Supporting revalidation: methods and evidence

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ABSTRACT – The aim of revalidation is to reassure the public that doctors are up to date and fit to practise. The Royal College of Physicians has developed various programmes of work, both ongoing and under development, in support of revalidation. The purpose of this work is to provide guidance for doctors about the standards of practice expected and the types of evidence required for revalidation. A range of methods and tools are outlined that could be used by doctors to demonstrate their commitment to evaluating and reflecting on the way they practise medicine. These methods include ways of assessing both professional standards and clinical competence. Although the conclusions of the Chief Medical Officer in terms of the absolute requirements for revalidation are still unknown, the College is committed to supporting its Members and Fellows to prepare for revalidation through setting educational, professional and clinical standards in medicine.

KEY WORDS: appraisal, assessment, clinical practice, competence, professional standards, revalidation, standards

Introduction

The revalidation of doctors is becoming an essential prerequisite for continuing medical practice. The planned introduction of licensing and revalidation by the General Medical Council (GMC) in April 2005 was postponed until the completion of a review announced by the Chief Medical Officer (CMO) in December 2004.[1] The review is being undertaken by a group chaired by the CMO, Sir Liam Donaldson, and was established in response to the issues raised by Dame Janet Smith in the fifth report of the Shipman Inquiry. The terms of reference of the CMO's advisory group include the review of the role, structure and function of the GMC and the need to strengthen procedures to assure patient safety.[2] Specific attention is given to the importance of evaluating a doctor's clinical performance and conduct to ensure effective revalidation.

The purpose of revalidation is to provide reassurance to the public that the vast majority of doctors are practising to a high standard.[3] In doing so, it will also identify the small number of doctors who are not competent to practise. The GMC has described revalidation as 'one element of the quality framework to ensure patient safety and improve the quality of patient care'.[4] The three broad policy aims for revalidation are to: [5]

- encourage doctors to reflect meaningfully on their practice
- shift the emphasis of registration from qualifications to being up to date and fit to practise, and
- establish the regular evaluation of doctors.

In terms of revalidation, the GMC has stated that:

> *the role of the Royal Colleges is vital in terms of standard setting especially as, in practice, the standard varies for individual doctors depending upon what they do, their experience and seniority.*[4]

The Royal College of Physicians promotes the highest quality care for patients by setting educational, professional and clinical standards in medicine. These standards are set in order to advise Members and Fellows about good practice and to inform patients and carers, healthcare commissioners, managers and the Department of Health about the requirements for a high-quality service. The conclusions of the CMO in terms of the absolute requirements for revalidation are still unknown, but the College is developing a programme of work to support and guide physicians about the standards of practice expected and the types of evidence required for revalidation.

Background

In May 2001, the GMC launched *Good medical practice*, which 'described the principles of good medical practice and standards of competence, care and conduct expected of doctors in all aspects of their professional work'.[6] Essentially, *Good medical practice* was developed as a guide to help doctors prepare for annual appraisal and revalidation. Following this, the GMC asked the medical Royal Colleges to prepare supplementary guidance to cover their areas of practice. The Federation of Royal Colleges of Physicians of the UK developed the *Good medical practice for physicians* guide,[7] which was circulated to all Fellows in 2004. *Good medical practice for physicians* is based on the seven headings of *Good medical practice* and is applicable to all aspects of clinical practice, including private practice and periods spent in locum appointments.[7] As part of its development, each of the med-

ical specialties (through the Joint Speciality Committees) was asked to draw up at least two standards to support good medical practice. These specialty-specific standards are referenced in the booklet and can be found on the Royal College of Physicians website at **www.rcplondon.ac.uk/specialty/index.asp**. While these specialty-specific standards are based on the original GMC recommendations, many are indicators of structural or administrative aspects of a service and are difficult to measure reliably.

