

○ The Patient Voice in Revalidation:

A DISCOURSE ANALYSIS

HELEN SHELDON, DANIELLE SWAIN AND LOUISE
HARRISS

Prepared in collaboration with Dr Marion Lynch on
behalf of the South Central SHA Revalidation Board

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Buxton Court

3 West Way

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Tel: 01865 208100

Fax: 01865 208101

Email: info@pickereurope.ac.uk

Website: www.pickereurope.org

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CONTENTS

1. Introduction	4
Methods	4
Analytical Framework	5
Limitations	5
2. Summary and Overview: key discourses and pivotal moments in patient and public involvement in revalidation	6
Conceptual rationale	6
Practical mechanisms	6
3. Pivotal moments in the life of revalidation	7
Early days	7
1999 - revalidation outside the UK	8
The public's response to the Bristol Inquiry	9
Watering down of GMC's 2000 proposals between 2001-2003	10
2004 - 5: The Shipman Inquiry and immediately after - the patient voice in revalidation emerges	10
2005-2010	12
2010 GMC 'Way Ahead' Consultation on Revalidation	13
4. Key discourses in patient and public involvement in revalidation	15
Theme 1: Revalidation to benefit patients and the public	15
Theme 2: Cultural shift to patient centred medical professionalism as the basis for revalidation	16
Theme 3: Lay input to the process of revalidation	18
Theme 4: Patient feedback as a component of revalidation	18
5. Conclusion	21
6. Recommendations	23
7. References	25

1. Introduction

This report presents the findings of a discourse analysis of the patient voice in published documents on medical revalidation. It has been prepared in collaboration with Marion Lynch to inform the work of the South Central Strategic Health Authority Revalidation Board.

The aim of the study was to analyse documents in the public domain to determine where and how the patient is located within discourses about medical revalidation.

Methods

Two key sources were drawn upon for this analysis of the patient voice in revalidation. The first was documents published on the websites of key agencies steering revalidation. It covered a broad range of different document types including, position statements, consultation reports and the minutes of board and steering group meetings. The second source was papers published in the peer reviewed press.

During October 2010, searches were conducted on the following websites using the search term “revalidation”:

- Department of Health: <http://www.dh.gov.uk>
- NHS Revalidation Support Team: <http://www.revalidationsupport.nhs.uk>
- General Medical Council: <http://www.gmc-uk.org>
- British Medical Association: <http://www.bma.org.uk>
- Academy of Medical Royal Colleges: <http://www.aomrc.org.uk>
- Royal College of General Practitioners: <http://www.rcgp.org.uk>
- Picker Institute Europe: <http://www.pickereurope.org>
- PubMed: <http://www.ncbi.nlm.nih.gov/pubmed>

An initial search on PubMed using the term ‘revalidation’ generated 85 articles. A subsequent search using both the terms ‘revalidation’ AND ‘patient’ generated a further 28 references. Abstracts were reviewed to identify articles in the English language that appeared relevant to the theme of the review and full text copies were obtained.

The contents of the documents identified in this broad search were rapidly reviewed to identify those that were key in the history of revalidation and/or those that implicitly or explicitly referenced a role for patients. Analysis of each document was conducted to

identify the meaning given to the role of the patient voice in discourses about medical revalidation and specifically to address the research questions agreed:

- how has the presentation of patient involvement changed over time and how does it differ in publications produced by different organisations?
- what role do patients play in revalidation in other countries?
- when did patient feedback and multi-source questionnaires first emerge in discourses about revalidation?

Analytical Framework

Rapid appraisal of the documents generated from searches of the websites of key agencies involved in revalidation led to the development of an analytical framework with two main elements in time and two in space.

In terms of time, revalidation can be broadly constructed as the period since the launch of the GMC 'Way Ahead' consultation in March 2010 as opposed to everything that went before that key milestone - the beginnings of revalidation and developments to 2010.

Spatial constructs can be derived from the distinctive voices of insiders as opposed to outsiders - the discourses of those speaking from within the agencies steering the development of revalidation as opposed to those seeking to influence its development from outside. The analytical framework defined 'insiders' as the key agencies steering revalidation such as the Department of Health, the GMC, the Academy of Medical Royal Colleges (AMRC), the NHS Revalidation Support Team, individual Royal Colleges, the BMA and the Revalidation Pathfinder and Pilot Projects. This construction specifically included lay members of those organisations as 'insider' voices.

Limitations

From the outset accessing documents which allowed analysis of discourses around patient involvement in revalidation proved difficult, particularly in terms of public and patient input to the development of revalidation mechanisms. This element of the analysis relies heavily on papers published in the peer reviewed medical press - a source almost entirely dominated by the medical profession. The 'outsider' voice has barely been accessed and the patient voice has not been accessed at all. Further work would be required to complete this aspect of the analysis and proposals for this are set out in the recommendations at the end of this report.

2. Summary and Overview: key discourses and pivotal moments in patient and public involvement in revalidation

Discourses of patient and public involvement (PPI) are virtually absent from the large volume of publications devoted to the subject of medical revalidation, however it is possible to identify four key discourses. Two of these relate to the conceptual rationale for revalidation and the other two cover practical processes.

Conceptual rationale

1. The purpose of revalidation presented in relation to benefits to patients and the public through the use of concepts such as 'reassuring patients', 'patient safety' and 'public confidence' (especially in the context of restoring the loss of public confidence following publication of the Shipman Inquiry 5th Report in 2005).
2. Discussions of revalidation in the context of the concept of new medical professionalism, particularly in publications about 'patient centred professionalism' by Sir Donald Irvine between 2003 and 2005 and in general discourse during the same period and continuing to the present.

Practical mechanisms

3. Discourses around lay input to the process of revalidation, particularly following publication of the Shipman Inquiry 5th Report, the announcement of the Chief Medical Officer's (CMO) review and subsequent recommendations in 2006.
4. Accounts of arrangements for incorporating patient feedback on individual clinicians in the portfolio of evidence that doctors are required to submit for assessment, particularly after the publication of the Shipman Inquiry 5th Report.

