Revalidation is not to be feared and can be achieved by continuous objective assessment

"the routine collection of these data during training and subsequent specialist practice makes revalidation easier and even irrelevant"

Summary

- Revalidation is defined by the International Association of Medical Regulatory Authorities as "the process by which doctors have to regularly show that they are up to date, and fit to practice medicine".
- In December 2012, the General Medical Council in the United Kingdom introduced revalidation processes that involve medical practitioners collecting a portfolio of evidence for assessment and appraisal by a "responsible officer".
- The responsible officer is usually the medical director of the hospital or group of primary care providers and reports directly to the General Medical Council on the fitness of the doctor to practice in their current role. The time taken to collect and analyse the portfolio and sources available are all contentious issues, along with the cost of the revalidation process.
- We propose that effective revalidation processes based on performance measurement would be cost-effective and, if correctly applied, could lead to significant cost savings in Australian health care.
- The driving force for an effective and efficient revalidation process should be the professional and ethical responsibility that each doctor has to their patients and to the society which has granted them the right to practice.

Medical professionalism in the United Kingdom has been a contentious issue for over a decade.[1,2] Lack of competence may contribute to patient harm and is, therefore, part of the debate involved in defining and assessing professional competence.[3,4]

The International Association of Medical Regulatory Authorities defines revalidation as "the process by which doctors have to regularly show that they are up to date, and fit to practice medicine".[5] On 3 December 2012, the UK General Medical Council (GMC) introduced revalidation procedures that require doctors to collect evidence of professional competence and fitness to practice in their current role. This evidence is presented by a "responsible officer", who is usually the medical director of the hospital or primary care provider, directly to the GMC for appraisal; but more may be required.[6] The time taken to collect and analyse the portfolio and sources available are all contentious issues, along with the cost of the revalidation process. To understand this bureaucratic drive to demonstrable competence and to identify mechanisms to achieve this laudable goal, it is necessary to understand the context in which these proposals were developed.

An unforeseen consequence of health care's increasing complexity is the identification of systemic health care error as a cause of patient harm and unnecessary cost.[7] Safety experts calculate the cost of error in Australia is "over $1 billion — possibly $2 billion — annually" with 50% of errors potentially preventable.[8] Australian health care expenditure was $130.3 billion in the 2010–11 financial year.[9]

Emerging evidence indicates that the rate of systemic health care error has not declined significantly since it was initially identified, although some limited trials have shown promise in improving outcomes presumed to result from failures of coordinated health care delivery.[10-12] The medical profession should accept some responsibility for systemic health care error, particularly those errors which harm patients. We believe that the profession should be committed to rectifying current deficiencies and minimising future errors for ethical reasons, as well as the obvious reason of financial rectitude. The importance of an ethical component to the approach to patient safety is that it imposes an overarching imperative to guide professional behaviour.

Professional ethics are the rules or guidelines that dictate professional behaviour. They are related to, but not inseparable from, the morality of the society in which the profession practices. In 1999, the Tavistock Group of medical ethicists proposed that minimising errors, minimising unnecessary and inappropriate variation in practice and a continuing responsibility to help improve quality were important professional ethical principles.[13] These principles were further endorsed by Peter Singer (professor of bioethics) in his review of medical ethics in 2000 and they remain applicable today.[14]

In this article, we examine how an ethical and professional commitment to reducing errors, adhering to best practice and improving quality of care should be reflected in the training and practice of competent doctors. One obvious mechanism to embed such competent, professional practice is through the process of revalidation once doctors have completed training.[4,13,15] There is little doubt that patients would request and respect such a revalidation process if it provided them with less harmful, less costly, more available and higher-quality health care. This expectation is recognised by experienced medical educators and is implicit in the definition of professional competence published in 2002 by Ronald Epstein (professor of family medicine, psychiatry, oncology and nursing) and Edward Hundert (dean for medical education and professor of global health, social medicine and medical education): "the

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1 Essential facets of competence*

- Scientific and empirical grounded method of working
- Knowing and maintaining own personal bounds and possibilities
- Active professional development
- Teamwork and collegiality
- Active listening to patients
- Verbal communication with colleagues and supervisors

* Reproduced from *Essential facets of competence that enable trust in medical graduates: a ranking study among physician educators in two countries*,[17] published under the Creative Commons CC-BY license. ◆

habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served".[16] This thoughtful and inclusive definition from the United States exceeds current definitions from Europe. The essential facets of competence (FOC) proposed by Dutch and German medical educators in 2013 identifies six more limited professional competencies,[17] shown in Box 1. These FOC overlap the GMC's four domains of expected standards of practice,[18] shown in Box 2.

The potential for broad, societal input into the processes defining medical competence is highlighted by the different emphases of the various definitions: the science, empiricism and professional development of the Dutch and German medical educators' FOC; the reflection on daily practice and consideration of community benefit in the US definition; and the inclusion of the patient and the public in the GMC's domains. Including the views of patients and the lay public in the revalidation process enables professionals to acknowledge community considerations of competence and revalidation in the society in which they are practising. It is possible to incorporate such broad definitions of professional competence into valid assessments of individual and organisational professional practice that will contribute to improved outcomes, systematic safety, reduced health costs and higher-quality care. The principles of these assessments were developed in the 1980s and are supported by good evidence. They fall into three broad groups, linked by the need for measurement or assessment of performance in all specialties.

