REVALIDATION: in Policy

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The views expressed in this report are those of the participants and the authors and do not reflect those of the Health Foundation.
Thematic cloud

Graphic representation of the 100 most popular themes coded from interview transcripts. The identification of these themes has informed the structure of the following report and provided the foci for analysis of the findings.
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## Abbreviations

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<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>RCA</td>
<td>Royal College of Anaesthetists</td>
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<tr>
<td>PCC</td>
<td>Professional Conduct Committee (within the GMC)</td>
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<td>FPP</td>
<td>Fitness to Practise Procedures (within GMC)</td>
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<td>RST</td>
<td>Revalidation Support Team</td>
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<tr>
<td>AoMRC</td>
<td>Academy of Medical Royal Colleges</td>
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<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
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<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
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<td>NCAS</td>
<td>National Clinical Assessment Service</td>
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Executive Summary

Introduction
Revalidation is one of the most significant policy developments in the history of the National Health Service, with implications for patient experience, patient safety and quality improvement. Revalidation will ask all doctors for the first time to demonstrate that they are ‘up-to-date and fit-to-practise’ on a 5 yearly cycle informed by annual appraisals. It is espoused to be a process by which poor practice will be identified and all doctors will benefit from performance review. However as a policy it has suffered a chequered history, and it remains a controversial initiative: perceived (particularly within the medical community) as lacking clarity in terms of purpose and direction. Roll out of Revalidation in the UK is planned for late 2012, following two years of piloting, so now presents a unique opportunity to explore its imminent launch.

This report provides a much needed independent evaluation of the controversies and events that have beleaguered the progress of Revalidation, and sheds light on the role of policy makers’ and senior decision-mak ers’ agendas and discourses in shaping the conditions within which it will be implemented. By understanding these discourses within the Revalidation debate we have sought to develop new information translational to policy, education and practice. Our aim has been to support a more consensual approach to Revalidation policy moving forward.

Methodology

Data collection
We reviewed the key policy documentation relating to Revalidation starting from the Merrison report published in 1975, in which the question of regulation was first raised. We also conducted interviews with 31 high profile policy-making medical, political and legal leaders, drawing from both the current and significant past, which took place during the latter six months of 2010.

Data analysis
We used thematic analysis to explore, describe and understand perceptions of Revalidation, and its role as part of a wider clinical, cultural and political system. We then considered the historical trajectory of Revalidation to date, capturing activities and debates relevant to our research questions. Finally, we applied discourse analysis to understand what lies beneath complex changes in governmentality, professional identity and the role of the patient in Revalidation.

Core findings
Exactly ‘what’ Revalidation is and ‘how’ it should be implemented have proved challenging. Discontinuities have become the focus of Revalidation’s history, rather than any sense of continuity and patient-centred practice.

The report identifies three overarching discourses within Revalidation; regulation, professionalism and patients. Regulation frames Revalidation as a way to identify ‘bad apples’, requiring a summative approach and minimum standards. Professionalism looks to Revalidation as a process by which all doctors improve; requiring evolving standards and a developmental model. These two discourses are not simply divergent, indeed most documents and participants used them interchangeably, but they are in some regards at odds. Their co-existence has been supported by a
shared discourse around the patient yet we found little patient centred policy. It has been hard to demonstrate that Revalidation in its proposed form originates from patients, has been shaped by patients or is explicitly centred directly on patient care. A series of recommendation have arisen from this original research:

- **Truly patient-centred**  ‘The patient discourse’ needs to be recognised within the discursive formation, thus making the patient ‘present’ and therefore have an active voice. To achieve this, the current focus on strategy needs to be reversed and the focus placed on patients. In other words, Revalidation should act directly on the doctor/patient relationship. Currently the policy is more likely to have an effect on the doctor/regulator relationship.

- **Clarity & purpose**  A clearer composite of the mix between regulation and professionalism needs to be developed – a mix that is determined by the needs of the patient.

- **Standards**  Trying to balance the interests of all parties has paradoxically led to inertia. Efforts might be more constructively focused on clarifying what is meant by “quality”, and how standards are set or might shift over time.

- **Ongoing evaluation**  There have been too many ‘givens’ in Revalidation. This has led to tension – implementing such a complex intervention requires not just a clarity of purpose, but the anticipation (and measurement) of both intended and unintended consequences. Evaluation of Revalidation as a policy and process needs to be established and ongoing.
1. Introduction

Revalidation potentially represents one of the most significant developments in the history of the National Health Service (NHS), with implications for patient experience, patient safety and quality improvement. Revalidation has a chequered history and remains a controversial initiative within the medical profession: typically being perceived as lacking clarity in terms of purpose and direction. Although first proposed at the General Medical Council (GMC) in 1998, Revalidation remains an issue very much of the moment. Indeed, since beginning this research, significant developments have taken place as part of the Coalition Government’s review of health provision.

Although there is a wealth of policy documents and literature on Revalidation, there has been a dearth of focused research that evaluates its introduction, or considered its potential impact on professional change, quality improvement and patient safety. The introduction of Revalidation in the UK is now set to begin in late 2012, presenting a unique opportunity to explore its implementation, both in terms of best practice and its influence in shaping professional identity in real time. This research provides an empirical ‘baseline’ against which such changes can be assessed.

We worked continuously to evaluate the direction of the research, and to refine its focus in the light of ongoing developments. We secured interviews with 31 high profile policy making medical, political and legal leaders, drawing from both the current and significant past, which took place during the latter six months of 2010. The data collected from this group, who are uniquely positioned to interpret and drive the policy process, have yielded an extraordinarily rich collection of primary data.

Our findings will contribute to the development of Revalidation, by providing a much needed independent evaluation of the controversies and events that have beleaguered its progress. The practical application of our findings flow from the identification of Revalidation’s multiple and conflicting meanings – thus providing an evidence base that will be invaluable in informing future policy and implementation.
2. Background

“Revalidation” is a broad term used to refer to the policy of proactively ensuring that practitioners who are registered to practice are still safe and competent to do so. This contrasts with the policy of investigating competence only when complaints are made or concerns are raised. *Health Committee Fourth Report – Revalidation of Doctors Feb 1, (2011)*

Since 1858, the system for regulating qualified doctors has been the addition of their names to a professional register, maintained by the GMC. The professional register is an enduring historical tradition, reflecting a trust in doctors continuing to be fit to practise throughout their careers, unless otherwise highlighted. However, reports in 2001 & 2004 of the public inquiries into Bristol Royal Infirmary and Harold Shipman called this into question: trust alone was no longer regarded a sufficient guarantee of fitness to practise, and calls were made from both within and outside the profession for trust to be underpinned by objective assurance. The name given to the proposed policy intervention that would guarantee objective assurance was Revalidation. But it has not seen a smooth progression to implementation. Its troubled history is presented in detail in the next chapter.

The GMC had already undertaken work on its disciplinary procedures and Revalidation, when Sir Liam Donaldson, Chief Medical Officer for England, was asked in 2008 to undertake a broad review of medical regulation. His second report *Medical Revalidation – Principles and Next Steps* (2008) asserted that Revalidation had three main aims:

- to confirm that licensed doctors practise in accordance with the GMC’s generic standards (relicensing)
- for doctors on the specialist register and GP register to confirm that they meet the standards appropriate for their specialty (recertification)
- to identify those who require further investigation and remediation, poor practice where local systems are not robust enough to do this or do not exist

However, Revalidation also appeared to harbour secondary aims, including the generation of ‘further focus and energy to doctors’ desire to keep up to date and improve their practice through continuous professional development and reflective practice, [which] is one of several mechanisms for improving the quality and reducing the risks of patient care’ *Medical Revalidation – Principles and Next Steps* (2008). Subsequently, Lord Darzi, a health minister charged with reviewing the NHS more widely, defined quality as the patient experience, patient outcomes and patient safety (Darzi A 2008). Yet ‘quality of care’ remained a subjective concept, which could be understood differently by the different agencies that work with patients, and differently again by those developing policy. Professional validation may have provided a key route to improving the patient experience, outcomes and safety, but there remained a clear need for consensus on what these objectives mean, in more precise terms, if professional review was to re-educate, or realign, practice in a systematic way.

If Revalidation is now to become a meaningful activity, it is vital to arrive at a clear consensus on its definition, objectives and processes. It is important to gain a clear understanding of the conflicting discourses that may be identified between individuals, organisations, past documentation and contemporaneous spoken intentions. An understanding of why such contention surrounds
Revalidation may help us in developing a shared vision that is workable for all parties. For example, in order to implement a reliable Revalidation strategy, we must reach some consensus on the definition and operationalisation of those key aims of patient safety and quality of care. If we can identify which conceptions, attitudes and practices provoke controversy, we may be better able to work with them in developing a more consensual understanding.

We must also take a longer view: some of the contention is likely to be historical in nature, as Revalidation was first proposed over a decade ago. It is therefore important to explore discourses over time as well as in the current climate. Without this clarity, it will be difficult to implement Revalidation in any systematic way, let alone measure its impact. This research seeks to address these issues, drawing on in-depth qualitative research to examine the controversy and consensus surrounding Revalidation in detail.

There is a primary need to clarify the term Revalidation from the perspective of policy makers as much debate has focused on the technical aspects of Revalidation and what it may, or may not, achieve - rather than precisely what policy and decision makers mean by Revalidation. By taking a measured step back and analysing the discourses around the controversies and events that have dogged Revalidation it becomes possible to:

1. understand the challenges and history of the policy process
2. identify its multiple and sometimes conflicting purposes and meanings
3. explore policy and decision makers’ views of the origins, definitions, and potential purpose of Revalidation, and its relationship to concerns about assuring and promoting patient safety and quality of care
4. understand the interaction of varying interests, the ways in which Revalidation might influence respective roles and the issues it may raise for professionalism in general.

Therefore, this research explores the notion of Revalidation, its aims and proposed processes (as well as claims to its likely consequences), as it is understood and applied by different members of the policy and decision making community.

### 2.1 Methodology

**Aims**

- To explore the origins, definitions, and potential purpose of Revalidation
- To understand the relevance of Revalidation to identity construction in clinical communities

**Objectives**

- To analyse prevailing definitions of Revalidation, the circumstances of their origin and proposed applications - as they are portrayed in academic literature, key policy documents, public debate and the views of decision makers and patients
- To explore the relationship between Revalidation and the (re)development of clinician and patient identities
- To provide new information translational to policy, education and practice
- To highlight the purposes and methodologies of clinician engagement in Revalidation
**Conceptual framework**

This study is based on the premise that no form of Revalidation should ever be viewed as a neutral process. The development of competency criteria and their application in judging doctors present us with a clear issue of medical governance. *Who* develops criteria, *which interests* decide their basis, *what factors* influence them, and the *ways in which* they are proposed, justified, applied and received are all political questions. In terms of researching these issues, our vision of Revalidation as a subjective and controversial phenomenon demands an appropriately designed qualitative methodology. We consider it essential to incorporate a political conceptualisation of Revalidation into this study’s theoretical framework for a number of reasons.

Firstly, the partial transference of autonomy away from clinicians themselves (self-governance) to the GMC (institutionalised governance) is a clear challenge to professional power. Secondly, it is important to question why a shift in focus and methods has become necessary in the first instance. For example, we should ask whose interests Revalidation might serve - the medical profession, government, patients, the public, or a combination of the above? Thirdly, institutional change inevitably involves immense bureaucratic activity, incurring significant human and financial resources. Strategic effectiveness will be dependent on the conferring of clear roles, defined tasks and measurable value outcomes. Finally, taking these factors into account, it is clear that Revalidation will play an important role in shaping or, more precisely, *reshaping* doctors’ professional identities.

Thus our overarching question was: how has Revalidation been defined and understood by policy makers? We operationalised this into three specific domains: i) the premises upon which Revalidation is based; ii) the various interests it represents, and; iii) the social and political conditions that support or negate it.

**Methodological framework**

We have approached the research data in three main ways. Firstly we used thematic analysis to explore, describe and understand perceptions of Revalidation, and its role as part of a wider clinical, cultural and political system. Secondly we considered the historical trajectory of Revalidation, including both past histories and the present history, capturing all activity and debate relevant to our research questions. We took a longer view of professional validation and re-validation over time, adopting a genealogical method. Genealogical Method – or ‘history of the present’ - is an analytical approach to understanding what lies beneath complex changes in governmentality. Providing a critical and dynamic overview, we used it to examine the conditions that have and do support or challenge the continuity (or discontinuity) of Revalidation as a policy. Placing the findings of our discursive analysis within the genealogical method, we assessed:

- what wider societal, cultural and political conditions have led to the alleged need for change?
- how and why are advocates of Revalidation in favour of a shift in methods of governance at this particular point in time?
- what does this tell us about institutional autonomy, medical culture and professional identity in the current political climate, in comparison with previous eras?