Each of these discourses or themes can be located in four pivotal moments or periods in the life of revalidation to date, described in more detail in section 3:

- **Before revalidation** (1980's private members bill) and inception (1990's NHS reforms; calls for tighter regulation of the medical profession, especially after the 1995 GMC Bristol Hearing; GMC first publishes its 'Good Practice' code of conduct for doctors in 1995).
- **1998** Bristol Inquiry; GMC conference on revalidation on 10th February 1999; 2000 GMC Revalidation Report; Act of Parliament 2002 extends GMC powers.
- **2004**: publication of Shipman Inquiry 5th Report by Dame Janet Smith and announcement in January 2005 of CMO Liam Donaldson review following the Department of Health's decision to postpone the planned start of revalidation in April 2005; 2007 White Paper on Revalidation.
- **2010** GMC consultation.

3. Pivotal moments in the life of revalidation

The key points of change in the history of revalidation can be conceptualized as responses to external pressure on the medical profession from outsiders demanding tighter regulation. Following each key moment of change, a period of retrenchment can be discerned. During this time, insiders within the medical profession, particularly the BMA negotiating compromise on the standards, can be seen to regain control over the process. It is possible to characterise the periods of retrenchment as insiders getting a consensus amongst a broader range of stakeholders to move away from proposals for external regulation back towards existing systems of self-regulation. Conceptualizing the pivotal moments in this way leads to the following chronology:

1998 – Bristol Inquiry – catalyst for proposals to radically change

2001-3 – Retrenchment: claims that proposals were impractical and too costly resulting in the ‘watering down’ (Irvine, 2004 and 2005) of proposals before they were accepted by the medical profession; consensus on proposals achieved and the GMC formalises these through a national consultation

2004 – Shipman Inquiry – catalyst for proposals to radically change

2005 to 2009 – Retrenchment (mirrors events in 2001-3)

Present – The 2010 GMC consultation indicates that consensus on some aspects of the proposals has been achieved but it is evident that there are still strong objections from some quarters, particularly on the grounds of practicalities

Future: Further retrenchment?

Early days

Sir Donald Irvine’s ‘The Doctor’s Tale’, published in 2003 places the roots of revalidation in the cultural shift repositioning the relationship between doctors and their patients. He draws on Stacey (1992) who provides a sociological perspective relating the pressure for medical regulation to the ‘new professionalism’ as a response to societal change. Allsop (2002; 2006) describes the shift in the relationship between patients, doctors and the state in the context of the workings of the GMC.

The NHS reforms of the early 1990’s can be viewed as one of the early pivotal moments in the development of modern medical revalidation. Donaldson describes the impact of these reforms in a 1994 article - how the 1990 NHS and Community Care Act paved the way for the abolition of the Regional Health Authorities in 1995 and the creation of NHS Trusts. One implication of this legislation was that the contracts for consultant and senior doctors held by the former would pass to the latter. Donaldson describes concerns about the associated transfer of responsibility for performance review and disciplinary procedures to the medical directors of NHS Trusts. The problem of medical directors having no experience of carrying out this role would be further exacerbated by

the need to implement the new disciplinary procedures and job plans introduced by the reforms with doctors who were their peers and colleagues. There seem to be parallels here with current concerns over the ability of medical directors to take on responsibility as Revalidation Responsible Officers. Donaldson also describes a continuing problem because of the lack of an explicit form of contract for hospital doctors.

The early 1990's NHS reforms also extended the powers of the GMC. Donaldson (1994) describes the background which led to the introduction of changes at the GMC, the publication of the GMC's 'Good Medical Practice' code of conduct for doctors and the extension of its remit into new performance review procedures. The latter he describes as "a step of major importance in finding the ultimate solutions to these problems (of doctors' poor performance)." Irvine (BMJ 1997) describes how the powers of the GMC were extended through the second half of the decade after 1995 which saw two linked pivotal events in the early inception of revalidation:

- The Medical (Professional Performance) Act 1995 gave the GMC new powers from 1997 to investigate doctors' performance in which "protection of the public is the first priority."
- The publication in 1995 of the GMC's 'Good Medical Practice.'

Seven years later Irvine (MJA 2004) describes the latter as representing the establishment of a consensus between the medical profession and patients regarding standards for practice and what constituted breaches of the code of practice. In the BMJ in 2005 he implies that the GMC's standards are based on "an evidence based understanding of patients' needs, expectations and experience." However, the evidence that this is what the standards were originally founded on does not readily emerge from a review of the literature. Other means would probably be required to identify the key players and to access the evidence around what sorts of patient input there was to the development of the GMC's proposals for revalidation, including the 'Good Medical Practice' code of conduct.

1999 – revalidation outside the UK

In Autumn 1999 the BMJ published five articles on revalidation including one on the UK (Southgate and Pringle) and others on the USA, Australia and New Zealand, Canada and the Netherlands. The Canadian system appears to have most patient input. Dauphinee describes how one existing assessment programme focused on doctors about whom patients have formally complained. Dauphinee also refers to a new system which would include feedback from patient questionnaires about the quality of care as well as feedback from colleagues on a broad range of matters including communication and patient management skills. However the article does not provide any detail about nature of these proposals.

Norcini describes how the system for recertification in the USA includes "an assessment of patient outcomes." He describes this as "the most important component" because "it offers evaluation of what doctors actually do" but how there are technical difficulties involved in collecting and interpreting the data. Newble and colleagues describe the system introduced in Australia and New Zealand by the Royal Australian College of Physicians in 1994. This focuses on elements of practice likely to directly improve patient care and includes "a peer review process based on direct observation of actual clinical

practice” which was shown in pilot studies to be acceptable to patients. They provide a list of categories of physician assessment that include ‘patient management skills’ and ‘interpersonal/communication skills,’ including ‘compassion’ and ‘respect.’ Swinkels describes a system in the Netherlands which does not include patient feedback but does incorporate assessment by colleagues of communication skills, including provision of patient information.

