Revalidation for gastroenterologists, with or without sedation!

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Accepted 15 January 2010

From 16 November 2009, all doctors require a license to practise in the UK. Revalidation encompasses relicensing and recertification. This article focuses on recertification for gastroenterologists. Revalidation should not be viewed as a threat, and for the vast majority of doctors it should be straightforward, with the aim of demonstrating safe doctors, while keeping to a minimum time spent on exhaustive data collection. Specialty specific standards for physician medicine are ready to be endorsed by the General Medical Council and the first revalidations will be introduced around 2011. Subspecialty specific standards for gastroenterology are under evaluation and in the early stages of consultation.

Introduction

Revalidation represents the biggest change to medical regulation since 1858. The concept and underlying principles of revalidation were described in the Chief Medical Officer's consultation document 'Good doctors, safer patients' and adopted in the Government's White Paper (February 2007) on professional regulation, 'Trust Assurance and Safety—The Regulation of Health Professionals in the 21st Century'.¹

From 16 November 2009, all doctors require a license to practise medicine in the UK. Licenses will require renewal by revalidation every 5 years whereby gastroenterologists will need to demonstrate to the General Medical Council (GMC) that they are practising in accordance within the generic standards of practice set out in *Good Medical Practice*² and meet the standards that apply to the specialty set by the Royal College of Physicians (RCP). Gastroenterologists will also require recertification to maintain their place on the specialist medical register. Revalidation for gastroenterologists combines the process of relicensing and recertification. The work into revalidation has been taken forward by the Department of

Health and the GMC with the Academy of Medical Royal Colleges. From 16 November 2009, the new licenses will have been issued. Revalidation could take place in early 2011.

Revalidation is imminent and unavoidable but if introduced in a sensible manner should improve patient care. It may appear time consuming and could be perceived by some as a threat; it need not be so. Gastroenterology has a reputation for high quality audits and guidelines and has demonstrated the ability as a specialty to continuously improve care. It has embraced change, facilitated by increased consultant and trainee numbers over the past 10 years, welcomed nurse specialists and 80% of gastroenterologists are also involved in delivering the general internal medicine take.

High quality appraisal should provide a welcome opportunity for reflection and positive feedback, often lacking for those busy 'at the coalface'. Appraisal is to be the mainstay of revalidation. The challenge is to ensure it is used to improve care, satisfy the public and the GMC while avoiding wasting time and effort on non-productive data gathering. Examination (knowledge based assessment (KBA)) is not appropriate while the Certificate of Completion of Specialist Training and specialty specific examination for trainees are the culmination of the generic gastroenterology curriculum, consultants often find themselves subspecialising. Hence a generic gastroenterology appraisal template will not fit all; for example, a hepatologist performing no colonoscopy does not require a global rating scale assessment for colonoscopy as part of their revalidation. The large spectrum of professional activities performed by gastroenterologists challenges the concept of a generic recertification template for the specialty.

The mechanism

The UK Revalidation Programme Board, which is accountable to the GMC, provides strategic leadership towards revalidation

and oversees the work of the four Revalidation Delivery Boards (England, Scotland, Northern Ireland and Wales). The Boards are responsible for ensuring that local systems of appraisal and clinical governance are robust enough to support revalidation. In addition, the Department of Health funds the Medical Revalidation Working Group who were established to implement the recommendations in the 2007 White Paper and support the NHS in England to prepare practically for revalidation. The RCP has led workshops on revalidation with representation from the subspecialties, including the British Society of Gastroenterology. Progress has been intentionally cautious as professional bodies such as the RCP and British Society of Gastroenterology have been careful not to transgress their professional roles into policing roles. Nevertheless, it is better that the mechanism of revalidation is derived by the colleges and specialist societies, rather than the Department of Health.

Glossary of terms for gastroenterologists

Revalidation has introduced a number of new terms that may appear 'alien' to our traditional practice. There is no doubt that the approach suggested in this article will need refinement and revision during the near term; appraisal is in the process of evolution. However, it will be helpful to become accustomed to the terminology, and the aims of revalidation, to fulfil the requirements of the GMC. Here is a glossary of terms.