Thirdly, drawing upon sociological, political and critical discourse theories, we conducted a systematic analysis of the discourses that are seen to shape Revalidation strategies (objects and
activities) as they are conveyed in practice, as well as perceptions of its potential impact on the profession (outcomes). Discursive analysis provided the opportunity to describe and better understand the narratives operating within the culture of policy makers and leaders of Revalidation. It helped us to identify the interaction of discourses about Revalidation, and the power plays within their systems of understanding the policy and its processes. This methodological choice was underpinned by the view that the likely success and effectiveness of Revalidation depends in the first place upon the level of fit between these discursive aims. Our discourse analysis involved exploring various dimensions of Revalidation, including proposed objectives, appraisal methods and justifications for change. It examined these as complex phenomena that are supported or negated by their cultural and political contexts. Specifically we approached the data with the following queries:

- what discourses have shaped the Revalidation debate?
- how have various aspects of validation and Revalidation been presented?
- how do different viewpoints conflict or converge?
- how have these been combined in wider discourses (complex systems of meaning incorporating sympathetic ideas, perspectives, practices, ideologies and so on)?
- what dominant Revalidation discourses have emerged as a result?
- how have doctor/patient/public identities been constructed in different discourses?
- how have different discourses been used to influence decision-making and policy?
- how have they been used to frame high level debates?
- how has discussion of appraisal methods been influenced?
- how have policies been validated and challenged?
- whose interests have been prioritised or marginalised?
- what are the likely impacts on current roles and relationships?

These three stages of the analysis were complimentary with findings applied to our overarching research questions, and our conclusions have been written up for dissemination - more broadly in this final report and with specific academic detail in subsequent peer-reviewed publications.

2.2 Methods

The aims of the study and the research question led us, in the first instance, to consider the relevant data as that which pertained to Revalidation in the related literature: including government reports, published institutional and professional responses, academic peer-reviewed publications and media coverage starting from the Merrison report (Merrison 1975). On initiating our study, however, it became clear that these ‘official lines’ of discourse about Revalidation could be usefully supplemented with more rich, subjective data – collected from the voices of those leaders in the field who had thus far shaped the policy and its reception within the medical profession.

We therefore decided primarily to focus on the detailed, in-depth and unique dataset of interviews, drawing on (but not formally analysing) the relevant literature. This transpired to be a valuable reflexive move, as the data yielded far more in-depth and cutting edge information for our discursive analysis, which we outline below.
Sampling
We invited the leading members of Revalidation policy development to be interviewed. These individuals ranged from the leaders past and present from the main stakeholder bodies such as the General Medical Council, the Academy of Medical Royal Colleges, British Medical Association, NHS Employers and the Departments of Health from across the devolved nations. Thirty one of the 44 approached consented to a unique elite interview. These respondents represented the most senior medical and legal policymakers and leaders from over 20 different stakeholder ‘bodies’ (as outlined in table 1 below). Anonymity and confidentiality was assured and so none of the interviewees are identifiable by name in this report. The participants are instead named by their primary stakeholder body affiliation whilst acknowledging that most had affiliations with more than one organisation.

Table 1: List of anonymised participant by primary affiliation

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<tr>
<th>Member of the GMC 1</th>
<th>Member of the GMC 2</th>
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<tr>
<td>Past member of the GMC 1</td>
<td>Past member of the GMC 2</td>
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<tr>
<td>Member of the RST 1</td>
<td>Member of the RST 2</td>
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<td>Member of the AoMRC 1</td>
<td>Member of the AoMRC 2</td>
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<td>Past member of the AoMRC</td>
<td>Member of the NHS Confederation</td>
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<td>Member of the BMA 1</td>
<td>Member of the BMA 2</td>
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<td>NHS Employers 1</td>
<td>NHS Employers 2</td>
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<td>Member of the Shipman Inquiry 1</td>
<td>Member of the Shipman Inquiry 2</td>
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<tr>
<td>Member of the RCGP</td>
<td>Past member of RCGP</td>
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<tr>
<td>Member of NHS Professionals</td>
<td>SHA Director</td>
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<tr>
<td>Member of the NCAS</td>
<td>Member of the UK Revalidation Programme Board</td>
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<tr>
<td>Member of the RCA</td>
<td>Member of the RCS Eng</td>
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<tr>
<td>Member of the Welsh Assembly Government</td>
<td>Member of Scottish Government</td>
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<td>Member of NHS Quality Improvement Scotland</td>
<td>Member of the Northern Ireland Executive</td>
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<td>Member of the Independent Doctors Federation</td>
<td>Member of the Independent Healthcare Advisory Services</td>
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Data collection
Fieldwork took place during the period of July to December 2010. At the outset of each interview, the participants were provided with paper and pens, and invited to draw a visual representation of Revalidation. This was designed to open up the interview, to focus both interviewer and interviewee, and also to capture more conceptual and symbolic information that was of a different format to purely spoken words. All but five of our interviewees agreed to take part in this drawing phase.

Interviews were semi-structured allowing interviewees to frame their own narratives around Revalidation, their perceptions and experiences. Each interview lasted approximately one hour. The recordings of our interviews were transcribed verbatim, and the transcripts checked for accuracy.

2.3 Data analysis
The descriptive phase of analysis was performed on the data set, using a thematic framework analysis (Richie J and Spencer L 1994), providing an appropriately refined data set for more theoretical levels. As outlined in the above section (methodological framework) an applied theoretical phase using discourse and genealogical analyses was then undertaken – the initial findings of which are presented in this report.
2.4 Research ethics

Ethical approval was sought and obtained from the Peninsula College of Medicine & Dentistry (PCMD) ethics committee (see appendices 1 & 2).
3. Revalidation in context

3.1 Introduction

Revalidation represents a significant challenge to the historically established relationship between the profession, the public and the Government based on trust. As the sociologist Eliot Freidson has argued in his analysis of the medical profession, a contract or a ‘bargain’ is struck: with the Government conceding self-regulation to the profession in recognition of its monopoly on highly specialised knowledge in return for a reliable and safe service. This autonomy was guaranteed with the 1858 Medical Act and the founding of the GMC as the body responsible for medical education and professional discipline. But Freidson cautions that autonomy is not absolute “the profession’s privileged position is given by, and not seized from society, and it may be allowed to lapse or even be taken away” (Freidson E 1970; 73). Autonomous professions tend to develop their own dynamic, which may become divergent from the needs of the state and, as Mark Davies has observed with the development of the health service (the NHS being founded in 1948), self-regulation focused on individual conduct, is at odds with the modern practice of medicine which is “dominated by complex structural issues” (Davies M 2007; 9).

Revalidation shares common goals with many other developed countries in improving patient care, by encouraging doctors to maintain their clinical knowledge and skills, professional attitudes, and behaviours through ongoing assessment\(^1\). However, Revalidation is a uniquely national solution, shaped both by the structure of healthcare provision in the UK and the historical remit of the separate medical institutions.

Revalidation as a process for regulating the medical profession has been under active discussion for the last twelve years, although the question of regulation was first raised by the Merrison Committee in 1972.\(^2\) Although the principle of Revalidation now has general assent (the GMC was empowered to introduce Revalidation from 2002 under the Medical Act (Amendment) Order), its development over time has polarised the medical community and placed considerable strain on the historical relationship of trust between Government and profession. The rhetoric of both sides place the patient at the centre of their argument. However, the debates that have informed Revalidation’s history to date have been professional debates about policy, professional governance, and

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\(^1\) A survey prepared by RAND Europe for the GMC in 2009, to examine medical regulation in the countries of origin of doctors seeking to practise in the UK, found that although there were some similarities in regulatory structures none of the ten countries examined had any formal system for Revalidation similar to that in the UK RAND Europe (2009). International Comparison of Ten Medical Regulatory Systems: Egypt, Germany, Greece, India, Italy, Nigeria, Pakistan, Poland, South Africa and Spain. Cambridge, RAND Corporation. In the US a process of periodic assessment known as Recertification has been in place since 1990 but there are key differences in relation to Revalidation. These include a summative rather than formative focus, limited application and voluntary rather than mandatory participation.

\(^2\) The report of the inquiry, published in 1975, does not mention Revalidation as such but it notes an interest in re-licensure as a way of “tying continued registration to periodic tests of competence” (Merrison 1975; 47) and recommends that “continued registration should not depend on continued participation in education, but the GMC should encourage the development of continued participation in education.” (Merrison 1975; 52) The report also recommends 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.” (Merrison 1975; 129)
leadership within the broader cultural context of a ‘new professionalism’ and the shift from autonomy to accountability.

In this chapter we describe, with reference to the policy documents, the ways in which wider cultural forces have impacted on the development of Revalidation in the UK. We also discuss how the shift in Revalidation’s initial focus as a mechanism for catching the ‘bad apples’ to a process that will provide a framework for overall improvement (with catching ‘bad apples’ as a secondary aim) has created a tension between the two key drivers for change – regulation and professionalism.

3.2 Drivers for Change

Revalidation has had two key drivers that can be broadly defined in terms of Professionalism and Regulation. Firstly, Revalidation is the product of a reflective response to broader changes in the professional and cultural context by a dedicated group of medical policy makers (including Sir Donald Irvine, Sir George Alberti and Sir Liam Donaldson) who have maintained a sustained and often unpopular campaign for reform. Secondly it is the product of a reflexive response, by the Government and the profession, to the media frenzy surrounding significant medical malpractice (2001b), Leadwood (2000a), Neale (2004b), Ayling (2004a), Keer and Haslam (2005b), Harold Shipman (2004c) and the high impact of the reports that followed. These two drivers of professionalism and regulation, although they exist in tension, are not mutually exclusive. Both cite the centrality of the patient to their goals. The history of Revalidation has been the working out of these competing agendas over time, within the broader cultural evolution of managerial, consumerist and accountability agendas.

The Leadership Issue

The first real debates about Revalidation began in earnest in November 1998. The GMC had agreed with the Government’s new proposals for clinical governance which would include clinical auditing, CPD and annual appraisal, but the membership of the GMC immediately divided between those who supported Revalidation and those who did not. Some members felt that it was better to wait and see how the new clinical governance procedures worked, and there were concerns where Revalidation would fit in with clinical governance. Concerns were also raised about the appropriateness of linkage between performance and the register, and it was decided to set up a steering group to investigate the issues of implementation in preparation for the Revalidation Conference in February 1999. At the council meeting following the conference it was agreed that Revalidation would be linked to registration and that Revalidation would include all registered doctors.

In 2001 the GMC had published Acting Fairly to Protect Patients: Reform of the GMCs Fitness to Practise Procedures (2001a) which set out fully integrated arrangements to manage Fitness to Practise Procedures (FPP). In 1999, independently of NHS audit initiatives but responding to public concerns, the GMC stated that in order to maintain their registration, “all doctors must be able to demonstrate that they can continue to be fit to practise in their chosen field”. In 2000 the GMC produced the Principles of Revalidation Consultation Paper (2000b), the first proposal of a formal process of Revalidation. This was followed later that year by Revalidating Doctors: Ensuring Standards, Securing the Future (2000c). It was an extremely difficult intervening twelve months for the profession as the Consultation Paper immediately split the profession. The GMC proposals had the support of the GPs and the Royal Colleges but the BMA, hospital specialists and public health
committees opposed a system that required a new sort of accountability from every doctor. The BMA passed a vote of no confidence in the GMC at their conference, and the press called for the abolition of the GMC following the publication of An Inquiry into Quality and Practice within the National Health Service Arising from the Actions of Rodney Ledward, (also known as the Ritchie Report), which was critical of the GMC. While initially carrying the day, in 2002, the GMC buckled under pressure and retreated to a less rigorous position, which merely required all doctors to participate in annual appraisals conducted by their employers, and employers to issue a statement every five years to confirm the absence of specific concerns. The degree of acrimony was palpable and arguments became deeply personal.

In 2001 Annual Appraisal had been introduced for NHS consultants following a recommendation in the consultation paper Supporting Doctors, Protecting Patients (1999), which described the introduction of Revalidation as “an historic stride forward in the improvement of quality and the protection of patients.” Appraisal for other groups of NHS doctors, including locum doctors, was also introduced. The GMC agreed that, rather than have a parallel system; Revalidation would be subsumed into annual appraisal. Noting this change of position in her report, Dame Janet Smith concluded that “Appraisal clearly did not involve an evaluation of fitness to practise. In my view, the GMC’s change of direction was made, not for reasons of principle but of expediency” (2004c).

She commented further on the development of the GMCs proposals for Revalidation:

I have described those proposals above and have expressed my view that they are not satisfactory. They do not provide adequate protection for patients. In the early days, the GMC had visionary plans but, when it came to implementation, there was a retreat. That retreat caused dissent within the GMC but it was accepted by the majority. I am driven to the conclusion that, for the majority of GMC members, the old culture of protecting the interests of doctors still lingers on. I have reached two conclusions. The first is that the GMC as a body does not seem to be proactive in the interests of patient protection. It will often (although not always) take appropriate action when the need to do so has been pointed out to it but it does not see such things for itself. The second conclusion is that, when there is a conflict between the interests of ‘being fair to doctors’ or doing ‘what the profession thinks is right’ and the interests of patient protection, the majority sometimes takes the doctors’ view. I am not saying that that is always the case, but Revalidation is an important illustration of the point. Shipman Inquiry 2004

Dame Janet’s comments effectively halted the process of Revalidation in its tracks. The Chief Medical Officer in England (Sir Liam Donaldson) was asked to look into the issue. The working group’s report, Medical Revalidation - principles and next steps: the Report of the Chief Medical Officer for England’s Working Group (2008) set out the principles and next steps for implementing Revalidation in the United Kingdom. It was based on the Government’s wide ranging White Paper Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century (2007).