The public’s response to the Bristol Inquiry

The concept of revalidation as we currently know it emerged in the aftermath of the 1998 Bristol Inquiry. Irvine (2004 MJA 181) cites Richard Smith in a 1992 article in the BMJ describing “the force of the public’s response (to Bristol that) shook the profession.” The Department of Health consultation document, ‘First Class Service’ published after Bristol described the new committees, rules and regulations that were established in response. The GMC ‘Revalidation of Doctors’ were part of the same package of proposals that were developed in response to Bristol. Interestingly, in view of the furore around the ‘watering down’ of the 2000 proposals that emerged during and after the Shipman Inquiry in 2005, a copy of the GMC’s 2000 proposals cannot be found on the internet, though the earlier 1995 Code of Conduct replaced in 1998 can easily be obtained on the GMC website.

Much of the discourse about professional regulation at this time was couched in language around public pressure as a driver for change. Irvine (2004 MJA) cites evidence published by the National Consumer Council in 1999 of “the growing public criticism of the professions secretive attitude to risk...” He places the roots of revalidation in societal change that had created an acceptance of the notion of ‘patient autonomy.’ However, it was public pressure resulting from the Bristol Inquiry that acted as the catalyst for rapid change. He describes the challenge to the historic collusion between government, NHS and the BMA in which “the profession was the dominant partner...until quite recently” and how the BMA “did its best to protect doctors, sometimes at the expense of patients.”

In much of the early discussion about revalidation the patient was at the centre, but only in terms of the purpose. Almost every article begins by emphasising the reason for revalidation to ‘reassure the public’ and ‘ensure patient safety’ and ‘public trust.’ These concepts are explored in section 4 - the purpose of revalidation for patient benefit. The early literature is characterised by a positioning of the patient upfront but an almost total absence of debate about what role patients should play. This seeming contradiction could be presented as a shift in language not being supported by a similar shift in practice. Though the language places patients at the front in terms of the purpose, they are still very much the receivers of the benefits and revalidation is couched within a language of things being ‘done to’ patients. At this time (1990’s – 2005) patients seem largely absent from the debate merely being seen as recipients of the improved safety because of revalidation. They appear absent as subjects and as authors of revalidation or commentators on its production.

Towards the latter part of the 1990’s, for example in the 1999 BMJ series on revalidation, there is occasional mention of ‘lay’ input into assessment and of patient contribution via questionnaires (see section 4 below for references). Detailed examination of patient and public involvement in the process is entirely absent.

In 1999 clinical governance was explicitly incorporated into proposals for revalidation through the CMO's consultation document 'Supporting doctors, protecting patients', prepared in response to the Bristol Inquiry. There was a clear logic behind this because clinical governance provided a local system to gather the evidence about individual doctor's performance required for revalidation (Freedman and Macaskill, 2002). This could also be conceptualized in the context of the increasing dominance of discourses about evidence-based medicine during this period. The focus of both revalidation and clinical governance on continual improvement, ensuring quality of care, evidence and accountability provide additional rationale for the establishment of this link. They further dovetail as part of clinical governance is the requirement for doctors to conduct clinical audits which include gathering patient and service user views.

Watering down of GMC's 2000 proposals between 2001-2003

There appears to be limited discussion about revalidation in the early years of the new Millennium and a total absence of debate about the involvement of patients and the public. The GMC's 2000 proposals are hidden and there is a gap in the literature that is only filled by analysis of publications written after the Shipman Inquiry 5th Report. Unpacking the flurry of articles that followed the Shipman report suggests that the key moments in public involvement in revalidation took place behind closed doors in the first half of the decade.

In 2005 Esmail, who was a medical advisor to Dame Janet Smith during the Shipman Inquiry, explains her criticisms of the GMC's proposals. Esmail describes how the key change was the removal of external scrutiny of appraisals. The GMC's initial proposals in 2000 included a local revalidation panel with a lay representative. However in April 2003 plans for a local panel were abandoned and it was "now intended to revalidate without further scrutiny all doctors who had successfully completed five appraisals." For Esmail at this point the GMC "lost sight of their aspirational proposals to evaluate doctors' fitness to practice". He describes how the Shipman Inquiry found that many relevant meetings were held in private, "in contrast to its usual procedure of consulting publicly on important policy issues".

Walshe and Benson (2005) focus on inadequacies revealed in the Shipman Inquiry about lay involvement in the GMC and an electoral system that creates a conflict of interest between the electoral membership and the GMC mission around 'patient protection'. They present similar arguments to Esmail in that it was the elected GMC's actions to "prioritise professional self interest over public protection" that resulted in the 2000 proposals being 'blocked and watered down'.

2004 - 5: The Shipman Inquiry and immediately after - the patient voice in revalidation emerges

It is in a series of BMJ articles on revalidation in mid-2005, linked to the announcement of the CMO's review following the publication of the Shipman Inquiry 5th Report that the concept of patient input in revalidation first takes any weight. The term 'patient voice' is used in connection with revalidation perhaps for the first time, when Norcini suggests that articles in the series have "several good ideas for ensuring that revalidation gives

patients a voice and responds to their needs.” The articles actually contain little detail about patient involvement in the mechanisms of revalidation but they do address the concept and four attribute the Government’s decision to halt the imminent launch of revalidation to failings associated with patient and public involvement.

According to Norcini, the GMC’s proposals were rejected because they did not involve patients. Norcini, Walshe and Benson, Esmail and Irvine attribute the rejection to the failure of the proposals to ‘protect the public’ and Pringle and Walsh and Benson to the inability to meet modern standards of ‘accountability and transparency’. Norcini writes of the “public’s need for a mechanism to ensure good care for patients” and explicitly comments on patients providing feedback on their doctors and on how “patient expectations... make revalidation a necessity.” Norcini argues that the need for specialised knowledge makes lay involvement in regulation difficult, but that “the absence of the patients’ voice in the regulation of medicine” and of ‘outside pressure’ is the reason why revalidation is not in place.

