
Feature Article

Twenty Myths About GMC Appraisal and Revalidation

Revalidation is the process by which doctors will have to demonstrate to the General Medical Council (GMC) that they are up-to-date and fit to practice, and that they are complying with the relevant professional standards. All doctors now need to demonstrate that they meet the standards of Good Medical Practice for revalidation and therefore relicensing.

According to the *Medical Profession (Responsible Officers) Regulations 2010*, from the end of 2012 all UK doctors involved in clinical practice will be required to relate to a Responsible Officer (RO) from a Designated Body (DB) to which they have a 'prescribed connection' and must have an annual appraisal, working towards GMC revalidation.

It will be through the annual appraisal process, that doctors can show that they are meeting the relevant standards, together with information provided by the DB with which they have a prescribed connection.



Satisfactory appraisals over a five year period will enable an RO to recommend revalidation to the GMC. This would be followed by the re-licensing of the doctor by the GMC for a further five years.

Those doctors working mainly for the NHS or a specific private hospital will relate to the RO attached to that organisation, but those who work mainly or solely in the independent sector, will have to identify an RO themselves. This decision will relate to their clinical work. For those doctors who do not know which Designated Body they have a prescribed connection to, the GMC provides advice as to who a doctor's DB will be. Once the doctor has a link to a DB, the RO can provide the doctor with the name of an appraiser.

Our guest author, **Dr. Paul Myers, Director of Doctors Appraisal Consultancy**, who provide independent advice and information about the new UK system for appraisal and revalidation reveals twenty mistakenly held myths about the process.

1. YOU DO NOT NEED AN APPRAISAL UNTIL YOUR SUBMISSION DATE

The RSD or Revalidations Submission Date is the date that the GMC will have sent to all UK registered doctors, after 3rd December 2012 when the new revalidation / relicensing regulations came into existence. Some doctors think that they can keep 'below the GMC radar' and avoid having an appraisal until just before their RSD. This is a dangerous game to play for several reasons.

Firstly to do so is in breach of the GMC regulations in that all GMC licensed doctors are now obliged to have an appraisal every year. If an appraisal is not completed each year this will put the responsible officer in a difficult position when assessing whether he should make a recommendation for the doctor to be relicensed.

However, my own view of why it is essential to have an annual appraisal is that in doing so you are providing evidence that you are 'engaging' with the process and should therefore be in good standing with the GMC. If a complaint was received about a doctor's fitness to practice then a review of known information about the doctor, including appraisal evidence of good practice, may help the doctors position, a situation which would not be in place if it emerged they were not being appraised. Moral; have an appraisal every year!

2. EVERY APPRAISAL MUST TAKE PLACE AT YOUR PLACE OF WORK.

Some doctors think that it is essential for the appraisal to take place at the doctor's surgery, clinic or hospital, but this is not correct. Firstly, nowadays doctors often have a diverse scope of practice, with portfolio careers, meaning that there is not necessarily one specific venue that would be relevant anyway. Beyond that it would not necessarily be appropriate for every appraisal to be there, with other factors such as the geographical location of the both the appraiser and the appraisee being determinant factors. Sometimes it is helpful for the appraiser to see the doctor's

working environment, but it must be remembered that it is the doctor that is being appraised and not his environment, nor the team in which he works that matters.

Other assessments such as CQC inspections relate to the premises, the appraisal deals with the doctor. A rule of thumb is that each appraisal interview should take place at a location agreed by both the appraiser and appraisee, but who has the final say will be determined by the appraisal policy of the Designated Body for who the appraiser provides appraisals.

3. YOU CAN ARRANGE A PATIENT FEEDBACK SURVEY YOURSELF

The patient feedback process that comprises mandatory information required for a doctor to be relicensed is defined by quite precise recommendations documented on the GMC website. Amongst the recommended process is that it should be clear that this is done independently and that there is no bias involved. The collection of data should be conducted independently so that the completion of the survey form, for example, is arranged so that the patient can complete the form freely and without any pressure.

Further, the results should be collated and presented to the doctor by an independent process. This means in practice that there should be a clear separation between the collection and collation of feedback so it is conducted in a fair manner. Often this will be through the use of an independent organisation that provides a patient, (and colleague) feedback service.