The process of Revalidation will involve two strands: relicensing (confirming that doctors’ practise in accordance with the General Medical Council’s generic standards) and recertification (confirming that doctors on the specialist and GP registers conform with standards appropriate for their specialty of medicine). Medical Revalidation - principles and next steps (2008; 7)

While acknowledging the challenges, the report stated the imperative for the GMC, the NHS and the Royal Colleges to work together. It established the role of Responsible Officers (ROs) to oversee Revalidation at a local level.
The Professionalism Agenda

Between October 1997 and May 1998, three doctors from the Bristol Royal Infirmary appeared before the GMC PPC and were eventually found guilty of serious professional misconduct. Widespread public interest in the GMC verdicts as evidenced by extensive media coverage (most of which was hostile) shows that the debate on clinical governance and professional accountability was now firmly in the public arena. Pivotal to the GMC Bristol hearing “were the two key issues of clinical performance and clinical accountability. These same two themes lie at the heart of the new Labour Government’s health strategy.” (Talfryn H and Shields AV 1999; 335) Change became inevitable. The then Health Secretary, Mr Frank Dobson, subsequently announced a Public Inquiry to be chaired by Professor (now Sir) Ian Kennedy which ran from October 1998 to July 2001. The inquiry concluded, in relation to the competence of healthcare professionals, that while there were failures of individual doctors, there also needed to be enforceable systems in place to ensure competence.

For the future, it must be part of all healthcare professionals' contracts with a trust (and part of a GP's terms of service) that they undergo appraisal, continuing professional development and Revalidation to ensure that all healthcare professionals remain competent to do their job. Summary: Bristol Royal Infirmary Inquiry (July 2001b)

This conclusion echoed the wider issues identified by the PCC, which recommended the evaluation and assessment of clinical competence, the individual responsibility of doctors to reflect and act on their performance and the responsibility to report concerns about colleagues. In May 1998, just before the end of the Preliminary Proceedings Committee hearing, the GMC published a new edition of Good Medical Practice, which explicitly linked standards with registration. Good Medical Practice was a statement of generic medical standards which formed the foundation of quality assured practice; it placed the patient at the centre and stressed personal accountability to the patient and colleagues. Meanwhile, more cases of poor practice came to light, followed by Government inquiries and an already primed media were quick to capitalise and present the GMC as an ineffective regulator.

The situation developed further following the Inquiry into Quality and Practice within the National Health Service Arising from the Actions of Rodney Ledward (2000a) – which examined the case of the dismissal of a consultant gynaecologist and obstetrician by his local South Kent Hospitals NHS Trust in 1996 in relation to the high number of complications resulting from procedures he had carried out and his subsequent referral to the GMC who removed him from the medical register in September 1998. In 2001, the then Secretary of State for Health announced the setting up of three further separate, independent statutory Inquiries, none of which was to be held in public. One of those Inquiries related to Richard Neale, a consultant obstetrician and gynaecologist who worked in a number of hospitals in North Yorkshire, the second to Clifford Ayling, and the third to William Kerr and Michael Haslam, two consultant psychiatrists who practised in North Yorkshire.

The Inquiries had broadly similar terms of reference: to investigate how the NHS locally had handled complaints about the performance and/or conduct of the doctors. The separate inquiries reached broadly the same conclusions as the Leadward Inquiry - that patients concerns were not acted upon, and that the GMC Disciplinary Committee was slow to react and seemingly unwilling to remove doctors from the register. For example, the Keer/Haslam Inquiry described an “unhealthy” culture in

3 At the time of writing the GMC has recently introduced a consultation on a new edition of Good Medical Practice
which “professionals were reluctant to take action against consultants, through either a misguided sense of loyalty or fear of confrontation. Administrators felt powerless, and devised mechanisms to protect themselves, rather than the patients or those who raised concerns. Responsibility for action was fragmented and unclear; policy and protocols were confusing or were incorrectly implemented, if at all.” (2005b) The report refers to the proposed introduction of Revalidation in 2005 and it comments approvingly on the “new sense of transparency” in the work of the GMC. The other reports considered, while acknowledging that much work had already been done by the GMC in this area, the positive benefits of Revalidation in ensuring the early detection of malpractice. The Inquiry report, welcomed the GMC proposals on Revalidation “as a long stop measure to ensure that no doctor, about whom there should be concerns, has slipped through the net.” (2000a; 327).

However, it was the case of Harold Shipman, an independent practitioner in Hyde charged with the murder of 15 patients in October 1998 and convicted and sentenced to life imprisonment in January 2000 that had the most public impact. The exhaustive inquiry chaired by Dame Janet, and the subsequent report entitled Safeguarding Patients: Lessons from the past, proposals for the future (2004c), devoted considerable attention to the regulatory procedures of the GMC. It paid particular attention to the FPP and Revalidation.

The Role of Patients and the Public
The 1980s had witnessed a general rise in managerialism, which combined with free-market policies to have a significant impact on the NHS. Sir Roy Griffiths’s report on NHS management, which became the basis of a Government White Paper Working for Patients (1989), led to the re-structuring of the NHS. Market principles were introduced: GPs were given control over their budgets, and hospitals were encouraged to opt out of local health authority administration with the introduction of the so-called internal market. One highly significant outcome of this restructuring was the GP contract, which resulted in doctors becoming increasingly situated as employees.

In 1991 the Government had produced The Patient’s Charter, which was set out in consumerist terms with a focus on the rights of patients, and a diminution, in theory at least, of paternalistic medicine. However, with no reference to the quality of care provided - or powers to reinforce the promises it made, the change was one of attitude rather than action. As Klein suggested, its importance lay not so much in its specific content as in the “new rhetoric and a new set of expectations in the NHS, marking precisely the kind of shift of power from providers to consumers envisaged in the Griffiths Report” (Klein R 1995). The decade that the Patient’s Charter was ushered in was to be an extremely difficult one for the medical profession; one in which the relationship of trust between the profession, the public and the Government was severely tested. In spite of this, the public continued to grade doctors as the most trusted of professional groups.

Research undertaken by Opinion Matters for the HMC in 2010 showed that an appraisal system for doctors would be welcomed by patients, the majority of whom thought that such a system was already in place. In the same year, Secretary of State, Andrew Lansley, representing Revalidation as a public expectation, postponed full implementation, until more evidence could be generated about what works for patients as well as the profession.
3.3 Conclusion

A review of the policy documents testifies to the complex history of Revalidation that has led up to the present, with the first Pilots conducted in 2010. On the 30th June 2011 an independent report, commissioned by the Department of Health (DH) and the Revalidation Support Team (RST), was published, evaluating the Revalidation Pathfinder Pilots conducted in England during the previous twelve months. The tone of the report was optimistic and concluded that there was increased confidence among doctors, RO’s and organisations as a result of appraisal (2011c). This was swiftly followed by the RST’s own ‘snapshot’ Review of Integrated Clinical Governance in the Context of Revalidation in October 2011 which, while it found significant improvements since 2009, identified some inconsistencies across the sectors. The GMC described this report as “a wake up call to health service organisations”, but stressed the importance of Revalidation in driving improvement - and the significant role of the GMC in working with stakeholders to ensure its success (2010a).

The emergence of the GMC as a leader with a clear mandate in relation to Revalidation contrasts with previous decades, where Revalidation suffered from the inability of the profession to decide not only what it was but also who was doing what. The House of Commons Health Committee identifies “the role of the GMC as the “owner” and “leader” of the debate about Revalidation” adding that the “prime responsibility for planning and executing effective and timely Revalidation … rest squarely on the shoulders of the GMC” (2011a).

Through its series of documents ‘Revalidation: The Way Ahead’ (2010b) the GMC has continued to drive the debate forward. In the most recent document, Revalidation: The Way Ahead Consultation on the General Medical Council (Licence to practice and Revalidation) Regulations, it proposes revising the 2009 regulations to give the GMC the increased powers needed to “maintain, withdraw, restore or refuse to restore licences in the context of Revalidation” (2011d). By situating Revalidation at the heart of its registration function, the GMC is making a fundamental change to the register: from an historical towards a ‘live’ register. It is a clear recognition that the profession both acknowledges, and is adapting to, the changing socio/medical dynamic. Effectively the ‘bargain’ between the profession and the government has been reconfigured to reflect wider socio-cultural changes and key events over recent decades.

The relationship between doctors and society, the doctor–patient relationship, and the environments in which doctors undertake their training and their practice, have all changed. Events that have undermined public trust in medicine, and a questioning of traditional values and behaviour have also greatly influenced the life and work of doctors. They have challenged characteristics that were once seen as hallmarks of medicine. Report of a Working Party of the Royal College of Physicians of London (2005a)

While acknowledging that the relationship between doctor and patient has changed over time, the patient is the constant within Revalidation debates. That being so, the patient has been talked about differently over time; from Revalidation as a mechanism to protect patients from a few ‘rogue’ doctors, to a system providing better care for all patients. The negations around exactly ‘what’ Revalidation is and ‘how’ it should be implemented have proved cumbersome to both profession and the GMC. Discontinuities have become the focus of Revalidation’s history, rather than any sense of continuity and patient-centred practice.
Documentation relating to Revalidation provides useful insights into its development as a policy process. However, in order to develop a deeper understanding of Revalidation competing agendas and practices, we must also consider the discourse of the key Revalidation policy makers.
4. The Issue of Leadership

"I guess I see Revalidation as the spider in the centre of a web. Revalidation is the centre and then we have got all sorts of other interests clustered around the outside: NHS employers, university systems, public opinion, training... or educational training, registration, Colleges and specialties. Past Member of the GMC"

4.1 Introduction

Revalidation sits at the nexus of a variety of interests and agendas. The metaphor of the web was used by our interviewee (above) to demonstrate the necessity of linkage and cooperation between these stakeholders to form a mutually supportive, cohesive and robust whole. It illustrates the need for a positive relationship between the spider (Revalidation) and the web (supporting elements) with a clear structure that is both strong and flexible. But spider’s webs are sometimes related to capture and entanglement. We might therefore read the web as ‘catching’ poor practice in which case Revalidation takes on a predatory nature or we could read it as a cautionary tale of Revalidation caught in its own web; entangled in political struggle.
Leadership, shaped through the discourse of political struggle, is the focus of this chapter. Using critical discourse analysis we sought to identify collectively held assumptions that operate across medical management as vocalised by those involved at the heart of the Revalidation policy process. We attempt to summarise the thematic and then discursive themes arising from this unique cohort of medical leaders. It is the social relations and structures including leadership that are central and these are necessarily founded on power. Struggle arises when some of the links in the metaphorical web are stronger than others, indicating that power even when dispersed is rarely distributed evenly.

All but one of our interviewees discussed leadership specifically. They consistently presented leadership as an evolving obstacle to the development and implementation of Revalidation policy. Firstly it must be acknowledged that some aspects of this dominance are likely to be due to the purposeful participant sampling; current and key historical leaders within Revalidation. Resistance to leadership is also likely to dominate as those interviewed sought to bring about such a major policy change.

It is therefore perhaps not surprising that most interviewees expressed some frustration at the vacillations around the issue of leadership and were quick to apportion blame for the lack of progress:

> I think what it’s needed is...leadership and the leadership... it hasn’t been clear who’s out front with the standard.... That’s, I think, the challenge and the solution for the next two years. Member of the UK Revalidation Programme Board

Still as with this interviewee our participants saw leadership as a solution as well as a potentially inhibitory factor and it is these findings that we discuss in this chapter.

### 4.2 Defining “the issue”

**Failure of self regulation**

We, the medical profession, have been operating a con over the years, for understandable reasons, which have got progressively less understandable and less defensible as time has gone on, which is that as a profession we have always been prepared to tolerate poor practice in some doctors. Past Member of the GMC

Increased public knowledge of failures in self-regulation and the response to these events by the profession led to open criticism by the media. Revalidation has therefore been seen as an attempt to make up for this lack of self-regulation; as discussed further under The Professional Agenda. But any move away from self-regulation was recognised by participants as likely to meet resistance from the profession and that this would require clear leadership. Interviewees were often critical stating that this was lacking historically.

**The hard sell**

Developing policy, when some doctors see Revalidation as unwanted with a loss of autonomy, raises challenges for leaders in order to ‘sell’ Revalidation. It was identified by interviewees that Revalidation needs a marketing strategy. Some felt that a lack of leadership in describing the clear reasons for why Revalidation is required led to the policy becoming unpalatable. Poor communication was put at the heart of the problem making complex policy changes even more
difficult to accomplish. Others went further and saw the lack of leadership and communication as the root cause for the lack of clarity and purpose of Revalidation itself.

Others directly involved in implementation at the RST, whilst recognising the challenge of leadership without clarity, also highlighted the complexity of trying to communicate to various audiences and the impact that this can have by developing various narratives about the same policy:

So part of the tension you have to do is to talk to [the BMA] as if it is all about poor-performance, talk to the educationalists and the quality assurance people and the managers and the leading edge as if it is about aspiration and quality enhancement and about good behaviour patterns that lead to improved services, and then we have to talk to NHS managers saying, “If you had done what you were expected to do over the years then we would not be in this position and we might even have a very light touch Revalidation…. There are dangers in every policy where you are not focusing on a very simple, one single outcome and that is very clearly communicated to everybody but actually I cannot think of—well, this is the most complex policy that I have ever been involved in the development of—but I cannot think of a policy that I have been involved in the development of which has not had many implications for different groups. Often you are presenting one view to politicians, one view to patients and one view to doctors as to exactly the nuance of how a policy gets to where it is and how it is developing. I think that this is the most complex policy certainly in the last twenty to thirty years and therefore, I think it is inevitable that it has multiple faces. Member of the RST 2

The theme of leadership at the heart of Revalidation highlights struggles around selling a process that is perceived to be a threat to self regulation, a need at times for reformers but ultimately requiring a more balanced consensual approach moving away from blame. The enduring political struggle to bring Revalidation to fruition has provided the time for complexity of process, resistance from within the profession, and scandal to accumulate and amplify. So, beyond the challenge of agreeing the details of Revalidation as a process, there are the additional and significant challenges of leaders having to deal with the weight of the policy’s history. Therefore the theme of leadership is permeated by important discursive threads that illuminate matters beyond the reported history of events.

