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Revalidation: Patients or process? Analysis using visual data

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ABSTRACT

Revalidation is a significant recent regulatory policy reform from the UK General Medical Council and being considered elsewhere around the world. The policy aims to regulate licensed doctors to ensure that they are 'up-to-date and fit-to practise'. Fundamental to the policy is that the revalidation of doctors should benefit patients and improve doctor–patient relationships. As part of an evaluation of the development of *revalidation*, 31 policy makers involved in its development were interviewed in 2010–2011 and were asked to draw what *revalidation* meant to them. From this, 29 drawings were produced and this article focuses on their analysis. The drawings emphasised abstract systems and processes, with a distinct lack of interpersonal interactions or representation of individual patients and doctors. Only 3 of the 29 images included individual patients and doctors. This depersonalisation of policy is examined with respect to the purported key objective of *revalidation* to benefit patients. Using a distinctively different modality, the drawings serve to confirm the two key discourses of regulation and professionalism prevalent in the interview data, while highlighting the notable absence of the patient. The benefits and limitations of using drawings as a research method are discussed for a health policy context.

1. Introduction

Revalidation, a new system of regulating doctors commenced in the United Kingdom (UK) in December 2012. For the first time all licensed doctors have to demonstrate that they are 'up-to-date and fit-to practise' in accord with the guidelines issued by the General Medical Council (GMC). It is anticipated that the majority of doctors will have been initially revalidated by March 2016; this is informed by annual appraisals, followed by revalidation every five years. This is a significant reform in the regulation of a national medical workforce which has generated interest across the world, sparking fresh debate in Canada [1] and Australia [2] about medical regulation programmes. However the evolution of the policy has been controversial for over a decade, with its purpose and direction subject to much debate.

The interests of patients and ensuring that they receive the best quality of care are espoused to be at the heart of the *revalidation* reform. This is indicated by the GMC:

> *Revalidation* aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. [3]
>
> Benefits for patients
>
> Over time we believe *revalidation* will improve the care you receive from doctors, and will mean that you are safer when you receive treatment from them. [4]

Given this, we were interested to examine if the focus on patients and improving patient care was central in

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the thinking of those who developed the *revalidation* reform. An evaluation of the development of the policy was undertaken and reported in 2012 [5]. This evaluation involved a textual analysis of relevant government reports, published institutional and professional responses and academic peer-reviewed publications. In addition, the evaluation included interviews with leading policy makers involved in the process of developing *revalidation*. As part of the interviews these policy makers were asked to draw what *revalidation* meant to them; the drawings, which are the focus of this article, provide an interesting perspective into the development of this major reform.

From the interviews, policy makers claimed that the focus of *revalidation* is on improving the patient experience, patient safety and quality improvement of the doctor–patient interaction. As one participant stated:

> [*revalidation*] has to be about the best interests of the patient. This is not just about 'the doctor' or any other clinician for that matter in the other professions; it has to be about, "What does this mean for patients?" It is about the culture and the ethos of doing your best for the patient but striving continuously to do better. . .that desire to improve outcomes for patients that, I think, has to be at the heart of it. (Member of NHS Quality Improvement Scotland in: [5])

The overarching narrative of *revalidation* and the policy makers stated that the aim and underpinning premise of *revalidation* is principally about improving health care for patients. However in a formal analysis of the spoken discourse, *revalidation* was shown to have two key drivers that can be broadly defined in terms of professionalism and regulation. The history of *revalidation* has been the working out of these contrasting agendas over time.

1.1. What is revalidation?

Revalidation in the UK shares common goals with many other developed countries in seeking to improve patient care through the ongoing review of individual medical practice [6]. *Revalidation* is however a uniquely national solution, informed both by the structure of healthcare provision in the UK and the historical authority of the separate medical institutions. *Revalidation* represents the first significant challenge to a system of medical self-regulation that was established in the UK through the 1858 Medical Act. It testifies to a lack of fit between a system of regulation focused on individual conduct and the modern practice of medicine which is "dominated by complex structural issues." [7]

The development of *revalidation* as a regulatory system has been shaped by a number of key events [8] and provides a useful discussion of the contingent factors that have led to the erosion of a collegial system through new forms of managerial control. Waring et al. [9] identify three reasons for these regulatory shifts; firstly, the liberalisation of the market and increasing pressures on public services; secondly, a loss of trust in medical expertise; and thirdly, examples of serious medical malpractice, followed by high profile public inquiries.

The idea of developing a process for the ongoing review of doctors in the workplace was put on the agenda by the Merrison Committee in 1972 which recommended that:

> "the GMC mount a study of the desirability of an annually issued practice certificate on the lines of that required by solicitors. The chief point of such a scheme would lie in requiring doctors to make a declaration of their continued fitness to practise." [10]

In May 1998 the GMC published a new edition of *Good Medical Practice*, a statement of generic medical standards which formed the foundation of quality assured practice and explicitly linked standards with registration. It is from this point that the debate began in earnest within the profession. A spate of high profile medical malpractice incidents, serious enough to prompt Government inquiries, placed regulation firmly on the political agenda. These incidents included poor clinical performance and accountability at the Bristol Royal Infirmary (1996–1998), negligent practice by gynaecologist Rodney Leadward (1996), and most significantly, the arrest of trusted and popular GP, Harold Shipman (1999), for the murder of at least fifteen patients. Importantly, these cases not only located poor individual practice but also a professional culture that was perceived as lacking accountability. An already hyped media were quick to blame the ineffectiveness of the GMC as the regulator. However it should be noted that the GMC plans to link *revalidation* to annual appraisal were criticised by the author of the Shipman Inquiry Fifth Report [11].

As a direct outcome of the Shipman Inquiry, Chief Medical Officer for England Sir Liam Donaldson undertook a broad review [12] of medical regulation that identified the three key aims of *revalidation*: relicensing, recertification and remediation, and set out a plan for its implementation. In response, the GMC produced a series of consultation papers under the general heading of *Revalidation: The way ahead* [13,14]. These papers set out a process of enhanced standardised appraisal with colleague and patient feedback, augmented by clinical governance data such as audit and significant event case reviews.

In early 2009 the GMC had set up the Revalidation Programme Board to give strategic leadership of the roll out of *revalidation* across the UK. The first pilots, across ten areas in England with 3000 doctors taking part, were announced by the Secretary of State in January 2010. The purpose of the pilots was to test the components of *revalidation*. Even then central government delayed full implementation for a further year over concerns of readiness until *revalidation* was formally launched on 3 December 2012, a full ten years since the GMC was empowered to introduce it through the Medical Act Amendment Order 2002.

Commentators from both within the medical profession [15] and outside [5,7,16] all acknowledge that the proposed changes to medical regulation divided the profession and placed considerable strain on the historical relationship of trust between the Government and the profession. The rhetoric of both the Government and the profession places the patient at the centre. In contrast, the debates that have informed *revalidation's* history to date have been