As described earlier, articles in the 2005 BMJ series describe problems with lay involvement in the processes of decision making at the GMC generally (Walshe and Benson) and specifically during 2001-2003 when the initial proposals for lay involvement in local revalidation panels were removed from the GMC’s plans (Esmail). Irvine suggests that patient organisations saw this last aspect of public involvement as “crucial to their trust in licensure”. What Irvine refers to as a ‘watering down’ of these arrangements for lay involvement was what is widely described by commentators at this time as attracting most criticism by Dame Janet Smith in the Shipman Inquiry 5th Report.

In a critique of Pringle’s 2005 John Fry Fellowship lecture, Elwyn describes his account of the shift in the GMC’s proposals in 2003 that “downsized significantly” lay involvement in revalidation and how their failure to respond to heavy criticism during the Shipman Inquiry led to the Department of Health decision that revalidation could not be allowed to proceed (cf Esmail, 2005). Elwyn suggests that Pringle’s account left many in the audience, particularly patients, wondering if the GMC should be replaced.

At this time, there are few challenges to the validity of the criticisms of the GMC and its proposals for revalidation contained in the Shipman Inquiry 5th Report. In the British Journal of General Practice, Keighly (2005) suggests that the GMC had achieved ‘considerable agreement’ and ‘widespread support’ for their proposals in a ‘long and difficult consultation.’ He suggests that the criticisms were wrong because of this and also that the ‘careful consultation’ included agreement by the very public that the Inquiry claims are not represented by the proposal. He argues that the proposals that have started to emerge in response may potentially be costly and lead to a shortage of doctors. Describing a heavily regulated profession that “now faces yet more hurdles” he concludes that the profession needs to be considered “worthy of regulating itself in partnership with the public”. In August 2005, Lewis, also in the BJGP, describes the recommendations emerging from the Shipman Inquiry around lay involvement in inspection of doctors’ folders of evidence as ‘impractical’ and not cost effective. He states his preference for the use of patient feedback questionnaires. Perhaps there is some significance, that it is around this time that we see the terms ‘multi-source’ and ‘360-degree’ feedback used in the medical press (for example, Shaw and Armitage, 2005). However it is not until after the publication of the White Paper in 2007 that explicit explanations of the patient element of multi-source feedback begin to emerge (Burge, 2007).

In July 2006, Pringle comments on the CMO's review of revalidation 'Good doctors, safer patients' which had just been published. He suggests that the report is 'groundbreaking' and that "professionally led regulation...is now evolving into partnership regulation." The use of the latter term suggests that Irvine's calls for regulation as a partnership between doctors and patients (2004; 2005) have been acted upon. He describes the recommendations as including provision for 360-degree feedback and lay input to local processes but provides an account of a shift back to the position on revalidation as it was in 2000. Significantly he cites the GMC 2000 report, 'Changing times, changing culture' and Allsop (2002 chapter in Allsop and Saks) in emphasising the need for change in the culture of the medical profession.

During the following month, August 2006, the BMJ published a number of letters commenting on the CMO's review (Catto; Twisselmann, Keighly). The key discourses around the purpose of revalidation at this point focus on 'patient safety' (Catto and Twisselmann) and 'protection of the public' (Keighly). In September 2006 in the BJGP, Keighly expands on the problems with the CMO's recommendations for revalidation he described in a letter published in the BMJ a month earlier. He is particularly critical of the proposals to replace the elected GMC with government appointed representatives which he regards as removing the independence of the GMC and putting the power in the hands of the Secretary of State. Significantly, Pringle (2006) whilst positive about other aspects of the CMO's recommendations also expresses concerns about the proposed GMC appointments procedure.

2005-2010

Consultation on the CMO's review of arrangements for medical regulation (Good doctors, safer patients, 2006) was conducted between July and November 2006. Neither the consultation document (July 2006) or the analysis of responses (February 2007) contain specific recommendations for patient involvement in revalidation. Patient feedback as a component of revalidation is mentioned in the 2007 Government White Paper (*Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century*) which was adopted following the 'Good doctors, safer patients' consultation. It is not until July 2008 however that a Department of Health publication on revalidation makes explicit detailed reference to patient input in the findings of the CMO's working group on implementing the proposals in the White Paper .

In setting out the next steps for medical revalidation the group identifies patient input as a 'key principle' (p.5) but also recognises it as one of the five main challenges to implementation, necessary to "greatly enhance the quality of the process of revalidation and help promote public confidence in the profession itself" (p.7). The report outlines the main input from patients as providing one source of 'periodic multi-source feedback' intended to contribute to the annual appraisal system (p.12) to inform continual quality improvement (p.14). It also identifies a 'critical' role for patients in the design of the 360° multi-source feedback process (p.17) and "in helping to define what counts as good healthcare and good health professionals" (p.28). "Engaging patients and lay people in developing the detailed plans for revalidation" is identified as a clear priority for the future (p.28). However, there is a clear presumption that patient feedback will be secured through questionnaires (p.17 and p.28). A specific contribution from patients is described as "drawing attention to unacceptable standards of care... especially in

communication skills” (p.28) and in providing feedback on “how well a doctor performs in relation to:

- effective communication, including listening, informing and explaining;
- involving patients in treatment decisions;
- care coordination and support for self-care; and
- showing respect for patients and treating them with dignity” (p.28).

Other priorities for the future set out in a section on patient and public involvement include:

- “developing a communications strategy to inform the public about the new developments and ensuring they know who to go to if they have concerns or complaints; and
- reassuring the public that revalidation is only one part of the continuum of clinical governance and performance management and not the only way of identifying poor performance” (p.29).

It is these recommendations – close to those in the 2000 GMC proposals that form the basis of the GMC’s 2010 proposals.