Reformers

And, of course, behind it all as an éminence grise of a wholly satisfactory nature was Donald Irvine. Member of the Shipman Inquiry 1

Against the perception of a lack of general leadership, both individuals and discrete groups have consistently pushed the Revalidation agenda forward. Individual agency within the discourse of Revalidation is best illustrated by Sir Donald Irvine who has been a tireless promoter of Revalidation. The defining theme of his presidency of the GMC from 1995 - 2002 was the work he undertook on developing a modern, standards based medical regulation.

But Irvine was by no means a lone voice:

I think this perfect storm. I remember reading this article in the British Medical Journal and Richard Smith called them the Newcastle Mafia. Donald Irvine became Chair of the GMC and then George Alberti became the Head of the Royal College of Physicians and Liam Donaldson became Chief Medical Officer....and they all came from the same locality and also I think that there was a group that came together at that particular time, who took high office, who then said, “Let us do something about this.” Member of the Shipman Inquiry 2

But some interviewees expressed how despite this they felt alone:
I was a member of the GMC when they made this decision to go for five appraisals and clinical governance sign off. And I was the only person in the GMC to speak against it, a very lonely voice. 

**Member of the RST 1**

It is difficult to entirely separate individuals from the stakeholder groups they are involved with, although for some, individual reforming agendas have been pursued even when roles have changed. This adds weight, or spin, to the accounts of Revalidation that foreground ongoing work as opposed to the reactive response to medical scandal as drivers of Revalidation. In particular the RCGP are keen to promote themselves as leaders, a member (coded as member of the RST 2), stating “We, the RCGP leadership, has been criticised regularly for being too far ahead of the troops”.

**Political Struggle: some more equal than others**

The complex web resulting from the numbers of stakeholders involved in Revalidation and the problems this causes for leadership has been referred to in the introduction to this chapter. One of our interviewees summed up the distribution of roles:

The Government has been charged with putting in place the RO structure (the legislation for Revalidation, which they have done but they have not yet got the RO legislation through even though the recess is coming up), and then they have got to identify the funding and the funding streams to make sure that Revalidation works (and that means obviously not just for the Department but working with the Treasury), and they have also got to give, finally, the ‘go-live’ (it is a dispute at as to whether the GMC has the right to do the ‘go-live’ or the DH but basically by just sheer political force, and financial force, the DH probably has a veto on the ‘go-live’ date). The BMA have got to argue for the resources and be reasonably content with the outcome and that of course is still to be played for. The GMC has got to design the policy framework for it, it has got to approve all the bits, and it has got to do the final ‘go-live’ announcement and that means it has got be satisfied that every bit is in place. The Revalidation Support Team has got to support the NHS and to make sure that the pilots have been done effectively especially in England but also co-ordinating it across all of the countries. Then lastly, the NHS—which is the very big player—has got to put in place the right structures (like Clinical Governance, the right people, like ROs and the support structure around them).... So the NHS has got a major role in this. I think those are the major players. **Member of the RST 2**

The potential tensions in the relationships between stakeholders are immediately apparent from this synopsis and therein lay many of the reasons why the implementation of Revalidation has become such a protracted process. The relationships between the stakeholders have been fraught from the outset and our interviewees consistently testified to a perceived lack of leadership brought about by political infighting:

I think the biggest problem at the moment is one I have already alluded to which is no single body taking an effective lead. I might even be dragged to say that they are fighting like rats in a sack rather than showing leadership on this. **Member of the BMA 1**

One of the challenges for leadership in relation to stakeholders is identified by many as managing this ongoing confusion. This is described as confusion about what Revalidation means for doctors, what it means for governments, Royal Colleges and what it means practically in terms of component parts. Confusion is expressed in terms of what organisations should be doing to support the process, and that leadership is difficult if roles and responsibilities are not clear.

The role of the Royal Colleges has been to lead on standards for their individual specialties but they have not been considered by some of our interviewees to have been particularly cooperative and have frequently been slow to accept Revalidation:
If I was being uncharitable I would say arrogance. I think they [The Royal College of Physicians] feel they have to do their members’ bidding. I think their idea of leadership is quite a long way away from mine but I think they feel that they are serving their members. Their members do not want to be revalidated or they think it is almost insulting. *Past member of the AoMRC*

The political struggle has resulted into apportioning blame for the lack of progress and as we will see later, at times has become personal.

**4.3 Discourses of leadership as the locus of struggle**

Not surprisingly the overarching discourse of leadership is one arises from the struggle between medical autonomy and external regulation or governance. This discourse parallels the discourses of professionalism and regulation that will be discussed further in this report. Leaders have struggled with the challenge of ‘balancing’ medical autonomy with the drive for greater regulation of the professions. The perceived need to achieve a balance has come from trying to sell a regulatory policy to a traditional autocratic profession. Leaders have attempted to handle this through a number of discursive strategies.

The first strategy has been one of leadership ‘from within’. As a member of the RCGP put it; “I think really we are crying out for more effective clinical leadership”. This argument places the medical profession as opposed to external bodies, at the heart of the policy making it at least appear a more profession-driven approach. The discourse of limited external regulation by medical leaders has been a clear strategy but as one interviewee demonstrates, attempting to ‘rebalance’ self regulation proves more difficult:

> I think it is self-regulation depending on how you define self-regulation. This is all done within the profession. It may not necessarily be done by the GMC. … I think were the decisions being made by purely a lay-body then it would be the end of self-regulation… or purely by a Government body, it would be the end of it but that is not the case. *Member of the AoMRC*

Indeed since this interview the GMC are now directly answerable to the Health Select Committee rather than reporting to the Privy Council as a result of the *Revalidation of Doctors, Fourth Report*. The balance of regulation external vs. self has shifted again.

A second discursive strategy has been to ‘play down’ Revalidation – arguing that it represents no or little change to medical practice. A past member of the RCGP put it as “...what it should mean is that people can go to work everyday and do a very good job and that data will be collected about them of which they have approved and to which they have been given consent but for which they have to spend hardly any energy.” This strategy seeks to reduce any bureaucratic burden of the policy and therefore attempts to play down any perceived regulatory focus.

Thirdly our interviewees have described ways in which individuals and organisations have tried to gain agency within the process; blame as a discursive device. The use of blame is highlighted as it was pronounced (although not dominant) within the data.

**Blame**

With the persistent delays to implementation of Revalidation, or even agreement about what it was, one of the ways the frustration experienced by the various stakeholders manifested itself was by attributing blame. The GMC has been historically the main focus for complaint and our interviewees
expressed the passion they felt by making very candid observations and frequently citing individuals. This suggests the ways in which the personal agendas, if not the career aims, of key players are seen by others as instrumental in frustrating progress. ‘Backroom deals’ and obfuscation are cited as deliberate delay tactics employed at the highest levels.

The issue of blame perhaps presents the darkest aspect of Revalidation when opportunities to move things forward were lost as those involved became mired in defensive posturing. The bigger picture was subsumed by factional in-fighting as professional differences and competing agendas became progressively reduced to personal attack. Blame is highlighted here not as a means to apportion blame further but rather as an opportunity to raise the important divisive phenomenon so that lessons can be learnt and consensual discourses can be explored going forward.

There is a huge ongoing controversy about who was responsible for the very detailed and very onerous attribute list that was drawn up with, essentially, everybody responsible for drawing it up blaming everybody else, the GMC, the Colleges, the Revalidation Support Team, all blaming each other for making the process more complicated than it need to have been. **Member of the BMA 1**

These main discursive strategies should be understood in the context of time. We have already seen that medical self regulation has changed since this research was conducted with the changes to the reporting of the GMC to the UK government; so this research reports at a moment in time while drawing on historical narratives. It is an understanding of these narratives in time that we turn to next.

**The Temporal Context**

The main discourses as we have discussed arise from the leadership trying to balance a self regulatory, status quo discourse with that of increasing external regulation. What has shaped these discourses over time has been the various medical scandals that have driven leaders, at least temporarily, towards a more regulatory discourse. But when this has met resistance the temptation has been to change the language once again. An example of ‘retreat’ comes from a past member of the GMC 2 “slightly to my surprise, in the late 1990s, the GMC said they would do this, they would get hold of Revalidation and it would be impossible to work without being revalidated by the GMC. That may have been a good idea but it was not a good idea to surprise people…. The BMA were offended, all the Colleges were offended... The GMC was beginning to paddle upstream against a fairly strong tide of hostile opinion.”

Understandably such resistance alters discourse from one of regulation to that of a more consensual self regulatory rhetoric. A member of the NCAS recognised the challenge saying; “what’s the word I am looking for...Not selling but are promoting Revalidation in this simplification and perhaps making it a bit [of a] softer approach....” It is therefore not surprising that with the various shifts in discourse, leaders have found it difficult at times to communicate the policy.

I absolutely believe that no one has yet properly articulated what we are trying to achieve. **Member of NCAS**

As time has passed the new leaders with different agendas from their predecessors have impacted on policy and the structure of some organisations has changed. In discussing the role of the GMC our interviewees were more positive about current leadership and its ability to take Revalidation forward.
I know there is a worry but the GMC is a very different beast now. It is a totally new body. It is not elected. So in one sense I think it takes its remit very seriously and everything about it has changed. I think the Colleges will learn.  

Member of the Shipman Inquiry

I would have told you that the ship was rudderless and that we could end up anywhere here, bottom of the sea, on the rocks, nobody seems to know. I think the ship has quite good rudders. I think the tiller is set now. I think the GMC have got their act together.  

Member of the UK Revalidation Programme Board

4.4 Conclusion

We began this chapter with a brief discussion of the spider and the web drawn by one of our interviewees and noted how it was used to visualise the necessity of a cooperative and supportive relationship between Revalidation and the stakeholders. It was suggested that an alternative reading of the image was a cautionary one in which Revalidation risked becoming entangled in the political struggle between stakeholders.

Through the course of examining our interviewees’ discussions around the area of leadership dominant themes emerged with two discourses of autonomy and external regulation in tension. These have been shaped by time and political storms, mainly those of medical scandals. The uneven distribution of power within stakeholder organisations has become increasingly apparent as the debates on Revalidation have progressed. The move from autonomy to more collegiate working practices between stakeholders has been deeply challenging for many and has resulted, initially at least, in brinkmanship. The ebb and flow of political struggles over leadership as played out by the stakeholders has indeed seen Revalidation caught in its own web. Leadership over time has evolved. The general feeling among our interviewees is that Revalidation will and needs to happen and those systems are beginning to be put in place to ensure that it does. However, there remain fears that in order to resolve outstanding issues the process will need to be ‘watered down’ to obviate potential areas of conflict between stakeholders by simply not addressing them. The worry being that the continuing political struggle between the stakeholders will threaten the implementation of something robust and meaningful. Strong leadership is needed to communicate more clearly the underlying purposes of Revalidation and therefore why current content and structures are evolving.

For some the most recent postponement announced by Andrew Lansley in 2011 was welcome. It is worth noting in terms of leadership that the Government rather than the GMC have originated this delay. Throughout the history of Revalidation the GMC has been criticised for undue deliberation and lack of leadership and yet the two most significant postponements have been initiated by the Government. Firstly as a response to the lack of confidence expressed by Dame Janet Smith in the Shipman Report (2004) and most recently as part of a review of health provision. For others, delay risks a loss of momentum and perhaps a general diminution of resolve. “The trouble is the letter from Andrew Lansley delaying it for a year has sort of...[lost]...the momentum...”  

Member of the RCS Eng

This study is a snapshot in the continuing story of Revalidation and it appears that things may well be already changing as regulators and employers communicate better between themselves to get the message across. Set against the perceived lack of will historically our interviewees seemed more positive about the future in particular towards the GMC. The real challenge remains though in defining Revalidation better in terms of autonomy and regulation or perhaps simply having a more open conversation about where Revalidation sits as implementation moves forward.
5. The Professionalism Agenda

This is the individual doctor. At the end of the day it’s about the individual doctor’s relationship with the regulator, the GMC, and this is them proffering their evidence to show, to demonstrate their saintliness, shall we say. This is a system that supports them in doing that... And this is the general public, who they are supposed to be ultimately [pause] their saintliness is meant to benefit. ... Well they [the doctor] are having to demonstrate their saintliness. It isn’t taken for granted as maybe it might have been in the past, who knows? Member of the Northern Ireland Executive

5.1 Introduction

The image above and its description is a personal view of Revalidation. It places responsibility with the individual Doctor to provide evidence to the GMC that he/she merits the public trust placed in their ability. The focus here is unremittingly on the doctor since everyone else in the image and indeed the viewer all look at him/her. The repetition of “saintliness”, visualised by the halo, indicates that for this interviewee, the doctor’s professional identity is bound to the notion of them as an exceptional individual. However, adjacent to the halo and above the doctor’s head is a question mark suggesting that the security of the doctor’s professional identity as an exceptionally good (saintly) person cannot be guaranteed until they have successfully revalidated. In the image the doctor carries a selection of evidence to present and the uncertainty he/she expresses may also
refer to professional confidence in Revalidation to confirm the status of “saintliness” that was traditionally a given. Revalidation, as discussed previously, can be understood as an expression of the desire for continuing confirmation to the public that their doctor is up to date and fit to practise and as such it represents a more general cultural/professional shift away from self-governance towards transparency and accountability. Our interviewees recognised Revalidation as a key intervention in the re-negotiation and re-definition of medical identity. An identity that answers to the requirements of ‘new’ professionalism based on performance and measured against nationally agreed standards rather than the traditional form of self-regulation by the profession.

