Update on revalidation

Sir Donald Irvine

It has been an extraordinary two years. The self confidence of the medical profession, and public confidence in the system of medical regulation, have been shaken to the roots by highly publicised clinical failures beginning with the deaths of children undergoing cardiac surgery at the Bristol Royal Infirmary. Medical regulation, once a quiet backwater, is now a focal point of media and public attention. The cases have been the more disturbing because, with the exception of the murderer Shipman, they have occurred in specialist practice where it was assumed that safety standards were high. But they are not the only cases. A small but steadily increasing number of doctors whose practice is seriously deficient are coming to light through the GMC's performance procedures which are now becoming fully operational.

The government and the profession have been taking vigorous action to build a new system of medical regulation more appropriate to today's conditions. The main elements are now either in or being put into place. In sum, they amount to a completely fresh approach which should greatly enhance the level of safety in the system, reduce the chances of risk or error, and help good doctors to sustain their performance through well-supported training and continuous professional development (CPD). Essentially, they comprise the local and central institutional arrangements for assuring quality which are the responsibility of employers and private providers and which come under the general heading of clinical governance. Alongside these are the arrangements which the profession is putting in place to encourage high standards of clinical practice, assure good practice, and recognise and act on unsatisfactory practice when it arises. The profession's and employers' responsibilities come together at doctors' places of work through practical arrangements for appraisal and revalidation.

The key themes which unify these strands of the regulatory process include:

- the importance of the environment for care and therefore of the policies, systems, data and other arrangements which are indispensable parts of institutional quality
- recognition of the need for greater clarity about precisely what each element of the system contributes to the whole, and how they all inter-relate
- the need for clearer accountability and for the more effective co-ordination of all the contributing parts.

Some say that these changes are adding new layers of regulation to medicine in a haphazard way. That is certainly not the intention. On the contrary, the object is to secure high levels of clinical performance and patient safety with the least intrusive regulation consistent with achieving that end.

The GMC is currently consulting on its proposals for revalidation, in which the royal colleges will have a key role. The principle is broadly accepted, though there is much more to be said about the all important operational details.

Revalidation, to make sense, needs to be seen in the context of medical professionalism and how that is changing to meet the expectations of a society which seeks a more even-handed relationship with doctors, and more explicit accountability for ongoing performance.

Developing our professionalism

The GMC, like the medical royal colleges, is concerned primarily with the professionalism of doctors. Medical professionalism is based on the possession of scientific and technical knowledge and skills, clear ethical values and standards, and a vocational commitment which puts the interests of patients first. With the rise of specialist medicine following the Second World War, the focus in training and practice has tended to be on knowledge and skill - technical expertise - the direct result of the revolution in medical science. Yet lately, on both sides of the Atlantic, there has been a growing realisation that scientific and technical expertise of themselves may be insufficient to constitute a viable expression of professionalism as far as the public is concerned. In addition to technical competence, people want doctors who will, for example, respect their right to make decisions about their care, understand that consent means consent, and who will not abandon them when medical science has nothing more to offer. The public wants doctors who can communicate effectively. And there is an expectation that doctors, individually and collectively, will systematically ensure their competence and will be proactive in protecting patients from harm. Many patients experience this full expression of professionalism which explains why, despite the recent troubles, opinion polls show that the profession is still highly regarded by the public. But it is clear that a significant minority of doctors is less patient-oriented - hence comments about doctors acting as gods and, at a practical level, the fact that the vast majority of patient complaints
are rooted in attitudes of doctors which people are no longer prepared to accept.

What the GMC, the royal colleges and the specialist societies are attempting to do is to create a culture in medicine which brings doctors and the public together on the things both think are important. It is very much a case of combined operations. The GMC is concerned with the general principles of medical practice. The royal colleges and faculties are the repositories of wisdom in their own fields about the requirements for effective practice as, for example, a physician, a surgeon or a psychiatrist.

In taking this agenda forward there are several common elements which we all share. The foundation must be an explicit statement of professional duties and standards. Yet professional values and standards, even when expressed in some form of a code, are themselves insufficient if there is no means of ensuring that individual doctors practise – and continue to practise – in a manner to which we are collectively committed. Hence the need for a direct link between professional standards and a doctor's registration and specialist certification. That link, we have now decided, has to be continuously demonstrated through revalidation, the various schemes of voluntary recertification, and college CPD requirements.

The link between professional standards and medical education in all its stages is being made equally explicit. Both the public and the profession want to be sure that medical education produces doctors with the qualities we all want.

Finally, we have a duty to strengthen the arrangements for handling doctors who err significantly. We need a system which facilitates the early recognition and diagnosis of dysfunction before harm is done to patients and doctors and, where possible, help doctors back to normal practice.

These are the principles which in future will inform and underpin the work of the GMC. They are principles which have equal validity in the work of the royal colleges in their respective fields of practice.