2010 GMC ‘Way Ahead’ Consultation on Revalidation

During 2010 the GMC published a number of key documents relating to its consultation on revalidation. The document that formed the basis of the March – June 2010 consultation includes a separate appendix on patient questionnaires and resources to be used to gather feedback about the consultation from peers and colleagues. It includes a discussion guide for facilitating events with patients and the public. The analysis of responses published in October included a PPI section with detailed analysis of responses to each question presented separately. Responses to patient input via feedback questionnaires were positive (67%) although doctors seemed to feel provisions for patient involvement went too far - patient organisations felt they did not go far enough. Concerns were expressed about detailed aspects such as how locums, junior doctors and those working overseas would gather patient feedback and the logistics relating to the costs and practicalities of implementation. There was also concern about how feedback to doctors would be managed to ensure positive improvements rather than negative outcomes. Response to patient involvement in GMC decisions when concerns were raised was broadly positive but involvement in the responsible officers’ recommendations was less positively received.

In contrast to the dominance of the patient voice in the GMC consultation documents and the generally positive way in which responses relating to patient and public involvement were documented, its presentation has been negative or absent in subsequent publications. The presentation at the GMC launch event on 18 October 2010 included just two slides on PPI in revalidation, both of which present a mostly negative picture. Significantly, the formal GMC statement on revalidation published at the same time contains no reference to the ‘patient voice’ or to ‘patient input’ and little reference to patients and the public. This shift needs to be considered in the context of the content of the GMC ‘Statement of Intent’ that is vague and suggests a ‘rethink’ and leaves the reader wondering why after twelve years of deliberation on the subject of revalidation the GMC proposals still appear far from ready for implementation.

Two key sources contain evidence to explain the apparent change in the plans of the GMC for revalidation:

- The announcement of the Government inquiry on revalidation at the end of 2010 suggests that the new Government - and perhaps particularly the new Secretary of State for Health - is seeking to put plans for revalidation on hold whilst it decides how to make its mark on the process.
- Along with the BMA response to the GMC consultation on revalidation and a letter from Andrew Lansley, the Secretary of State for Health to Peter Rubin regarding the revalidation consultation the following statement can be found on the BMA website:

“Our response to the General Medical Council's (GMC) consultation was successful in convincing the Government to extend piloting by a further year in order to develop a system of revalidation that is:

- *cost effective*
- *practical*
- *benefits the healthcare of patients”.*

This last quote from the BMA is key and brings us full circle back to the position in 2000. The 2010 consultation indicates that consensus on some aspects of the GMC's proposals has been achieved but is evident that there are still strong objections from some quarters, particularly on grounds of practicalities. Concerns about the costs of implementation are paramount and need to be contextualised within the economic difficulties of late 2008 onwards and massive deficits in NHS Trusts who will have to bear much of the costs within the current proposals. Resistance from medical profession insiders is couched in the language of 'cost' and 'taking doctors' time away from patients.'

4. Key discourses in patient and public involvement in revalidation

Discourses of patient and public involvement are virtually absent from the large volume of publications devoted to the subject of medical revalidation, however it is possible to identify four key discourses. Two of these are around the conceptual rationale for revalidation and the other two cover practical processes.

Conceptual rationale

1. The purpose of revalidation presented in relation to benefits to patients
2. Revalidation in the context of the concept of new medical professionalism

Practical mechanisms

3. Lay input to the process of revalidation
4. Arrangements for incorporating patient feedback in revalidation

Theme 1: Revalidation to benefit patients and the public

A discourse that explicitly places patients at the centre in terms of the purpose of revalidation is a feature of much of the literature from the first articles published to the present. Where patients are mentioned it is almost always in the context of 'benefits to patients and the public' (McKay, 2003). The discourses shift, with different aspects emphasised by different authors and certain themes being more dominant at specific points in time:

- 'reassuring patients' (Norcini, 1999; Beecham, 2001; Lewis, 2005; Shaw and Armitage, 2005 and 2007; Pringle, 2006; Keighly, 2008)
- 'improving the quality of patient care' (Norcini, 1999; Shaw and Armitage, 2007)
- 'protect patients' – 'from poorly performing doctors' (described by Esmail, 2005 as being enshrined in the 2002 amendment to the Medical Act 1983; Taylor, 2009)
- 'provide evidence of acceptable care for patients' (Middlemass and Siriwardena, 2003; Zolle et al, 2009)
- 'public safeguards' and 'patient safety' (Irvine 2005; general shift to emphasis on 'patient safety' from 2005 onwards particularly prevalent following publication of the Shipman Inquiry 5th Report in 2004)
- 'patient expectations' (Irvine, 2005); 'new societal expectations of professional accountability' (Walshe and Benson, 2005); 'to address public concerns or demands' (Pringle, 2005, argues that patients want revalidation to ensure their protection); 'reassuring the public' (Shaw and Armitage, 2007)
- 'public confidence' – especially restoring loss of public confidence (dominant following publication of the Shipman Inquiry 5th Report eg Walshe and Benson, 2005; Kmietowicz, 2005; Esmail, 2005, Godlee, 2005); later publications talk more in terms of 'maintaining the confidence of patients' (Finlay and McLaren, 2009)
- regulation in 'partnership with the public.'

In 1999 Norcini describes how according to Benson, the goals of recertification are to improve the care of patients, to set standards for the practice of medicine, to encourage continued learning, and to reassure patients and the public that doctors remain competent throughout their careers. In his 2003 book 'The Doctor's Tale' and in two 2004 papers, Irvine places the patient at the centre. He presents an account of revalidation as a response to 'public expectations' that the medical profession protects their safety through regulation of doctor's practice. His placing of this account within a context of patient-centred professionalism is presented below in theme two.

Godlee in an editorial on the BMJ's mid-2005 series on revalidation describes the "loss of public confidence" that resulted from the rejection of the GMC's proposals. In their article in that series, Walshe and Benson (2005) also refer to the "loss of public confidence" in professional regulation, suggesting that "public and political faith in the professions and their regulators is lower than ever before." Referencing research published in 2002 by Allsop, they attribute this loss of public confidence to criticisms of medical regulation in the Bristol and Shipman Inquiries but also from a series of high profile investigations into doctors between 2000 and 2004. Bruce and colleagues (2004) compared two models of revalidation for general practitioners to identify "whether either model would allow patient groups to have confidence in the revalidation process".