5.2 The crisis in professionalism

In the UK perhaps the most direct public challenge to traditional medical self-regulation stemmed from media revelations about medical malpractice. While not all interviewees were willing to concede that these events demonstrated a failure of the profession to self-regulate, there was widespread recognition that aspects of it, either had or were perceived to have failed and that this needed to be addressed. When speaking of the failures of the profession to self-regulate practice the majority of interviewees related this specifically to Bristol and Shipman. With many pointing to a professional culture that turned a blind eye on errant or incompetent behaviour: citing the norms of professional culture which deterred informing on peers:

Whistle-blowing is excessively rare in the medical profession, whatever people say. People who whistle blow do not usually get treated very well. We have not got many examples of where they have been treated well at all. I do not think people do it very often so you could not rely on that. Past Member of the AoMRC

In their narratives our interviewees demonstrated that they either had anecdotal evidence or personal knowledge of doctors who either had, or were currently underperforming:

...we realised that Ledward was not safe. We did not tell anybody that he was not safe, we just said, “There is not an operating slot for you. I am terribly sorry. Off you go. Go and do your damage somewhere else.” Member of the Independent Healthcare Advisory Services

This pathologist had participated in self-reflection, had participated in a slide club, and what is more everybody in the slide club knew that this pathologist was making some very funny diagnoses but no-one felt empowered to do anything. Member of AoMRC 2

...people do not split on each other. You do not split on a colleague. I know one or two people in this building who do not do a good job and who do not do it at the right time either because they are disorganised but I am not going to say so. You just don’t. Member of the Shipman Inquiry 1

...if there is a poorly performing General Practitioner the question is first of all, “Why haven’t their colleagues in the practice been doing something about it?” ...Many practices have turned a blind eye until the problem is so severe that they then throw their hands up, throw the person out of the practice and it is at that un-remediable stage really that things suddenly are recognized to be wrong. But if you scratch at the surface, they knew that this was a problem blowing up for a long time. Member of the Revalidation Support Team 2

For one interviewee the combination of independence alongside a reluctance to blow the whistle has precipitated a crisis in professionalism. And the interviewee makes the subtle point that self-regulation potentially creates a choice between career and patient safety that jeopardises the clarity of professional focus and to the detriment of the profession as a whole:
It is partly autonomy and independence but it is partly reluctance to do down your colleague. It is when you become confused about what is pre-eminent. Is what is pre-eminent the doctor and the career of the doctor? Or is what is pre-eminent the safety of the patient? The self-regulation failed, in my view, because the profession confused the two, as many professions do. ... It is not unusual but the simple fact is if you put the patient as pre-eminent, you will from time to time do down doctors and sometimes you might be wrong. I think what we saw at Bristol was the profession putting the profession first.  

**Member of NHS Confederation**

The culture of professional solidarity that discourages whistle-blowing dates back to the 1858 Medical Act which reflected the ideology of the gentleman’s club and a professional identity that was individualistic and frequently charismatic. Modern medicine in contrast is dominated by complex systems and is predominantly team orientated and therefore needs a culture of openness to be effective. A recognition of this change is evidenced in the strengthening of the wording in the ‘conduct of performance of colleagues’ section in successive editions of *Good Medical Practice*.

Medical scandals gave a very public focus to the crisis in professionalism. As discussed in Chapter 3, events like Shipman and Bristol became key drivers for reform and there were demands for public assurance that this could never happen again. Our interviewees were divided as to whether Revalidation would ‘catch’ another Shipman:

**There is no question that no Revalidation process would identify a Shipman.  
**Member of the NCAS**

I have heard people say that revalidation would not catch another shipman but if it is done properly along the way that it is currently being developed, which is getting closer to it, you would not be able to stop him murdering the first few victims but I think you could probably have stopped him a lot sooner because people did raise issues about the fact that more patients were dying in his practice than you would have expected. **Member of the RCA**

Revalidation may well not have stopped Shipman but our interviewees considered that it would have alerted the profession to Bristol etc:

**There is a view that if regulation were more robust and if revalidation were more robust then you would avoid those problems. My view is that you probably would have avoided Bristol.  
**Member of the NHS Confederation**

### 5.3 New professionalism

It is about redefining a modern relationship between doctor and patient and society.  

**Member of the General Medical Council 1**

Professionalism in the sense of the relationship between the profession, the government and the public is most commonly understood in terms of a ‘contract’ or ‘bargain’. Although the terms of this contract are not always clearly articulated, in her study of the prevailing literature, Sylvia Cruess identifies society’s expectations of medicine as ‘the services of the healer, assured competence, altruistic service, morality and integrity, accountability, transparency, objective advice, and promotion of the public good’ (Cruess S 2006). It is worth noting that, in interview, members of the GMC specifically linked Revalidation to changes in the ‘contract’ spurred on by public demands for greater accountability, increased transparency of regulatory processes and a recognition that the licence did not provide an ongoing guarantee of competence:
They [the public and lay members of the GMC] were concerned that the doctors were not concerned about incompetence, they were only concerned with who you slept with, or did you advertise or do things that appeared to be behaviourally, ethically unacceptable. Incompetence or poor, lack of competence was not an issue but for patients that was the central issue. You cannot alter the fact that the basic reason why the [Medical] acts exist, why the GMC has the power to issue licences, is that the licenses, underneath that, sits that basic contract with the public. What you see is what it says on the tin; they know what they are doing, they are properly qualified, they are properly up-to-date, they know how to behave themselves and are honest. How you fiddle around with the bits of legislation that go to make all that work, you cannot detract from that central premise. *Past Member of the GMC 1*

I think for us now and for most patients and people that we talk to … simply because somebody has qualifications at a particular point in time that that should enable them to continue to have really quite powerful privileges in relation to what they can do and the power that they have with individual patients and with patients as a whole, I think most people now would find that fairly challenging. I think we are less inclined to be wholly respectful of a profession that is based exclusively on qualifications and much more likely to challenge people’s or individual’s rights and powers in particular contexts … I think that Revalidation and regulation generally is part of that checks and balances process. *Member of the General Medical Council 2*

It is perhaps unsurprising that representatives of the GMC demonstrated a heightened awareness of the disjuncture between the public and the professions expectations of professional regulation, since as regulator the GMC has been an obvious and frequent media scapegoat. The interviewees quoted above confirm the GMC’s positioning of Revalidation as key to a new professional contract, by demonstrating a break with professional tradition by directly linking standards of performance and the medical register. Many of our interviewees discussed the anxiety felt by individuals through changes to the professional status quo and cited the perceived threat to professional autonomy as a point of resistance to change. However, while recognising this anxiety many interviewees did not see Revalidation as a Machiavellian tactic to wrest autonomy from the profession:

*Past Member of the Northern Ireland Executive*

Paradoxically, I think it probably gives a framework where autonomy can be protected rather than taken away. You could look at it that way, and I think it is certainly there’s a case, because if you can show that you are competent and you are OK then you can probably go ahead and do what you want in a way. A bit like permission almost. *Member of the Shipman Inquiry 2*

In the example below it is suggested that if the Medical Profession can meet patients’ and public expectations through the implementation of Revalidation they may be able to expect reduced interference from the State in return:

*Past Member of the General Medical Council 1*
This is not to say that the status quo would be restored and full professional autonomy and power be returned to the profession, but it signals the hope that Revalidation will be the means by and through which the profession will demonstrate that it can be trusted to fulfil its part of the agreement.

5.4 Trust

The ‘bargain’ between the state the profession and the public relies on trust. Indeed, relationships of trust are, according to a number of social theorists, believed to be so important in the context of healthcare because of the risks, uncertainties and vulnerabilities involved. Trust however, is not always immediately identifiable but is, according to Erving Goffman’s analysis, ‘the routine background of everyday interaction’ (Misztal BA 2001) and its existence may not come to the fore until a breach in trust between parties occurs. Indeed the need to restore public trust following the ‘scandals’ was identified by many as one of the key drivers behind the need to implement Revalidation:

The response to the Bristol case, which blew everything apart, was the sense of trust betrayed. “We trusted them. We thought they were taking care of it and they were not.” Then after that, straight away, you had another series, Richard Neale, Ledward, etc. ...The driver then was the sense in the public of trust betrayed. Past member of the GMC 1

Many of our interviewees acknowledged the distinction between public trust in the profession as a whole and trust they had in individual doctors:

If you ask people, “Do you trust your doctor?” they will always say yes or most of the time they will say yes. If you say, “Do you trust the medical profession?” you will get a newspaper-style response, “They make loads of money don’t they?” you get the jokes coming out. Member of the NCAS

Some however felt that patients’ trust in the profession and in individual doctors has remained strong despite the well-publicized scandals:

We have held up remarkably well in terms of our social capital. I was very fearful about that for a few years back but actually we have carried the public sympathy with us despite all the stories that come out, all the doubts and worries. Most people’s experience of the NHS is positive. Most people’s experience of doctors is positive. And doctors themselves, by and large, have maintained I think their reputational status and their trust. Member of the BMA 1

With this in mind some interviewees suggested that Revalidation needs to be a “proportionate” response:

I think eighty-six percent is the most trusted profession and it has been the most trusted profession for a long time now that is why Revalidation needs to be proportionate, not necessarily demonstrate to the other fourteen percent that their doctor is up-to-date and fit-to-practise. Member of the BMA 2

Well a couple of key points of evidence there. One is that the surveys that most members of the public think that doctors do this anyway and the other is that the annual MORI survey of who is trusted, doctors invariably come out top and the politicians who lambaste us usually come out somewhere near the bottom. To that extent, again, I do not think it will make a great deal of difference. There is lots of rhetoric being produced about how Revalidation will increase the trust of the public: no, I do not believe it. I think you could say it will justify the trust of the public. It will make
that trust more justified because the public think we do it anyway in which case it is difficult to argue that we should not. Member of AoMRC 2

The second quotation signals that the public already assume that some form of Revalidation is taking place. It therefore testifies to the expectations the public have of today’s professionals working within a professional context predicated on managerial, consumerist and accountability agendas.

5.5 Professional Identity

It is clear from our research that the licence is regarded as a key indicator of professional identity:

In medicine it is part of their personality, it is part of them. It is in their bones. There is a key point in there in relation to the culture of Revalidation that the attitude the medical profession has to registration with the GMC is fundamentally different to all other registrants in the UK. It is in their bones that they are registered medical practitioners and they will go to their coffin with it in their hand. Member of the NCAS

This presumed indivisibility of the doctor from their licence is a reason why Revalidation, by linking performance to registration, has been perceived as a personal as well as a professional threat. One interviewee recognised that changes in the broader professional context impacted on individuals and placed different expectations on them:

I think some doctors still think that they can happily qualify at the age of twenty-four, twenty-five, put their certificate on their wall and that is it but those days are long gone for any true professional I think of any description really. You cannot do that and you should not do that. The whole ethos of being a professional is about having professional standards, standard setting bodies, and making sure that you do keep up-to-date and fit-to-practise and demonstrating that. Member of the Welsh Assembly Government

And many stated how important being up to date was to their own professional identity:

I have always felt that this importance of keeping up-to-date is very, very important. That should be an integral part of the practice of medicine and again, the point about Revalidation to me is an educational purpose. Member of the Shipman Inquiry 2

…it is part of our professionalism. We pride ourselves on being able to show that we are on top of the job. Past Member of the GMC 1

There were also concerns expressed about how to engage the minority of more reluctant doctors:

…I personally believe that that should be a professional ethic but I know it is not 100 percent so how do you make the recalcitrant ones do it? Member of the Shipman Inquiry 2

The positioning of Good Medical Practice as the lynch-pin of Revalidation goes some way towards providing doctors with a professional code embedded in practice that answers the call for standards and a “professional ethic” and many of our interviewees referred to this document in a positive way.

