortfolio every 5 years, supplemented with information from local sources, including clinical governance data. The RCGP lists the supporting information provisionally required in 13 areas grouped under four headings (*Table 2*).⁸ These will be finalised after feedback from pilots in general practice (including one outlined in this article).

All the royal colleges have adopted the suggested learning credit principle for continuing professional development. General practitioners will need a minimum 50 learning credits per year (250 in the 5 year revalidation cycle). The RCGP, with the intention of rewarding learning outcomes and impact rather than time spent, gives one credit per hour of education plus an additional credit if the doctor can show that patients, the doctor and/or the practice have benefited from that learning via audit or other evidence of reflection. However, the appraiser can also refer the doctor to the local primary care organisation's screening procedure. The

Table 1. The GMC four domains of good medical practice⁷

<p>Domain 1. Knowledge, skills and performance</p> <ul style="list-style-type: none"> • Maintain your professional performance • Apply knowledge and experience to practice • Keep clear, accurate and legible records
<p>Domain 2. Safety and quality</p> <ul style="list-style-type: none"> • Put into effect systems to protect patients and improve care • Respond to risks to safety • Protect patients and colleagues from any risk posed by your health
<p>Domain 3. Communication, partnership and teamwork</p> <ul style="list-style-type: none"> • Communicate effectively • Work constructively with colleagues and delegate effectively • Establish and maintain partnerships with patients
<p>Domain 4. Maintaining trust</p> <ul style="list-style-type: none"> • Show respect to patients • Treat patients and colleagues fairly and without discrimination • Act with honesty and integrity

Table 2. Supporting information provisionally required for revalidation⁸

Generic heading	Supporting information
General information	Personal details Scope of practice including extended practice Contextual details Participation in annual appraisal, personal development planning and review Statement of probity and health
Keeping up-to-date	Learning credits
Review of practice	Significant event audits including any serious incidents Clinical auditing
Feedback on practice	Colleague survey Patient survey Review of complaints Compliments

benefits are self assessed but need to be confirmed at appraisal through audit and/or clinical/organisational change. The hope is that appraisers will identify GPs whose performance is giving cause for concern, or has deteriorated over the previous year, and offer support. However, the appraiser can also refer the doctor to the local primary care organisation's clinical governance unit, which may result in a recommendation for remediation. At the end of the 5 year cycle, the decision whether a GP can be revalidated is made by the local responsible officer (a senior and experienced doctor). Importantly, the public's direct input is restricted to patient satisfaction questionnaires, although the RCGP did include lay representation on its working group in contrast to the GMC, which has been criticised for lack of consumer involvement.⁹

Piloting the process

In 2010, the authors were involved in piloting the new revalidation process in UK general practice. We targeted 118 GPs in three areas of the UK for participation in the pilot. However, only 69 were able to compile a portfolio based on 1 years data.¹⁰ Supplementary evidence participating GPs were required to submit was:^{8,10}

- patient satisfaction questionnaires – for individual GPs
- a feedback from colleague survey (previously known as multisource feedback. Colleagues include other GPs, nurses and practice administration staff)
- reflection on learning.

As part of the pilot, GPs were asked to comment on the process and complete a follow up survey.

While most supported the concept of revalidation, the format was not thought to be entirely satisfactory. General practitioners had major concerns about the amount of work required in assembling the supplementary evidence, taking people (doctors and administrators) away from patient care. In addition, the process was much more difficult for sessional and locum GPs who were not always invited to engage in practice activities such as audit and significant event analysis and who had little time to gain valid feedback from colleagues. Some of the GPs also raised concerns about whether the revalidation juggernaut would actually improve standards in the long run, and be cost effective.¹⁰

It is important to note that the process does not require any demonstration of clinical performance, for example via observed patient consultations.¹¹ In addition, there is no test of knowledge.

Evidence of outcomes

A common question from GPs in the pilot¹⁰ was whether there is evidence that revalidation enhances patient care: a valid question in this era of evidence based practice. But of course there will be no direct evidence until the process is initiated. While revalidation is still being piloted and developed, there is no indication of what type of evaluation will be built into the process to monitor its effects. Moreover, any effects, for better or worse, will not be known for some time.

There is also little convincing evidence from outside the UK. There is a mix of formal and informal systems in place in the European Union, some monitored by professional bodies, some by health insurance companies. The differences reflect the diversity of the member states and their health service funding, government roles and notions of professionalism.¹² Importantly, while continuing professional development can be effective in improving practice and patient outcomes, it does not identify doctors who are performing poorly.¹³ A literature review of the impact on regulatory interventions on quality of healthcare found that research evidence, predominantly from the United States of America, was mainly observational and descriptive, and any conclusions from this data that suggests links between regulation and outcomes is primarily associative rather than causal.¹⁴

The Australian context

In Australia, The Royal Australian College of General Practitioners (RACGP) triennium system of quality improvement and continuing professional development (<http://qicpd.racgp.org.au>), which links education points to ongoing registration has been in place for some time. However, despite initial concerns that the new national registration scheme via Australian Health Professionals Registration Agency would lead to a system of revalidation in Australia,¹⁵ there are as yet no plans for this to occur. The RACGP process includes the choice of submitting multisource feedback and audits for points, but while the activities themselves may be accredited via a college adjudication process, there is no external assessment of the quality of learning by individual GPs or change in performance following learning activities.

Currently, there is probably not the political will in Australia to demand revalidation: a process that would potentially alienate a large part of the medical profession at a time of healthcare reform. The response so far to patient safety issues, such as occurred in Bundaberg in Queensland,¹⁶ has been the setting up of the national registration scheme and the National Medical Board, with its mix of lay and medical members. Perhaps this is enough. Importantly, in our pilot an older GP said he was glad to be retiring before the process is in place, and we have noted the difficulty for locums, sessional GPs and doctors working outside conventional general practice to meet the proposed requirements. The fact that the UK process has been delayed several times, and is still undergoing refinements, highlights the complexity of revalidation and the need to get it right for the professionals and the public. Perhaps Australian colleges should wait to see what happens in the UK before committing further resources to assessing doctors and relicensure.

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