Professional standards

The GMC took the first step in 1995 with the publication of Good Medical Practice. This statement has been welcomed by the profession and the public alike as representing the kinds of qualities we all want to see in our doctors. Last year, all the royal colleges were invited by the GMC to interpret these principles as they would be most helpful for their own specialties. So, for example, the Royal College of General Practitioners is about to publish Good Medical Practice for General Practitioners. Similar statements have come from the Royal Colleges of Ophthalmologists and Anaesthetists, and a statement from the Royal College of Surgeons of England is imminent. The Royal College of Physicians of London has decided that the principles set out by the GMC are clear in themselves and need no elaboration. But it has made sure that members and fellows are aware of their importance.

Since the link with medical education is fundamental, the GMC will produce a new edition of Tomorrow's Doctors next year. This will embody the principles of Good Medical Practice in the requirements for basic medical education up to the point of full registration. There is an agreement with the royal colleges that Good Medical Practice will inform all programmes of specialist training up to the point of completion, and then extend to the requirements for continuing professional development which follow for established specialists.

Revalidation

The revalidation of doctors' registration is seen by the GMC as a positive process designed to encourage good practice and to identify areas for improvement in a way which enables changes to be made as a matter of good practice rather than as a result of disciplinary action.

Revalidation will begin in the undergraduate course when students are introduced to the basic 'Duties of a Doctor'. It is likely that students will start their revalidation folders early, so that they become familiar with the method, something which many students seem keen to do. Students see this development as preparing for the responsibilities of being a doctor when they graduate. Provisional registration with the GMC becomes the real starting point. On completion of the pre-registration year, when the assessment of their performance as real doctors will have been noted, they will acquire their first fully valid registration. Thereafter, assessments in specialist training will take account of the core elements of Good Medical Practice so that on completion of the CCST, new specialists will have in effect completed their first revalidation.

For career doctors, revalidation will then follow as a formal process every five years, but that formal assessment will be informed and guided by the results of the annual appraisal for those who are in employed practice, and by a process of interim assessment which is no less robust for those who are not.

The key to revalidation is the doctor's folder of evidence, the contents of which are now the subject of detailed discussion between the GMC, the colleges and the BMA. The details of a doctor's practice, the record of CPD, the results and outcomes of audit, and information about substantiated complaints of poor performance will form the core, all drawn together through appraisal. It is the royal colleges that are best able to advise on the nature of the evidence required on performance and on the standard to be achieved, since revalidation is directed to the doctor's personal field of practice.

If the local arrangements for maintaining good medical practice through the methods of clinical governance and quality improvement applied at the level of clinical directorates and clinical teams are working well, then for doctors revalidation should be an automatic process with no surprises. Any problems with practice should have been identified locally and put right so that signing off for revalidation is
virtually automatic. Further work should be required only in exception cases.

The royal colleges

Complementing the role of the GMC is the role of the royal colleges, which have the responsibility of setting the standards of practice in their specialties. At present they are loosely co-ordinated through the Academy of Medical Royal Colleges. Traditionally, the focus of activity has been on the training of new entrants. More recently, the colleges have emphasised the continuing professional development of established members.

But the real challenge and opportunity for the colleges in future lies in the further enhancement of doctors' professionalism through the meaning of membership and fellowship of the colleges themselves. With GMC re-licensure providing the statutory safety net which will deal with poorly performing or wayward doctors, the colleges have an unrestricted opportunity to show that their memberships and fellowships are contemporary statements of good practice. The Royal College of General Practitioners began exploring this aspect of fellowship some years ago when it introduced Fellowship by Assessment. Since it is voluntary, it is seen in a very positive light by those choosing to take it – a true celebration of good practice.

It seems likely that those achieving such recognition would have it accepted for the purpose of revalidation.

It is through this kind of development that the royal colleges should continue to be the dynamic growing point of professionalism in medicine, and the ultimate custodians of our basic values and standards.

Next steps

In any system of regulation, there is by definition an inherent tension between the interests of the main stakeholders, namely the public, the medical profession and employers (which in Britain tends to equate with government). What we are seeing is a readjustment in the distribution of roles and responsibilities, based on the assumption that each has complementary rather than competing functions. This is new.

Equally, in terms of medical professionalism we have learned that culture matters, and for patients it may be the ultimate determinant of the quality of care and outcome. For, in the privacy of the consultation room, what the patient experiences is crucially dependent on the competence, integrity and commitment of the doctor. All the forces of regulation can merely influence this.

Rudolf Klein put it well when he said that it was the business of government to make sure that the medical profession is robust and rigorous in promoting and insisting on the observance of recognised professional standards by individual members. Accepting that, I would say that it is the business of doctors, individually and collectively, to make sure that governments in turn provide the optimum environment for care so that doctors have the time to give the quality of care both they and patients expect.

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