As the previous chapter discussed some detail interviewees acknowledged that there was hostility to a process that was potentially burdensome and would take doctors away from their patients. The interviewee quoted below, while recognising this perception, suggests that Revalidation needs to be embedded in good local systems so that it integrates seamlessly and becomes part of professional identity:
Generally I think if you ask doctors they see this very much as an imposition on doctors, something that they would be required to do that they do not do currently, and something that makes them quite nervous. … my view is that it should be really embedded in local processes, so that five, six, seven years down the line, doctors really do not notice the point of revalidation. It is much more about embedding good local systems, having good appraisal processes, it is much more about organisations doing a range of things rather than doctors doing a range of things but I appreciate that it is not necessarily seen in that way. Member of the GMC 2

5.6 Conclusion

When the 1983 Medical Act was amended by the Professional Performance Act (1995), which facilitated external regulation of the health professions, it was a clear indication that the Government was no longer satisfied with the ‘bargain’ and sought to actively redefine professionalism. The debates about how this could be achieved while maintaining clinical standards, protecting patients, assuring quality etc. have all contributed to the debate about what professionalism means in the 21st century. In terms of the crisis in professionalism our interviewees predominantly cited Bristol and Shipman over cultural change. However, the problem with an over-emphasis on catching rogues is that it compromises debates about professionalism by harnessing them to regulation; This risks placing an over reliance on complaints machinery for controlling quality rather than building more developmental approaches to professionalism that will improve quality across the board. The friction between these two opposing agendas has dominated at the expense of exploring the common ground between them – the patient.

Professionalism is not an object or quality but something that must be enacted and continually enacted to be maintained. The question of how doctors maintain or continually enact professionalism in the end becomes a constituent feature of professionalism. In other words, how professionalism is regulated enters the debate of what it means to be a professional.

From a Foucauldian perspective Revalidation is a governmentality tactic (Foucault M 1991), a technique to ensure that eventually individuals discipline themselves without awareness that they are being in any way externally directed to do so. If Revalidation as a formal process enforces professionalism and this enforcement eventually becomes internalised and taken on, then self-regulation may once again come into being. But if Revalidation is to be the eternal fate of doctors does that imply the end of trust in doctors and tie professionalism to a mere trust in process?

Ultimately whether internalised or not, Revalidation needs to resist the danger of focussing on doctors’ careers, as illustrated in the opening drawing and quote of this chapter. If regulation and process becomes the focus the eyes of the profession may inadvertently be taken away from the patient.
6. Patients and the Public

Interviewee: That is you, sitting at the table with Doc. That is a stethoscope around the neck and a balloon which says... OK. “Thinks:”—the balloon goes with the patient—“I know you know what you are doing today Doc, and are you really up-to-date!”
Researcher: So this is the essence of Revalidation?
Interviewee: That is it... So I started with a patient.
Researcher: That is what it boils down to?
Interviewee: That is what it boils down to.

6.1 Introduction

Expectations, experiences and attitudes of patients towards Revalidation were almost universally presented as being pivotal to its success. The policy was presented as a one firmly rooted in the interests of patients – whether in terms of safety, assurance, trust and expectations or experiences of the UK’s doctors and health care systems. However, although patients were commonly defined as the very raison d’être of Revalidation, their specific roles were subject to various interpretations within different stakeholder agendas - patients were often defined by their relation to doctors, the medical profession, or the government. In other words, they were used as a tactical fulcrum for pushing other stakeholder agendas. Furthermore, patient engagement in shaping policy and supporting Revalidation was under-defined. We will cover this later in the chapter, since these are significant qualitative distinctions that reflect the complexity of the patient’s role.
6.2 Who is the patient?

Perceptions of the interests of patients (individuals) differed subtly from those of the patient body (a collective population of health care recipients), “patient stakeholders” and “consumers” (a social and political force), or the wider and perhaps more dynamic notion of “the public” (encompassing the cultural mores and machinations of broader society). Considering these distinctions in patient identity provides us with a deeper understanding of both micro and macro-level debates about how Revalidation has come about, the nature of patient expectations and the impact on the doctor-patient relationship. The notion of patients as ‘the public’ highlights a social contract that makes up the professional relationship between medicine and society. Discussions encapsulated a sense of population and the dynamics of society over time.

I suppose the changing demographic of patients as well. Our parents’ generation were grateful for whatever the NHS did to them. Now, people are more critical and more willing to ask questions and more willing to challenge... You know, “Show me my doctor’s record. How safe is he?” *Member of NHS Employers 1*

So what instead we are talking about is not a) a patient who is not completely ignorant, but a patient who has access to a tonne more information than they ever had. Actually now they do not become somebody who contains all this knowledge, they [doctors] become someone who is able to navigate their way through, or navigate themselves and the patient through, if it is a difficult situation. *Member of the GMC 1*

This realisation incorporated the socio-economic and cultural dimensions that provide the grounds for viewing patients as shifting identities. Interviewees implied that patients are now educated in both the ways of medicine and in their own responses to it.

Like it or like it not, increasingly now doctors will work with their patients, who are very well informed, possibly and increasingly, have more information certainly in their heads on their specific condition than the clinician has. *Member of the Northern Ireland Executive*

People would always say it was the usual suspects in terms of the awful cases and all the things that happened, etc. but I think it is because we are in a huge time of change with the role of the professions, a much better educated public, a lot of public participation in decision making and so on. I think that is very healthy. *Past Member of the RCGP*

Our sample recognised an apparent shift in patients’ identities from passive recipients of care, to active consumer bodies, highlighting the importance of how the profession responds to public expectations of Revalidation. Most of our participants conceptualised consumer expectations as being socially shared, encapsulating both ‘needs’ and ‘desires’, with generic consumer identity driving the need for regulation.

I think that the relationship between patients and doctors has changed dramatically in the last, certainly in the last forty years, thirty years, twenty years, perhaps even ten years. I think we all have expectations of not just professionals, people that we see, we have expectations as consumers, and we have a different view of doctors now than certainly my parents had in my generation. My parents had a view of doctors that was wholly obsequious.... I think that Revalidation and regulation generally is part of that checks and balances process. I think that there is an expectation now that that should happen whereas twenty or thirty years ago I do not think there was. *Member of the GMC 2*

Our parents’ generation were grateful for whatever the NHS did to them. Now, people are more critical and more willing to ask questions and more willing to challenge... You know, “Show me my doctor’s record. How safe is he?” *NHS Employers 1*
Consumer identity reflects market principles (with medicine as part of a free market), indicating some form of buy-in. But it was not clear from any of our interviews precisely whether, or how, patients had ‘bought in’ to Revalidation. It was assumed they would - if it was successful. None ventured to speculate which would come first: success or buy in. Nevertheless, the notion of the patient as stakeholder emerged as a strong one in Revalidation rhetoric.

The purpose of regulation, which is about providing an assurance to the public that the profession is mature enough to handle its standards and that people are actually staying within them, that is the entire purpose of regulation, there is no other. It is about providing public assurance that the delegated responsibility that the public have given the profession is that they are able to be clear of the standards that people need to meet and that their members, members of that profession, are meeting them; that is the only purpose of regulation. Revalidation is about a real time regular demonstration of that. It is simply making explicit what is done on trust at the moment. That is the bottom line. Member of the NCAS

Licensing is for the public, not for the medical profession Past Member of the GMC 1

6.3 How are ‘patients’ promoted in Revalidation rhetoric?

The assumption that the patient is, or should be, at the heart of Revalidation was highly evident. What arose most clearly was that the patient was viewed as the original driver of Revalidation, in a general shift towards more patient-centred medicine.

My aspiration for Revalidation is to get to the point where that continuing professional development and sense of professionalism drives quality improvement for patient care. It 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. If we can get that sense of the personal, but to the clinician it’s the professionalism, and that desire to improve outcomes for patients that, I think, has to be at the heart of it. Member of NHS Quality Improvement Scotland

There was general consensus that Revalidation is about redressing a lack of trust at the ‘clinician/patient interface’.

I guess from our point of view it has got to be patients ultimately at the end of the day. That is the thing that we are here to do: protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. So unless Revalidation can make a contribution, and it might not make a contribution initially, unless it can make a contribution and be seen to be making a contribution to standards in terms of practicing doctors, to the quality of care that doctors provide to patients and ultimately to the care that the patients receive at the end of the day then what would it be for? Member of the GMC 2

Discussion focused on how Revalidation would benefit patients - as recipients of it, rather than active participation in it. Particular attention was paid to ensuring a more ‘patient-centred form of professionalism’. This is an interesting concept, since it reflects two different agendas – those of the patient and those of the profession. The terms ‘patient’ and ‘professionalism’ were referred to interchangeably, most often related to the broader ‘patient-centred’ agenda.

It [Revalidation] provides some further assurance that the doctors, that we all see as patients, are up-to-date and fit-to-practise, so it is about maintaining confidence in doctors and providing further assurance to patients ultimately as well at the end of the day. Member of the GMC 2
I do not think that the dynamics will come out right until the public, the patients, have a bigger say. In medicine I say we need to have pushy patients. **Past member of the GMC**

I would not know how to get a second opinion but increasingly people are. The language of the government at the moment is feeding that expectation about patient choice. ...so people have an expectation that information is going to be made available. **NHS Employers**

Notably, discussions related to reassuring patients of the strengthening of structures - to ensure safety, and to redress the decline in public trust that followed Shipman and other medical scandals.

Everybody has a General Practitioner so the idea that some might be good and some might not be, if you turn it round and look at it from a patient’s perspective, you might say, “But why pick on me?” “What happens if I get one of the twenty or thirty percent who are really duff doctors?” **Past Member of the GMC**

While discussion of these matters appeared to pertain to a patient centred approach, critical exploration reveals more paternalistic agendas at work.

If I look back over my lifetime the medical profession, attitudes in the medical profession, have changed beyond all recognition. You just would not believe the way in which people were treated by doctors fifty years ago, shocking! It simply does not, well it only very, very rarely happens now I think, that people are treated disrespectfully, disregarded. There were a lot of very arrogant doctors about in those days. I think there are very few that display those kinds of personal attitudes and I think personal attitude is terribly important. **Member of the UK Revalidation Programme Board**

It is duty of care, it is about safety and it is about continuing professional development in their specialised area, so that as procedures change they move with it. As doctors we are capable of dealing with the full range of cases as they present. **NHS Employers**

It was suggested that patients are a group whose interests in Revalidation are more knowledgably or effectively articulated by members of the profession. Thus, when some of our interviewees discussed Revalidation matters that related to patients, they were actually oriented to promoting the interests of the profession itself, in terms of re-establishing a respected relationship with the public - or to individual doctors’ identities, by producing assurance of their competence.

One view “would be ‘I very much welcome the fact that I will be publicly relicensed because it speaks my competence to the world.’” **Member of the NHS Confederation**

It is a bit like the McDonald’s badge with the stars on, you know, that somebody has done something really good. You look at something and it tells you or you walk into a building and you look, if you are that way inclined as to whether there is a safety certificate or somebody has got insurance. **Member of NHS Professionals**

Interviewees also highlighted ways in which these aims can also be used explicitly to further the interests of professional bodies or government-centred agendas.

The attractiveness of it was rather than just hunting out the bad apples, should we, could we develop something which shifts the whole curve and thereby improves quality across the board?... It is interesting how its origins through--probably what I suspect were mainly adverse events--may turn into something very positive for the whole profession. **Member of the RST**

Increased transparency and accountability were viewed as being primarily for the benefit of patients. Many of our interviewees discussed Revalidation in terms of changing societal expectations and the connections in the public perception between greater transparency and medical professionalism. Interviewees described how Revalidation can be understood as a mechanism by
which simultaneous convergence of greater medical skill, and expectations of the public of greater transparency, could be reconciled.

This may reflect the tenets of patient-centred medicine in as far as it breaks down traditional boundaries and exposes medical practices for all to see. But on a practical level, they also require a framework of organisational structures and formalised, standardised audit. Some of our interviewees suggested that the burdensome nature of bureaucracy may well counteract any benefits emerging from greater accountability, in that patients would be more likely to want their doctors to spend their time doctoring, than for them to become medicalised bureaucrats.

I think there is a worry that all these ghastly, back-office managers are going to go through either a burdensome, or a costly, or a pointless exercise for little to show at the other end. So I think there is ambivalence. **NHS Employers 2**

It is interesting to consider that an agenda driven presumably for the benefit of patients might conversely be viewed as being detrimental to quality care. The locus of this contention can perhaps be found in the juncture between the rhetoric (and different goals) in transparency/accountability, clinical governance/management, and prevention/risk management discourses. Our interviewees’ comments suggest that tension is often situated between the apparently compatible agendas of quality improvement and patient safety. In any case, it was acknowledged that ensuring quality and standards (a management task) could never ensure complete patient safety.

Revalidation will never be a cast-iron guarantee that you are not going to have another Shipman. I would suggest that it will minimise the risks compared to where we are now but I don’t believe it will completely remove that risk. **Member of NHS Quality Improvement Scotland**

Our study revealed the imperatives to improve quality and increase standards as being far more multi-factorial than they might be considered when taken at face value.

### 6.4 What should patients’ “expect” of Revalidation?

We have got to a situation now where doctors have the potential to do more good than they have ever been able to do and also have the potential to do more harm than they have ever been able to do. They are more dangerous weapons than they have ever been. That has coincided with an expectation, a justifiable one in my view, on the part of those who use doctors, and that is to say patients primarily, but also of course by proxy, Governments or providers or employers or whoever else, an expectation by all those groups that professional transactions need to be more transparent than they have been in the past and that there is an expectation that anybody who is involved in those transactions as a professional can demonstrate that they are able to do the job that they have been given. **Member of the GMC 1**

Interviewees considered Revalidation a ‘reasonable expectation’, particularly in the light of broader societal changes related to attitudes towards the professions generally by the public, and the shift away from confidence in the paternalistic model of professional practice.

