A REVALIDATION PRIMER

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We would like to thank the UKCEA for awarding a grant to enable us to conduct this study. Professor Jacky Hayden, Dean of Postgraduate Medical Studies, and Dr Barry Lewis, Director of Postgraduate General Practice Education, at the North Western Deanery both provided invaluable support throughout. We owe particular gratitude to all our busy colleagues who willingly gave up their time to speak to us and upon whose input the success of this study depended.
1. Introduction

The study was commissioned by the UKCEA to explore the context for revalidation and a consideration of the possibilities for the process. The Chief Medical Officer's (CMO) paper on the future of medical regulation, Trust, Assurance and Safety (2007), set out the need to introduce a process to revalidate the competence of practising UK doctors. The proposed process, as initially described by CMO, has two stages: (i) re-licensing, so that the doctor can retain basic registration with the General Medical Council (GMC) and (ii) re-certification of the doctor’s competence in a specialist area. Re-licensing is to be based on principles set out by the GMC in Good Medical Practice (2009), whilst re-certification will be managed by Royal Colleges on behalf of the GMC, with the mandate to demonstrate the competence of a doctor in their specialist area so that their Royal College can recommend to the GMC that the doctor should remain on the appropriate specialist register. This dual approach will form the basis of revalidation, and is expected to utilise an enhanced system of appraisal. As plans have developed it increasingly has been seen as a symbiotic process, thus we have used the term revalidation for both stages throughout the report.

The UK has in excess of 41,000 General Practitioners, therefore the prospect of revalidation presents considerable logistical problems. The need to revalidate doctors’ competence is an international issue and there is considerable experience of such activity in many other countries. It is vital that the outcomes of existing and developing programmes inform the UK system. The concept has been the subject of much discussion over the years, which is reflected in the literature. In addition, there have been related experiments in various regions of the UK with, for example, assessments of performance forming part of appraisals.

The introduction of revalidation as outlined by the CMO will have a significant impact on GP education and development. This raises questions about the most effective approach to demonstrating competence of GPs. As well as ensuring that GPs are fit to practice, it is also an opportunity to review the educational needs and provision for GPs. Whatever scheme is introduced has massive potential to influence the development of education needs of all GPs, and hence should be based on sound educational principles and a review of experience nationally and internationally in medicine and comparable professions. Proposals will need to fit with the RCGP’s 4 pillars of revalidation as well as being valued by educators:
The RCGP’s 4 pillars of Revalidation

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Revalidation will need to consider GPs across a range of performance, to both encourage high performance and enable the identification of GPs with performance problems. The introduction of revalidation is more likely to secure the positive engagement of the medical community if it can be shown to support their professional development and effective working practices.

The publication, in July 2010, of the NHS White Paper, *Equity and excellence: Liberating the NHS*, which sets out the UK Government's long-term vision for the future of the NHS, raises a number of important new questions about the introduction of revalidation. Without Primary Care Organisations (PCO) in their current form and carrying their existing responsibilities it is very difficult to see how revalidation will be managed in practice. A pressing concern is where Responsible Officers (RO) will ‘sit’ and the mechanisms available to the RO beyond reporting to the GMC. The role of postgraduate deaneries, which might hitherto have been expected to support the process in terms of remediation, careers advice and mentorship, for example, is open to question given that such provision doesn’t fit with the commissioning functions currently envisaged for these organisations. In addition the changes envisaged in the paper reinforce the need for doctors to be able to deliver care effectively, as well as demonstrating the leadership and skills to effect new ways of working. Revalidation delivered effectively would be able to help with the skills and development that will be needed. This will have a major bearing on the implementation of the revalidation process in general practice.

The three strands of the study are as follows:

- A survey of information on revalidation schemes used internationally.
- A survey of the UK literature to identify enablers for the implementation of revalidation.
- An analysis of the views of a group of primary care educators on revalidation in the UK.
2. **Summary of findings**

This section presents a brief summary of our findings, based on a survey of published material on international revalidation systems, the UK literature on revalidation and related topics, and qualitative evidence from our own empirical research. They are given more detailed consideration in Chapters 3, 4 & 5.

The survey of information on international systems has shown considerable variation with what happens elsewhere, with some countries more advanced compared to what we are doing in the UK and others less developed. It is important to consider that the evidence presented may not represent planned changes to revalidation, which may mirror the plans in the UK. New Zealand is probably the most organised, with an established system in place, which is reasonably well accepted. The voluntary system in the USA is now completed by at least 87% of doctors as a result of pressure from the public and the healthcare organisations. In the Netherlands revalidation is a condition of being on the medical register. Belgium has a system incentivised by higher pay for those who take part in revalidation. In France, despite a legal obligation, many physicians don’t participate in Continuing Professional Development (CPD), most likely because of a combination of lack of incentives for compliance combined with absence of monitoring.

Evidence from the UK literature in general supports the current plans for revalidation. It does raise contradictions in some areas, for example how one of the proposed tools, Multi-source feedback (MSF), should be developed to support revalidation. The interviews with GPs, meanwhile, highlighted a number of themes to consider for implementation of revalidation in the UK. These include:

- Appraisal will need to be more robust if it is to support revalidation.
- The role of the PCT, with appointment of a responsible officer, and strong clinical governance structures will be vital. Views were expressed that Postgraduate Deaneries will need to act as catalysts to bring key parties together.
- CPD structures must be in place to support revalidation. Helping GPs recognise the professional development they obtain through daily practice could help support this.
- Electronic platforms e.g. the RCGP Essential Knowledge initiative were commended. The need for electronic system to support revalidation was highlighted.
- Systems will be needed in order to support GPs having problems with revalidation, and also those in particular situations, for example at the end of their career, or engaged in limited clinical practice.
- Increased clarity on the resources to support revalidation, and the potential re-training costs for those GPs identified as underperforming is required.
- The delays in implementation of revalidation have brought additional challenges, with evidence of disengagement from the process by GPs as a result.
- Evidence on outcomes from revalidation elsewhere varies, and will be an area that would benefit from ongoing study as revalidation is introduced into the UK.
3. **Survey of information on international revalidation systems**

We conducted a desk-based survey of publicly available material, including official websites and existing research. Recent investigative analyses by two major public bodies were incorporated into the survey: a policy brief prepared by Merkur, Mossialos, Long and McKee for the World Health Organisation (2008), and an earlier analysis of international medical recertification models by SHM Ltd, an independent consultancy firm, commissioned by the GMC (2003). The latter report is unpublished although a summary of recommendations is publicly available on the GMC website. These highly detailed and wide-ranging studies proved to be particularly valuable sources for the purposes of this survey of information on existing revalidation systems. We are mindful that further developments are likely to have occurred in many countries since these investigations were conducted. Checks for updated information have been carried out wherever possible, and whilst the status quo has been verified in most instances, guarantees of accuracy cannot be made, particularly where data is not readily available in English.

The information we reviewed investigated how revalidation is addressed in different countries. There was, perhaps unsurprisingly, considerable variance in how countries deal with revalidation. Commonly identified contextual factors include the regulatory environment and the maturity of other clinical governance systems and procedures. Some broad principles have been distinguished in the literature. Certainly in terms of the goals of revalidation, most countries recognise the importance of continually improving physician performance and have introduced CME/CPD. There is no consensus internationally on the need for assessment and evaluation, or how best to implement revalidation systems. Self-regulation predominates in approaches to ensuring fitness to practise. Professionally led regulation, with varying forms of co-regulation, or partnership regulation with statutory bodies or commissioners appears to be increasingly common. This is generally perceived as enabling greater transparency and stronger accountability to external authorities.

With regard to responsibility for enforcing assessment methods, it is widely accepted that this should be transparent but non-punitive, to respect the rights of both patients and physicians, with efforts focused on professional development. In Belgium, physicians who actively participate in professional development activities are rewarded with the potential to earn a higher wage, thus a formalised system of encouragement prevails. Many physicians fail to engage with CME in France where, although the requirement is enshrined in law, compliance is neither regulated nor monitored. Whether and how a policy to enhance quality is enforced, therefore, does appear to contribute notably to its degree of effectiveness.
Europe

Definitions and mechanisms of revalidation appear to vary significantly across European member states. While some countries, e.g. Austria, Germany and Spain, utilise CME as a means to promote revalidation, other countries, e.g. Belgium, France and the Netherlands, also incorporate peer review. There is considerable divergence between countries in monitoring and enforcement. Portugal, Sweden, Greece, Denmark and Finland, for example, currently have no revalidation procedures. Germany and the Netherlands are currently the only countries in Europe to have formal revalidation systems in place. Amongst the member states, there is no uniform type of body or scheme that regulates doctors. Professional self-regulation predominates, in some cases independent of government and in others subject to a form of government oversight or engagement, such as in the Netherlands and Austria. In many European nations professional medical bodies are the regulators of revalidation, which may in turn be accountable to government ministries. Insurers take the lead in some countries in requiring doctors contracted with them to fulfil particular requirements. More often than not it is a combination of stakeholders that assumes responsibility for ensuring that standards are maintained.

Germany

In Germany, doctors receive their licence to practise from the Ministries of Health, although specialist training, accreditation and continuing education are regulated by the Regional Chambers of Physicians, which are professional bodies. The Regional and Federal Associations of Social Health Insurance Physicians monitor compliance with CME amongst those doctors contracted with them. The country’s revalidation scheme requires doctors to fulfil CME requirements every five years (250 credit points of approximately 45 minutes each). They are regulated through their regional chambers (professional associations). The federal level revalidation requirements were introduced in the 2004 Social Health Insurance (SHI) Modernisation Act. Doctors contracted with the SHI funds and working in ambulatory care are not subject to detailed regulations on the topics that must be covered by CME, unlike hospital-based specialists who have to show that 70% of their vocational training has been on topics concerning their specialty. In the event of non-compliance, the regional associations of SHI physicians can reduce reimbursement rates by up to 25%. If the CME certificate is not achieved within two years after the due date, accreditation may be withdrawn. Most regions have introduced a computer-based registration system for CME, and there are moves to combine participation in CME with quality assurance systems, thereby promoting a broader system of CPD.
**Netherlands**

In the Netherlands, professional regulation covers practitioners working in hospital and independent practice and is overseen by a coalition of government (Central Information Centre for Professional Practitioners in Healthcare) and professional bodies (Central College of Specialists). In the Dutch system, revalidation is a condition of being on the medical register. Doctors have to undertake CME and every five years undergo a visit by peers, comprising a team of three other doctors, including one recently visited and one about to be. The visit involves a comprehensive assessment of practice, with ongoing discussions on monitoring adherence to clinical guidelines and patient input. GPs must demonstrate that they have worked at least 40% of their time in general practice, present evidence of at least 200 hours of accredited training, and should have done at least 10 out-of-hours sessions per year.