4. IT IS EASIEST TO WAIT UNTIL A WEEK OR SO BEFORE YOUR APPRAISAL TO GET TOGETHER YOUR SUPPORTING INFORMATION

This is very wrong and contravenes all recommendations in how appraisals should be conducted. Firstly good practice dictates that the appraiser should be able to review the appraisal form at least two weeks prior to the proposed appraisal date. This will allow the appraiser doctor to check that sufficient supporting information has been provided to allow the appraisal meeting to proceed. However, of equal importance is the fact that it is bad practice to save all the work for the appraisal right to the time of the appraisal. It is much better to accumulate the required evidence such as a record of your Continuous Medical Education (CME) or quality improvement gradually over the 12 months prior to the appraisal.

5. YOUR APPRAISAL WILL BE EASIEST IF YOU GET A CLOSE FRIEND TO BE YOUR APPRAISER

This contravenes the terms of standard appraisal policies of Designated Bodies whereby there are specific pairings between appraisers and appraisees that are forbidden. Typically these would be family members, spouses or doctors with whom there has been a business arrangement, all in order to remove any bias from the proceedings; a close friend would similarly not be allowed. This is for several reasons, but mainly to avoid bias.

6. ANY DOCTOR CAN UNDERTAKE YOUR APPRAISAL

This is no longer true for a number of reasons. Prior to December 2012 there was no regulatory obligation on doctors to have an appraisal, although a number of healthcare employers made this a contractual obligation; sometimes combining this as a performance review. The person who did this was often the medical director, but there were no specific standards of either the appraisal itself or training for the appraisers. This changed when the responsible officer (RO) regulations came into place, and the GMC will only accept an RO recommendation if this is based on revalidation ready appraisals, i.e. appraisals that confirm to standards set by the Designated Body (DB) but based on GMC minimum standards. This includes the requirement for appropriate training in the current appraisal and revalidations regulations.

7. THE APPRAISAL IS EASIEST TO RECORD ON A PAPER FORM

There are several reasons why this is not correct. Firstly by using an online electronic appraisal form all the information that you collect over the "appraisal year" is easier to store in one place, and this eliminates problems with lost files and documents. Furthermore, using an online appraisal system, both your appraiser and your RO can easily access your supporting information. This is particularly important in the year prior to your revalidation submission date, when you would want the RO to have access to all that he needs, in order to make a recommendation to the GMC about your relicensing.

8. COLLEAGUE AND PATIENT FEEDBACK NEEDS TO BE ARRANGED EVERY YEAR

This is not correct as although colleague and patient feedback are a mandatory requirement for each five year revalidation cycle, it just has to be done once every five years, not annually.

9. YOU CAN CHOOSE YOUR OWN APPRAISER

The specific arrangements whereby an appraiser is connected to an appraisee is dependent on the appraisal policy of your Designated Body (DB). However good practice dictates that some "pairings" are not allowed, for example between friends, relatives, doctors involved in business dealings, or doctors who have had acrimonious relationships previously. These clearly are undesirable as they would introduce a bias into the process. If there are any doubts about the appropriateness of a pairing, this can be discussed with the appraisal administrator or the DB.

Other reasons why a particular pairing would not be permitted include the guideline whereby a doctor cannot have the same appraiser for more than three consecutive years. This is so that any accusation of collusion between the appraiser and the appraisee can be avoided. Having several different appraisers to appraise you in each five year cycle has the advantage of a doctor having several different independent views on their clinical work, and demonstrates that the appraisal is both supportive and without bias.

10. PROVIDED YOU AND YOUR APPRAISER GET ON WITH EACH OTHER, YOU CAN HAVE AS MANY APPRAISALS TOGETHER AS YOU WANT.

As stated although the specific regulations do not dictate absolutely the number of appraisals you may have with any one specific appraiser, you cannot have more than three consecutive appraisals with the same appraiser.

11. IF YOU RUN OUT OF TIME PREPARING FOR YOUR APPRAISAL YOU CAN EASILY GET A DEFERRAL TO A MORE CONVENIENT TIME.

The Responsible Officer (RO) regulations do allow for appraisals to be deferred, and in fact current statistics show that approximately 7% of all revalidation submission dates are being deferred for a variety of reasons. These may be due to illness, maternity leave, or other absence on the part of the appraisee, or because sufficient supporting information for the RO to make a decision has not been provided.

However, if this was simply due to appraisee lethargy, inefficiency or 'lack of engagement', this would not be acceptable, and the RO might be asking questions about how committed you are to the appraisal process.

12. AN APPRAISAL IS A TEST TO MAKE SURE YOU ARE PRACTICING TO A HIGH STANDARD

This issue is often raised in relation to medical appraisals. It is often asked whether an appraisal is a formal fitness to practice assessment on the one hand, or simply a supportive process to demonstrate a range of supporting information required by the GMC, on the other.

