Revalidation: clearer and closer

The General Medical Council (GMC) is consulting on its proposals for revalidation.¹ The new UK Secretary of State for Health, Andrew Lansley, has confirmed his support for revalidation but delayed its introduction by a year. These are the latest in a series of veils being lifted to give us a clearer picture of what revalidation will look like, how it will work, and when it will start.²⁻⁴ So what do we know at the moment?

Revalidation will become a 5-year cycle rather than a fifth-year process. While the greatest change to the regulation of the medical profession in 150 years is not yet set in stone, the way ahead is being defined. The current 'pathfinder pilots'⁵ should lead to an 'early adopter phase' in which the first doctors, including GPs, will be revalidated in 2012.

All doctors will need to experience a strengthened annual appraisal,⁶ agreeing supporting information each year that will inform their revalidation. Every doctor will have a Responsible Officer⁷ (likely to be in place by October 2010) who will make a recommendation to the GMC as to whether that doctor should be revalidated. The GMC will then renew the doctor's licence. We will be revalidated for what we do; therefore, from the first revalidation onwards, our licences will describe our work.

Quality assurance of revalidation will be overseen by the GMC. However, appraisals will be quality assured by the local Responsible Officer, and Colleges will quality assure the revalidation decision making process on behalf of the GMC.

All this is straightforward but it raises a number of questions. First, why are we doing this? Although revalidation should protect patients from the very small minority of doctors who are not fit to practise, the main benefit will be in providing regular reassurance that doctors are keeping up to date, reflecting on their care, and developing year on year.

Many doctors want to know what will happen if they 'fail' revalidation. If local

appraisal and governance processes work effectively, any GP who is poorly- or under-performing should be recognised before their revalidation and offered targeted support. Such support is being designed at present but, for GPs, many agencies including primary care organisations, deaneries, local medical committees, and the Royal College of General Practitioners (RCGP) will be involved. If, however, a Responsible Officer cannot recommend a doctor for revalidation — and this should be a rare occurrence — that doctor's licence will not be put at risk until the GMC has applied its fitness to practise processes.

GPs want to know what they're expected to do. Most GPs have already embraced annual appraisal, and are reviewing any formal complaints, undertaking significant event audits, conducting clinical audits, attending educational events, and encouraging patient feedback and participation. These are the core components of the supporting information required for revalidation.

All we need to do is to gather this information together. That is easier said than done, and for many of us it will require more recording, especially of education, than we are used to. The RCGP will release in the autumn the first version of an ePortfolio that will offer GPs an integrated package from day-to-day practice through appraisal to revalidation. In time it will be linked to aids to education, such as the Essential Knowledge Update.

The only requirement that may be unfamiliar is to ask for colleagues' feedback every few years. In pilots, GPs have found such surveys to be informative and useful.⁸ A number of approved questionnaires already enable such surveys, but it may be wise to wait until the best choice for revalidation is clearer.

One of the strengths of general practice lies in the diversity of careers that we follow. Revalidation must be accessible to, and achievable by all GPs. The supporting

information required⁴ must be flexible enough to accommodate GPs working as sessional and locum doctors; in small and/or remote practices; exclusively in out-of-hours settings; in secure environments such as the HM Prison Service; in the Defence Medical Services both in the UK and overseas; or as GPs with special skills or interests. The RCGP has been conducting bespoke pilots with several of these groups to encourage contributions from the full breath of our speciality.

Many GPs have career breaks due to illness, maternity, or choice. Others spend time within healthcare systems in the EU and beyond, or supporting non-governmental organisations and charitable activities worldwide. Revalidation will apply to anyone wishing to remain licensed by the GMC.

To collect supporting evidence for recertification in clinical general practice, the RCGP is recommending a minimum of three appraisals and 3 years of continuing education within each 5-year cycle, with at least 200 half-day clinical sessions.⁴ If a GP is abroad or not clinically active when their revalidation becomes due, they can let their licence lapse and apply to the GMC for a renewed licence when ready to return. They will then need to apply, like any returning GP to be included in a Medical Performers List in a primary care organisation; this may require evidence of suitable retraining for UK clinical practice.

There are other GPs who are not clinically active, but working as doctors within medical management, industry, education, and academia. Such colleagues will be revalidated for what they do, and their licence will describe them as non-clinical GPs.

It is vitally important that revalidation is proportionate, fair, and fit for purpose. The current proposals from the GMC appear to meet those criteria.

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Professor of General Practice, University of Nottingham, RCGP Clinical Lead for Revalidation.

Provenance

Commissioned; not peer reviewed.

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ADDRESS FOR CORRESPONDENCE

Mike Pringle

Division of Primary Care, Floor 13, Tower Building, University of Nottingham, Nottingham NG7 2RD.

E-mail: mike.pringle@nottingham.ac.uk