Van der Heuvel (2008) has described how the majority of GPs are successful, and whilst there is no empirical data, anecdotal evidence suggests that those who fail to recertify tend to be older GPs who had stopped doing on calls and consequently did not fulfil the criteria. A lack of flexibility has been perceived as problematic, particularly the non-accreditation of activities like audits, significant event analyses and providing GP training. A degree of flexibility has subsequently been built into the process, and ‘alternative learning experiences’, such as publications in journals, are now countable for recertification. A one year programme has been made available for GPs who lose their registration. This replaces the necessity for ex-GPs to complete the whole 3 years of GP training again to be accredited, and if completed successfully results in recertification. The programme comprises 4 days a week of GP work under supervision and 1 day a week for education or study, with a salary equivalent to that of a 3rd year registrar and education costs are paid for.

**France**

In France, revalidation systems are set by three professional bodies, the national councils for CME for ambulatory care doctors, self-employed ambulatory care doctors and hospital doctors. Only the council for self-employed doctors working in the ambulatory care sector currently have defined CME requirements. In addition, medical audit is promoted by the High Authority on Health, an authority accountable to parliament. Regional councils for CME are responsible for ensuring that doctors fulfil the requirements, and if not, the Regional Council of the Order of Physicians is meant to take appropriate action.
As Merkur et al point out, the country now has a scheme with elements which resemble revalidation, with the particular intention of containing costs which are thought to be the result of variation in the provision of care. CME and medical audit, also known as the evaluation of professional practices (EPP), were introduced independently in 2004. Both CME and EPP are intended to be compulsory and should be validated every five years. Neither system is monitored, however, and numerous challenges have been identified by D’Autume and Postel-Vinay (2006), including: a dearth of information on the clinical practices of doctors; the cost and maintained financing of CME activities; conflicts of interest in the management of the system; and weaknesses in the conceptual foundation as well as the management of the system. The legal status of institutions responsible for the regulation of CME and EPP requirements are not the same, EPP has been difficult to implement and enforcement has been delayed. The introduction of CME on a compulsory basis in 1996 did not lead to an increase in doctors’ participation. It seems that there is uncertainty as to whether this behaviour will change unless participation is enforced.

Spain

A voluntary system of CME exists in Spain, which is conducted under the aegis of the medical colleges and the Spanish Commission of Continuing Education of Health professionals. The Spanish Accreditation Council for CME is currently seeking to integrate a multitude of CME activities. CME is reported as fragmented although there is growing interest in developing certification and recertification schemes in the regions, which are responsible for the provision of healthcare. National legislation has identified the need for both certification and recertification. The medical colleges have established voluntary CME systems. The Spanish Commission of Continuing Education of Health Professionals initiated a nationwide continuing education system in 1998, which is gradually being implemented across the regional commissions.

Austria

In Austria, doctors are primarily regulated by the Austrian Medical Chamber, a professional body that is accountable to the Federal Ministry of Health and Women. The Austrian Academy of Physicians advises the medical chamber on content and methods of CME. A CME programme, Diplom-Fortbildungs-Programme was introduced by the Austrian Medical Chamber for licensed medical doctors and dentists, and participation has been legally mandatory since 2001. CME must be independent, internationally competitive, meet high scientific standards and be free from economic interests. Through this programme, doctors are encouraged to acquire 150 CME credits every three years. Within this total, a minimum of 120 points have to be acquired through specialty-related, certified CME programmes, with a minimum of 40 points in the doctor’s particular specialty. CME points can also be accumulated for undergoing peer review.
Belgium

In Belgium, physicians receive their licence to practice from the Minister of Public Health; however, receipt of this licence only grants doctors the right to use the title of general practitioner or specialist. They must also apply to the National Institute for Insurance Against Disease and Invalidity if their patients are to be reimbursed for treatment, with the option to seek further accreditation that will allow them to earn higher fees. GPs and specialists are legally obliged to comply with certain standards and have financial incentives to pursue further accreditation. GPs must fulfill specific criteria, such as maintaining patient files, participating in the local on-call service, ensuring continuity of care, undertaking at least 500 consultations each year, and regularly developing and maintaining their knowledge, skills and medical performance. Accreditation can serve as proof of this last criterion; alternatively, the doctor must provide evidence of 20 hours of CME per year, recognized by the Licensing Committee of General Practitioners. While accreditation is not an essential requirement, it does enable doctors to charge higher reimbursable fees to patients, boosting their annual salary. Accreditation lasts for a period of three years. To renew accreditation, GPs must obtain 200 CME credits and participate in at least two peer reviews per year.

North America

USA

In the USA, professional self-regulation is standard and the American Board of Physician Specialists (ABPS) requires assessment and CME of their members. While not mandatory to practice, board certification is increasingly required by commissioners, hospitals and patients. In 2002, more than 85% of licensed physicians held a certificate.

The American Board of Family Practice was the first American Board of Medical Specialties Member Boards to require recertification. The Maintenance of Certification Program for Family Physicians (MC-FP) has four components:

- Evidence of Professional Standing: Medical Licensure & Peer review

- Lifelong learning and self assessment: i) Self-assessment of a physician’s knowledge of a disease domain; ii) Self-assessment of a physician’s ability to apply knowledge in a clinical setting using patient simulation technology; iii) Lifelong learning – A total of 300 hours of approved CME (time spent completing I & ii will be credited against the 300 hour CME requirement) over 7 years.

• Evaluation/Enhancement of Practice Performance: Based on the ABFP Computerized Office Record Review. Performance feedback will be given to the physician. Based on the feedback the physician will be directed to complete an individually tailored quality improvement plan, which they will subsequently be required to audit.

Currently, renewal of certificates is required every 7 years for family physicians. This was originally a voluntary system but increasing pressure has resulted in 87% of physicians in the US being certified in 2006. This is thought to be due to growing consumer movement in health care; managed care plans began to prefer board-certified physicians for their networks; all 24 boards under the American Board of Medical Specialties agreed on comparable standards for board certification, including recertification requirements and a new component requiring evaluation of performance in practice known as maintenance of certification.

Sutherland and Leatherman (2006) conducted a review of the then available evidence from the USA, where certification is a well established process, on the impact that it has on quality of care, and the implications for UK revalidation. A systematic review of studies published between 1966 and 1999, by Sharp et al (2002), found that over half (16/29) showed positive and statistically significant associations between certification and superior outcomes. Since 1999, a number of studies (Chen et al, 2006; Silber et al, 2002; Prystowsky et al, 2002; Norcini et al, 2002) have concluded that board certification is associated with provision of higher quality care across a range of outcomes. As well as correlations between certification and clinical processes and outcomes, recent studies have found that a lack of certification is associated with increased risk of disciplinary action. Thus, the association between certified status and higher quality of care is consistent across a range of clinical specialties, geographical locations, and permutations of applying and interpreting regulation.

Canada

Currently no external verification of Canadian physicians' ongoing competence is required. The processes for ensuring that physicians maintain their competence depend on the independent and heterogeneous regulatory decisions of each provincial College of Physicians and Surgeons. At present, 3 provinces (Saskatchewan, Ontario and Quebec) have mandated that physicians participate in an educational program to maintain their licence. Normally, this requirement is met by participation in the Royal College of Physicians and Surgeons' Maintenance of Certification program or the College of Family Physicians' Maintenance of Proficiency program. Although these programs address the conceptual elements of maintaining competence, they are based on self-reporting and therefore lack rigour in holding physicians accountable. An alternative approach used in Alberta and Nova Scotia requires physicians to participate in a review process in which they are offered feedback from patients and peers about their performance. The program is designed to foster quality improvement, but it lacks an external standard for "passing."
Moreover, the process is only feasible for primary care and larger specialties because it is hard to do peer review in specialties with few members.

There are calls for a more transparent and accountable process to uphold professional standards. A position paper by the Federation of Medical Regulatory Authorities of Canada (2007) stated that all licensed physicians in Canada must participate in a recognized revalidation process in which they demonstrate their commitment to continued competent performance in a framework that is fair, relevant, inclusive, transferable and formative. It stated that the programs administered by the Royal College of Physicians and Surgeons and the College of Family Physicians provided a Canadian standards-based framework for professional development but that the programs lack evidence of whether physicians actually put their knowledge and skills into practice. Although the Federation of Medical Regulatory Authorities of Canada does not have the authority to implement changes, the broad support for this position paper from national medical organizations has put pressure on the provincial colleges to consider policy changes. The Canadian Physician Achievement Review, largely developed in general practice, consists of a number of questionnaires, with a varying focus on clinical and non-clinical skills for patients, medical colleagues and non-medical colleagues, has become a mandatory part of a revalidation programme.

**Australasia**

**Australia**

The Royal Australian College of General Practitioners operates a QA & CPD program to promote GP participation in effective and efficient quality assurance and CPD; to demonstrate the accountability of GPs to the community; and to enhance the professional responsibility of individual GPs and Australian General Practice by ensuring that the program meets acknowledged world standards for quality improvement. The program operates on a three year cycle and is mandatory if an individual is to maintain status as a recognised General Practitioner with the Health Insurance Commission (HIC). The emphasis of the program is on active learning by each participant, based on a personal ‘learning cycle’ with a focus on educational activities with a demonstrated benefit of generating change and thus improving clinical practice. General Practitioners must gain 130 points over the triennium with a minimum of 30 points obtained from Group 1 activities. With the requirements being the same for both full- and part-time GPs, the balance of points may be gained by participation in any Group 1 or Group 2 activities:

Group 1 options (minimum requirement: 30 points): clinical audit; 5 points per hour of educational activities/Accredited Providers activities; small group learning; supervised clinical attachment.
Group 2 options (no minimum requirement): 2 points per hour education activities; university courses; conferences; individual applications; teaching students/registrars; examiner; presentation to peers; other CPD activities.