My own view is that a medical appraisal is a process to show that the doctor is practicing to an acceptable standard, and specifically a way of showing that the doctor is keeping up-to-date, practicing according to good medical practice guidelines and this is reflected in his or her work. What it is not is a judgmental process, test or examination.

If issues about the doctor's work arise during the appraisal, this would lead to an open discussion about them, and perhaps appropriate additions to the personal development plan. If issues about the doctor's clinical competence, emerging from an appraisal, were so serious that patient safety was at risk, the appraiser would then be in a position no different to that of any other doctor. All doctors, irrespective of their clinical situation, have a responsibility to notify the GMC if a colleague's clinical care was putting patients at risk and being an appraiser doesn't deviate from this general obligation.

13. TO PASS YOUR APPRAISAL YOU HAVE TO HAVE SHOW CERTIFICATES CONFIRMING YOU HAVE COMPLETED AT LEAST 50 HOURS OF EDUCATION SINCE THE LAST APPRAISAL

This statement is incorrect for several reasons. Firstly the GMC have not given prescriptive guidelines as to what quantity of CME activities any particular doctor is required to undertake each year. This is because this can vary between clinical specialties, the specifics of the doctors scope of practice, whether they are full time or not, and how clinical workload and commitment can vary from year to year. For example, a doctor on maternity leave would not be expected to provide evidence of CME while they were absent from work. The various Royal Colleges, deaneries and advisory organisations often suggest an average of 50 hours educational activities per year would be a reasonable minimum target for most full time doctors in clinical practice. In reality a more reasonable target would be an average of 250 hours for every five year cycle, so as to take into account variability in a doctor's workload and accessibility to educational materials.

The issue of having to provide definitive certification of a doctor's educational activities should be based on a common sense approach, whereby documentation, where available, should be uploaded to the appraisal form; although this will not always be a formal certificate issued by an approved body. For example, the appraiser may wish to accept as accredited CME a range of educational activities that would not necessarily come with a formal certificate, examples being the attendance at in-house clinical meetings, or online self-directed learning programs.

14. THE RESPONSIBLE OFFICER MAKES THEIR DECISION ABOUT RELICENSING BASED JUST ON YOUR APPRAISALS

Prior to your revalidation submission date the Responsible Officer (RO) will certainly look at the five consecutive appraisal documents in the revalidation cycle, to see that there has been compliance with the conditions for a recommendation for relicensing. However, in addition the RO will also look at relevant information held by your Designated Body (DB); for example, adherence with the clinical governance guidelines of the DB, and reports of significant events and complaints that have occurred during the five year cycle. Therefore it is important to appreciate that it is not just appraisals that matter, it is also how doctors work within the organisation with which they are connected.

15. THE ONLY WAY TO SHOW QUALITY IMPROVEMENT FOR YOUR APPRAISAL IS TO DO A CLINICAL AUDIT.

The provision of Quality Improvement (QI) evidence in an annual appraisal is one of the various types of documentation that has to be shown in order to successfully be recommended for relicensing. Such evidence comes in various forms, and would certainly vary according to the scope of practice of the doctor. Certainly clinical audits are an easy and frequently used method of demonstrating quality of the doctor's clinical work, and can show how their work is consistent with that of colleagues providing similar clinical services. However, this is by no means the only way QI evidence can be provided for your annual appraisal.

For example, a doctor may provide a portfolio of clinical case studies and their reflection on the impact of a review of their work on their practice as evidence of clinical reflection and quality. Similarly a review of significant events can also demonstrate quality. Outcome reviews are another method of reflecting on one's clinical work, and the documentation of this information can be provided to show quality, for the purposes of an annual appraisal. Many hospital doctors are provided with data about both their own work and their colleagues, working in teams, such as 'Key Performance Indicators', and this information can be useful to reflect upon and to report during an appraisal.

16. THE RESPONSIBLE OFFICER'S JOB IS ONLY TO RECOMMEND OR REFUSE TO RE-LICENCE THE DOCTOR BEING APPRAISED.

This is incorrect for several reasons. Usually a Responsible Officer (Ro) has other roles within the Designated Body (DB) to which they are connected. Frequently they will have the position of medical director and will have to carry out this role in addition to that of being an RO. ROs will frequently have a role in quality assuring the appraisal system within the DB, and ensuring that the regulation requirements that an organisation has to fulfill to continue as a DB are complied with.

With regard to relicensing doctors, the RO has three choices. He can decide whether to recommend to the GMC that a doctor should be relicensed. Although he would not be able to refuse such a recommendation, his second option is to say that insufficient evidence has been provided for him to make a decision. Finally, the third option is to request a deferral of the revalidation submission date.