Theme 2: Cultural shift to patient centred medical professionalism as the basis for revalidation

A number of articles about the concept of a new medical professionalism make reference to revalidation as part of the changing context of medical professionalism. They mention the changing relationship between doctors and patients as part of this. Some are not directly about revalidation; one makes reference to 'patient centred care' being synonymous amongst other things with the new model of medical professionalism (Borgstrom et al, 2010) and another talks of 'enhanced patient power' as part of the new context of medical professionalism (Ellis, 2004).

Smith (2006) and Irvine make a direct link between revalidation and the new professionalism. Irvine's 2003 'The Doctor's Tale' is the story of the roots of the pressure to change medical professional regulation and of why the GMC's initial proposals for a system of regulation failed. Summarising his book in two papers in 2004 (AAM 33 and MJA 2004), Irvine firmly places the root of medical revalidation in the cultural shift "to assertive patient autonomy", drawing on Angela Coulter's 'The Autonomous Patient'. This can be conceptualized as a moment that represented the shift from good medical care as an expectation to an expectation of it as an 'entitlement.'

For Irvine (one of its creators) revalidation is firmly rooted in the shift to a patient-centred professional culture and its associated language:

- "doing this with public and patients", "working together" in "coalition", "a partnership between public and doctors";
- "public demand for greater accountability and more transparency";
- "new contract between the medical profession and the public."

In the 2004 AMJ article he describes the beginnings of modern regulation in the failure of the medical profession to shift in tune with 20th Century attitudes about “paternalism, communication and patients’ consent”; to the profession’s “ambivalent approach to accountability and transparency” and the “profession’s secretive attitude to risk.” He places the origins firmly within changing societal expectations for patient autonomy in place of unqualified professionals’ autonomy. Irvine talks of the shift required to enable a new model of regulation and suggests that this began in 1994 and was given impetus in 1998 by the Bristol Inquiry. He also describes two programmes as being closely linked to the inception of revalidation:

1. Clinical governance
2. The development of a patient-centred GMC Code of Conduct which he describes as being a “national standard of patient centred professionalism”, “public affirmation of their values and standards” that “reflects.... mutual understanding.”

At the time these papers were written, revalidation was planned to begin in April 2005 but the Shipman Inquiry 5th Report put a stop to that. In the AMJ article Irvine talks of the ‘tensions’ between what the public want versus what the profession wants but the implication in his work is that patient input is upfront, in providing the evidence through patient surveys about patient expectations and experiences to inform the development of the Code of Practice - the standard against which doctors’ performance is then measured in revalidation. He describes work by others at the King’s Fund, the RCP and Doctor Foster and Picker Institute Europe’s Patient Centred Professionalism international collaborative to develop patient-centred codes of practice. The latter three-year programme was designed to ensure that medical practice standards, education and regulation were patient-centred (Picker Institute Europe, 2008). In 2006-8 the Picker Institute carried out research on patient expectations with regard to professional standards to assist the GMC in its reviews of Good Medical Practice (Chisolm et al, 2006; Magee and Askham, 2008).

Between 2004 and 2008 Picker Institute Europe contributed to the GMC’s consultations on ‘Good Medical Practice’ and to the CMO’s work to develop an implementation plan for the proposals for revalidation contained in the 2007 Government White Paper ‘Trust, assurance and safety: the regulation of health professionals’. Through its work it aimed to:

- ensure that the standards by which doctors work and are appraised include an emphasis on engaging and empowering patients
- establish direct patient feedback as one of the tools to assess doctors’ performance.

Despite this a record of the extent to which the development of the initial GMC’s Code was based on evidence from patient surveys is not easily accessed from the published literature.

Theme 3: Lay input to the process of revalidation

As described above, the GMC's 2004 proposals for revalidation were most heavily criticised because of the lack of lay involvement both in their development and in the mechanisms for implementation. The consequent lack of transparency is emphasised in three articles in the mid-2005 BMJ series on revalidation (Irvine, Pringle and Walshe and Benson 2005).

Irvine (2005) is explicit that "patient involvement in assessment decisions about individual doctors" was part of the initial plans for revalidation but that as part of the dilution of the plans during 2001-3 this was removed. The 'watering down' as Irvine described it was criticised heavily by Dame Janet Smith during the Shipman Inquiry. The various accounts presented of this in the BMJ and other medical publications around this time are explored in detail earlier and will not be presented again here.

Pringle (2005) describes how the RCGP had lay representation on its working group on revalidation. The workings of the GMC however were heavily criticised for a lack of lay involvement. Walshe and Benson (2005) argue that it is "unacceptable for the regulators to be run by boards or councils dominated by the professionals themselves, elected by their peers, and with weak, internally appointed lay membership." They support the recommendations of the Shipman Inquiry for appointed rather than elected regulators, with representation from a range of stakeholders and suggest that these "would be far better placed to act as guardians of the public interest and much less likely to be driven by the concerns of professional self interest."

Lakhani (2005) describes lay involvement in local strategic decision making around appraisal and clinical governance. In contrast, Pringle (2005) argues that there is no lay involvement in either of these which underpinned the GMC's proposals.

Norcini (2005) summarises ideas presented in the 2005 BMJ series that he implies seek to minimize patient input on the rationale that there are inherent problems in lay involvement in the regulation of a highly specialised profession like medicine (Cain et al; Walshe and Benson; Lakhani; Dauphinee). He goes on to argue that in the current socio-political context - where the need for transparency is prioritised - increased involvement in revalidation cannot be deterred despite these difficulties.

Theme 4: Patient feedback as a component of revalidation

There are two key elements to the discourses around patient feedback in revalidation. The first concerns the use of patient feedback in developing the standards on which doctor's performance is measured against. The second relates to patient feedback as part of the evidence that doctors gather for their assessment portfolio. A limited number of papers address the first of these. Irvine's description of the way in which the original GMC 'Good Medical Practice' code of conduct was derived from patient surveys has already been described above in relation to discourses of patient-centred professionalism (Irvine, 2005). Burge quotes the Government's expectations in the 2007 White Paper,

'Trust, assurance and safety' that "standards will be tested against the needs of patients and healthcare providers and based on wide consultation with all relevant stakeholders" (Burge, 2007). She also references proposals that doctors should include evidence of copying letters to patients in their portfolios for assessment.