New Zealand

Since 1995 the Medical Council of New Zealand (MCNZ) has required all medical practitioners to obtain an Annual Practicing Certificate in order to remain on the register. Doctors on vocational registration must be regularly recertified by their appropriate specialist college or vocational branch. MCNZ approves recertification programs against set criteria for up to five years. Doctors must report their recertification activities to the Medical Council every year as part of their annual practicing certificate application. Each year some doctors on vocational registration will be audited to ensure they meet the requirements. To enable vocationally registered doctors to satisfy the recertification provisions of the relevant Act, MCNZ has recognised the maintenance of professional standards programmes administered by the branch advisory bodies. These programmes may also be known as quality assurance, recertification, continuing medical education, re-accreditation or continuing professional development. MCNZ requires that recertification must include: (a) Audit, peer review or team-based assessment, e.g. external audit of procedures, quality assurance activity, peer review of cases, review of cases, practice visits, analysis of patient outcomes and an understanding and respect of cultural competence; and (b) Educational conferences, courses and workshops.

Recertification programmes may include self-directed learning programmes and learning diaries; assessments which have been designed to identify learning needs, e.g. of procedural skills, diagnostic skills, knowledge; journal reading; examining candidates for college examinations; supervision, mentoring others; teaching; publications in medical journals and texts; research and committee meetings which have an educational content, such as guideline development. Members are required to spend at least 50 hours per year on recertification activities.

To assist GPs to maintain their Vocational Registration by meeting part of the recertification requirements of the MCNZ, since 1991 The Royal New Zealand College of General Practitioners (RNZCGP) has operated a mandatory Maintenance of Professional Standards (MOPS) program on a three year cycle. A minimum of 150 credits are required over the full three years. Credits are obtained from three different categories of activity, participants decide on the combination and timing of activities that make up the minimum totals over the triennium. The three categories are:
(i) Practice Review Activities (minimum 30 credits per three years): The purpose of a Practice Review Activity is to allow determination of personal performance, or the performance of the practice, in a particular area as objectively as possible, and with reference to valid performance indicators. This includes clinical issues, physical and environmental issues, and systems/processes for the delivery of services. This process should include a ‘Quality Cycle’ where review findings feed back into practice.

(ii) Continuing Medical Education (minimum 75 credits per three years): CME involves activities designed to enhance knowledge, skills, attitudes and judgement so as to improve the health care provided for patients. Endorsed CME consists of programs and providers endorsed by the college and is available through registered CME Providers and registered Peer Review Groups. It also includes endorsed courses, and degrees, diplomas and certificates that have been approved by College committee and endorsed clinical attachments. CME from other sources is called non-endorsed CME, which is permitted but earns fewer credits per hour than endorsed CME.

(iii) Additional Professional Development Activities (no minimum requirement): This category includes activities, other than Practice Review and CME, which benefit patients and the wider community and promote professional growth and personal well being.

A study by Tracey et al (1999) was designed to measure the acceptability of the RNZCGPs’ Recertification programme to the GPs in the programme. Areas explored included the nature of the recertification programme and its effect on the profession and the individual GP. A semantic differential attitude scale was developed and validated. The scale was administered to 300 GPs before the Recertification programme began and repeated after 18 months and 3 years.

Baseline data showed reasonable acceptance of the concept of recertification, including a belief in the positive effect of the programme on the whole profession, and in raising standards of general practice. Respondents were less convinced that it would raise the standard of their own care, suggesting that most perceived the standard of medicine that they practiced to be higher than the average for the profession as a whole. There was an appreciation that the programme could lead to an increase in personal attendance at continuing education courses. There was an age effect on responses in that those aged 40 or under had more positive attitudes to recertification. By 18 months there was a significant deterioration in the way the programme was perceived. This change was sustained at 3 years, suggesting that it reflects more than just initial difficulties adjusting to programme requirements.
4. **Practical enablers for the effective implementation of a revalidation system: a survey of the UK literature**

We identified UK literature through a non-systematic review, using PubMed, Ovid, Ingenta, CINAHL and targeting specific known journals in medicine and primary care, relating to revalidation in medicine, with a particular focus on practical enablers for the implementation of revalidation. The literature was surveyed and grouped thematically.

**Revalidation (general)**

Bruce *et al* (2004) conducted a randomised, comparative study of two revalidation models in Scotland between September 2000 and January 2003: a minimum criterion based model with revalidation as the primary purpose; and an educational outcome model which combined revalidation with continuing professional development. The study involved 61 GPs, a patient representative, representatives from secondary care, the RCGP, the Local Health Care Council and a non principal GP. The criterion model went on to form the basis of the Scottish Revalidation Toolkit which is published by RCGP (Scotland) with the endorsement of the GMC and the GPC in Scotland.

A study by Shepherd and Cameron (2010) sets out to identify how well prepared prospective responsible officers are for the role which was introduced by The Health and Social Care Act 2008 and which entails responsibility for ensuring that doctors who are revalidated meet the required standards. Semi-structured interviews were conducted with 12 medical directors from Scottish health boards who agreed to participate. The authors found that prospective responsible officers remain uncertain about their role in medical revalidation. Specific concerns were raised: (1) What will responsible officers be responsible for? (2) How can appraisal be quality assured? (3) How will the information requirements for revalidation be met? and (4) How can organizations meet the requirement for revalidation? The authors conclude that these are important issues which have not previously been described and which may impact on the effectiveness of prospective responsible officers.

The views expressed in a paper by Lewis *et al* (2007) represent a consensus between the Directors of Postgraduate GP Education on behalf of the School of Postgraduate Medical and Dental Education in Wales, Postgraduate Deaneries in England, the Northern Ireland Medical and Dental Training Authority (NIMDTA) and NHS Education Scotland (NES). The authors set out their position statement as to the role of postgraduate deaneries in contributing to the revalidation of GPs in the wake of the publication of *Trust, Assurance and Safety – The Regulation of the Health Professionals in the 21st Century* (2007). The emphasis is on those aspects of revalidation, such as the quality assurance and operation of medical appraisal, with which many GP directors/postgraduate deaneries are already
closely associated. Recognition of how appraisal communicates with what is described as a clinical governance spectrum is clarified and suggestions for a collaborative way forward with others in primary care management are made. It is argued that postgraduate deaneries are well placed in terms of their expertise and the scale of their organisations to contribute substantially to this agenda. The authors recognise that some aspects of clinical governance might not yet be at the same level of maturity in each of the four countries. The described model is proposed as the best option to progress all aspects of clinical governance in order to ensure a meaningful methodology for relicensing. The paper proposes that postgraduate deaneries, in collaboration with the RCGP and healthcare organisations, should establish and maintain a uniform approach to the necessary quality standards of delivery of GP appraisal and how this links with the clinical governance spectrum.

A paper by Shaw et al (2007) presents a summary and introduction to the concept of revalidation in the UK, its history and its impact on clinical governance and regulation. It provides a review and analysis of the proposed changes to clinical governance at the local, SHA level and the strengthened connection between consultant appraisal and revalidation, contained in both the Department of Health White Paper Trust, Assurance and Safety and the report Good Doctors, Safer Patients by the CMO for England and Wales.

The paper is a policy review related to revalidation and appraisal, and includes primary sources from the Department of Health, the GMC, the fifth report of the Shipman Inquiry and published journal articles. It is stated that local clinical governance will be a significant part of the route to re-licensing for the vast majority of doctors working in the NHS and many of the larger private sector hospitals. It is generally accepted that the information collected by doctors for their annual appraisal will also form the basis of evidence for revalidation. The authors suggest that, if appraisal is to be effective, robust and consistent, it is important that the clinical governance framework within which it operates is appropriately designed for its increased role within the regulatory system.
Continuous Professional Development (CPD)

The Academy of Medical Royal Colleges has stated that effective CPD schemes are flexible and largely based on self-evaluation, allowing doctors to develop what they do in the context of their individual professional practice while providing evidence for external scrutiny. It has produced a core model for CPD schemes which is intended to be the link between revalidation and the CPD schemes which are in existence or in development across Colleges and Faculties.

Lewis et al (2009) present a series of papers which document the Welsh Deanery’s experiences of delivering systems of appraisal and CPD for GPs over the past eight years, and their potential links to supporting revalidation are explored in some detail. The supplement includes the development and quality management of appraisal, CPD strategies for sessional and new GPs, and the IT requirements of revalidation, amongst other work. Much of this work has fed into the RCGP’s criteria standards and evidence for revalidation.

Howard et al (2009) consider how the introduction of revalidation in 2010 will require GPs to demonstrate they are fit to practise according to standards set by the RCGP, including the requirement to achieve 50 CPD credits per year. This paper describes a retrospective analysis of the learning logs kept by 71 practising GPs undertaking the interim Membership by Assessment of Performance (iMAP) programme, considering quantity of recorded learning, evidence of reflection on outcome and spread of content across the domains of the General Medical Council’s Good Medical Practice (GMP).

The authors describe how, on average, a GP iMAP candidate undertook 87 hours of CPD over the year (range 21.5 hours to 293.5 hours); 16 (22.5%) undertook less than 50 hours while 22 recorded more than 100 hours. The GPs averaged five different types of CPD and 31 recorded outcomes across the year. Most GPs recorded outcomes in each domain of GMP. Those who logged more activities were also those more likely to record a wider spread of learning across the RCGP’s curriculum. It is concluded that the results suggest that the RCGP’s proposed managed CPD scheme is feasible based on the current CPD activity of this self-selected group.

Agius and Baron (2008) conducted a UKCEA-funded study to identify the current state and value of deanery-managed CPD across the four countries of the UK. The aims of the study were to explore deanery educators’ perceptions of CPD and to propose a generic model for CPD management. The authors present evidence of considerable variance in deanery-managed CPD across the UK. Centralised systems of CPD management coordinated with appraisal were more apparent in the Celtic countries. Concerns about funding for the structures which supported CPD, and particularly the continuing role of
GP tutors, were widely held in the English deaneries. It was evident that many GP tutors had been involved in managing CPD, developing an effective appraisal system and providing education based on PCO priorities. There was evidence of significant diversity and variety amongst English deaneries which may challenge the future development of an effective national revalidation scheme. The authors found support across their study sample for greater cohesion between deaneries, the RCGP and PCOs in the management of CPD.