In *Good medical practice for physicians,* the importance of complying with authoritative clinical guidelines, where they exist, is emphasised. The College promotes high-quality clinical practice through the work of its Clinical Effectiveness and Evaluation Unit (CEEu) and the National Collaborating Centre for Chronic Conditions (NCC-CC). These Units work in collaboration with both the National Institute for Health and Clinical Excellence (NICE) and the specialist societies and have recently published guidelines on stroke (2004), chronic heart failure (2003), chronic obstructive pulmonary disease (2004), multiple sclerosis (2004), and type 1 diabetes in adults (2004). Guidelines are currently under development for tuberculosis, Parkinson's disease, atrial fibrillation, and anaemia management. Details of current and completed clinical guidelines projects are provided at **www.rcplondon.ac.uk/standards.asp**.

The Clinical Effectiveness and Evaluation Unit also collaborates with the specialist societies in developing a series of concise guidelines for clinical management. Recently published concise guidelines include: *The use of botulinum toxin in the management of spasticity in adults*; *Rehabilitation following acquired brain injury*; *HIV testing for patients attending general medical services;* and *Prophylaxis and treatment of infecive endocarditis in adults.* Proposed topics for future concise guidelines include: delirium in older people (British Geriatrics Society); the management of depression in adults undergoing rehabilitation following acquired brain injury (British Society of Rehabilitation Medicine); and the identification, management and referral of adults with chronic kidney disease. Details of the series are provided at **www.rcplondon.ac.uk/college/ceeu/ceeu_conciseGuidance.htm**. If you would like to become involved in the development of guidelines, the CEEu can be contacted at **ceeu@rcplondon.ac.uk**.

While the focus of revalidation is on the individual doctor, the quality of the care provided does depend additionally on the infrastructure and support provided for delivering the service. The College has recently completed the third edition of *Consultant physicians working with patients*, which provides speciality-specific advice on the organisation and structure of services necessary as a base from which to provide a high quality of care.[8] It sets out recommendations about the time, manpower and facilities required for specialist practice and includes advice on the workload and practice of individual doctors, including specimen job plans. It is a valuable tool to support the annual appraisal process.

Developing a revalidation portfolio

Revalidation needs to include assessments of both the doctor's conduct (measure of professional behaviour) and clinical competence. The GMC is expecting the medical Royal Colleges to work with their specialties to develop standards and guidance for the evaluation of the professional and clinical abilities of the individual doctor, taking into account their specialty, role and experience.

After consultation with Fellows, Members and the specialist societies, the College has identified a number of elements that might be included in the revalidation of all physicians. Some of these elements have been highlighted as core requirements for the revalidation of all physicians. Other elements are more specialty-specific and focus on particular elements of clinical practice. The core elements of revalidation (outlined below) are primarily related to the assessment of the professionalism and conduct of the individual doctor.

Establishing professional standards

The physician's first responsibility is to the patient, but they also have other important relationships with many other healthcare professionals and managers who contribute to service delivery. Physicians have responsibilities in leading the service, service developments and managing change. The College proposes that professional performance assessment for revalidation should be evaluated through the use of multi-source feedback, patient satisfaction questionnaires and ongoing participation in Continuing Professional Development.

The first method of evaluating professional performance for revalidation is through *multi-source feedback*, otherwise known as 360 degree assessment. Although essentially a subjective assessment, when used in conjunction with other more objective measures of clinical competence, multi-source feedback could provide a well-rounded evaluation of an individual physician. Patients are likely to view multi-source feedback as a credible form of assessment for revalidation. An earlier College project developing both multi-source feedback and a patient satisfaction questionnaire for performance assessment of specialist registrars (SpRs) is nearing completion. It is anticipated that the multi-source feedback tool will be in routine use for

Key Points

- **The Royal College of Physicians recognises the importance of revalidation and the need to be proactive in supporting revalidation**
- **Revalidation needs to include assessments of both a doctor's conduct (professional standards) and clinical competence**
- **Doctors could use a range of methods or tools to provide evidence for revalidation**
- **Professional performance assessment for revalidation should be evaluated through the use of multi-source feedback, patient satisfaction questionnaires and ongoing participation in Continuing Professional Development**
- **Clinical competence assessment for revalidation could involve the use of both generic and specialty-specific measures**

SpRs from October 2005. More information is available on the Joint Committee for Higher Medical Training (JCHMT) website at **www.jchmt.org.uk/assessment/performanceassessment.asp**. Moreover, the Federation of Royal Colleges of Physicians of the United Kingdom is currently developing a standard multi-source feedback tool for performance assessment for consultants, with pilots planned throughout the next 12 months. The aim of the project is to validate and establish a nationally accepted standard tool, which will evaluate both professional behaviour and some clinical aspects of the physician's work.