There is much more evidence around the second aspect - patient feedback as an element of assessment. From 2005 onwards, publications start to describe patient surveys as one element of the evidence that doctors will be required to collect for assessment (Burge, 2007; Shaw and Armitage, 2005 and 2007).

Arrangements for incorporating patient feedback on individual clinicians in the portfolio of evidence that doctors must submit for assessment were in the plans for revalidation from their inception. However, there was remarkably little analysis of the rationale, feasibility and implications of this in the medical peer reviewed journals until about 2005. Esmail (2005) describes how Dame Janet's proposals for revalidation in the Shipman Inquiry 5th Report included "some form of 360-degree appraisal, including feedback from patients." Following this articles about multi-source feedback became a common feature in the medical speciality press (see Cooney, 2010). These papers mainly cover the logistics with limited examination of the concept of patient involvement in revalidation (Mahmood, 2010; Campbell et al, 2010; Campbell et al, 2008). Some evaluations of the impact of 360-degree feedback make no mention of patient feedback at all (eg Potter and Palmer, 2003), focusing entirely on peer input.

In September 2005, Shaw and Armitage describe proposals for multi-source feedback and describe how the RCP is developing a standard patient satisfaction questionnaire, expected to be in routine use for Specialist Registrars from October 2005. In a 2007 paper in the same journal they also refer to a booklet on patient surveys as one of a series of guidance documents developed by the RCP.

As part of the Picker Institute Europe Patient Centred Professionalism Project the effectiveness of a selection of questionnaires designed to gather feedback from patients on individual doctors was examined (Chisholm and Askham, 2006). Work is currently underway at Picker Institute Europe to develop patient feedback questionnaires to input to professional appraisal (Cooney, 2010).

Burge (2007) describes the proposals for multi-source feedback contained in the White Paper - to examine "professional attitudes and behaviour" and draws on Coulter (2006) to present one of the few explicit explanations of what patient feedback might involve found in the literature examined for this review:

"Patients should be involved in judging some aspects of how a doctor performs. A questionnaire might assess whether the doctor had:

- Helped a patient to understand and cope with their condition
- Given clear, understandable information about diagnosis and treatment
- Listened and allowed patients to 'tell their story'
- Provided opportunities for patients to ask questions
- Involved patients in decisions about care and/or supported self-care."

She provides some examples of questions that could be asked and concludes that "more work is needed to develop questionnaires that will produce specific and valid data."

Last year it was suggested that “feedback from colleagues and patients is a core element of the revalidation process being developed by the General Medical Council” (Campbell et al, 2010). Campbell has been key in developing tools for gathering patient and colleague feedback tools so it is perhaps not surprising that he should take this stance. The authors describe validation analysis of the CFEP360 tool which has been designed specifically to gather feedback about GPs. The study found that 14 colleague responses and 25 patient responses were required for reliable analysis if the tool was to be used for ‘higher stakes’ performance evaluation and possible revalidation. Fewer completed questionnaires were required if the analysis was used for the purposes of ‘lower stakes’ personal development rather than revalidation.

An earlier article describes work by Campbell and others to evaluate the GMC patient and colleague questionnaires (Campbell et al, 2008). The authors conclude that the GMC patient and colleague questionnaires offer a reliable basis for the assessment of professionalism among UK doctors. If used in the revalidation of doctors' registration, they would be capable of discriminating a range of professional performance among doctors, and potentially identifying a minority whose practice should be subjected to further scrutiny.” A 2005 article describes a study to evaluate “the feasibility and reliability of children and their families assessing the quality of paediatricians' interactions using a rating instrument developed specifically for this purpose” (Crossley et al, 2005). It concludes that “Accompanying adults can provide reliable ratings of doctors' interactions with children” and “The method is ideal to measure performance for in-training assessment or revalidation”.

There is limited material relating to patient and public input published on the websites of the organisations steering revalidation. The only material that is easily accessed refers just to patient questionnaires as part of the evidence from multi-source feedback used in the appraisal process. The NHS Revalidation Support Team, the Academy of Medical Royal Colleges and the Royal College of General Practitioners (RCGP, 2010; Lockyer and Fidler, 2010) published papers to assist organisations in approaching patient feedback. During 2010 the first five NHS Revalidation Pathfinder Pilot projects produced reports which included the results of testing the use of patient feedback questionnaires in revalidation (Jelly et al; RCGP; RCP).

5. Conclusion

Discourses of patient and public involvement (PPI) are virtually absent from the large volume of publications devoted to the subject of medical revalidation, however it is possible to identify four key discourses. Two relate to the conceptual rationale for revalidation (patient benefit and patient-centred professionalism) and the other two cover practical processes (lay input to the process and patient feedback).

The only discourse with consistent strength is that where the purpose of revalidation is presented in relation to the benefits that it will bring to patients and the public. This conceptualization places patients very much as the recipients of benefits. It contrasts dramatically with the second conceptual rationale discourse that places revalidation in the context of new medical professionalism. The latter constructs patients as partners with doctors in the creation and implementation of revalidation. It is relatively weak except in publications by Sir Donald Irvine and the Picker Institute and at one pivotal moment in the history of revalidation, following publication of the Shipman Inquiry 5th Report. Significantly, this also marks the point at which discourses about the practical mechanisms that involve patients and the public as agents in revalidation first appear with any strength.

The key points of change in the history of revalidation can be conceptualized as responses to external pressure from outsiders demanding tighter regulation of the medical profession. Following each key moment of change, a period of retrenchment can be observed. During this time, insiders from within the medical profession, particularly the BMA negotiating compromise on the standards, can be seen to regain control over the process. It is possible to characterise the phases of retrenchment as insiders getting a consensus amongst a broader range of stakeholders to move away from proposals for external regulation back towards existing systems of self-regulation.

