

Standards and Revalidation or Recertification

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Abstract

Patients want doctors who are competent, respectful, honest and able to communicate with them. This is patient-centred professionalism. In the United Kingdom, it is being embedded into practice by the General Medical Council (GMC) through medical regulation in a partnership between the public and doctors. The foundation is a national code of professional standards – Good Medical Practice – that has been tied to medical licensure to secure doctors' continuing compliance whilst they are in active practice. The revalidation of a doctor's license to practise is the means of achieving such compliance. Revalidation requires that specialists and general practitioners must be able to demonstrate – on a regular basis – that they are keeping themselves up to date and remain fit to practise in their chosen field. It begins in April 2005. For revalidation, doctors' performance, conduct and health will be assessed against the headings of Good Medical Practice. Doctors will collect a folder of illustrative evidence that will form the basis of an annual appraisal carried out at the workplace by an appropriately trained colleague. The results of these annual appraisals will be submitted to the GMC for a revalidation decision every 5 years. Where doctors' performance or conduct gives cause for concern, they may have to undergo a further searching assessment under the GMC's Fitness to Practise Procedures. Under these procedures the GMC can order a doctor to retrain or, if circumstances warrant it, to stop practising.

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In my Gordon Arthur Ransome Oration and other papers,¹⁻³ I have described the nature and development of patient-centred professionalism, the key features of which are summarised in Figure 1. In this paper I expand on the core concept, that is, the linkage of the basic overarching professional standards that constitute competent, ethical practice to the means of enforcing those standards by making them the foundation for physician licensure, specialist certification, all of medical education, medical discipline and, where appropriate, doctors' employment contracts.

An important preliminary step was the clarification in the minds both of the profession and government that the primary purpose of medical regulation is unequivocally the well being and best interests of patients – hence, the recent emphasis on competent, ethical practice directed to patient safety and a sound relationship between doctor and patient on terms that are fully acceptable to patients. That is the only secure foundation for patient and public trust in doctors and the medical profession. Doctors' interests and

Patient-centred professionalism

- Starts with patient autonomy
- Patients and public as partners
- Based on the values and standards agreed by the public and the medical profession
- Embedded in medical education
- Guaranteed through licensure and certification, and contracts of employment

Fig. 1.

preferences, although clearly important, are secondary and can be represented through other routes. Given this, professional standard setting and the revalidation of doctors' license to practise have become the critical elements in the regulatory process for making sure that all doctors in the land, who are in active practice, are and

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remain up to date and in all respects fit to practise. Hence, the emphasis we now place on assessing objective evidence of professional competence and performance – they are what matter most to patients.

Of course revalidation has other legitimate functions, for example, as an aid to doctors' professional development and the improvement of their clinical practice, but these are consequential to the primary purpose. So, the UK position contrasts with many schemes of recertification that have physician professional development as their primary aim. The distinction is important. To be done well, revalidation intended to assure the public about the maintenance of good practice demands robust evidence of performance and a rigorous assessment of that evidence, whereas recertification intended mainly as an aid to professional development can be softer and more formative. Both functions are important and complementary. But the ordering of these two very different approaches, and therefore the priority given to each is likely to produce quite different results.

In my Oration, I said that the profession collectively has a moral obligation to see that, from now on, all doctors who are licensed to practise do so on a day-to-day basis in accordance with the standards the regulators of the profession have said are necessary. In the past, we did not do this systematically and thoroughly – we relied only on the conscientiousness of individuals – which is why too many patients were put at risk unnecessarily, and why some were hurt or killed when they should not have been. Knowing this as we do now, inaction is no longer an ethical option. Hence, the reason why we accepted that the case for obligatory revalidation had become compelling. The moral imperative was reinforced by the fact that the public, by and large, believed that the medical profession already did these checks, which you and I know is not true.

In developed countries, most of the effort directed to arrangements for maintaining competence has until now focused on specialist recertification rather than on the basic licence to practise. Recertification has been politically easier to manage within the profession because usually only volunteer doctors have been involved. Around the world, mandatory recertification is still exceptional, basically because professional self-interest has overridden the will to give the public full protection. So, it is not surprising that performance based relicensure does not exist despite there being much talk about it. Licensure, unlike certification, is by definition wholly inclusive. It affects all doctors' entitlement to practise.

Hence, our decision in Britain to go for relicensure based on assessment of performance. We are the first country to do so. We call the process revalidation. There have been plenty of doctors who have thought it the right thing to do,

to go ahead recently they were a minority. As I explained in my Oration, it was the public outcry after the serious failures at Bristol and elsewhere that provided the real impetus for change.

One last general point. When demonstrating the maintenance of doctors' professional performance, the professional standards and the assessment methods needed for recertification and revalidation are essentially the same. The main difference between recertification and revalidation is in the breadth and scope of public protection afforded. Because it is inclusive rather than selective, revalidation has the potential to be far more powerful provided that it is done well.