A study by Kelly (2007) explores perceptions of Scottish appraisers and CPD advisers on GP appraisal, CPD and revalidation. One hundred and twenty appraisers and CPD advisers responded to a survey. The author describes how the majority felt that CPD should address individual and team needs with the aim of improving individual and team practice and thereby having a positive impact on patient care. Over half felt revalidation should involve a pass/fail assessment. The study showed that in Scotland, the gap between what CPD should be aiming for and what respondents consider it is currently achieving is greatest for team learning, improved practice and patient outcomes. It is suggested that this is perhaps not unexpected as collective learning has only been a more recent focus. One example is protected learning time (PLT) initiatives where practices have had time allocated for learning. The author suggests that one challenge for those involved in CPD across all organisations (educational, health service and local authority) will be to work together to successfully integrate individual processes (appraisal, revalidation and CPD) with team learning and development to increase individual and interprofessional collective learning capability and contribute to improving patient care. Another challenge will be how to enhance the educational quality of protected learning events so that interprofessional collective learning can be supported. The paper concludes that evidence to date suggests that this has not yet been achieved.

In a paper about the role of CPD in developing professionalism, Tulinius and Hølge-Hazelton (2010) describe how the profession of medicine has long been characterised by virtues such as authorisation, specialisation, autonomy, self-regulation and adherence to an ethical code of practice, and its complexity has granted it the privilege of self-regulation. They argue that studies have shown CPD for GPs to be most effective when it is set up within a multi-method design. Their paper reports a research-based evaluation of a 2-year educational CPD project for 21 GPs, delivered through group supervision, teaching days, an e-portfolio, literature, newsletters and a desk checklist. The authors report that the GPs demonstrated an overall preference for supervision as an authentic method for self-directed professional development because it facilitated the creation of a common platform for relevant and useful knowledge in the context of general practice. Other methods were perceived as less valuable for GPs’ CPD. The authors argue that the results suggest that GPs need to establish a common platform of shared experiences.
before engaging in multi-professional CPD. Participation in the supervision allowed the three groups of GPs to develop their professional skills, but left them with a desire for more training in establishing cooperative practices.

Sriharan et al (2009) present an overview of CME/CPD credit systems around the world. They suggest that, internationally, there is a move to incorporate continuing medical education (CME) as an integral part of the medical education continuum, that the CME system has many variations across the globe and, to date, there have been few systematic approaches to document the CME systems internationally. This paper is an attempt to document some regional variations and trends related to CME credit systems, given that little has been written about the different CME credit systems in the scientific literature. Data were collected through field notes and grey literature, including conference proceedings. The paper is intended to create a discussion among the CME stakeholders and policy-makers to explore the variations of the credit systems and to develop international comparison studies to understand the effectiveness of different systems.

In a paper on how GPs learn, MacLeod (2009) argues that, as the requirements for the revalidation of GPs unfold, there is an increasing emphasis on demonstrating effective CME based on identified learning needs. This qualitative study was designed to promote understanding of how GPs currently approach their learning. The behaviour of one group of GPs was studied to explore how they assessed and met individual learning needs. The author reports that the GPs studied showed a pragmatic approach, valuing learning that gave them practical advice and instant access to information for patient-specific problems. The main driver for the GPs' learning was discomfort during their daily work if a possible lack of knowledge or skills was perceived. However, some learning benchmarked current good practice or ensured continued expertise. Learning purely for interest was also described. The GPs in this study all demonstrated a commitment to personal learning, although they were not yet thinking about demonstrating the effectiveness of this for revalidation. The GPs prioritised their learning needs and were beginning to use some objective assessment methods to do this and the GP appraisal process was found to have a mainly positive effect on learning.

de Villiers, Bresick and Mash (2003) explore the value of small group learning in an evaluation of a CPD programme for primary care medical practitioners. A competence model of CPD using facilitated small groups covering a range of clinical topics is an alternative model to lecture-based CPD. The aim of this study was to evaluate a new small group CPD programme and to determine whether the anticipated improvements in the quality of learning were realised. A nominal group technique (NGT) was used to compile two questionnaires for participants and facilitators, respectively, seeking quantitative and qualitative information. For group participants personal time constraints was the main reason given for not attending. 91% of the respondents indicated that the
small group programme improved their knowledge, 73% indicated improvement in their patient care and 61% that their clinical skills had improved. Learning practical skills and the ability to identify and focus on specific learning needs of participants were strengths of the small groups. Participants valued the ability to deal with one theme in-depth over a number of weeks rather than many topics superficially in didactic lectures. The authors conclude that the introduction of the small group CPD enabled an important shift from an update to a competence model of CPD, which has been shown to be more likely to lead to useful change in clinical practice. This approach to CPD should be encouraged.

Green, Reddy and Holmboe (2009) explore teaching and evaluating Point of Care Learning with an Internet-Based Clinical-Question Portfolio The authors describe how diplomates in the American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) program satisfy the self-evaluation of medical knowledge requirement by completing open-book multiple-choice exams. It is suggested that this method remains unlikely to effect practice change and often covers content areas not relevant to diplomates’ practices. The authors developed and evaluated an Internet-based point of care (POC) learning portfolio to serve as an alternative. The paper reports that participants found the instructions clear and navigated the module without difficulty. The majority preferred the POC portfolio to multiple-choice examinations, citing greater relevance to their practice, guidance in expanding their palette of information resources, opportunity to reflect on their learning needs, and “credit” for self-directed learning related to their patients. After completing the module, 52% of participants committed to at least 1 change in their POC learning strategies. The authors conclude that internists found the portfolio valuable, preferred it to multiple-choice examinations, often changed their practice after pursuing clinical questions, and reflected on their learning strategies.

Lam-Antoniades, Ratnapalan and Tait (2009) present an update on evidence from randomized controlled trials (RCTs) on electronic continuing education in the health professions. They propose that demonstrating the effectiveness of the rapidly expanding field of electronic continuing education (e-CE) has important implications for CE in the health professions. This study provides an update on evidence from RCTs assessing the effectiveness of e-CE in the health professions. A literature search of RCTs was performed in MEDLINE, EMBASE, and CINAHL from 2004 to 2007. Papers were reviewed separately by two of the authors and results were categorized and reviewed according to study comparisons. The authors indicate that overall, these studies suggest that multi-component e-CE interventions can be effective in changing health professionals’ practice patterns, and improve their knowledge. E-CE interventions based purely on flat text appear to be of limited effectiveness in changing either knowledge or practice. They conclude that these results support the use of multicomponent e-CE as a method of CE delivery.
Appraisal

In the context of the National Clinical Governance Support Team (NCGST) developing an advisory framework that identifies quality parameters for NHS medical appraisal, Lewis and Evans (2006) describe a large-scale GP appraisal system and analyse the quality of that system through internal and external mechanisms. The quality parameters tested map to the NCGST advisory framework and to internally developed quality criteria and attempt to demonstrate how these can be achieved in practice.

Jelley et al (2007), in a study conducted within the Northern Deanery, reviewed GP appraisal delivery by primary care trusts in England applying the NCGST QA framework. The background to the work was that GP appraisal had been implemented in a variety of different ways in the UK and quality assurance of these models was now underway — an essential process if appraisal was going to contribute in any robust way towards revalidation. The authors call for research into PCTs’ perceptions of how successfully GP appraisal is being delivered compare with views of GP appraisers and appraisees, and suggest that more formal outcomes of the appraisal process need to be defined and measured.

Law et al (2009) describe developments in the GP peer appraisal system in Scotland. The move from information-based courses towards skills-based courses enhances appraiser development and allows the effective evaluation of appraiser competencies. With appraisal becoming a key element in the revalidation process the quality assurance of appraisal and appraisers becomes increasingly important. Initially conceived and developed as a formative process, the changing political climate and the introduction of revalidation have brought a number of challenges not initially planned for. The authors go on to describe how, although appraisal remains formative, the role of the appraiser in evaluating the essential evidence for recertification is evolving and more objective judgements and outcomes are likely to be required in the future. Although appraisal has been recognised as being key to the successful delivery of the new regulatory mechanisms the final form that appraisal will take remains unclear. It is argued that quality appraisal has always been high on the Scottish agenda and current training aims to help appraisers provide an even better experience for their appraisees. Appraiser training continues to develop and has moved away from an initial course heavily information based towards a more interactive skills-based exercise. Additional ongoing training has been designed to facilitate the development of appraiser competencies and ensure appraisers can provide a challenging appraisal where the appraisee is stimulated to analyse and reflect meaningfully upon their practice in a supportive environment.
Conlon et al (2009), from the NHS Revalidation Support Team discuss the realistic role of appraisal in revalidation. They describe how, to meet the needs of revalidation, feedback from patients and colleagues, confirmation of satisfactory completion of College requirements for CPD, and confirmation that the portfolio contains the required evidence, are important in terms of revalidation and relevant to appraisal. The authors argue that the expectation that all these components can be satisfactorily assessed within the appraisal interview is to risk overloading that interview in such a way that, not only will each task suffer (thus undermining revalidation), but so also will appraisal in terms of its prime purpose of motivating and guiding doctors. It is therefore important to debate and test how they can be done in the most sensible way. They propose the following should occur outside the appraisal: feedback about the outcome of MSF from patients and colleagues; and annual confirmation from their college that a doctor has met their CPD requirements. Job planning is fundamentally an organisational process aimed primarily at service delivery and should occur outside the appraisal. For these three processes, the information should then be fed into appraisal to confirm they have occurred and to inform the appraisal discussion. The NHS Revalidation Support Team also believes that with clear guidance appraisers are in a good position to confirm that the doctor has accrued the required evidence each year.

Tavabie, Koczwara and Patterson (2010) describe a new approach to developing strengthened medical appraiser skills prior to the introduction of medical revalidation. The authors extended previous skills-based models and competency checklists to produce a behavioural model of effective appraiser performance. Development centre (DC) methods were used to produce a one-day workshop to encourage appraisers to reflect on their current level of ability and to identify and address additional required skills through observation, practice and feedback. In describing the DC, the authors discuss the impact of using the concept of emotional intelligence (EI) to develop appraiser skills and improve self-awareness. This aimed to support appraisers to effectively influence appraisees' continual professional development (CPD) and review appraisee practice through audit, significant events and patient and colleague feedback, with the ultimate aim of improving patient care. The paper also provides some initial evaluation data for the DC approach.