A second method for evaluating professional performance is the use of *patient satisfaction questionnaires*. These surveys provide important information about the professional manner of doctors and their relationships with patients. In conjunction with the development of the multi-source feedback instrument (outlined above), the Federation is developing a standard patient satisfaction questionnaire for consultants. The questionnaire will be developed in collaboration with the RCP Patient Involvement Unit and is to be piloted by consultants throughout the next 12 months.

Finally, the inclusion of *Continuing Professional Development (CPD) certificates and attendance records* is already a part of the annual appraisal of individual doctors. Doctors are required to demonstrate that they have completed 50 hours of approved CPD annually. Additional information regarding CPD is available at **www.rcplondon.ac.uk/professional/cpd/index.htm**. The College believes that the inclusion of CPD attendance records in revalidation would be an effective way for physicians to demonstrate their commitment to ongoing professional development and reflecting on the way they practise. The Education Department at the Royal College of Physicians has developed and maintains a CPD Diary, accredits educational events for CPD and issues an annual certificate. The College delivers a range of courses to support Continuing Professional Development, such as the Physicians as Educators Programme which includes appraisal training for consultants.

The Physicians as Educators Programme is a major initiative from the Royal College of Physicians to support doctors who wish to develop such skills as teaching, supervision, appraisal and assessment. The workshops are interactive and involve the use of videos, role-plays and discussion. The programme, now in its seventh year, consists of one- and two-day workshops which encourage discussion and development of practical skills. Competence in teaching and training can also be demonstrated by formal student and trainee feedback. Formal reports following General Professional Training or JCHMT reviews can also provide additional supportive evidence. Further information about this Programme is available at **www.rcplondon.ac.uk/professional/pae/index.htm**.

Evaluating clinical competence

As the process of revalidation has evolved it has become clear that the College needs to identify ways of supporting the assessment of the clinical competence of the *individual* doctor. The work of physicians varies hugely between and within specialities and reflects a great diversity of activities. As physicians work in teams, the quality of the service provided and its outcomes may not necessarily reflect the practice of an individual doctor. Early in 2005, after consultation with the specialist societies, the College established the Revalidation: Adding a Clinical Component (RACC) project to take work forward on identifying and developing ways of evaluating the clinical competence of the individual physician.

The RACC project is working in collaboration with the specialist societies to develop and refine the types of evidence needed to demonstrate clinical competence in each individual specialty. The project has identified a 'basket of tools' from which individuals could choose the most appropriate ways of evaluating their clinical practice. Some of the tools are well established, others are under active development or will require further work in the future.

(a) Generic tools across specialties

Within the basket of tools for the evaluation of clinical practice are a number of options that can be applied across the specialties. These tools provide a more generic view of the clinical competence of the physician and are primarily used to fulfil one of the main aims of revalidation, that is, for physicians to reflect on their own practice.

The first generic form of clinical evaluation is *case notes audit*. Internal review of case notes is a well-established audit method, but is rarely carried out using a structured approach. The regular audit of case notes requires standard methods of analysis and assessment. The Health Informatics Unit (HIU) at the RCP is developing evidence-based professional standards for medical record-keeping (paper notes) and investigating clinical requirements for electronic records. These medical record-keeping standards support the GMC's requirement to keep adequate medical records and are essential for the comparison and benchmarking of aggregate data from patient records. Draft record-keeping standards developed by the HIU, including an audit tool for case note audit, are available at **http:// hiu.rcplondon.ac.uk/clinicalstandards/index.asp**.

To advance awareness of how best to manage clinical information, the Health Informatics Unit and the Education Department have developed an educational resource named *Laying the foundations for good medical practice,* designed to teach doctors essential, generic professional skills.[9] Exercises on topics such as record-keeping standards, patient safety, prescribing, communications with colleagues and patients, and career development are mostly delivered in small groups, and training sessions for tutors are being delivered by the Education Department. More information about the *Laying the foundations* resource can be found at **http:// hiu.rcplondon.ac.uk/education/layingthefoundations/**.

