Credentialing and Revalidation: A Position Paper

Introduction

1. Recent years have seen growing interest in the concept of credentials, or credentialing, in UK medicine. But the enthusiasm for credentialing that is evident in some quarters is matched by scepticism and outright hostility in others. The lack of consensus reflects widely differing views on what credentialing means, or should mean, the nature of the problem it is intended to solve, and the costs or benefits it might deliver.

2. The debate was given impetus by Lord Darzi’s 2008 report *A High Quality Workforce: NHS Next Stage Review* which stated that credentialing ‘gives assurance to patients and employers that professionals have the right skills to deliver high quality care, whilst giving recognition to professionals themselves’. The report went on to charge the regulators and professional organisations with taking forward the idea of credentialing.

3. Against this background, the Department of Health (England) (‘DH(E)’) invited PMETB to lead exploratory work on credentials and the credentialing of medical practice. The work would involve two discrete, but related, streams of work. The first would look at credentials as an element of progression through specialty training, and would be led by PMETB under the chairmanship of Professor Alastair McGowan. The second, led by the GMC, would consider the relationship between credentialing and revalidation, and would be chaired by Professor Malcolm Lewis. The aim of both workstreams would be to explore the issues, without any commitment at this stage to the introduction of credentials and credentialing.

4. This position paper is concerned with the second of those workstreams; the relationship between credentialing and revalidation. Its aim is to set out a provisional view on whether there is a need for a system of credentials or credentialing within medical regulation, and thus to stimulate debate which will inform the conclusions of PMETB and GMC.

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What are credentials?

5. The starting point for any discussion about credentials needs to be agreement about what the terms actually mean. Analysis of the literature reveals a wide range of different uses in the UK and internationally. However, for the purposes of this paper we begin with the definition offered by Lord Darzi: ‘the formal accreditation of capabilities at defined points within the medical career pathway that takes into account knowledge, capabilities, behaviour, attitudes and experience.’

6. Credentials are distinct from recognised sub-specialties (which can already be recorded in the GMC’s specialist register). Definitions of credentials also raise questions about the potential breadth or depth of medical practice they are intended to describe, and whether their effect should be permissive or restrictive; that is to say whether doctors would be limited to practising only in those fields for which they have a recognised credential. However, these are second order questions, which can be addressed once we have decided whether, in principle, they have the potential to add value.

7. Within the concept of accreditation of capabilities, we also need to distinguish between two related ideas. The first is the acquisition of a credential as a qualification or award after following a curriculum. The second is the process of credentialing which recognises the demonstration of continuing fitness to practise in a particular field. The former treats credentials as products which require curricula design, approval and quality assurance, and the resources to support these activities. The latter is more closely aligned with revalidation in being related explicitly to evidence of ongoing performance in practice within a particular field.

What’s the problem that credentials are aiming to solve?

8. Part of the difficulty in reaching consensus about the value of credentials and credentialing is that they sometimes seem to be a solution in search of a problem. Although Lord Darzi refers to ‘international experience’ confirming the benefits for patients, employers and the profession, a literature review commissioned by DH(E) for this project is rather less clear cut in what it reveals about credentialing worldwide and its potential application in a UK context. Whilst the review highlights many examples of different types of credentialing, both in medicine and in other professions, it shows little evidence of the tangible benefits which have flowed from credentialing. This is not to say that such benefits do not exist. It is possible to see how they might meet defined needs in the healthcare systems where they operate. But we need to be very clear about the problems we are trying to solve in the UK context before we consider whether credentialing could contribute usefully to medical regulation here.

9. There are a number of areas where credentialing might help to meet an identified need.

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2 Department of Health Literature Review Relating to Credentialing in Medical Training, 2009, (unpublished)
3 A High Quality Workforce: NHS Next Stage Review, Department of Health, 2008, p16
Providing more and better information

10. The 2006 report by the Chief Medical Officer for England, *Good doctors, safer patients* and the Government’s 2007 white paper *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century* both showed an appetite for the registers held by the GMC to provide additional information.\(^4\) In the final report of his independent inquiry into Modernising Medical Careers, Sir John Tooke also recommended that ‘DH should work with the GMC to create…an inventory of the contemporary skill base and number of trained specialists/sub-specialists in the workforce’.\(^5\)

11. Research commissioned by the GMC in 2006 as part its review of the fitness for purpose of the specialist register suggested that additional, verifiable information about doctors’ sub-specialty practice would be welcomed by employers. However, the same research also indicated that patients and the public would be unlikely to use the registers to inform their healthcare choices, even if more information was provided.