First, collecting, analysing and providing feedback on outcome data at a unit level and an individual level will improve patient outcomes.[19-21] Although in New York State the performance monitoring exercise commencing in the late 1980s was originally labelled "report cards" and viewed with suspicion, the feedback of risk-adjusted performance data in surgical specialties is now an accepted means of ensuring the delivery of high-quality clinical services in many countries, including Australia.[20,22,23] Such data collections must be physician led and conducted in a non-threatening manner to ensure successful adoption.[19,20,22,23]

Second, specialist registries, which serve a similar function, have proved valuable as voluntary data collections that can be used to review practice, act as centre report cards and generate hypotheses for randomised trials.[24] Medical practitioners who self-report their performance are already reflecting on their practice and are therefore more closely aligned with modern principles of medical education and revalidation.[4,16] Such voluntary examinations of practice take the profession beyond the New York State performance monitoring exercise for providers of cardiac services that started in 1988 as a compulsory data collection. Contributing data to the state database was a licencing requirement for providers of cardiac services in New York State. However, these registries also represent evidence of "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served".[16] This can be seen as competence at the coalface, which should contribute to revalidation in a very practical way.[16,25-28] This routine collection of personal and unit performance data would render unnecessary retrospective examinations of performance at the time of perceived, or actual, problems with patient safety, or questions pertaining to a practitioner's competence.[29,30] Although the Bristol heart scandal and the Harold Shipman murders relate to the

2 General Medical Council's four domains of expected standards of practice*

1. Knowledge, skills and performance
   - Make the care of your patient your first concern
   - Provide a good standard of practice and care
     - Keep your professional knowledge and skills up to date
     - Recognise and work within the limits of your competence
2. Safety and quality
   - Take prompt action if you think that patient safety, dignity or comfort is being compromised
   - Protect and promote the health of patients and the public
3. Communication, partnership and teamwork
   - Treat patients as individuals and respect their dignity
     - Treat patients politely and considerately
     - Respect patients' right to confidentiality
   - Work in partnership with patients
     - Listen to, and respond to, their concerns and preferences
     - Give patients the information they want or need in a way they can understand
     - Respect patients' right to reach decisions with you about their treatment and care
     - Support patients in caring for themselves to improve and maintain their health
   - Work with colleagues in the ways that best serve patients' interests
4. Maintaining trust
   - Be honest and open and act with integrity
   - Never discriminate unfairly against patients or colleagues
   - Never abuse your patients' trust in you or the public's trust in the profession

* Source: *Good medical practice: the duties of a doctor registered with the General Medical Council*.[18] Reproduced with permission. ◆

National Health Service in the UK, the effect on the Australian public of the Jayant Patel case in Bundaberg should not be underestimated and any mechanism for preventing recurrence should be carefully examined.[2,29]

Third, the application of a combination of technology and statistical analysis to monitoring individual performance facilitates high-quality, objective performance monitoring and is easily achieved for practical procedures.[25] These advances represent an enormous opportunity for the objective measurement of competence and quality in health care.[4] This level of professionalism has been advocated by some European medical educators as a new standard for "entrustable professional activities" as a means of addressing medical professional competence.[31] This component of objective analysis of professional performance has proved valuable when coupled with the use of statistical methods to define and confirm competence. These methods were pioneered in paediatric cardiac surgery and subsequently applied in other specialities.[4,21,25,32] We are convinced that the routine collection of these data during training and subsequent specialist practice makes revalidation easier and even irrelevant.[4] The reason for suggesting that revalidation may become irrelevant is not to be controversial but to emphasise the value of routine performance monitoring. The collection of appropriate data in routine practice supports the revalidation process more accurately and objectively than the current processes suggested.[4] In fact, only those practitioners not collecting performance data may need to undergo a formal revalidation process because objective evidence of good practice would not be available for them.[4,6]

Revalidation based on the UK model may not fulfil all the requirements of the medical profession in Australia. However, the broader definition of competence — including reflection on practice, consideration of community benefit, or protecting the health of the patient and the public — arising from the US and the UK indicates that the process of performance monitoring is a much better tool for effectively identifying and supporting contributors to poor health care performance. The evidence that the collection of performance data and feedback of results improves unit and individual clinician performance, thereby reducing patient mortality and morbidity, represents examples of a tangible commitment to reflective practice and patient and public health.[19,20,33] Such professional activity provides a clear example of determination to achieve demonstrable competence. Participation in such data collections may be more valuable to patients, the medical profession and the bottom line than the more formulaic aspects of existing or proposed revalidation processes.

With respect to the unnecessary and inappropriate variation of practice and its impact on patient safety, there is now very good evidence that treatment which follows the guidelines of professional bodies ensures better outcomes than treatment that omits important components of care.[34] The high-quality data for this study was taken from a randomised controlled trial of the management of acute coronary syndromes (ACS), including acute myocardial infarction (AMI), in the US (the CRUSADE study). It confirmed that a 10% increase in process compliance with American College of Cardiology guidelines conferred a 10% decrease in mortality for patients with ACS and AMI. Collection of this process adherence data alongside personal performance data would improve the quality of revalidation assessments at multiple levels in health care — for example, at organisational (hospital), unit (team) and individual (doctor) levels. Coupling the collection of unit and individual performance data with supervised feedback of results should optimise assessments of individuals in their workplace. This will advance the goal of objective, measured competence confirming "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served".[16]

Through these processes, we believe that the medical profession can lead other health care professions to achieve a level of training and maintained competence that exceeds the current formulae for revalidation. Such processes of personal professional monitoring in medicine, through self-reporting, can confirm objectively and routinely the value of the health interventions of the medical profession in maintaining the health of the individual patient and the public. If the profession can take that lead, it will be well placed to ensure that the health interventions of the future will continue to be of higher quality, deliver optimal benefit and become more affordable to the populations in which they practice and the communities that they serve.

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