The Model

The starting point is the ethical statement of the duties and responsibilities of doctors in the UK, and the generic professional standards that expand on and explain those. These standards were published by the General Medical Council (GMC) in 1995 in the booklet *Good Medical Practice*.⁴ In 1998, the GMC proposed linking such standards directly to all aspects of licensure and medical education, and invited employers to embed them into doctors' contracts of employment in our National Health Service (NHS). This will be given practical effect in 2005 when revalidation starts. So the standards originally seen as advisory and therefore not binding have become mandatory, required of all doctors who wish to carry GMC registration and an active license to practise.

The revalidation decision will influence every stage in a doctor's practising life. So, for example, doctors wishing to keep an active license to practise will have to demonstrate regularly that they continue to practise in accordance with these standards. If there are doubts about a doctor's fitness to practise, it is against such standards that they will be judged and appropriate action taken to protect the public. When it comes to educating doctors, these are the standards that from now on will inform basic medical education and specialist training, and continuing professional development for all. For doctors who are employed in the NHS, which is by far the vast majority in the UK, *Good Medical Practice* forms the template against which workplace appraisal will be carried out.

So, the model is very simple. Set standards agreed between the public and the profession about what constitutes a good doctor and, armed with that consensus, require compliance from all doctors. We have found that the model is strongly appealing to the public. Most doctors, though anxious about the practicalities, see the force of the moral purpose behind it and see also that the concept of professionally led regulation would be a nonsense without it. The real challenge is not in the model, but in the way in

Duties of a doctor

The medical professional has a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must

- Make the care of your patient your first concern
- Treat every patient politely and considerately
- Respect patients' dignity and privacy
- Listen to patients and respect their views
- Give patients information in a way they can understand
- Respect the rights of patients to be fully involved in decision about their care
- Keep your professional knowledge and skills up to date
- Recognise the limits of your professional competence
- Be honest and trustworthy
- Respect and protect confidential information, making sure that your personal beliefs do not prejudice your patients' care
- Act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise
- Avoid abusing your position as a doctor
- Work with colleagues in the ways that best serve patients' interests

In all these matters, you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.

Fig. 2.

which revalidation is put into practice precisely because it will become an integral part of all doctors practising lives. There is quite a difficult balance to be struck. There needs to be sufficient rigour and public involvement in the process to command public trust. Yet, revalidation needs to be as simple and unobtrusive as possible, so that it does not become an unwelcome burden in busy doctors' lives.

The Standards

Let us look a little more closely at the professional standards since these are so important. When the GMC began the work on *Good Medical Practice* in 1992, advice to doctors about professional matters was couched in negative terms – it said what they should not do and what

might attract punishment. There was nothing to show what good practice was, and nothing to indicate what the public and patients thought about the qualities of a good doctor, because no one had asked them.

Good Medical Practice was the GMC's attempt to answer this. It was developed through an interactive process of discussion with professional groups and patients' organisations, to a point where the GMC could reasonably claim that the standards expressed reflected a consensus between the public and the profession. Patients' organisations emphasised the importance of expert medical knowledge and skills, an empathetic respectful attitude, good interpersonal skills and integrity as the basis of trustworthiness in a doctor. The reactions of both doctors and the public to *Good Medical Practice*, when it was first published in 1995, were very positive.

Good Medical Practice starts with general principles – the statement of Duties of a Doctor (Fig. 2). These are subsequently explained and elaborated in the text. On some particular matters, such as patient confidentiality and consent, further, more detailed advice to the profession is given in separate booklets.

Good Medical Practice is now being embedded into the curriculum of all our medical schools, and through the GMC's *Tomorrow's Doctors*.¹ In specialist training the Royal Colleges have all published versions suitable for use in their own specialties. It is used operationally by the GMC for its Fitness to Practise Procedures. Allegations against doctors whose fitness to practise may be in question are framed against the relevant parts of *Good Medical Practice*. And it is to be the template for revalidation.

In its time, *Good Medical Practice* represented a quantum step forward in medical regulation. This may help to explain why it is being used in many other countries – I believe about 15 or so at the present time. It would be inconceivable to think about implementing revalidation/relicensure without it – one would then be reduced to an arbitrary list of educational and professional competencies constructed by doctors around what they thought could be assessed rather than what is necessarily important to patients.

Revalidation

Revalidation requires that “specialists and general practitioners must be able to demonstrate – on a regular basis – that they are keeping themselves up to date and remain fit to practise in their chosen field.”² There are also supplementary objectives. Thus, it is also regarded as an aid to professional development and as a stimulus to doctors' contribution to improving the quality of medical care. Through licensure its effects are national – there are no exceptions. Revalidation should thus achieve consistency of standards from one end of the Kingdom to the other. And

by virtue of the evidence requirements, revalidation should contribute directly to the development of efficient national and local systems of quality improvement and quality assurance in the clinical teams and institutions in which doctors work.