- **Revalidation** is the process by which we will have to demonstrate to the GMC, normally every 5 years, that we are up to date and fit to practise and complying with the relevant professional standards. It has two elements: relicensing and recertification.
- **Relicensing** is to show that all of us are practising in accordance with generic standards of practice set by the GMC (based on *Good Medical Practice*). It will rely on annual locally based appraisal.
- **Recertification** is to show that practising gastroenterologists and hepatologists continue to meet the particular standards (specialty specific standards—see below) that apply to our specialty.
- **Generic standards.** The GMC's *Good Medical Practice* framework sets out the generic standards of practice which all doctors will need to meet. The framework can be divided into four domains: (1) knowledge, skills and performance; (2) safety and quality; (3) communication, partnership and teamwork; and (4) maintaining trust. Each domain contains a list of attributes.
- **Attributes.** There are 12 attributes. The information listed against each attribute is divided into two: core and additional. The former must be provided over a 5 year revalidation cycle (not all of it has to be provided every year) whereas the latter is optional.
- **Standards.** Currently there are 75 standards for physician medicine. They represent a range of actions, behaviours and skills that would be expected of a doctor who was practising according to the stated attributes.
- **Supporting information** is required to demonstrate compliance with each attribute.

- **Continuing professional development** is the process by which individual doctors keep themselves up to date and maintain the highest standard of professional practice.
- **Multi-source feedback** (MSF or 360°) is an independent process for obtaining feedback from patients and colleagues to assess the performance of individual doctors.
- **Specialty specific standards.** These are to guide gastroenterologists in their preparation and personal reflection leading up to appraisal and to support appraisers in the event that they need to explore further any issues or concerns that may arise about an individual's practice. They are central to recertification for the specialist register.
- **Responsible officer (RO).** In England, the RO will be a senior doctor in a healthcare organisation, normally, but not always, the medical director, who takes personal responsibility for those aspects of the local clinical governance system which deal with the performance and conduct of doctors. The RO will ensure that appraisal is carried out to a good standard; work with doctors to support them in addressing any shortfalls; ensure any concerns or complaints have been addressed; and collate this information to support a recommendation on the revalidation of individual doctors to the GMC. In England, doctors who work purely in private self-employed practice could relate to the RO of the organisation in which most of their practice is performed.

What will revalidation involve?

Appraisal will be the central vehicle for revalidation. Information will be drawn together from day to day practice, from feedback from patients and colleagues, from participation in Continuing Professional Development (CPD) and by a review of complaints or any other concerns about professional practice, health or probity. This information will feed into the annual appraisal, which for many consultants will have to shift from a superficial 'tick-box' exercise to a more detailed and time consuming process, requiring considerably more preparation from the appraiser and the appraisee. The outcome of the appraisal will lead to a single recommendation to the GMC from the RO, normally every 5 years, about the suitability of the clinician for revalidation. This single recommendation will cover both relicensing and recertification. For the majority of gastroenterologists the process will be straightforward.

The GMC framework for revalidation has four domains, with 12 attributes and 75 standards for physician medicine, with additional specialty specific standards for gastroenterology. Figure 1 shows how the standards for physician medicine and gastroenterology relate to the attributes in that domain. The framework is a lengthy table (about 14 pages) but figure 1 shows the first attribute (maintain your professional performance) of the first domain (knowledge, skills and performance) and the proposed supporting information for physicians in column 3, and further supporting information for the subspecialty interest of gastroenterology in column 4. The framework for revalidation outlines the supporting material that may be provided at appraisal to demonstrate that clinicians are practising to a high professional standard in accordance with the

GMC's attributes and the RCP's speciality specific standards. It is recognised by the GMC that "No doctor will be able to provide evidence of compliance with every generic standard". However, it is important that a doctor attempts to provide sufficient supporting information to demonstrate their practice across the breadth of the standards. The supporting information does not, therefore, attempt to address every individual

standard but is intended to provide sufficient information to demonstrate compliance with each attribute.