Society has become less trusting of the paternalistic professional model of the nineteenth and early twentieth centuries. ... It was not something specifically limited to medicine because otherwise one might reflect on the true irony that for the first time in recorded history medicine can do more than prognosticate, it can actually treat and treat effectively. At that precise moment in time the public becomes less accepting of the skills of professional medical practitioners. **Member of the BMA 1**
Some applied a class dimension, regarding classes as homogenous groups. Others differentiated not only between the ‘meaning’ that Revalidation held for different socioeconomic groups, but also stressed the role of the middle class as drivers for change.

I think for some people it will not mean anything. For a lot of people who do not think about this, lower socio-economic classes, I do not think this will have much meaning. Perhaps it would have more meaning if something went wrong with a relative. I think for probably the middle-class upwards, they might take notice of it, they might take notice of it. Certainly they take notice of it when it goes wrong. *Past member of the AoMRC*

References to consumer identity implied a greater sense of awareness and reflexive action, as well as promoting a form of regulation prioritising external public desires and politics. But consumer awareness was also challenged by some of our interviewees, who suggested that the consumers apparently driving the agenda may be surprised to discover that regulation was not already in place.

I think that most of the general public will be surprised that we have not had it already. People will find it amazing that within surgery, from getting an FRCS, which you get at a very early stage, until you retire you have no other assessment of your practice, ever. People probably may well be surprised. *Member of the RCS England*

We, the medical profession, have been operating a con over the years. *Past Member of the GMC 1*

Publics were divided into the ‘informed’ and ‘uninformed’. Ironically, according to our sample, to be ‘informed’ is to realise that, as yet, no form of Revalidation is happening. Thus, any subsequent realisation could only potentially undermine the trust enjoyed by the ‘uninformed’.

... so my impression of the public, in the broader sense, the informed public, is they’re surprised we don’t already have this. I don’t think the wider public have thought about it very much and I think they have made the assumption that there was some sort of system to check doctors were OK. I don’t think that they are truly aware that there isn’t. *Member of the UK Revalidation Board*

When I wear a Government hat, where we consult with the lay members of the public and we have them involved in our committees and so on, they think this was all happening. They are surprised and partly astonished that we don’t already have a structure that ensured that our doctors were up-to-date and fit to practise throughout their working life. *Member of the UK Revalidation Programme Board*

This issue is crucial, in that public assumption and expectation feeds directly into public trust in the profession. Several interviewees cited surveys that evidenced the public’s continuing trust being based precisely on the assumption that they are already regulated.

You could also see it and argue that by the very fact of doing it you are raising doubts in the public’s mind about the competency of doctors. *SHA Director*

Patients think it is already happening. ... I do not think that we should let it out that it is not. I think the communication with patients is being reasonable but not over the top because we should have done it a while ago. They do not expect people not to be re-checked and not to make sure their skills are not up-to-date. *Member of the Independent Healthcare Advisory Service*

Raising public awareness was therefore viewed as a double-edged sword, in that it may expose procedures (or the lack thereof) that previously engendered trust. Mediation between profession and public was therefore seen as pivotal. The role of the media in shaping expectations and relations...
was discussed at length. It was considered in terms of its potential both as a whistleblower for poor practice (thus undermining trust), and as a propaganda tool for the profession (used to re-affirm trust).

If you look in the Press there was never anything really about standards or education or training, it was always about Doctor Bloggs who may or may not have slept with a patient, or looked at child porn, or got MMR wrong. *Past Member of the GMC*

I think it means that they are going to finally discover that what they always thought was happening has started to happen; that somebody is keeping a little check on their doctors, that they are any good or good enough. Whatever that means in the public mind. That they are required to demonstrate that from time to time. So I think that is what the public will get and they will get increased confidence; they should do. Then this needs to be made public – not just in the Guardian either – the Sun readers need to know about it. *Past Member of the RCGP*

Of course, it should be noted that all these reflections on patient expectations were inferences of one kind or another, rather than evidence-based conclusions. None of our interviewees reported having surveyed in any robust sense, the actual opinions of patients and the public.

**6.5 Who is responsible for the patient in Revalidation?**

This chapter is a story of patients articulated by medical professionals and bureaucrats, with no sense of the patient voice being articulated by patients themselves. In the first instance this is due to the fact that our research did not involve any patients as participants – that will occur at a later stage. However, what has become clear is that patient interests are typically represented within Revalidation policy and process through, or by, other parties. Whilst consensus that vulnerable patients must be protected was obvious, it was not clear whose responsibility this should be. There emerged from the discussion a stakeholder struggle over responsibility for patient interests, in relation to both *knowing* and *protecting* them. All stakeholder groups wished to be seen as defending the interests of patients.

In terms of Chief Executives of organisations, I have never met a Chief Executive that does not want to do the right thing for his patients. Absolutely. *Member of the Scottish Government*

We have regular discussions about how the public need to be kept informed. That is why we have a representative of the public and the patients to help us with that. There is going to be a specific communication strategy to inform the public about what this process means and how it will affect them. *Member of the BMA*

This consensus is important because it is a unifying discourse, which has the potential to drive Revalidation forward. Where it falls short is that it is difficult to separate out which particular patient interests may best be served by each of these groups, and how this might be achieved. Conversely, there were some interesting assertions about the playing out of internal conflicts behind the ‘patient protection’ agenda:

They [the ‘old’ GMC] had the slogan “Protecting and safeguarding patients” and all of that but the way in which they were operating was self-protection of the profession. I think that that attitude is not prevalent in the present GMC therefore I hope that if there is an attempt to make them dumb down, coming from the BMA, that they will have the steel to resist it. I don’t know. *Member of the Shipman Inquiry*
There are actually some, as individuals, some very nice people working for the Government, some very good people, people who genuinely think about patients as much as I might, as much as any doctor might, and they genuinely want the system, to work well and for there to be good doctors in this country. I do not dismiss that in any sense, but I think that overall Government as a process, as opposed to Government as a collection of people wants to avoid the problems. **Member of the BMA**

Most significantly, some interviewees were cynical about whether the patient’s interests were driving Revalidation processes at all:

> Even in the pathfinder pilots—we are seeing some stuff today—where that intensive spotlight is on them, you have got just 138 strengthened appraisals which have been done. Why not 100 percent? I think this is where I get more cynical perhaps than [a colleague] about this is the ability of doctors to frustrate a system that should be there with the patient at the heart of it. **NHS Employers 2**

Little was said about direct engagement with the public, or precisely how patients could, or should, inform Revalidation. There was, however, recognition of the **challenge** of incorporating patient feedback in a meaningful way.

> It is to really make these things work as the early warnings that there may be a communication issue, there may be a relationship issue, there may be something about the way the doctor deals with patients, the feedback from the patient is ok, it was technically successful but actually it was a rubbish experience. There has to be a way of starting to face clinicians up to these subtle and small pointers to say “What are you doing about that in your CPD for the next year? and actually these are the top three things you need to look at and we will pick them up next year”. **Member of NHS Quality Improvement Scotland**

There was also some reference to patient engagement when it impinged on the interests of doctors - when doctors had no consistent patient base to support their appraisal – and the inequity this represented in a system that involves specialty and ‘niche’ care provision.

> there have been some irritations about it, it has caused around the country from an anaesthetic point of view in the places that are trialling it, because they developed a benchmarking system for what doctors should be but it has been based on doctors in all disciplines so obviously patients have used their GPs. One of the anaesthetists has got upset, that I have had feedback from, because the patient said, “How am I supposed to produce it, or get any idea of what the anaesthetist is like when I have only seen him for two minutes?” **Member of the RCA**

What was most significant to our findings then, is that, while patient-centredness was presented as a unifying idea or ideology (especially within the GMC), this was not translated into any consideration of practice or process.

### 6.6 Conclusion

Public trust and patient safety have historically been presented as the main drivers of Revalidation, and in our study these terms were used interchangeably. Patient-centredness was often used as a proxy for other (sometimes conflicting) agendas in Revalidation: for example, in drives towards enhancing patient experience and safety, to nurturing trust, to maintain status in the doctor-patient or medicine-society relationship, to facilitate risk management, to match expectations, or attend to the consumer agenda.

Public interests were therefore discussed more in relation to the interests of doctors and the status of the profession than of the patient. In the main, the benefits of Revalidation to patients were
implied rather than explained: assumed from the outset but not discussed critically at any point. Patient-related discourse varied - from patient-centred, to paternalistic profession-centred and doctor-centred talk. And while interviewees talked of patients as being involved in providing feedback for appraisals, they did not talk of them as an independent stakeholder body with an active voice in shaping Revalidation. Discussions were therefore invaluable in shedding light on the prevailing discourses that surround and inform the patient-related aspects of Revalidation amongst policy makers and, perhaps more importantly, the potential limitation of their realisation in future implementation.
7. Discussions and Conclusions

7.1 Introduction

Traditional forms of medical regulation, enshrined in the 1858 Medical Act, no longer fit with government and public expectations of how professional governance should be conceptualised and operationalised in contemporary care. The self-sufficient model of professional identity doesn’t resonate with the either modern doctor as NHS employee or the reality of practice; commonly based on teams rather than individuals. Our interviewees clearly recognised this lack of ‘fit’ and promoted the need to create new concepts and practices relevant to new times - not only in terms of ‘what’ they said about the development of Revalidation as the policy to answer this need, but also in the ‘way’ in which they spoke about it. They demonstrated a continuing level of frustration with a debate that was entering its second decade. In other words, beyond the challenge of agreeing the particulars of Revalidation as process there is the additional and significant challenge of having to deal with the weight of the policy’s history.

The public story of Revalidation has been one of conflict and delay, and the posturing and rhetoric that have dominated the story so far have served to focus attention on points of difference rather than exploring points of agreement. It is perhaps easy to blame individuals or stakeholder groups (as our interviewees frequently did), and this is symptomatic of the heightened emotions that changes to professional identity are bound to engender. It is important to remember that Revalidation takes the profession into unfamiliar territory, and that Revalidation’s effectiveness will have a significant impact not only on individual doctors but also on the credibility of the professions institutions.

7.2 Revalidation as discursive formation

“Discursive formations are the products of discourses and of their formation of objects, subject positions, concepts and strategies ... they both constitute their objects and generate knowledge about those objects ... they do not have ‘authors’ in the traditional sense, and are constituted by archives or anonymous collections of texts that have acquired a dominant role in their field” (Macey D 2001; 101)

Our research identifies the discursive formation of Revalidation as being the product of two determining discourses (regulation and professionalism). We have described how these discourses are the result of different drivers, how they express different aims and require different processes to achieve those aims; arguing that delays and frustration have their origins in the inherent contradictions between these discourses. We have explored the ways in which policy makers utilise the patient as a ‘glue’ to bind these contradictions discourses together at a single point of reference but do not identify patients as a stakeholder body of any equivalence or with a voice in the debate. Close reading of interview transcripts showed that ‘patients’ and ‘the public’ are given different weight as subject positions within different discourses. In our interviews, ‘the patient’ is more fully formed within a professionalism discourse, while ‘the public’ is typically evoked within the discourse of regulation.

But discourses, and consequently discursive formations, are not static. Initially regulation was the dominant discourse in Revalidation, with its aim of ‘catching bad apples’ being given weight by...
increasing media scrutiny of the GMC’s disciplinary processes. However as media events have receded, the discourse of professionalism has had an increasingly powerful voice within the discursive formation.

All relationships within discourse are relationships of power. We have seen, by examining the archive and the objects produced by and through discourse, that the very public dispute between key stakeholders about Revalidation masks a deeper power struggle. Such struggle tests the boundaries of the professions institutions, the relationship between the doctor and the regulator. It impacts directly on the re-definition of professional identity and the scope for agency within Revalidation discourse.

Revalidation will have both direct and indirect consequences for the profession in the domains of patient and intra-professional relationships. As proposed, it is not an intervention that directly targets the front-line interaction between doctors and patients. Rather, it is a mechanism that operates via the process of appraisal and involves a chain of interactions; travelling from the doctor/appraiser encounter, to the Responsible Officer and then on to the regulator, the GMC (a mechanism that is to be examined in Stage 2 of our programme of research). However, although it does not act directly upon the doctor/patient relationship it is anticipated to have an effect and will ultimately impact on the dynamic between doctor and patient.

Revalidation aims to improve the quality of healthcare, reduce the risk, and enhance the relative safety of medical practice. It purports to improve patient experience, to reassure the public, to increase the standing of the profession and satisfy the government and public demand for greater accountability and transparency. But these aspirations cannot be guaranteed or assured, and this was made patently clear by interviewees’ ambivalence and/or uncertainty when asked whether they felt optimistic about where Revalidation would lead.

What Revalidation is certain to change however, is the doctor/ regulator relationship, and the structure of medical registration already in process via the institution of medical licences. So, although there are three competing discourses, they are not all of the same order: regulation and professionalism are primary discourses that deal with what is structurally at stake (the changing nature of doctors’ relation to the regulator), whereas discourses of patient centrality are currently secondary—at one step removed—as they are at the level of justification and purpose.

Untangling and clarifying the relationship between the competing orders of discourse as they operate within the discursive formation of Revalidation (which includes the objects, archive and subject positions produced through and by those discourses), is vital for three reasons. Firstly it aligns us to understanding why the policy process has dragged on for so long, secondly it enables us to address the burden of that history in going forward, and finally it allows us to develop a strategy to overcome the conflicts and cross-purposes that threaten this policy’s resolution.