12. The GMC review concluded that recording doctors’ specialist credentials in the register ‘would help to make [the register] more up to date and transparent because it would be possible to capture the details of specialist competences acquired and maintained throughout doctors’ careers, not only at the point they become eligible for inclusion in the specialist register’.\(^6\)

13. But, crucially, when the review reported its findings to the GMC’s Council in April 2007, it was decided that further work needed to be taken forward in the context of the developing proposals for revalidation. There was an appetite for the registers to carry more information where that was of benefit to others, but this could not drive the GMC’s plans for revalidation. In short, the cart should not be put before the horse.

*Providing assurance that doctors are practising to the appropriate standards in their chosen field.*

14. The goal of providing more information through the registers is closely linked to the idea of providing assurance that doctors are practising to appropriate standards.

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\(^4\) Good doctors, safer patients: A report by the Chief Medical Officer, Department of Health, 2006, recommendations 38-40.


\(^6\) Accessible, Transparent, Informative: Proposals for Registering Information About Specialist Medical Practice, GMC Council papers, April 2007, Item 5a
15. For doctors completing specialist or GP training in the UK, the Certificate of Completion of Training (CCT) and inclusion in either the GMC’s specialist register or GP register provide visible confirmation that they have attained a prescribed standard in their chosen field. But such assurance is not available in respect of doctors in career grade posts (including staff and associate specialist grades, and Trust grade doctors). They represent a significant proportion of the workforce (the BMA estimates over 14,000 doctors) and play a crucial role in delivering specialty services within the NHS, but they do not generally hold CCTs, Certificates of Eligibility for Specialist Registration (CESRs) or specialist registration. Therefore, there is no means by which employers and patients can be readily assured that they have achieved the appropriate standards in their specialty.

16. Even for doctors who have attained a CCT and been included in the specialist or GP registers, the level of assurance this provides diminishes over time. That is because the nature of a doctor’s specialist practice changes as his or her career progresses. Someone may sub-specialise or move into entirely different fields of practice. Research for the GMC’s specialist register review showed that around 15% of the doctors on the specialist register are working either wholly or partly outside the specialty for which they were originally listed in the register.

17. Similar arguments apply for those areas of medical practice which fall outside recognised medical specialties, or which straddle two or more specialties. These might include fields such as medical management, cosmetic surgery or forensic and legal medicine. In these areas, there is an obvious value for those employing or contracting services in being assured that those services are provided to a national standard.

18. Against this background, the ability to recognise and record doctors’ areas of competence outside the CCT would be a means of demonstrating that they have achieved, and are continuing to maintain, appropriate professional standards.

Providing recognition of doctors’ capabilities

19. That recognition of developing professional competence may also be of value to doctors themselves. For doctors in career grade posts without CCTs or CESRs the recognition of their competence will enhance status, and help to make their achievements visible and transferable to other units.

20. Enhancing the recognition or status of particular groups of doctors is not a regulatory function. However, if the means of delivering this also provides visible assurance for employers and the public that doctors are practising to appropriate professional standards, then the regulator has a legitimate interest. The fact that there is currently no regulatory framework to support the education and training of doctors in career grade posts should sharpen that regulatory interest.
21. The appetite for more and better information about doctors’ competences, the need for assurance that doctors are practising to appropriate professional standards, and the desire for professional recognition, all suggest that there is a gap in the regulatory framework. The question, therefore, is whether credentials or credentialing of some form could be an effective and proportionate means of plugging that gap or whether there are other, more appropriate solutions within our grasp.

**Credentialing and revalidation**

22. At the beginning of this paper we offered a working definition of a credential; ‘the formal accreditation of capabilities at defined points within the medical career pathway that takes into account knowledge, capabilities, behaviour, attitudes and experience’.

23. The GMC’s plans for revalidation are already well developed and the GMC will shortly be consulting on its proposals. Revalidation is a set of procedures operated by the GMC for the periodic ‘evaluation of a medical practitioner’s fitness to practise’ as a condition of continuing to hold a licence to practise. It will take account of doctors’ knowledge, skills, behaviours and attitudes as demonstrated through performance in actual medical practice. It is not difficult to see how the concepts of credentialing and revalidation begin to overlap.

24. As part of the development of revalidation the medical Royal Colleges and Faculties have prepared specialty specific standards that doctors working in their particular fields will be expected to meet in order to revalidate. They have also described the types of evidence that doctors might bring to revalidation from their practice to show that they are meeting the required standards. The evidence will vary from specialty to specialty, but will include information such as evidence of participation in audit, outcome data, prescribing data, information about complaints and feedback from patients and colleagues. The standards and evidence will apply to all doctors working in the specialty, regardless of whether they are consultants, GPs or career grade doctors. The register will provide a description of the field of practice in which a doctor has demonstrated ongoing competence through the process of revalidation.