Practical arrangements for lay input into the process of revalidation and for incorporating patient feedback on individual clinicians both have a significant place in revalidation discourses at the key points of change. Although the patient voice is largely silent in revalidation it is attributed with considerable power in the published record.

Revalidation can be broadly constructed as the distinctive voices of insiders as opposed to outsiders. That is the discourses of those speaking from within the agencies steering the development of revalidation as opposed to those seeking to influence its development from outside. The analytical framework defined 'insiders' as the key agencies steering revalidation such as the Department of Health, the GMC, the Academy of Medical Royal Colleges (AMRC), the NHS Revalidation Support Team, individual Royal Colleges, the BMA and the Revalidation Pathfinder and Pilot Projects. Initially this construction specifically included lay members of those organisations as 'insider' voices, however this proved difficult to access. Further research is recommended to explore initial conclusions that these voices are absent rather than just obscured.

From the outset accessing documents which allowed analysis of discourses around patient involvement in revalidation was challenging, particularly in terms of public and

patient input to the development of revalidation mechanisms. This element of the analysis relies heavily on papers published in the peer reviewed medical press – a source almost entirely dominated by the medical profession. The ‘outsider’ voice has barely been accessed and the patient voice has not been accessed at all. Further work would be required to complete this aspect of the analysis and proposals for this are set out within the recommendations of this report.

6. Recommendations

The discourse analysis of the patient voice in revalidation literature suggests the need for additional work in the areas identified below.

NHS Trusts, the NHS Revalidation Support Team, the GMC and other organisations leading on revalidation

Commission research to:

1. Assess stakeholder perceptions of PPI in revalidation eg a Delphi consultation on the findings of the current report to achieve a consensus on priorities.
2. Identify and test systems for involving patients and the public in revalidation decision making processes within individual Trusts (in clinical governance and revalidation review panels), Royal Colleges and specialist faculties and the GMC.
3. Ensure that efficient processes are in place to provide patient feedback about individual doctor performance and to explore the feasibility of incorporating requirements into existing patient feedback mechanisms such as the Care Quality Commission's National Patient Experience Survey Programme.

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Work to complete report and disseminate findings:

4. Prepare articles based on this report for publication in the peer reviewed medical press with the aim of stimulating debate about the extent to which patients and the public should be involved in the processes of revalidation decision making.
5. Publish this report on Picker Institute Europe's website.

Identify funding to complete additional work to augment current report:

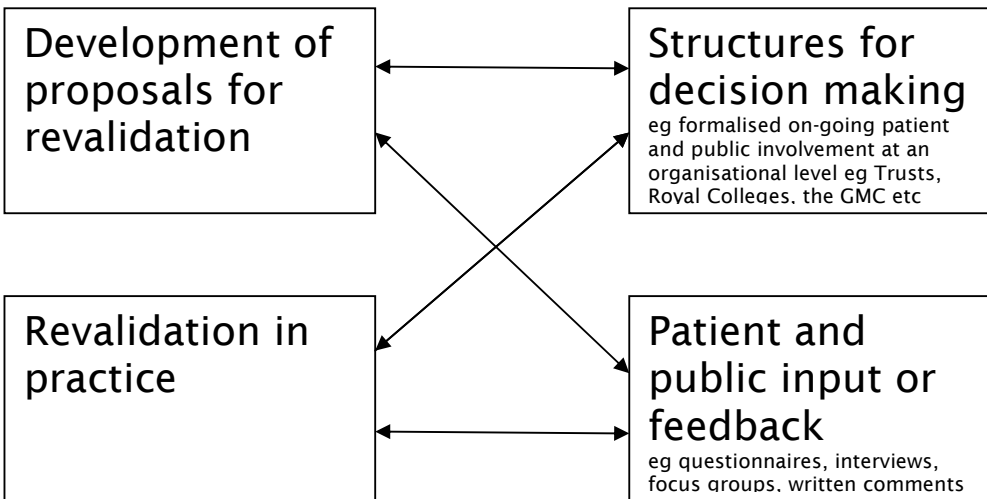
6. Complete planned discourse analysis of PPI in the GMC 2010 consultation documents on revalidation and in the professional and national press since the publication of the GMC 'Way Ahead' consultation document in March 2010. The aim will be to identify the organisations and individuals involved and the key messages they have made about the four main components of revalidation in the GMC 2010 consultation, including the patient involvement element that is included in the section on 'feedback from patients and colleagues'.
7. Complete analysis of GMC's 2000 'Revalidation of Doctors' proposals.
8. Carry out further literature searches to identify articles that may have been missed in initial searches.
9. Incorporate findings from other Picker studies eg 2010 review of patient feedback questionnaires (Gerry Cooney, 2010); Picker 2007 qualitative focus group research on GMC Code of Practice (Helen Magee, 2008).

Secure funding for new research to explore evidence base around specific concepts and themes raised in the current report:

10. Develop proposals for a study of the barriers constructed around PPI in revalidation such as:
 - 'costs,' 'taking doctor's time away from patients,' 'proposals impractical'
 - Revalidation requirements perceived as too onerous resulting in GPs leaving the NHS
 - Impact of proposals on GPs who are not members of the RCGP and other doctors who are not members of Royal Colleges eg locums, doctors registered outside UK

11. Develop proposals to explore the apparent contradiction in the construction of revalidation by the medical press: 1990's is constructed as a period of increased external regulation BUT it was a period of increased self-regulation in that early 1990's NHS reforms resulted in increased peer performance review at Trust level (through arrangements for clinical governance and personal development) plus increased peer review at the centre from the increased powers of the GMC and launch of the GMC Code of Practice.

12. Develop proposals for explicit research charting the extent of PPI in the proposals for revalidation based upon the following model:



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Picker Institute Europe

Buxton Court
3 West Way
Oxford OX2 0JB

Tel: +44 (0)1865 208100

Fax: +44 (0)1865 208101

Email: info@pickereurope.ac.uk

Website: www.pickereurope.org

Charity Registration no: 1081688