7.3 Regulation and Professionalism as points of divergence

The genesis of Revalidation was identified by our interviewees as situated either in specific historical events (in particular Bristol and Shipman), or in the broader social and political changes reflected both in the rise of reform movements within the medical profession and the development of new standards and regulation by successive governments since the 1980’s. This
contradiction essentially comes down to those who broadly see Revalidation as a reactionary response to medical malpractice brought to public attention by the media and the subsequent major government inquiries, and those who maintain that Revalidation is part of an ongoing process of professional development.

This division is highly problematic, since Revalidation is necessarily a response to the conflation of all these factors - rather than a causal relationship arising from one element. The perpetuation of this split in opinion (between reaction to events and the ongoing development of practice), has had significant consequences for the development of policy, since it has caused a divergence of aims and purposes – regulation (catching ‘bad’ doctors) requiring summative assessment and professionalism (an innate professional drive and duty to maintain high standards and to keep abreast of the medical advances) requiring formative assessment. This is illustrated in Fig. 1 below.

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**Fig.1 Regulation and Professionalism as diverging discourses**

- Driven by medical scandal
- Externally motivated
- Revolutionary change required
- The Safety Agenda: for patients
- Reassurance by measuring against a fixed standard
- Clinical Governance
- Summative Judgment
- Point-in-time Decision (product)
- Fit-to-practise

- Driven by a professional movement for reform
- Internally motivated
- Evolutionary Development
- The Quality Agenda: for patients
- Restore/maintain confidence by continuing to elevate standards
- Appraisal
- Formative Development
- Ongoing evaluation (process)
- Up-to-date
Functionally, Regulation must serve a ‘summative’ purpose: whereby a conclusive and confident point-in-time judgement about a doctor’s fitness-to-practise is made against a fixed standard. The Professional discourse, on the contrary, is defined by a ‘formative’ process: whereby conclusive judgement is deferred in favour of ongoing review and support to help foster an ethic of continual improvement that seeks to keep a doctor up-to-date. These two discourses impact on the doctor at the site of practice, and create tension in terms of what exactly the shape of that practice should look like.

The sustained use by our interviewees of the phrase “up-to-date and fit-to-practise”, to the point of it forming a mission statement for Revalidation, indicates that lengthy debates about Revalidation have served to fuse the differences between these two key discourses. “Up-to-date and fit-to-practise” are terms that have subsequently become naturalised within the discourse, as a single stated aim of the profession, in the interests of both doctors and their patients’ expectation. Through discourse analysis it has been possible to locate the frustration about Revalidation’s lack of clarity and progress, by identifying the conflicting underlying ideologies that over time have become uncritically fused.

Safety and quality are terms that are also paired throughout policy debates and, although also viewed as complimentary, they each grow out of separate strands of the regulation/professionalism contradiction described above (Fig 1). The patient safety agenda is predicated on an ethos of risk management, with a focus on the prevention of malpractice to reassure the public of safety. This terrain is that of the regulator, whose purpose is to regulate for safe practice by maintaining a clearly defined standard. Crucially to the unfolding debate, the clearly defined standard needed to ensure safety is a base minimal standard, with the purpose of minimizing risk. Regulation can function effectively as long as the standard drawn is interpreted as ‘safe’. Importantly for the purpose of regulation the standard does not need to be a high standard.

The professional discourse in contrast is less driven by safety than by quality; by the aspiration to push standards up in aid of ever increasing improvements. The quality agenda is not oriented to the public as a mode of reassurance but as a mode of restoring and building confidence in professional activity. Quality, is an ongoing process to keep abreast of advancements in medical science and of reading standards, not as goalposts for attaining basic safety, but as relative markers of progress that require continual improvement. The professional aim to restore public trust and to rebuild confidence led to a situation where Colleges were interpreted as producing unrealistic standards that described an excellent doctor as opposed to a safe doctor.

A key problem area in drawing up the specifics of Revalidation is the divergence of the discourses around the issue of defining standards. A Catch 22 situation is created since without clearly set standards, regulation cannot function. Yet, once standards are fixed, there is a risk that they will undermine the professional project to drive up standards. Interviewees expressed a collective desire for Revalidation to raise standards, whilst recognising the difficulty facing the colleges in arbitrating between a minimal summative/fit-to-practise standard and a more apparitional and personal formative/up-to-date one.
7.4 The patient as point of convergence

The key point of agreement between our interviewees about Revalidation, regardless of whether they saw it in terms of regulation or professionalism, was that it should benefit patients. Our analysis of the discourses of regulation and professionalism also point to the patient as an area of overlap, or convergence, between them. The patient emerges as a secondary discourse because the patient is spoken ‘about’ and used as justification ‘for’ policy - rather than having a direct voice in Revalidation ‘as’ policy at the present time.

This is not to suggest that patients have no part in the formal process of Revalidation: they will contribute to multisource feedback and are structurally in-built on a representative level to the GMC. But what we are dealing with is representative involvement, rather than empirically concrete participation, and the projected benefits for patients are uncertain and secondary to the actual site of Revalidation’s activity. Revalidation, on the contrary, will have definite, empirically concrete effects upon each and every doctor who wishes to remain on the register, and will enact a definite alteration to the nature of the regulatory function. Recognising the different orders of discourse is important here, as it helps us to clarify the difference between what Revalidation will effect and what it expects to effect. Whether or not the actual effects match those intended will have to wait to be seen.

Fig. 2 The patient as a point of convergence between regulatory and professional discourses

Revalidation is currently informed by political strategy, and this shapes the subject positions within the discourse. The different stakeholder groups have all, at different times, used the patient to promote and/or justify their own agendas, but at no time has any real case been built for Revalidation as a truly patient centred policy. The patient manifests as an absent presence in the sense of being spoken about but having no active voice within the discourse. Patients and public are terms used interchangeably, but they are not the same. Patient refers to the small local relationship between individuals or small medical teams, whereas the public encapsulates the collective of
patients as a stakeholder group. Patients’ needs are answered by the tenets of professionalism but the public’s are answered by regulation.

7.5 Conclusion

We identified three discourses within Revalidation; regulation, professionalism and patients. Regulation frames Revalidation as a way to identify ‘bad apples’, requiring a summative approach and minimum standards. Professionalism looks to Revalidation as a process by which all doctors improve requiring evolving standards and a developmental model. These two discourses are not simply divergent, indeed most documents and participants used them interchangeably, but they are in some regards at odds. Their co-existence has been supported by a shared discourse around the patient yet we found little patient centred policy. It has been hard to demonstrate that Revalidation in its proposed form originates from patients, has been shaped by patients or is centred directly on improving patient care.

Complexity of system and confusion of task is often felt to be the greatest challenge for policy process, and our findings suggest that the great expansion of interests and objectives have served to exacerbate this. But the source of confusion does not in itself emanate from the number of stakeholders sharing responsibility for Revalidation. Equally, it does not independently grow out of the systems complexity of healthcare delivery in the UK - as many of our interviewees suggested. The root of this confusion is found in the contradictions and cross-purposes of the discourse of regulation and professionalism, contradictions that were directly noted by participants during interviews, and that require serious consideration if Revalidation is to find its way ahead. The promotion of patient discourse as a first level discourse in Revalidation may be key to this.

From our data, we have identified the prioritising of strategies (underpinned by discourses of either regulation or professionalism), over the object of Revalidation (which all interviewees claim is the welfare of the patient).

As a member of the RST stated; “The whole service exists for this little relationship between individual professional and individual patient so everything else flows from that interaction. Sometimes I think it gets so big and so remote from that, that the focus is lost. I think, where Revalidation can help in a way, is to remind everybody what the real focus actually is and what the aim of delivery actually is”.
8. Recommendations

- **Truly patient-centred** ‘The patient discourse’ needs to be recognised within the discursive formation, thus making the patient ‘present’ and therefore have an *active* voice. To achieve this, the current focus on strategy needs to be reversed and the focus placed on patients. In other words, Revalidation should *act* directly on the doctor/patient relationship. Currently the policy is more likely to have an *effect* on the doctor/regulator relationship.

- **Clarity & purpose** A clearer composite of the mix between regulation and professionalism needs to be developed— a mix that is determined by the needs of the patient.

- **Standards** Trying to balance the interests of all parties has paradoxically led to inertia. Efforts might be more constructively focused on clarifying what is meant by “quality”, and how standards are set or might shift over time.

- **Ongoing evaluation** There have been too many ‘givens’ in Revalidation. This has led to tension – implementing such a complex intervention requires not just a clarity of purpose, but the anticipation (and measurement) of both intended and unintended consequences. Evaluation of Revalidation as a policy and process needs to be established and ongoing.
9. References


Appendices

Appendix 1: Letter of consent

What is Revalidation in policy?

CONSENT FORM FOR PARTICIPANTS

[VERSION 3: 12th April 2010]

I have read the Information Sheet Version 3 Date 12th April 2010 concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. my participation in the project is entirely voluntary; Y/N
2. I am free to withdraw from the project at any time without any disadvantage; Y/N
3. audio-tapes will be retained in secure storage; Y/N
4. the interview will use an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance Y/N
5. the results of the project may be published and I wish / do not wish (please delete as appropriate) my anonymity to be preserved.
6. I understand that a trainee researcher may be present during the interview for training purposes and I am / am not (please delete as appropriate) happy for them to be present

I agree to take part in this project.

My preferred contact details are:

.................................................       ...............................       ...........
(Printed name of participant)       (Signature of participant)       (Date)

.................................................       ...............................       ...........
(Printed name of researcher)       (Signature of researcher)       (Date)

This project has been reviewed and approved by the Peninsula College of Medicine and Dentistry Research Ethics Committee
Appendix 2: Consent information sheet

What is Revalidation in Policy?

INFORMATION SHEET  [Version 3, 12th April 2010]

FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you of any kind and we thank you for considering our request.

What is the Aim of the Project?

We are interested in understanding Revalidation as it is introduced this year in parts of the UK. Revalidation has had a long and chequered history since its conception. It remains controversial within the medical profession, and often lacks clarity in terms of its purpose and direction. The Chief Medical Officer’s report asserts that Revalidation has three main aims: i) ‘to confirm that licensed doctors practice in accordance with the GMC’s generic standards (relicensure); ii) for doctors on the specialist register and GP register to confirm that they meet the standards appropriate for their specialty (recertification), and; iii) to identify those who require further investigation and remediation’. However, Revalidation also appears to harbour secondary aims, which include generating ‘further focus and energy to doctors’ desire to keep up to date and improve their practice through continuous professional development and reflective practice, [which] is one of several mechanisms for improving the quality and reducing the risks of patient care’.

We plan to go on and explore the impact of Revalidation in practice and the public perceptions but first we want to understand Revalidation in terms of policy. Specifically we want to explore what discourses (or narrative) have shaped the Revalidation debate and how have different discourses been used to influence decision-making and policy?

What Type of Participants are Needed?

We have contacted you personally along with 24 other participants as you and your colleagues represent the leading professionals involved in the development and implementation of Revalidation.

What will Participants be Asked to Do?

Should you agree to take part in this project, you will be asked to complete and return the accompanying consent form. One of the research team, a research fellow to be appointed or Drs Archer, Regan de Bere & Corrigan from Peninsula College of Medicine & Dentistry (PCMD), will contact you by email to arrange a convenient time and place to meet. On one
occasion only we would meet with you to conduct an interview. This interview will be recorded. The research fellow may sit in on some of the interviews for training purposes but you have the right to ask for this not to happen if you wish.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

**Time Commitment**

Approximately one hour

**Can Participants Change their Mind and Withdraw from the Project?**

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

**What Data or Information will be Collected and What Use will be Made of it?**

This project involves an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although our Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used. In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

The interview will be recorded. The tape will be transcribed. The data will be coded with your personal details (name) removed. Your interview transcript will be combined to those of the other participants and the outputs of a literature review. The dataset will be analysed as a whole.

Results of this project may be published. If you so wish we will make every effort to assure your anonymity in any report or publication but you must be aware that this may be difficult with the nature of your work, position and its relationship to the subject matter. In all cases names will not be used but if you are happy on the consent form you can say that your comments can be linked to your position and organisation.

Participants in this project will be provided with a copy of the final report.

The data collected will be securely stored in such a way that only those mentioned above will be able to gain access to it.

**Why Me?**

You have been approached as you have been involved in shaping UK national policy in the development and implementation of Revalidation.

**What if Participants have any Questions?**

If you have any questions about our project, either now or in the future, please feel free to contact either:-
Dr Julian Archer or Dr Sam Regan de Bere
Department of Clinical Education
Department of Clinical Education
University Tel No: 01752 586750
University Tel No: 01752 586777

Complaints

If you have any complaints about the way in which this study has been carried out please contact the Chair of the Peninsula College of Medicine and Dentistry Research Ethics Committee:

Carol Barkle
Administrator to the Research Ethics Committee
Peninsula College of Medicine & Dentistry
The Knowledge Spa
Royal Cornwall Hospital
Truro
Cornwall
TR1 3DH
Email: carol.barkle@pms.ac.uk

Signed by lead researcher:

Dr Julian Archer, NIHR ACL in Medical Education

This project has been reviewed and approved by the Peninsula College of Medicine and Dentistry Research Ethics Committee