Price (2010) describes a model (FORMATIVE) for enhanced appraisal that is intended to be helpful for doctors in the revalidation process. This paper suggests methods by which the appraisal process in general can be utilised as the main driver in CPD for GPs, and furthermore, how the appraiser can be valued as supportive even though judgements will need to be made for the purposes of revalidation. He argues that, if enhanced appraisal becomes simply a forum for judgement, then the value of a face-to-face discussion with a peer is lost. In enhanced appraisal, the appraiser will more legitimately be able to offer
suggestions. A static once-a-year document does not meet the requirements of most learners. The ‘living’ PDP suggested by the author may address this problem. The requirements of revalidation will increase the importance of appraisal to every doctor. There is an opportunity to also increase its benefit to individuals, teams and patients.

Finlay and McLaren (2009) have investigated the experiences of GPs of the current appraisal process. Their specific objectives were to consider the impact the appraisal process had exerted on their learning, practice and individual CPD. The research employed a cross-sectional design using a postal questionnaire sent to all doctors who work as GPs in West Kent. The key findings obtained were that 47.5% \((n = 131)\) of doctors stated that taking part in the appraisal process had enhanced their learning, 40.2% \((n = 111)\) felt that the appraisal process had improved their practice and 55.8% \((n = 154)\) stated that the appraisal process had encouraged their CPD. Qualitative findings derived from thematic analysis of open questions revealed that the need for participants to view the role of the appraiser as respected peer to be vital and there was a need for independence in the appraiser's appointment. The time-consuming nature of the appraisal process was emphasised, with little protected time for preparation of documentation and engagement in CPD. Concerns were expressed about links between appraisal and revalidation. The authors conclude that many doctors considered that the appraisal process had enhanced their learning, improved their practice and encouraged their CPD. A vital, independent role for the appraiser was emphasised as was a need to review the time-consuming nature of the current appraisal process, together with identifying protected time to complete this and CPD engagement. As the role of appraisal within the revalidation process changes it is recognised that ensuring the quality, consistency and nature of appraisal will be essential to maintain the confidence of patients and doctors.

Roberts et al (2006) seek to determine whether assessors could make reliable and valid judgements about the quality of completed reflective personal development plans for the purpose of accrediting UK GPs for a postgraduate education allowance using a marking matrix. In addition they aim to plan a feasible model of PDP assessment in the context of forthcoming GP appraisal /revalidation that would overcome the main sources of error identified from this study. They investigated the construct validity of the matrix through its internal consistency and detection of differences in the quality of PDPs. The results show that, for a single PDP and one assessor, 37.6% of the variance in scores was due to true differences in the quality of the PDP. Between 5 and 7 PDP assessors are needed to achieve summative reliability of greater than 0.8. While increasing the number of judges is important, reliability could also be improved by addressing assessor subjectivity. Construct validity was demonstrated, as the matrix distinguished between good, satisfactory and poor PDPs, and it had good internal consistency. The authors conclude that PDP assessment has reasonable summative characteristics for the purpose of
assessing GPs’ reflective continuing professional development and that, if doctors could include their PDPs within their revalidation folders as evidence of reflection on pursuing better clinical performance, then the matrix described is a reliable, valid and feasible method of external assessment.

Colthart et al (2008) investigate the outcomes of GP appraisal in Scotland in terms of whether it has prompted change in medical practice, education and learning, career development, attitudes to health and probity, how GPs organise their work, and their perception of the overall value of the process. Collecting data using a cross-sectional postal questionnaire of GP performers in Scotland who had undertaken appraisal, their questionnaire is based on the seven principles outlined in Good Medical Practice, a literature review, and previous local research. The survey was conducted on a strictly anonymous basis with a random, representative sample of GPs. Fifty-three per cent (671/1278) responded. Forty-seven per cent (308/661) thought that appraisal had altered their educational activity, 33% (217/660) reported undertaking further education or training as a result of appraisal, and 13% (89/660) felt that appraisal had influenced their career development. Opinion was evenly split on the overall value of appraisal. The authors conclude that appraisal can have a significant impact on all aspects of a GP's professional life, and those who value the process report continuing benefit in how they manage their education and professional development. The results show, however, that many perceive limited or no benefit, leading to the proposal that renewed emphasis on appraisal requires examination of these findings and discussion of how appraisal can become more relevant.

Staples et al (2010) describe a one-day further intensive skills (FIS) course developed to provide additional training for existing general practitioner (GP) appraisers in Scotland. The course focuses on skills in developing the appraisee's personal development portfolio (PDP) and skills in responding to significant issues (with emotional content) presented by appraisees. Key findings of the course evaluation were that almost all participants found this training beneficial and judged it to have led to positive changes in their practice, as well as reassuring them that their skills were up to scratch. Some appraisers felt that it had encouraged a slightly more challenging approach. The acceptability of the use of video recording during the training, as a means of allowing participants to gain further benefit from the work undertaken after the course was finished, was tested. This technique received a mixed response, with opinion divided as to whether it added value. Opinion amongst the participants was also mixed regarding whether this training should contribute towards their reaccreditation as appraisers. However, a number of participants felt this could be a valid element in an appraiser reaccreditation process.
Multi-source feedback

In a report commissioned by the RCGP, Lockyer and Fidler (2009) provide a comparison of multisource feedback instruments designed for GPs in UK. The assessment of 6 measurement instruments, provided by the RCGP was undertaken to guide the selection of instruments that reflect both the competencies required for Good Medical Practice (GMP) and robust psychometric quality. The instruments were reviewed against the list of expectations described by the GMP structure and for evidence of validity and reliability. The six instruments examined were: (i) Colleague Feedback Evaluation Tool (CFET), (ii) GP-SPRAT, (iii) What is a good GP?, (iv) Edgecumbe 3600, (v) Academy of Medical Royal Colleges MSF (360° Clinical), (vi) General Medical Council (GMC) Colleague Questionnaire. The authors report that the instruments that reflected important GMP contents (good clinical care; maintaining good practice; teaching and training, appraising and assessing, relationships with patients, working with colleagues, probity and health) were GP-SPRAT, 360 degree Clinical and GMC Colleague Questionnaire. The most psychometrically robust instruments were found to be the CFET and GMC. These instruments had undergone reliability and validity analysis, factor analysis and generalizability analysis. Based on the results of this review it appears that the GMC provides the best match with GMP competencies and provides the best evidence of reliability and validity to date.

Shepherd and Lough (2010) describe the development and evaluation of a multi-source feedback instrument for GP appraisal, based on what primary healthcare teams consider to be a good GP. They found that the specialty-specific tool was feasible and acceptable to GPs, and suggest that the primary healthcare teams’ insight into qualities important for ‘the good GP’ raise supplementary standards to those identified in the GMC’s Good Medical Practice document, which have formed the basis of previous MSF tools, which reflect the role of the GP as a member of a multi-disciplinary team. Notably, the study found that narrative comments may be problematic for rater anonymity, a finding which mirrors Herson’s observation (2004) that participants can become preoccupied by comments made at the expense of other significant issues raised by the process. Other studies, however, such as one by Smither and Walker (2004), have produced evidence that narrative comments are especially powerful, particularly when they relate to behaviour.

A study by Smither et al (2005) suggests a degree of conflict in the evidence as to whether MSF can bring about improvements in doctors’ practice. Research carried out by Fidler et al, and Sargeant et al (2007), suggests that a number of barriers to change are recognised, including strong negative reactions to the feedback. In a study by Violato et al (2008), there is evidence that doctors can lack the ability to assess their own performance using MSF, suggesting that the process can reveal a lack of insight. It has
been found, for example in the work of Fidler et al (1999), that facilitation by a mentor or appraiser can help doctors overcome barriers to change and increase the chance of improvements in practice in response to MSF.

Evans and Edwards (2007) conducted a systematic literature review to identify existing instruments for rating peers (professional colleagues) in medical practice and to evaluate them in terms of how they have been developed, their validity and reliability, and their appropriateness for use in clinical settings, including primary care. The peer assessment instruments identified were evaluated in terms of how they were developed and to what extent, if relevant, their psychometric properties had been determined. A search of six electronic databases identified 4566 possible articles. After appraisal of the abstracts and in depth assessment of 42 articles, three rating scales fulfilled the inclusion criteria and were fully appraised. The three instruments did not meet established standards of instrument development, as no reference was made to a theoretical framework and the published psychometric data omitted essential work on construct and criterion validity. Rater training was absent, and guidance consisted of short written instructions. Two instruments were developed for a hospital setting in the United States and one for a primary care setting in Canada. The authors conclude that the instruments developed to date for physicians to evaluate characteristics of colleagues need further assessment of validity before their widespread use is merited.

Chisolm and Askham (2006) have reviewed a selection of questionnaires designed to gather feedback from patients on individual doctors. It examines how they were developed; their wording; their coverage of key content domains (such as interpersonal skills, communication, and patient engagement and enablement); and the thoroughness with which they have been tested for validity and reliability. The authors report that, of the ten instruments selected, three questionnaires are strongest overall in terms of content, development and testing: SHEFFPAT (UK), PAR (Canada) and CAHPS 2.0 (USA). However, the review identifies several areas of concern. Some issues of importance to patients are not covered at all in any of the questionnaires, and in light of this, the authors make several recommendations, including for questionnaires more attuned to the patient-engagement agendas of today are developed and include a fuller range of questions, and further research is carried out to investigate the various elements of physicians’ technical competence, patients’ capacity to comment on it, and how such findings should be interpreted.

Wood et al (2006) have reviewed the published literature on multi-source feedback systems within and without health services, drawing attention to aspects of MSF systems in which there is consensus on effective approaches as well as other aspects in which there is doubt about the optimum approach. In the light of the review, the authors propose 10 principles key in the development of effective MSF models. Smither et al (2005) have
reviewed evidence showing that multisource feedback ratings are related to other measures of leadership effectiveness and that different rater sources conceptualize performance in a similar manner. They describe a meta-analysis of 24 longitudinal studies showing that improvement in direct report, peer, and supervisor ratings over time is generally small. Their conclusions from a review of empirical evidence are that performance improvement is most likely to occur when feedback indicates that change is necessary, recipients have a positive feedback orientation, perceive a need to change their behaviour, react positively to the feedback, believe change is feasible, set appropriate goals to regulate their behaviour, and take actions that lead to skill and performance improvement.

