

International Revalidation Symposium

2-3 December 2010

The symposium was organised by the General Medical Council, the Federation of State Medical Boards of the United States and the Health Foundation. There were 38 attendees, who heard from 11 speakers over the two day event in London. The aim was to increase understanding and build the evidence base for systems that provide assurance that doctors are competent to practice.

The programme

The symposium was divided into four sessions over two half days, covering:

- regulation and patient safety
- international models and approaches to licensing and revalidation/relicensure
- evaluating the evidence base
- the challenges of implementation.

Draft speakers' papers were included in the delegate pack which was distributed at the beginning of the symposium. Copies of the presentation slides have also been sent to delegates following the event.

Regulation and patient safety

Ron Paterson (Professor of Health Law and Policy at the University of Auckland) focused on the balance between professionalism and regulation. He challenged the group about how to give patients the assurance they seek that any doctor is competent and fit to practise yet do so in a way that does not undermine trust and professionalism by excessive accountability.

Harry Cayton (Chief Executive, Council for Healthcare Regulatory Excellence in the UK) described 'right-touch regulation' and linked this to programmes of revalidation/relicensure. He encouraged regulators to focus on the risks they are seeking to regulate, to be proportionate in response to risk and where appropriate find ways other than regulation to promote good practice and high quality healthcare.

The subsequent discussion focused on whether:

- revalidation/relicensure should be about improving standards or identifying poor performance or both
- increased regulation will undermine the professionalism that has been crucial to the development of high quality care
- there are ways of ensuring that a system of revalidation/relicensure carries the confidence of both doctors and patients.

International models

Four speakers provided perspectives and shared experiences from four countries: Dr Freda Bush from the Federation of State Medical Boards in the USA, Dr Bryan Ward from the College of Physicians and Surgeons of Alberta Canada, Professor Malcolm Lewis from the General Medical Council in the UK and Dr Renee Weersma from the Royal Dutch Medical Association in the Netherlands.

The subsequent discussion focused on the following questions.

- Should the tools used for revalidation/relicensure processes be formative or summative?
- How do regulators secure buy-in from the profession?
- Should the process involve a point in time assessment or a continuous evaluation?
- Should we try to develop a learning culture rather than a testing culture?
- There are cultural differences and variations in systems but what can we learn from each other to avoid reinventing the wheel?

Evaluating the evidence base

The third session focused on reviewing the existing research and evidence for different forms of information and data that can be used to evaluate a doctor's practice. Presentations covered:

- a. colleague feedback by Professor John Campbell from Peninsula Medical School in the UK
- b. patient feedback by Mr Peter Cross from Picker Institute Europe
- c. continuing professional development by Dr Nick Jenkins from the College of Emergency Medicine in the UK
- d. knowledge assessments and examinations by Dr Rebecca Lipner from the American Board of Internal Medicine
- e. clinical audit by Mr Robin Burgess from the Healthcare Quality Improvement Partnership in the UK.

The subsequent discussion focused on the following questions.

- Do these tools and data sets provide indicators rather than evidence of competent practice?
- Is it possible to develop a robust evidence base before these tools are used more widely across medical practice?
- What about resources – both in terms of financial costs and opportunity costs?
- Should the focus of any evaluation of practice be a combination of what your patients and colleagues say about you and what your data says about you?

The challenges of implementation

In the final plenary session we discussed the challenges of implementation and focused on the following themes from the presentations and discussions.

What is the purpose of revalidation/relicensure?

Is it about improving standards and the quality of medical practice or is it about identifying poor performance?

There was no consensus on the answer to this question but among many there was a view that these two goals were not mutually exclusive and that revalidation/relicensure should be able to set minimum standards, encourage self reflective practice among adequate and good performers, and raise that minimum over time.

Is there a robust evidence base for the proposed evaluation methods?

There is a body of evidence supporting many possible aspects of revalidation/relicensure, for example in relation to some forms of CPD, appraisal and multi source feedback, but overall the evidence base still needs to be developed. It will only be when systems are established and implemented that a much richer stream of evidence will emerge about what does and does not work.

How do we ensure that there is active engagement and buy-in from the profession?

Clear and consistent communication and engagement is required to show doctors the benefits of revalidation/relicensure and to reinforce its importance in promoting patient safety. The words we choose really do matter and the language can often be confusing – screening, excellence, evidence, outcomes, and competence.

Revalidation/relicensure will not be perfect at the outset

It will change and develop over time. Once revalidation/relicensure is embedded and subject to continuous evaluation and review, we can learn more about what works and what does not. It is not a static process and we need to evaluate and capture learning so that we can improve it over time.

In addition, the following points were stressed by participants.

- a. The practice of medicine is complex – it cannot be distilled into a series of discrete, measurable and universal outcomes.
- b. Medicine is a team sport – doctors rarely practice in isolation and increasingly work in multi-disciplinary teams.
- c. Medical professionalism is an important component of any system of regulation.
- d. Revalidation/relicensure systems should have patient safety at their centre.
- e. Revalidation/relicensure systems need to be flexible and open to improvement.
- f. There is a need to clarify the roles of professional regulators versus systems regulators.
- g. While there is likely to be a degree of commonality, revalidation/relicensure will not be the same in every country. Different programmes will be required reflecting different cultures, healthcare systems and legislative frameworks.

Research

The final part of the symposium asked delegates to consider what the main research questions might be for further developing the evidence base for revalidation/relicensure. The group proposed the following:

- a. further research to increase the rigour, validity and reliability of instruments and data used to evaluate a doctor's practice
- b. research to better understand why doctors seem resistant to some evaluation methods and to the principle of revalidation/relicensure
- c. exploring the link between the systems and professional regulation
- d. what are the measures of success for revalidation/relicensure? How do we know it is working?

And finally

There was a real sense from delegates of the importance of keeping in touch to share best practice, developing methods and evidence and to learn from each other. There was an appetite for repeating the exercise at a future date, perhaps in two years time, to review progress and share developments.