17. THE RESPONSIBLE OFFICER DECIDES WHETHER YOU SHOULD KEEP YOUR LICENCE TO PRACTICE

Following from the above paragraph, it is not the Responsible Officer's (RO) job to make this decision. The responsibility for making this important decision remains with the GMC and they make the decision based on not just the RO's recommendation, but other factors that may be known about the doctor. However the doctors that have had no involvement with the GMC, (such as fitness to practice investigations or conditions over which they are allowed to practice), can usually assume that a recommendation by the RO would be followed by a positive decision for a five year licence to practice in the UK to be given by the GMC.

18. IF YOU ARE PRACTICING MEDICINE ABROAD YOU MUST RELINQUISH YOUR GMC LICENCE TO PRACTICE.

This is a grey area, and a doctor's decision to relinquish their GMC licence should be made carefully based on the specific scope of practice that they are currently providing. Certainly the GMC recommends that if you are

permanently working abroad and are no longer providing any clinical services in the UK, you do not need a UK licence and should relinquish this. The GMC further states that should your situation change and you subsequently take up a clinical post in the UK, you can apply for reinstatement of your GMC licence to practice. The interpretation of the regulations is more difficult for doctors that sporadically provide clinical services in the UK, or who do not know the precise nature of their future UK practice. In these cases it is best to discuss one's clinical situation with the GMC directly.

It is known that some Designated Bodies / organisations have suggested a recommendation to their connected doctors who are providing less than a third of their clinical work in the UK that they should not apply to be re-licensed, but this is not in any way a regulation. Eventually, once appraisal and revalidation becomes more established in this country, a definitive ruling about this may emerge.

19. YOU ONLY NEED TO PROVIDE EVIDENCE IN YOUR APPRAISAL ABOUT THE CLINICAL WORK IN WHICH YOU SPEND THE MAJORITY OF YOUR TIME

This is wrong as the GMC have been specific in that your annual appraisal must cover your entire 'scope of practice', and even clinical work comprising a small percentage of your working week must still be covered by the appraisal process, including the need to keep up-to-date and to reflect on your work. For doctors in some specialties this can cause some problems.

Take for example, an NHS General Practitioner who is also an independent sector aesthetic doctor who is providing injectable, aesthetic, anti-ageing treatments on an occasional basis. Such a doctor would have to have an NHS appraisal according to current regulations, following the GMC algorithm for determining your 'prescribed route to revalidation'. However NHS appraisers are not always capable of covering the non-NHS part of the doctor's clinical work, and sometimes will not be prepared to comment on this area. In fact appraisers are supposed to cover your entire scope of practice, and this scenario should not occur in theory! In such situations doctors have found a pragmatic solution is to have a 'mini-appraisal' covering their aesthetic work and then the report from this provided as supporting information for the 'main' appraiser.

20. IN ORDER TO BE REVALIDATED YOU MUST SHOW SUPPORTING INFORMATION GOING BACK FIVE YEARS

This will be true to some extent once the first full cycle of revalidation is completed after 2018, five years after it was introduced as a compulsory obligation for UK doctors in 2013. Up to that time doctors whose revalidation submission date arrives will only have to produce this evidence from 2012 onwards. Even then only some evidence has to be provided once every five year cycle, for example colleague and patient feedback. Other evidence, showing for example that you are keeping up-to-date, or have evidence that you are practicing to an acceptable standard does need to be provided every year. This means that the revalidation procedure has been introduced going forward from the 2012 introduction date, and is not chasing doctors for unreasonable requirements retrospectively.

Dr. Paul Myers, MBBS FRCGP BSc FRSM Revalidation and Appraisal Director, Doctors Appraisal Consultancy



Paul Myers is director of Doctors Appraisal Consultancy, an organisation which provides advice and support to independent (non-NHS) doctors undertaking appraisals and working towards their revalidation. His original background was as an NHS General Practitioner, when he also pursued his interest in doctor's education needs assessment, through a senior lecturer post with St. Barts Hospital medical school, previously and with University College London currently. Dr. Myers is currently a specialist advisor to IHAS, with whom he collaborated on an appraisal pilot. He now provides appraisal services to a wide range of Designated Bodies, including NHS England and the British College of Aesthetic Medicine (BCAM). His current research interest is the quality assurance of doctor's appraisals.

Website: www.doctorsappraisal.co.uk

Email: info@doctorsappraisal.co.uk

Telephone: (07956) 393916



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