Bracken et al (2001) have produced a handbook of multisource feedback intended as a resource for designing and implementing MSF processes. The work has been conducted on the pretext that, while use of MSF (or 360 degree) systems has proliferated rapidly, understanding of its complexities has not and many organisations are moving forward with MSF amid a dangerous void of systematic research and discussion on what can be a powerful process. Contributors identify best practices in the design and implementation of MSF processes and offer key guidelines for decision making when using MSF. The book covers MSF data collection and reporting, providing a process model encompassing each phase of an MSF system. It details the developmental and decision-making uses of multisource feedback, describing MSF applications for improving individual development, organization development and change, teams, performance management, as well as addressing system forces that influence MSF processes, including legal, ethical, and cross-cultural issues.

Murphy et al (2008) investigate the reliability and feasibility of six potential workplace-based assessment methods in general practice training: criterion audit, multi-source feedback from clinical and non-clinical colleagues, patient feedback (the CARE Measure), referral letters, significant event analysis, and video analysis of consultations. Performance of GP registrars (trainees) was evaluated with each tool to assess the reliabilities of the tools and feasibility, given raters and number of assessments needed. Multi-source feedback from colleagues and patient feedback on consultations emerged as the two methods most likely to offer a reliable and feasible opinion of workplace performance. The authors suggest that the combination of patient and colleague views of doctors’ performance, coupled with reliable competence measures, may offer a suitable evidence-base on which to monitor progress and completion of doctors’ training in general practice.

Campbell et al (2008) have investigated the utility of the GMC patient and colleague questionnaires in assessing the professional performance of a large sample of UK doctors. They found that both patient and colleague responses were highly skewed
towards favourable impressions of doctor performance, with high internal consistency and that to achieve acceptable levels of reliability, a minimum of 8 colleague questionnaires and 22 patient questionnaires are required. The authors conclude that the GMC patient and colleague questionnaires offer a reliable basis for the assessment of professionalism among UK doctors. If used in the revalidation of doctors’ registration, they would be capable of discriminating a range of professional performance among doctors, and potentially identifying a minority whose practice should to subjected to further scrutiny.

Sargeant et al (2007) have explored the challenges in multisource feedback, focusing on intended and unintended outcomes. The purpose of this qualitative study was to increase understanding of the consequential validity of MSF by exploring how doctors used their feedback and the conditions influencing this use. The authors conclude that their findings suggest circumstances that may contribute to low consequential validity of MSF for doctors. Implications for practice include enhancing procedural credibility by ensuring reviewers’ ability to observe respective behaviours, enhancing feedback usefulness by increasing its specificity, and considering the use of more objective measures of clinical competence.

**Remediation and revalidation**

There is a substantial body of literature on remediation in the medical profession, but very little in relation to remediation and revalidation together. The Tackling Concerns Locally report (2009) states that the DH, as part of their work in support of revalidation, should provide or commission operational guidance for healthcare providers on the steps needed to ensure access to remediation for all healthcare professionals who need it. The AoMRC has published a recent report on Remediation and Revalidation (2009) which describes how the authors conducted a survey of Royal Colleges, Faculties and Deaneries. The results of this consultation raised a number of issues, including: problems/deficits identified may be initially identified as clinical/craft concerns but are often more wide-ranging; existing systems are mainly based on dealing with craft and clinical concerns; not many colleges currently provide support to deal with behaviour problems; there is a lack of clarity about the role and responsibilities of Colleges in remediation. Colleges/Faculties are membership organisations; there is concern that the relationship between a College and its members should not change and Colleges should not move to a more ‘policing’ role of individual performance or concerns; often remediation is poorly documented and concerns and actions are not communicated effectively; there appears to be reluctance to deal with concerns at an early stage due to a lack of, or uncertainty about, the robustness of evidence; there is a lack of quality assurance of present systems. The Academy’s report goes on to identify the need for remedial interventions and pathways into remediation, identifies issues for consideration.
when developing multi-stakeholder guidance for remediation, establishes principles for remediation as part of revalidation, roles and responsibilities in remediation, and considers resource and quality assurance implications.

Lake (2009) considers doctors in difficulty and revalidation, proposing a series of recommendations for the profession. Firstly, there is a need for high quality research on the subject matter to be carried out in the medical setting. Secondly, the profession should try to streamline processes for dealing with doctors in difficulty. It is argued that in the UK the organisations which have already developed expertise for dealing with the trainee in difficulty – postgraduate deaneries – represent a natural source of expertise which could be utilised to help a wider group of doctors if appropriately funded and support by such agencies as NCAS and the GMC. Standardized and evidence-based assessment processes should also be developed by all deaneries. Thirdly the paper suggests that information about doctors in difficulty is often poorly shared by employing organisations, and new systems of information sharing should be developed which can be integrated into an open culture in which performance problems can be discussed. Fourthly, it is argued that recruitment and selection must be capable of choosing candidates with the capacity to have fulfilling and successful careers to enter the professions and, later, specialty training. The author concludes with the suggestion that, in both teaching and medicine, the role of the mentor is vital for those in and out of training schemes.

Clinical audit

A working group of The Academy of Medical Royal Colleges has published a report on clinical audit and revalidation (2009). Based on the understanding that the information that doctors will need to provide for revalidation will be drawn largely from their actual practice, the working group has developed guidance on providing evidence of participation in clinical audit and evidence that the doctor has both reflected and acted on the results of clinical audit.

The document sets out the following areas: (i) What activities can be considered clinical audit, (ii) Principles for the use of clinical audit in revalidation, (iii) Criteria and key indicators for demonstrating involvement by a doctor in the process of clinical audit, (iv) Criteria and key indicators for demonstrating reflection and action in response to the results of clinical audit, and (v) the criteria and indicators of a good clinical audit project previously developed by Healthcare Quality Improvement Partnership (HQIP).

Bowie et al (2008) state that clinical audit informs GP appraisal and will provide evidence of performance for revalidation in the UK, and that objective evidence is now required. They suggest that an established peer assessment system may offer an educational solution for making objective judgments on clinical audit quality. Non-
medical NHS clinical audit specialists could potentially support this system if their audit assessments were comparable with established medical peer assessors. This study aims to quantify differences between clinical audit specialists and medical peer assessors in their assessments of clinical audit projects. A comparison study of the assessment outcomes of clinical audit reports by two groups using appropriate assessment instruments was conducted. The authors describe how the study findings suggest that a sample of NHS clinical audit specialists can give numerically accurate feedback scores to GPs on the quality of their clinical audit activity compared with established peer assessors as part of the model outlined.

Mckay et al (2006) have conducted a study based on the argument that concerns have been raised about the poor design and impact of clinical audit studies and the ability of practitioners to apply audit methods. They argue that one method of making informed judgements on audit performance is by peer review. The authors state that, in the west of Scotland a voluntary peer review model has been open to general practitioners since 1999, while general practice trainees were compelled to participate as part of the summative assessment process then in existence. This study compares the outcomes of peer review for two methods of audit undertaken by different professional and academic groups of doctors. Participants submitted a criterion audit or significant event analysis in standard formats for review by two informed GPs using appropriate instruments. The paper concludes that a significant proportion of GPs may be unable to adequately apply audit methods, potentially raising serious questions about the effectiveness of clinical audit as a health care improvement policy in general medical practice.

Bowie et al (2005) describe how significant event analysis (SEA) is proposed as one method to improve the quality and safety of health care, and that GPs and their teams are under pressure to provide verifiable evidence of participation in SEA from accreditation bodies and the GP appraisal system in Scotland. A peer review system, based on educational principles, was established in 1998 to provide formative feedback to participating GPs on whether their event analyses were judged to be satisfactory or unsatisfactory. The authors stated objectives are to identify and classify SEA reports judged to be unsatisfactory, and determine the types of deficiencies and learning issues raised by peer reviewers. Their participants are GP principals in the west of Scotland region. The study comprises qualitative content analysis of SEA reports and peer review feedback. Their results lead the authors to conclude that an educational issue is potentially raised for a significant number of GPs in applying the SEA technique. This may impact negatively on the appraisal and revalidation of these doctors as well as on improving patient care and safety. It is argued that the study has helped to define and share some of the factors and inconsistencies that may contribute to an incomplete and therefore an unsatisfactory event analysis. The authors suggest that, if SEA is to be taken
seriously as a risk and safety technique, then it is clear there must be a valid means of verifying and assuring performance in this area.

Jutley et al (2001) state that, in order to provide better patient care, clinicians will need to be subject to revalidation and re-certification. This may be partially based on existing and ongoing data collection, yet many units fail to incorporate mechanisms that validate the data that may be used. In their study, the accuracy of audit data was evaluated in a unit that has been using commercially available audit software for over 10 years. A total of 655 consecutive surgical admissions were documented over a 6-month period and errors in data collection and entry were gathered and analyzed. An overall accuracy of 90.5% was confirmed but examination of the data found them to be open to misinterpretation. Moreover, 13% of errors were made during a single week when locum staff were involved. The authors argue that their study highlights the fallibility of data collection during audit, and urges caution if using such data when judging performance-related issues as part of the process of appraisal.

**Clinical skills & knowledge tests**

Considering the Canadian system of revalidation, Levinson (2008) suggests that available evidence shows that the public supports the idea of regular knowledge examination of physicians. One survey reported 87% of patients believe this should occur. Furthermore, there is evidence that scores on a test can be an indicator of performance. In Quebec, investigators found that family physicians' scores on their certification examination and Medical Council of Canada Qualifying Examination were related to provision of quality care after 4–7 years in practice. More recently, Holmboe et al (2008) found physicians' scores on the American Board of Internal Medicine's Maintenance of Certification examination were associated with higher rates of performance in care for Medicare patients. The authors argue that, although cognitive knowledge tested with examinations is not the only measure of competence, it is an important dimension of accurate diagnosis and clinical decision-making.
5. **Perception of UK medical educators**

a. **Methods**

The study involved a qualitative methodology and a modified Grounded Theory approach was adopted which allowed interview and focus group data to be analysed to establish recurrent themes which then could be used to develop concepts and more detailed conclusions about the participants’ perspectives and meaning. Grounded Theory methodology proposes that data collection should be carried out and analysed in tandem until the data is saturated with respect to emergent themes and concepts. Saturation is reached after examination of further cases to demonstrate the relevance of categories or themes. It is difficult therefore to quantify the exact number of interviews that will be carried out due to the nature of this approach, but extensive prior experience with using this methodology suggested that 15–20 would be needed.

**Sample**

The identified research sample comprised the following groups:

- GP medical educators;
- GPs with no formal education or appraisal role;
- Regional (Deanery) Revalidation leads; and
- Senior colleagues involved with Revalidation policy-making at a national level.