Subspecialty specific standards for gastroenterology

The standards for physician medicine (table 1, figure 1, column 3) are likely to be signed off by the GMC for the introduction of recertification in 2011. Work is underway

Domain 1 – Knowledge, Skills and Performance

Attribute	Standard	Supporting Information for all Physicians	Specialty-specific information that can be used to support revalidation in Gastroenterology.
1.1 Maintain your professional performance	<p>All doctors</p> <ul style="list-style-type: none"> ■ Maintain knowledge of the law and other regulation relevant to practice (13) ■ Keep knowledge and skills up to date (13) ■ Participate in professional development and educational activities (12) ■ Take part in regular and systematic audit (14) 	<p>Peer Feedback</p> <ul style="list-style-type: none"> ■ Validated tools for feedback about quality of doctors' practice including MSF (at least once per five year revalidation period) ■ <i>Evidence of involvement in other assessments of individual or team practice if undertaken by subspecialty eg Peer Review or Service Accreditation where applicable.</i> <p>Patient Feedback (if appropriate)</p> <ul style="list-style-type: none"> ■ Validated Patient Questionnaires (at least once per five year revalidation period) ■ Reflection and learning from substantiated complaints ■ <i>Evidence of quality of advice given to patients (eg anonymised patient records and outpatient clinic letters) and information/educational material given to patients</i> <p>Training and Education</p> <ul style="list-style-type: none"> ■ Record of "open book" knowledge assessments related to e-learning, or other knowledge assessments. ? ■ Evidence of any specific training, assessment or re-assessment of practical and other skills <p>Development</p> <ul style="list-style-type: none"> ■ CPD record - specific learning needs identified and met – signed off as related to individual professional practice <p>Audit</p> <ul style="list-style-type: none"> ■ Participate in, or carry out, one full audit cycle in relation to professional practice within each five-year revalidation period with evidence of any practice change ■ Participation in national or other multi-centre (eg regional) and local audit, where present, with evidence of any practice change demonstrated by re-audit <p>Clinical Practice</p> <ul style="list-style-type: none"> ■ For most physicians, this will be covered by audit and MSF (above). For some, observed clinical practice may be recommended, or agreed at appraisal ■ <i>Logbook of clinical cases encountered and discussed, with reflection and practice change</i> ■ <i>Record relevance of legislation to clinical cases or other situations encountered in practice in log-book or e-portfolio</i> ■ <i>Results of clinical outcomes compared to College or specialty recommendations, where available and validated</i> 	<p>MSF Patient Questionnaire CPD record, eg BSG meetings. Local Governance & audit (mandatory?). Participation in National BSG audits (not mandatory)</p>

Figure 1 The first attribute (maintain your professional performance) of the first domain (knowledge, skills and performance) from the General Medical Council (GMC) framework for revalidation. Proposed supporting information for physicians with a specialty interest in gastroenterology. The GMC framework has four domains, with 12 attributes and 75 standards for physician medicine, with additional specialty specific standards for gastroenterology. The GMC framework runs for some 14 pages. BSG, British Society of Gastroenterology; CPD, Continuing Professional Development; MSF, multi-source feedback.

on subspecialty specific standards for gastroenterology (table 2). Appraisal will cover many areas of practice but for the purpose of revalidation some standards will be classed as ‘core or essential’. Some standards may be essential for some but not all gastroenterologists (‘optional, or additional’; not all practice colonoscopy). Table 2 shows a list of

options under evaluation for gastroenterology. Ultimately, a complex and extensive list needs to be avoided, not least because of time restraints on collecting data, and we need to avoid the risk of de-certification if ‘targets’ are not achieved. There needs to be equity in the burden of revalidation for all physicians; some specialties should not have tougher