A second non-discipline-specific tool that could be used by physicians to support the clinical element of their revalidation is the *iLab Project*. Developed within the College's Health Informatics Unit, the *i*Lab aims to improve the quality and utility of Hospital Episode Statistics

(HES data) attributable to an individual consultant. The 'Information Laboratory' (*i*Lab) is a secure, controlled environment in which routinely collected clinical data can be accessed and analysed by individual doctors, with support from *i*Lab staff. Analyses are tailored to the individual's needs regarding their specialty interests, specified diagnoses and procedures, and peer group for benchmarking. It aims to improve patient care by generating clinical interest in improving the quality, validity and use of routinely collected clinical data. The *i*Lab's first major project is to review the information needs for consultant appraisal and revalidation and assess how routine data will be able to support these needs. Participating consultants will be able to use these data as supporting evidence for revalidation. Details about the *i*Lab project are provided on the HIU website at **http://hiu.rcplondon.ac.uk/ilab.asp**.

A third generic tool that could be used by physicians to support their clinical practice for revalidation is a *management plan template*. Several specialist societies have developed a standard requiring that all patients have an 'agreed management plan'. Such a plan demonstrates that relevant investigations and treatment options have been considered in consultation with the patient. The College is currently developing a standard management plan template in collaboration with the specialist societies. The advantage of a management plan is that it can be copied to the patient and also serves as documentary evidence that each patient has an agreed plan. The template would support outpatient consultations and could be of particular value in the management of chronic conditions.

Finally, the *recording of complaints and critical incidents* is already monitored by some Trusts as part of the annual appraisal of an individual doctor. A similar process should be included in revalidation. However, careful analysis and interpretation is important, as some incidents may be beyond the influence of the physician. Moreover, the fact that an individual may have no complaints does not automatically imply that they are clinically competent.

(b) Specialty-specific tools

Unlike the generic options outlined above, physicians could opt for a number of more specialty-specific ways of evaluating their clinical competence for revalidation. Each of these methods is resource intensive and requires a higher degree of development if they are to be effective methods for revalidation. However, they also provide more detailed information about the specialist clinical skills and competence of the physician.

In collaboration with the Specialty Advisory Committees, the JCHMT has developed competency-based curricula for medical specialties, together with a generic curriculum that applies to all trainees. To support these curricula, a number of assessment methods will be used as a regular form of trainee assessment. Direct Observation of Procedures (DOPS) and the mini-Clinical Evaluation Exercise (mini-CEX) are now validated assessment tools and have been successfully piloted for the assessment of clinical competence at SpR level. These assessment tools could be extended to assess physicians throughout their careers, in order to demonstrate that they have maintained and updated their knowledge and skills. More information is available at **www.jchmt.org.uk/assessment/performanceassessment.asp.** The practical constraints of time, particularly if external assessors are used, and the devising of appropriate standards are daunting. Physicians who perform interventional procedures could undergo the same type of assessment as an airline pilot, using simulators, and these are under development in some specialities (eg cardiology).

A second way of assessing specialty-specific clinical competence is through the development and use of examinations. In her final report of the Shipman Inquiry, Dame Janet Smith considered the possibility that GPs should take a written knowledge examination as part of revalidation. The role of a regular knowledge-based examination throughout a doctor's career to support revalidation needs to be considered, although many Members and Fellows are concerned about this possibility. Patients and healthcare commissioners might find this form of assessment highly reassuring and credible as evidence to support revalidation, as it does reflect the knowledge of an individual. However, the practicalities of organising such examinations, including setting questions, level of pass mark, the balance between general medical and specialist knowledge, and the validity of a test of knowledge adequately reflecting clinical practice, are all challenges that require further consideration. The JCHMT is currently developing knowledge-based assessment of SpRs within five specialties (gastroenterology, elderly medicine, cardiology, neurology, dermatology) as a pilot project due for completion by summer 2006.[10] The College may need to evaluate the potential for using these new assessment programmes to support ways of assessing clinical competence throughout a physician's career.

