Revalidation - Raising the Bar Higher

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I have often wondered if the parents of the children having heart operations at Bristol in the early 1990s ever doubted the standard of care that their loved ones would receive. Most likely they did not; instead implicit trust was placed in individuals and the system; trust that would be betrayed.

While it would be simplistic to ascribe medical mishaps to individual factors, a collection of such failings and poor governance sets the stage for such events to recur.[1] Good medical practice (GMP)[2] goes beyond keeping skills up to date, and includes attributes that were traditionally overlooked but are equally crucial to effective medical care. The principle that all practising doctors should maintain high standards throughout their career is not in dispute, but is revalidation in the proposed form the right solution?

Come the 3rd of December 2012, revalidation will be necessary to maintain a licence to practise medicine in the UK. The GMC expects to revalidate licensed doctors by March 2016. For the nearly 250,000 doctors in the UK, the outlined framework of revalidation consists of four main identified domains: appraisal of skills, patient safety, communication and maintaining trust. These broad terms encompass a whole gamut of medical practice, and while this makes revalidation relevant, it also makes it very difficult to achieve in an objective manner.

The core method proposed for achieving successful revalidation is a series of annual appraisals that look at the four domains. GMC states that annual appraisals will be evaluated at a local level through a Responsible Officer, who would then be able to recommend revalidation of the doctor every five years.

The scope of the required annual appraisal is large. Each of the four domains is divided into three subdomains, each of which in turn has a number of attributes that need to be assessed. These total up to a total of 59 (fifty-nine) examples of principles and values linking in to GMP. This changes the concept of appraisal completely from being a formative assessment focusing on reflection and areas for improvement, to being a definitive report card, a completely different beast.

It would require huge time and effort to compile the requisite data. The Academy of Royal Medical Colleges, in their statement on the impact of revalidation, report that fewer than 50% of doctors expect to absorb revalidation in the current NHS time, with most expecting that revalidation-related activities will take away valuable time currently allocated to service development, improvement and governance.[3] They also report significant concerns about lack of support from employers, confusing information and lack of clarity on goalposts. And this is before taking into account that 25% of all doctors report not even having an appraisal in the last year! Assuming the appraisals of the nearly 50,000 doctors to be revalidated every year are in order, allocating 15 minutes of the RO's time per doctor would require 12,500 hours of work every year just from the ROs. This would require huge support from the employers who will have to fund this activity. There is as yet no cost estimate of the process, either from the Department of Health, or indeed the GMC, but the costs involved are likely to be substantial and implemented when there is significant pressure on the NHS to cut costs.

The impact of revalidation on speciality doctors and those who work less than full-time will be even greater. The rate of appraisal for speciality doctors is only 50%, and this group of doctors has long felt undervalued and unappreciated by their employers. With limited time allocated for activities outside of service provision, this group of doctors will find it especially difficult to achieve successful appraisal as their job plans do not provide adequate opportunity to address the four domains linked to GMP. A disproportionate number of speciality doctors belong to the BEM background and are International Medical Graduates, a group that has particularly felt hard done by both employers and regulators. There are genuine concerns that revalidation will perpetuate inequalities that this group has battled with over many years. The burden of appraisal and revalidation on doctors in less than full-time work will be proportionally larger as well, and may well be unachievable as they will have to provide a similar burden of proof for successful revalidation, while having disproportionately less allocated time to do so in.

Most Responsible Officers will also be line managers for the concerned doctors. This raises concerns both about conflict of interest and lack of transparency. Lack of objective criteria for both appraisal and revalidation have the potential to make unfavourable outcomes contentious. The fear is that revalidation may be used as a tool by the employers for disciplining or weeding out doctors and circumventing employment law. Failure to engage with revalidation will automatically lead to Fitness to Practice proceedings and this is never good news for the doctor involved, their employer, patients or even the GMC. Although the GMC expects 'most' doctors to be able to maintain their licence to practise, remedial measures

for the ones who are not able to meet these criteria are conspicuous by their absence. The expectation is that remedial action will happen at a local level, funded by employers, but no assessment has been published about the costs involved with such an exercise or of the impact that this will inevitably have on service delivery. There is a valid concern about adverse outcomes for International Medical Graduates who have often found themselves at the receiving end of disproportionately higher rates of complaints, disputes with employers, and subject of FTP proceedings at the GMC with a higher rate of adverse outcomes.

On the flip side, as the vast majority of doctors are expected to have no problems during revalidation, the effectiveness of the whole exercise is brought into question. Is revalidation going to end up merely being a rubber stamp, an extensive and expensive charade that will fail to fulfil the purpose that it is designed for? Would it have been successful in identifying Harold Shipman, the GP who had glowing testimonials from his patients and colleagues? Will it be able to prevent another Bristol heart scandal, where the medical directors ignored whistle-blowers and continued to support failing colleagues and a faltering system?

Doctors are the first to admit that revalidation is both essential and long overdue, but there remain many unaddressed valid concerns on the structure and implementation of this important change. It is essential that the GMC and employers gain the confidence of doctors in the initial phase of revalidation. Clear guidelines, transparent working and visible representation of minority groups will go a long way in gaining widespread trust of the doctors and making revalidation a positive process. Clarity in its implementation will also gain public confidence in both the GMC and doctors, which has steadily eroded over recent years. The alternative scenario of doctors who remain sceptical of their employers and the GMCs intent, and consequently fail to engage with revalidation, will be a huge opportunity wasted, perhaps for a generation. At this time, when the NHS is going through financial and political turmoil, the need for public support cannot be overstated. If we continue to let our patients down - Mid Staffordshire is a recent case in point 5 - the damage to the reputation of both the NHS and doctors may well be irretrievable. The stakes for the future of medical practice in the UK could not be higher. ■

References

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