Table 1 Physician medicine—appraisal and revalidation checklist

General
GMC registration number
Evidence of a license to practice
Medical qualifications
Description of practice
Title and role
Job summary including responsibilities and activities throughout the 5 years since last revalidation
Job plan for each year
Description of voluntary roles undertaken in capacity as doctor
Appraisal for each year
Description of indemnity
Personal development plan for each year
Statement of concerns and their resolution
Statement of probity including interests and gifts
Statement of health to confirm ability to undertake practice as described
Registration with a GP
Peer feedback
Multisource feedback
Peer review
Feedback from teaching/training
Patient feedback
Patient feedback
Practice
Complaints and compliments
Incidents—including contribution to NPSA and confidential enquiries
Observed clinical practice (as a mandatory item there is considerable resistance to this as being too time consuming for all physicians to be observing each other)
Knowledge of and compliance with national best practice guidelines
Case based discussion (this also may not be formal, as for trainees, but may be a record of cases discussed with colleagues)
Anonymised responses from patient referrals
Log books (may be useful but need to be for those who wish to use them)
Audit
Clinical audit
Case notes/records review
Education, training and development
Learning and development through CPD
Specialty training
Local training
(Knowledge based assessment (see comments in text). Examination does not have wide acceptance and is unlikely to be included in revalidation)
Governance
Documentation of compliance with relevant local clinical governance policies and protocols—for example:
Risk management
Employer confidentiality policy
Equality and diversity
Informed consent
Handover policies and documentation
Adult and child protection policies
Disability policy
Implementation of safe/best practices/response to clinical risk

Developed by Royal College of Physicians and Academy of Medical Royal Colleges.

CPD, Continuing Professional Development; GMC, General Medical Council; NPSA, National Patient Safety Agency.

Table 2 Gastroenterology specialty specific indicators under development

Endoscopy global rating scale
Colonoscopy
Colon completion rates
Sedation for under and over 70s
Flumazenil usage
30 day readmission rates
Global rating scale mortality audits
Endoscopic comfort audits
Adenoma detection rates
ERCP
Cannulation rates
Complication rates—pancreatitis
30 day mortality (available from hospital episode statistics (HES))
Hepatology indicators
MSF/hepatology orientated
Patient survey and complaints
Viral hepatitis numbers/outcomes
Workload/mortality
Varices outcomes
Liver biopsy complications
Alcoholic hepatitis mortality
Hepatitis C
Testing for hepatitis C viraemia/genotype/RNA
Consideration of antiviral therapy/combination therapy
12 week follow-up after treatment initiated
Hepatitis A and B vaccination

See text. The final list will be simplified and map into the physician standards.
ERCP, endoscopic retrograde cholangiopancreatography; MSF, multi-source feedback.

revalidation compared with others. Where possible, subspecialty specific standards for gastroenterology will be linked to the specialty specific standards for all physicians to avoid excessive duplication and data collection. It is likely that the final version of subspecialty specific standards for gastroenterology will feed seamlessly into the physician standards; figure 1 shows how this may be achieved, where column 4 (subspecialty specific standards for gastroenterology) relates to column 3 (physician standards). The aim of revalidation is to ensure safe doctors, not a checklist of workload.

How to start preparing

Without doubt collating all the information required for annual appraisal will require time, effort and organisation. Ideally, a dedicated folder or portfolio for the evidence should be used. Before starting, we suggest that clinicians familiarise themselves with the GMC and RCP documents listing the attributes, generic and specialty specific standards (see figure 1; tables 1 and 2; and references). Table 1 shows an appraisal and revalidation checklist for relicensing and recertification in general medicine. Table 2, a checklist for recertification in gastroenterology, is under evaluation; the final version will be simplified.

The appraisal portfolio should include the following information.