A third option, peer review, would be a credible and valuable source of information for revalidation about the quality of a service and the clinical competence of an individual physician. Repeat visits give the opportunity to re-evaluate and assess changes in a physician's practice. A number of specialist societies have already established peer review schemes (eg the British Thoracic Society, and Cancer Network Reviews). However, the widespread development and application of these schemes would be resource intensive in terms of organisation, time and funding.

The College has a dedicated Invited Service Review Scheme. This process supports physicians when they feel the practice of good clinical medicine is compromised, and forms an important method for protecting patient care. The College acts independently of other authorities and is able to offer advice and recommendations in an environment of trust. Trust management (chief executive or medical director), or Fellows and Members of the College may request an Invited Service Review when there is a particular issue which is proving difficult to resolve, or on which they

need advice. Such issues incorporate clinical practices including unsatisfactory performance, service delivery, the provision of medicine in merging trusts, or in small medical/isolated units, technical services and workload issues. The visiting team analyse the situation concerning individuals and services, via interviews with trust staff. Verbal feedback is provided at the end of the review and a detailed written report with recommendations is provided. Problems identified may be team based, due to failure of relationships or systems failure, or may be related to the competence or behaviour of an individual. The Invited Service Reviews enable the role of the physician in unsatisfactory performance to be set in context. Further information about the Invited Service Review scheme is available at: **www.rcplondon.ac.uk/nhsmanagers/nhs_isr.asp**.

Comparative national audit is a fourth method that could be used for the evaluation of clinical competence. The CEEu has pioneered the concept of comparative national audit, in which data are collected on specific conditions from every hospital unit. Reports to trusts show their performance benchmarked against the national and regional picture and this feedback has led directly to improvements in care. Data are shared with Strategic Health Authorities, the Healthcare Commission, the National Audit Office, as well as with managers and doctors in the local trusts. RCP audit data have also been used in the development of star ratings within the NHS and have demonstrated that good organisation of care is linked to a better process of care and better outcomes. Details of current and completed audit projects are provided **at www.rcplondon.ac.uk/standards.asp**.

While national audit addresses issues of clinical care delivery, it is currently designed to measure the clinical performance of units or trusts, rather than individual physicians. The completed audits demonstrate a wide range of different performances between trusts that cannot be explained by casemix or other factors. Nevertheless, where local teams have scored poorly, the RCP has encouraged them to investigate possible reasons for their performance. Such reasons may include poor or erroneous data, inadequate facilities, or one or more poorly performing staff. Physicians should include participation in national audit as evidence to support revalidation.

The reports of local audits should also be kept in the revalidation folder, as should the records of multidisciplinary team meetings, when physicians participate. There should be regular review of the relevant national guidelines and documentation to support evidence of local adherence to guidelines, including a note of resource difficulties that affect an individual's ability to meet best practice. This evidence is likely to be based on self-assessment and less robust than national comparative audit but will still be useful in supporting revalidation.

A fifth and final specialty-specific method for assessing clinical competence for revalidation is the development of clinical indicators. Using the experience of audit, the College plans to take forward work on the development and application of specialty-specific standards. Several specialties have set out possible measures that might be helpful in evaluating care in their field of practice. Over the next 18 months, a series of dedicated workshops are planned in collaboration with the specialist societies, to develop auditable clinical indicators. The concept is attractive and would be credible to both the GMC and patients. The challenge is to identify indicators that can be measured and recorded accurately, as well as reflecting the practice of individual doctors as closely as possible.

Conclusion

Revalidation is a significant process of change and its impact on the practice of doctors will be widespread. The College recognises the importance of revalidation and the need to be proactive in supporting revalidation, rather than being a passive recipient of policy change. This paper has outlined the various programmes of work, both ongoing and under development within the College. The purpose of this work is to guide physicians about the standards of practice expected and the types of evidence required for revalidation. A range of methods and tools have been outlined that could be used by physicians to demonstrate their commitment to evaluating and reflecting on the way they practise medicine. Although the conclusions of the CMO in terms of the absolute requirements for revalidation are still unknown, the College is committed to supporting its Members and Fellows to prepare for revalidation by setting educational, professional and clinical standards in medicine.

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