Potential GP educator participants were identified by using the lists of GP educational advisers/GP appraisal leads which are maintained by the UKCEA or are otherwise in the public domain (e.g. on postgraduate deanery websites). A random sample of educators/non-educators was approached to take part in a telephone interview. Regional and national GP revalidation leads were identified from information in the public domain (e.g. UK Appraisal and Revalidation Support website, RCGP website) and a random sample were approached to take part in an interview. We also held a focus group, which was conducted with a random sample of GP tutors working in a single region.

All potential participants were approached via a written invitation to take part in the study. The invitation included a full description of the research, an assurance of confidentiality and an assurance that they might withdraw from the study at any point without prejudice. The invitation was issued by the research team at the North Western Deanery, and potential participants were made fully aware that the study had been commissioned by the UKCEA. Potential participants were sent an invitation and asked to confirm in writing whether they wish to take part in the study. Those who agree to participate were recruited to the study.
Full ethical approval was obtained for the study through the Integrated Research Application Service (IRAS).

Data Collection

We used semi-structured telephone interviews, each lasting approximately 30 minutes, and a focus group lasting approximately one hour, to explore the overarching research question, i.e. *How do GPs, including educators and national/regional revalidation leads, perceive the introduction of revalidation?* The interviews and focus groups were conducted by the Chief Investigator and/or co–investigator using a schedule of questions which typically contained the following items:

- What opportunities may be afforded by revalidation?
- What is achievable in practice?
- What are the potential pitfalls of revalidation?
- How do you think a system of revalidation can work for General Practitioners across all ranges of performance?
- How can revalidation contribute to the development of General Practitioners who are already performing well?
- What are the implications for General Practitioners who do not achieve successful revalidation?
- How do you think revalidation will impact upon the education and Continuing Professional Development of General Practitioners?
- What kind of infrastructure should be in place to help GPs go through the process, particularly in the 1st round?
- What electronic support should be available for revalidation (including the role of e-learning)?
- Do you have any other comments/observations about revalidation?

Each interview and focus group was digitally recorded, and the recordings transcribed and anonymised prior to analysis. The research team recorded reflexive field notes during and immediately after each interview and focus group to further inform qualitative analysis.
**Data Analysis**

The transcripts from interviews and focus groups were systematically analysed for recurring discourses and themes, or patterned ways of articulating experiences and points of view and conveying meaning, as well as contradictions in the ways that the participants discussed these issues. The research team acted as co-analysts, and a coding framework was devised as a result of their deliberations. This construction of codes was done by the co-analysts working independently, and deliberating together on interpretations until agreement was reached. Following this initial coding, the analysis developed concepts linking a number of these codes, which in turn were grouped into categories. The quality of the findings is highly dependent on the rigour of the data collection and subsequent analysis and interpretation. We attempted to minimise these limitations by using established techniques to ensure credibility, transferability, dependability and confirmability.
b. Results

We conducted 18 one-to-one interviews and a focus group comprising 5 participants. We identified eight major themes in the data, each of which will be presented in this section. The themes were (i) Appraisal, (ii) Clinical Governance, (iii) CPD, (iv) Technology, (v) Support Systems, (vi) Resources, (vii) Engagement and (viii) Accreditation. These results are drawn from the interviews and focus groups, and therefore reflect the collective beliefs of the individuals who constituted our sample. Below is a list of the themes, each one of which includes a summary of the dominant perception of our sample along with some illustrative quotes taken from the qualitative dataset.

1. **Appraisal**: must be more robust if it is to underpin revalidation, with comprehensive training for the appraiser workforce, calibrated across the UK.
   
   “Highly skilled, highly trained, well supported, accredited appraisers are crucial to make revalidation work.”

   “We need properly trained and supported appraisers. Appraisal in England is not fit for purpose. Appraisers must then be made aware of their remit, the boundaries or limitations to their role, particularly with regard to technical governance.”

2. **Clinical governance**: critical for stakeholder organisations (PCO/Deanery/RCGP etc.) to work closely together in developing systems and processes for gathering information and decision-making

   “I think the Responsible Officer job is a very important stimulus by which organisations can improve their overall quality, people management and support of the medical profession. Organisations will need to look beyond their existing boundaries and engage with others in order make the necessary changes to custom and practice, to make revalidation work.”

   “Deaneries will need to act as catalysts for the whole process, particularly bringing key individuals together... We are keen to appoint a GP Revalidation Fellow to help develop new appraisers, with standards & QM, and assist Responsible Officers in developing the information gathering process.”

3. **CPD**: provision must be of higher quality and quantity. Some excellent innovations, e.g. RCGP’s Essential General Practice, but needs augmenting with gold standard real world and virtual learning opportunities.

   “There needs to be a steep learning curve in making emerging e-learning mechanisms more sophisticated. It would be beneficial to have an online system
whereby one could record in the portfolio a lecture series, a course, or whatever the educational intervention might be, and to have the knowledge tested by the provider.”

“I’m concerned that there may be a step backwards, with people attending meetings to collect credits, and drug companies reappearing with ready-made packages. The skill of the appraiser, and the construction of the PDP, will be crucial in avoiding dependence on this route to credit collection.”

4. **Technology**: consensus that collection of evidence must be electronic, ideally in form of an e-portfolio, for ease and to make it readily accessible to the responsible officer. More needs to be done to ensure that new and existing e-learning technology is made compatible with whatever e-portfolio is adopted, so that users can easily record their learning experiences.

“One of the hardest things about CPD is recording what one does, and it would a very positive development if electronic learning materials (BMJ Learning, Doctors Net, etc.) could be linked directly to an individual’s e-appraisal toolkit, so that information could be migrated at the touch of a button.”

“It would be great if practice IT systems could accommodate linkages between flagging up a learning need stemming from a patient consultation to the electronic PDP.”

5. **Support systems**: clear systems need to be established to support specific groups going through revalidation (e.g. those near end of career; absent from, or engaged with limited, clinical practice; the unwell, those considering career options, etc.).

“There needs to be quite a lot of thought about how peripatetic locums, single handed doctors, etc. can collect appropriate, comparable levels of evidence to people who are in highly managed and organised situations such as good teaching general practices.”

“Support infrastructure should be set up so that any GP at a careers crossroads can access it, including high flyers moving into more senior management or educational roles, so as to remove the stigma attached to accessing support networks.”

“We need a very clear, consistent pathway for doctors who have serious health or addiction or alcohol problems: an occupational health support stream with specialist expertise in providing medical support for doctors.”
6. **Resources**: There are concerns about the lack of clarity with regard to the ongoing cost of funding revalidation, and the cost of re-training those GPs identified as underperforming.

“A major issue is resources, the cost of bureaucracy, of time spent away from clinical service to revalidate the workforce, of QA-ing the system.”

“There’s the cost of retraining those who fail...Getting back into the system for those who are out of it for whatever reason (abroad, ill, etc.) is going to be difficult. There’s no system or funding of supervised training to bring these people back in.”

7. **Engagement**: Concerns about level of knowledge and engagement about revalidation amongst GPs. This needs to be remedied with a more robust communication strategy. Sense that plans have been on the table for so long that there is no need to engage with the process until the 11th hour. There are fears that it may trigger some doctors to leave the profession early. However, there is a belief that GPs will value the process once it is established.

“If it is made to feel too scary, people who are within a couple of years of retiring anyway will decide now’s the moment to go, and that could have huge workforce implications.”

“I think there are an awful lot of very good doctors out there who have imposter syndrome and a little voice on their shoulder saying you should never have passed finals...and actually being recertified, having a piece of paper that says you are good enough and that it’s been reassessed every five years, is going to be hugely valuable in taking away a little bit of that anxiety.”

8. **Accreditation**: Many GPs don’t yet realise that much of what they do in their day-to-day working lives should be recognised and valued as professional development activities which can be credited for revalidation purposes. There was a sense that, when this is better understood, and examples of creditable activities are produced, then engagement with the process will be greatly enhanced.

“I don’t think the average GP thinks about introducing a new service into practice as being an educational learning opportunity, but the amount of work that goes into that, the research and the evidence base that they look at, they assimilate and then put into best practice, is huge.”

“There is an urgent need for examples of what is good enough and what is not good enough.”
c. Discussion

Revalidation is the process by which all doctors will have to demonstrate to the General Medical Council, normally every five years, that they are up to date and fit to practise and complying with the relevant professional standards. The majority of our sample expressed the opinion that revalidation did indeed present an opportunity to establish a robust set of standards, focused on patient needs and day-to-day practice. This is perceived as potentially benefiting all stakeholders, including those ‘worried well’ GPs who are unnecessarily concerned about passing revalidation but are actually doing fine. There is, however, thought to be an urgent need to develop examples of what are, and are not, considered examples of practice which meet the requisite standards. There is also a need for more research to understand the relation between revalidation and quality of care in practice and to explore the most effective methods to assess physicians’ maintenance of skills, knowledge and attitudes.

Our interviewees thought that the majority of GPs are already doing far more than the minimum required for revalidation. As a consequence of this likelihood, it is believed that a primary role for the implementers of revalidation is to focus on changing perceptions amongst GP, so that educational/developmental activities are recognised in, and credits captured from, many of their regular activities. All the indicators from such bodies as the GMC, AoMRC and RCGP point to a system whereby the information doctors will need to provide for revalidation will be drawn from their day-to-day clinical practice, from feedback from patients and colleagues, from participation in CPD, from feedback from colleagues and patients, and from such activities as clinical audit. It is intended that all this information will feed into doctors’ annual appraisal. The outcome of appraisal will lead to a single recommendation to the GMC from the Responsible Officer in their organisation, usually every five years, about the doctor’s suitability for revalidation. With regard to stakeholder organisations, our sample thought it was critical for stakeholders (PCO/Deanery/RCGP, etc) to work more closely together in developing processes and systems for the gathering of information and decision-making. This was considered all the more important given the concerns about resources, including the ongoing cost of funding the revalidation process.