- **MSF results.** At least once per 5 year revalidation period. The RCP developed a validated MSF and patient feedback questionnaire which is available via an independent provider (<http://www.360clinical.com>). A fee is payable for each MSF. The MSF covers the following peer reviewed questions: clinical work, teaching and training, teamwork, communication skills, management and leadership, availability, professional development, health and probity. The appraiser nominates 15 colleagues for MSF to include doctors (ideally eight doctors, consultant, junior doctors and medical students), nurses, allied health workers (eg, dietician) and management/clerical (eg, secretary).
- **Results of a validated patient questionnaire.** At least once per 5 year revalidation period. See MSF above; a validated patient feedback is available commercially from <http://www.360clinical.com>.
- **A log or record of specific training or assessments.** Log-books may be helpful for some gastroenterologists but not essential.
- **RCP CPD diary credits.** It will be important to complete the reflection and feedback for the CPD event (see comments on KBA below).
- **Endoscopy global rating scale tool data.** If you do not perform endoscopy, then say so. Performing an 'occasional endoscopy' is unlikely to be acceptable.
- Participation in local, regional or national audits.
- Attendance at local clinical governance, morbidity and mortality and multidisciplinary team meetings.
- A record of all complimentary letters and complaints.
- A record of teaching; feedback from trainees (JAG form, MSF).
- Research, grants, publications.
- Managerial roles and activities.
- Work for local, regional, national or international committees, etc.
- Trust data on service delivery and quality (waiting times, activity, *Clostridium difficile* toxin infections, etc).
- KBA examination should not be part of revalidation. The British Medical Association remains opposed to KBA, favouring the Royal Colleges' CPD requirements instead. Examination is suitable to test knowledge of a generic curriculum (eg, MRCP or exit examination for the Certificate of Completion of Specialist Training). But as a consultant becomes subspecialised, a single examination becomes meaningless. For example, a hepatologist in a tertiary centre should have considerably different knowledge and expertise than a colonoscopist who does not attempt to run a hepatitis C clinic. There may be a case for online case studies but recorded CPD feedback and evaluation may be the best measure of knowledge.

Roll-out

Current expectation is that there will be an incremental roll-out across the UK starting in 2011. It is likely that this will be based on the physician medicine standards. Subspecialty specific gastroenterology standards will follow in future recertification. Local systems of appraisal, clinical governance and

Further reading

- Academy of Medical Royal Colleges. Revalidation. <http://www.aomrc.org.uk/revalidation.aspx> (accessed 26 January 2010).
- General Medical Council. Licensing and revalidation. <http://www.gmc-uk.org/revalidation>.
- Royal College of Physicians. Revalidation. <http://www.rcplondon.ac.uk/professional-Issues/revalidation/Pages/Overview.aspx> (accessed 26 January 2010).
- Department of Health. Medical Revalidation—Principles and Next Steps: The Report of the Chief Medical Officer for England's Working Group. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086430 (accessed 26 January 2010). 2008.
- 360 Degree Clinical. A Commercially Available Validated MSF and Patient Feedback Tool. <http://www.360clinical.com> (accessed 26 January 2010).

ROs will need to be in place first. It will not start until the GMC are sure that appropriate systems are in place.

Summary

Appraisal is the mainstay of revalidation. The aim is for it to be sufficiently comprehensive to demonstrate competent and safe practise to the GMC and public while minimising time spent on onerous and time consuming data collection.

This article has focused on revalidation for medical gastroenterologists. A concern which is yet to be addressed is that there should be equity among specialties in terms of supporting evidence required and the time taken to collate the evidence. The Academy of Medical Royal Colleges' consultation on specialist standards and supporting information for revalidation shows some specialties to have a much more 'streamlined' and less onerous framework compared with other specialties. Will revalidation for endoscopy prove to be the same process for surgical and medical gastroenterologists and general practitioners with an interest in gastroenterology?

Acknowledgements The authors thank the Academy of Medical Royal Colleges, the Royal College of Physicians and Dr Ian Starke at the Royal College of Physicians who has led the many workshops and consultations on revalidation for the College.

Competing interests None.

Provenance and peer reviewed Commissioned; not externally peer reviewed.

References

1. **Department of Health.** The White Paper Trust, Assurance and Safety: The Regulation of Health Professionals, 2007. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/publicationsPolicyAndGuidance/DH_065946 (accessed 26 January 2010).
2. **General Medical Council.** Good Medical Practice, 2006. http://www.gmc-uk.org/guidance/good_medical_practice.asp (accessed 26 January 2010).