There are 5 main elements to the revalidation process. These are as follows:

1. *The Standards Template*

The headings of *Good Medical Practice* form the operational template. The explanatory statements and the detailed criteria and evidence required to assess and demonstrate compliance, will all sit below them. The headings cover:

- Good clinical care
- Maintaining good medical practice
- Relationships with patients
- Working with colleagues
- Teaching, training, appraising, assessing
- Probity
- Health

2. *The Evidence*

Demonstrating compliance is critical. In the UK, we have decided that the evidence should mainly be about a doctor's performance – what a doctor does. Performance subsumes competence – what doctors are capable of doing because of their clinical knowledge and skills. Evidence of performance is much more attractive to doctors because it reflects more closely their everyday work with patients.

As you can imagine, there has been much controversy about the nature of the evidence, how comprehensive and representative of a doctor's practice it should be, how objective, how robust, and so on. A great deal of work remains to be done, especially by the GMC and Royal Colleges who share the responsibility for setting out in detail what should be expected of a doctor in terms of specific criteria and evidence describing technical clinical competence and performance.

The evidence will be kept by the doctors in a revalidation folder. This folder of evidence will form the basis of the periodic appraisal – really assessment of a doctor's performance.

For employed doctors in the UK, the main sources of evidence are expected to flow from the institutional arrangements for clinical governance, which have been set up in parallel by the government through the NHS. The key thing is that the evidence should be doctor-specific. So clinical governance should yield data on, for example, a doctor's results of clinical audit, patient mortality,

complication rates where relevant, prescribing data, the record of relevant significant events and complaints, any action taken, and so on. Another important element will be the record of the doctor's involvement in continuing professional development. There should be direct evidence of a representative sample of patients' experience and satisfaction with a doctor's care. And there must also be direct evidence of the doctor's health and the doctor's performance as a member of a clinical team, as a teacher, and as someone who is known to patients and colleagues for their integrity and honesty.

3. *Assessing the Evidence*

All doctors in the NHS have started to have an annual appraisal by a peer. That appraisal should take full account of evidence of performance recorded in the doctor's revalidation folder. Discussions continue as to whether the evidence should also be looked at by a lay person at that stage. The review of evidence for revalidation is intended to be an essentially continuous process. The process is grounded on the regular internal review of clinical practice in every clinical team, which should become part of everyday clinical governance. The annual appraisal will provide an opportunity for a rather more detached and systematic review at one removed from the team. At the end of 5 years, after 5 appraisals, the doctor will submit the totality of evidence to the GMC for the formal process of revalidation.

Because the process of revalidation will be relatively continuous, we can predict with reasonable confidence that difficulties a doctor may have will be identified early and acted upon. That way, danger to patients should be minimised and doctors should be given help to put things right before any harm is done to patients or to their own reputations.

It is anticipated that most doctors will be revalidated successfully. Some at the moment see the collection of evidence and the appraisal as something of a threatening chore but others, particularly amongst the young, see it as a proper expression of their transparent accountability to their patients, part of responsible doctoring.

4. *Action on Dysfunctional Practice*

A critical element of the revalidation process is the underpinning by what are known as the GMC's Performance Procedures. Where a doctor's performance gives cause for concern, the GMC has developed a portfolio of assessment instruments designed to give an accurate diagnosis of the nature of the problem. These assessment instruments are already part of the GMC's Fitness to Practise Procedures. Operational experience to date suggests that the methods are sound, but that the standards need recalibrating upwards, to bring the baseline for licensure as close as possible to the

standards which reflect “good” practice rather than a bare minimum.

In cases of doubt, no doctor’s license to practise will be revalidated without the GMC first completing a full assessment of the doctor’s performance. These assessments, normally carried out at the workplace, are done by 3 highly trained assessors (2 medical and 1 lay) and usually take 3 days. Evidence is gathered from colleagues and patients to give an independent view of that doctor at work. They include formal tests of knowledge and skill and clinical problem solving abilities.

If there is indeed a problem, the results of the assessment are presented to a formal panel of the GMC which has the task of adjudicating and of deciding what should be done.

5. *Quality Assurance*

The GMC, as the licensing authority, carries ultimate responsibility both for the integrity of the process of revalidation and for the results in the case of individual doctors. It is the licensing authority – so the buck stops with it.

Where it delegates part of the work of revalidation to others such as management of the NHS, or to a Royal College or to one of the institutional quality assuring bodies, it will have to put in place measures through which it can be sure of the integrity and the reliability of the work carried out by these others in its name. The work continues on how precisely this should be done.

Conclusion

Revalidation is a radical departure from the past. It puts the well being and safety of patients firmly at the heart of matters. I have every expectation, that, once the process is

established, it will be progressively refined as part of a dynamic process of development.

One illustration of that dynamism is the international “partnership of the willing” being assembled by the Picker Institute Europe, a charity dedicated to patient-centred care and patient-centred professionalism in medicine. As I speak, work is just starting on a new generation of codes of professional practice which will be more firmly rooted in direct evidence of patients’ experiences and expectations of doctors. The new evidence-based codes which should be ready in 2 to 3 years, should provide a truly up to date basis for the assessment methods that can be used to demonstrate compliance.

I look to the day, in the next 5 years or so, when doctors everywhere see revalidation as the natural and desirable thing to do, an expression of their accountability to and respect for their patients, and of their self respect as professionals of standing in their communities.

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