The GMC, RCGP and the Department of Health in England all envisage appraisal as being the primary vehicle for presentation of evidence for the purposes of revalidation. We encountered a widely held perception within our sample that appraisal must be made more robust, with comprehensive training for the appraiser workforce that is calibrated across the UK. It was also strongly suggested that appraisal will need to be even more formative, given that the revalidation process in the UK has dual aims, both diagnostic and developmental. The proposed elements of revalidation do appear to be based on established components of the existing appraisal process: PDPs, clinical audit, significant
event audit, patient feedback, and learning from complaints. All tools utilised in appraisal must be of formative use to the great majority of medical practitioners who don’t experience significant problems yet who are nevertheless required to participate in the revalidation process. The tools must also be able to identify the small proportion of doctors who are underperforming. In this study we identified particular concerns about lack of a funded process to re-train those GPs identified as underperforming, which will need to be addressed if remediation is to be effective.

The contribution of CPD to revalidation is set out in the Chief Medical Officer’s Report, *Medical Revalidation – Principles and Next Steps* (2008). CPD is defined as the process by which individual doctors keep themselves up to date and maintain the highest standard of professional practice. The report emphasises that the GMC will require documented proof of CPD as an essential component of the information needed for successful appraisal and revalidation. It states that CPD belongs to the individual, but there is a need for the organised collection of evidence of appropriate activity, together with some audit of the adequacy of any individual’s programme. Our sample expressed concerns about the quality of external CPD currently available. It was generally perceived that CPD provision must be of higher quality and quantity if it is to successfully underpin revalidation. Interviewees were aware of some innovations, e.g. the RCGP’s Essential General Practice’, however the feeling was that this should be augmented with equally robust real world and virtual learning opportunities. This was accompanied with fears that private providers will simply step in with old-style PGEA course packages, which would be a retrograde step.

We identified concerns about the ability of revalidation processes to capture the plurality of activities which doctors undertake, some of which may be more difficult to link with individual patient care but still have a definite influence on patients as a group. This is an area highlighted by the AoMRC in its report on non-clinical work and revalidation (2009) which has identified doctors working in medical education, including in medical schools or postgraduate deaneries, doctors working in research, and doctors working to improve the health of populations through combinations of health service and societal interventions, as falling within this camp. Many doctors step off the traditional clinical path at various points in their careers to undertake roles not involving face-to-face patient contact with the intention of returning to such work in the future. The Academy has stated the principle that all elements of a doctor’s practice, including those aspects that do not involve direct patient treatment, are demonstrated for revalidation, as all may affect patient care to a greater or lesser extent.

Similarly, many interviewees expressed the view that clear and robust systems need to be established to support specific groups going through revalidation (e.g. those near end of career; those absent from, or engaged with limited, clinical practice; the unwell, etc.). It
cannot be seen as punitive, so support should be available to those GPs seeking careers advice, mentoring for different or more senior roles, etc. as well as those who are not performing at an acceptable level. It is reassuring that many of the recent revalidation-related publications by AoMRC and RCGP reflect an active engagement with these issues.

*Limitations of the study*

There are several possible weaknesses with our study. Inherent in qualitative research is the limitation to the generalisability of any findings. Participants in interviews and focus groups were selected randomly but the number of participants was relatively small. The collection of data from across the UK, however, has reduced the possibility of unrepresentative perceptions as a result of area-specific variables. We chose to use interviewing and focus groups to explore the beliefs that participants held about revalidation, but we recognise that some will have tended to express views consistent with perceived social standards and not presented themselves negatively. This social desirability may have led respondents to self-censor their actual views. We have attempted to limit this possibility by placing emphasis on the assured anonymity of participants, and explicitly requesting that interviewees be as open and honest as possible.
6. **CONCLUSIONS**

Our review of available information on international systems of revalidation suggests that no single system recurs worldwide. Instead systems are designed to be sensitive to widely varying contextual factors, whilst being responsive to the needs of a locality. It is noteworthy that, amongst the many models, whilst the provision of safeguard mechanisms is referred to, greater emphasis is placed upon improving competence and performance based around professional development. No revalidation system would appear to explicitly assess doctors’ integrity, as although this might provide a way of protecting patients, it is difficult to conduct in practice. In addition, the area of doctors’ probity and health poses a challenge to medical regulators in the way they balance patient protection and the support of doctors.

The sources we consulted reveal that an important variable impacting on regulation of professional practice is the availability of information. Well-functioning information systems are needed for many forms of auditing, linked to valid patient outcome measures. Countries with well developed health informatics systems and effective electronic health records will have an advantage. Many countries appear to have experienced difficulties with raising the necessary resources to implement basic physician performance policies, such as continuing professional development. There are potential resource implications for the diversion of large numbers of physicians into monitoring activities at a time when many countries are facing workforce shortages.

With specific regard to the UK system, our survey of the literature suggests that the nexus between revalidation, appraisal and clinical governance is a critical issue for policy makers to deal with. The literature explicitly relating to revalidation is not yet extensive although there is no doubt this situation will rapidly change with the completion of national pilots and the formal implementation of the process. The role of responsible officers is a typical example of revalidation-specific issues materialising in the medical press. The Department of Health has now produced a framework for responsible officers and their duties relating to the medical profession. Indeed, national stakeholder bodies have published a flurry of policy documents in the past year or so. Empirical evidence on such recent developments is, however, naturally lacking at present. The bulk of our survey was therefore taken up with subjects such as appraisal, assessment and CPD: all well-researched areas which will underpin revalidation.

There is a large and expanding body of empirical evidence about the function of CPD in the context of revalidation. Whilst there is no evidence of an international template for CPD, progress has been made within the UK to establish a standard: the RCGP has produced a detailed guide to a credit-based system of CPD for GPs, following the AoMRCs national template and drawing heavily on the Welsh experience. The literature
suggests that GPs place the highest value on learning that gives practical advice and instant access to information for patient-specific problems. The effectiveness of small group CPD is well evidenced, and the value of electronic continuing education increasingly so.

We found evidence of a need to strengthen medical appraiser skills to better enable the formative and summative function of appraisal in the light of its centrality in revalidation, and some models of how this can be achieved through training. There are concerns about overloading the appraisal interview and we found suggestions for other ways of drawing together the strands of evidence for revalidation, an example being the ‘living’ PDP. The literature included evidence of disparity with regard to the perceived effectiveness of existing appraisal systems, and calls for more research in this area. A number of studies have been conducted on the quality of appraisal systems. Our survey suggests that there is a steadily increasing body of evidence on the ways in which appraisal can be enhanced and conducted in such a way as to optimise it’s role both for individual GPs and the revalidation process. It is clearly envisaged by all the national stakeholders as the cornerstone of the whole revalidation process, and a number of bodies, including the AoMRC and the RCGP, have produced substantive documents on the subject, such as guidance for appraisers on the personal development planning process.

We identified a number of systematic literature reviews relating to the effectiveness of MSF tools. Comparisons of the different instruments have produced some evidence of which might be best utilised for the purposes of appraisal and revalidation but there is clearly scope for further investigation into the optimum form and content to make them fit for purpose. Some issues raised in the literature include the need to ensure MSF tools include questions which cover all requisite domains and be phrased appropriately for different groups, including medical, non-medical and patient. We also found evidence that narrative comments obtained via MSF can be problematic for rater anonymity, and participants can become preoccupied by comments made at the expense of other significant issues raised by the process. Other work, however, suggests that comments can be a source of significant learning. The AoMRC has itself made a number of recommendations about the use of MSF and patient feedback tools, including the importance of investigating the relationship between the ratings on a MSF questionnaire and other methods used to measure performance for revalidation, which should form part of a national evaluation following the implementation of revalidation about the impact of regular MSF. Unlike MSF, there are as yet no plans to introduce the testing of cognitive knowledge for the purposes of revalidation in the UK. There is, however, some international evidence which supports the value of such tests as an additional dimension of accurate diagnosis and clinical decision making.
The AoMRC has recently published guidance on how clinical audit will feed into the revalidation process (2009). This is timely, as we found evidence in the literature relating to the sub-optimal application of clinical audit and significant event analysis techniques by GPs. We found related evidence that NHS clinical audit specialists can give numerically accurate feedback scores to GPs on the quality of their clinical audit activity.

The qualitative data which we collected through interviews with a small sample of UK GP medical educators has provided empirical evidence to corroborate many of the issues beginning to arise in the medical press. Our study identified concerns about level of knowledge and engagement with revalidation amongst GPs. This needs to be remedied with a more robust communication strategy. There is a sense that plans for revalidation have been ongoing for so long that it may never happen, and hence there is a reticence to engage in the process. There are also fears that it may trigger some doctors to leave the profession early. However, there is a belief that GPs will value the process once it is established. We recorded a perception that many GPs don’t yet realise that much of what they do in their day-to-day working lives should be recognised and valued as professional development activities which can be credited for revalidation purposes. There was a sense that, when this is better understood, and examples of creditable activities are produced, then engagement with the process will be greatly enhanced. We heard that appraisal must be more robust if it is to underpin revalidation, with comprehensive training for the appraiser workforce, calibrated across the UK. We encountered a firm belief that CPD provision must be of higher quality and quantity. Some excellent innovations have been developed, e.g. RCGP’s Essential General Practice, but these need augmenting with gold standard real world and virtual learning opportunities.

With regard to technology, our sample was unanimous in the view that collection of evidence must be electronic, ideally in the form of an e-portfolio, for ease and to make it readily accessible to the responsible officer. More needs to be done to ensure that new and existing e-learning technology is made compatible with whatever e-portfolio is adopted, so that users can easily record their learning experiences. As for support systems in a broader sense, we found that clear systems need to be established to support specific groups going through revalidation (e.g. those near end of career; absent from, or engaged with limited, clinical practice; the unwell, those considering career options, etc.). With regard to clinical governance, our sample thought it critical for stakeholder organisations (PCO/Deanery/RCGP etc.) to work closely together in developing systems and processes for gathering information and decision-making. We also identified resource issues, particularly concerns about the lack of clarity with regard to the ongoing cost of funding revalidation, and the cost of re-training those GPs identified as underperforming.
Our survey of the UK literature, including the significant number of recent publications by such national stakeholders as The Academy of Medical Royal Colleges, The Royal College of General Practitioners, The National Revalidation Support Team suggests that many of the issues raised by our sample reflect the preoccupations and concerns of many within the medical profession. The national revalidation pilots which are currently underway will provide invaluable evidence to inform the roll-out of the process. Urgent consideration should also be given to the impact of the NHS White Paper, *Equity and excellence: Liberating the NHS*, on the implementation of revalidation. Furthermore, the need for ongoing research into the long-term effectiveness of revalidation is vital in order to refine the UK system as well as contributing to the international evidence base.
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