25. Viewed in this way, revalidation becomes the means of recognising a doctor’s credentials in a particular field based on national standards developed by the colleges, and the GMC’s register becomes the visible expression of that credentialing process. The register thus also becomes a contemporary statement of a doctor’s credentials over time, capable of reflecting changes in practice between one revalidation cycle and the next. It might show, for example, how a doctor has moved out of clinical practice and into medical management.

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7 Medical Act 1983, section 29A(5) [not yet in force].
26. Using revalidation as the means of credentialing doctors’ practice has some obvious advantages. Not the least of these is that work to introduce revalidation for all licensed doctors, across all specialties, is already well advanced. By contrast, establishing a separate regime of registrable credentials is likely to be slow, resource intensive and evolve piece-meal.

27. Revalidation will also aim to address the problems identified earlier in this paper. By providing a description of the scope of practice against which a doctor has revalidated, there is an opportunity to satisfy the appetite for further information about doctors’ practice. In doing so, employers, patients and the public will be able to be reassured that doctors are practising to appropriate professional standards in their chosen field. The fact that these standards will apply both to consultants and career grade doctors will help to ensure recognition of the demonstrated capabilities of doctors in staff grade and associate specialist posts.

28. There remain some challenges with this approach. For example, an appropriate taxonomy will need to be devised for the descriptors of doctors’ revalidated practice. Although medicine is categorised through defined specialties, what doctors do in practice is less easily demarcated. One doctor’s practice may extend across a range of different activities. If the descriptor is defined too broadly, it may be of limited use to those consulting the register. Too much granularity, on the other hand, risks confusion and would be difficult to regulate.

29. Further, since revalidation will draw on information from each doctor’s practice, any statement on the register about a doctor’s practice must, to some degree, be unique to that doctor’s practice profile. There are limits, therefore, to the extent to which it would be possible to draw conclusions about a doctor’s particular competences from information on the register. This would make comparisons difficult, though it may be argued that this is not the job of the register.

30. These challenges will need to be tackled as part of the development of revalidation, regardless of the view taken of credentialing. What seems important is that, for the vast majority of licensed doctors, the current plans for revalidation should provide the solution to the problems that a separate system of regulated credentials would seek to address. For the majority, therefore, there is no obvious need to develop an additional suite of regulated credentials. A more measured approach would be, in due course, to evaluate the effectiveness of revalidation before determining whether regulated credentials would bring added value.
Some regulatory gaps

31. However, if revalidation is the answer for the vast majority, this begs the question of what happens for the minority. The specialty standards developed by the colleges and faculties for revalidation do not address fields of practice which fall outside the recognised specialties, such as cosmetic surgery where the need for more effective regulation is well recognised. Nor do they provide the answer for fields such as medical management (though work on standards and evidence for revalidation in this area is underway) or areas of practice which span more than one discipline, for example breast disease management. The development of national standards in such fields will be important to support revalidation. Indeed, revalidation provides an impetus for identifying isolated branches of medicine where credentials may add value.

32. But we also need to recognise the extent to which credentials in some fields may develop independent of revalidation or of national regulation generally. Individual specialties have always, and will continue, to develop forms of accreditation or credentialing for particular procedures or areas of sub-specialist practice without involvement of the national regulator. The Royal College of Ophthalmologists, for example, has developed a curriculum and assessment in laser refractive surgery which leads to a certificate of competence to practise in this area, subject to satisfactory appraisal and continuing professional development.

A provisional position statement

33. Medical regulation seeks to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

34. Revalidation will contribute to delivering this objective by requiring doctors to demonstrate that they continue to practise to the appropriate professional standards, and by using the registers to describe the field of practice within which a doctor has revalidated. This revalidation will be based upon specialty standards developed by the medical Royal Colleges and Faculties and agreed with the GMC. In this way, revalidation will confirm doctors’ credentials for continuing practice in their chosen field.

35. In the light of revalidation, for the vast majority of doctors it would be premature to introduce an additional system of credentials and credentialing at the present time. We should also be mindful of the opportunity cost of doing so. The need for additional credentialing should therefore be evaluated following the introduction of revalidation.

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8 Expert Group on the Regulation of Cosmetic Surgery: Report to the Chief Medical Officer, Department of Health, 2005.
36. There are, however, some discrete areas of medical practice where the establishment of national standards in the form of credentials may add value by supporting doctors in their revalidation and thus providing assurance for employers, patients and the public that doctors in these fields are practising to the appropriate professional standards. These include fields for which there are no existing specialty standards or where medical practice embraces a number of different disciplines.