Revalidation in Orthopaedics

Lee Breakwell

As the sixth anniversary of the introduction of Revalidation for Doctors in the UK approaches, we have looked back at the rationale behind the inception, design and implementation of the current system. We have reviewed what evidence we have as to the value and effectiveness of the process, and whether it has improved the professionalism of doctors or the safety of our patients.

We will now look at the requirements and processes affecting orthopaedic surgeons currently working in the UK.

Lee Breakwell is a full-time spinal surgeon at Sheffield Children's and Teaching Hospitals. He is a current Trustee of the BOA and past President of BOTA. He co-designed the British Spine Registry and represents the BSS. Lee is Secretary of the UK Spine Societies Board, as well as Chairman of Sheffield Orthopaedics Ltd.

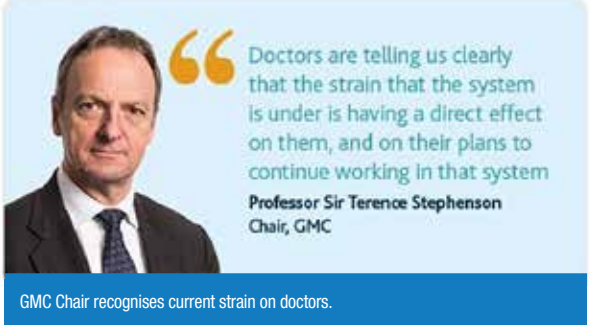
Many orthopaedic surgeons work in more than one hospital and in other roles, and as such, need to be aware of their duty to review their whole practice at the time of appraisal. Fundamentally, a doctor must include evidence on any role they perform which requires a medical licence to undertake. This of course, covers clinical work, but also clinical research, teaching/ training, and management. In addition to the notion of whole practice review, demonstration of the appropriate nature of the scope of a doctor's practice is required. To some, this may seem obvious, but in the light of the Kennedy and Verita Reports into the behaviour of Ian Paterson, the processes, defined by Dr Rayner, as to the triangulation of information between Designated Bodies about any individual doctor, must be improved.

It is now a GMC requirement for all doctors to undergo annual appraisal and is a contractual obligation in the NHS and a necessity to maintain privileges in the Independent Sector. Whilst appraisal at its best can be a rewarding, inspiring, challenging and nurturing experience, it is often lost in the process of a busy life and relegated to a perfunctory exercise of task-oriented box-ticking. The GMC has recently recognised via social media, that current workloads and pressure within the system are affecting doctors on both a daily basis and in their future planning.

It is vital therefore, to ensure prospective information gathering occurs to avoid the otherwise inevitable last-minute rushed and superficial preparation for appraisal. Several streams of evidence are required to complete a satisfactory appraisal, and a series of these leads to a positive recommendation for revalidation.

Surgical disciplines lend themselves well to evidence capture on certain levels, with procedures easily described offering clear description of a doctor's role. Orthopaedics has led in this area, with rigorous data capture for many via the sub-specialty registries. Participation in available national audits is another GMC requirement under Good Medical Practice, and increased compliance with registries is therefore to be encouraged. A surgeon's output from the recognised registry is an ideal method of demonstrating the nature of their practice and enables scrutiny of scope and breadth of the work undertaken in all centres.

In addition to logbook type evidence, there is a requirement to demonstrate participation in quality improvement activity. Whilst this is typically enshrined in the process of audit,



GMC Chair recognises current strain on doctors.

Supporting information for appraisal and revalidation (GMC).

this is by no means the only option, and the GMC has avoided being overly prescriptive in this area to allow professional judgement and flexibility.

Feedback is a fundamental part of being human, with constant interaction with others honing our responses and behaviours. Formalising this process has, at times, stunted the natural flow and makes many uncomfortable. Documented feedback from both colleagues and patients is a strict requirement and a dedicated 360-assessment is mandatory in each revalidation cycle.

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On collation of this evidence, the most important step can then be undertaken. This is the requirement to demonstrate reflection. Any functional surgeon will reflect multiple times a day during practice, whether it be about a decision in clinic or during a procedure. Review of imaging leads to reflection on accuracy of diagnosis or implant position. Where many struggle is in the recording of this. Clinicians naturally gravitate to the self-critical and include evidence of mistakes or poor outcome leading to complaints, and whilst this does enable personal and system learning, it does not maximise the nurturing, developmental aspect of the appraisal. It is imperative to reflect on positive aspects of professional life in addition, to ensure balance is maintained and positive encouragement for the future.

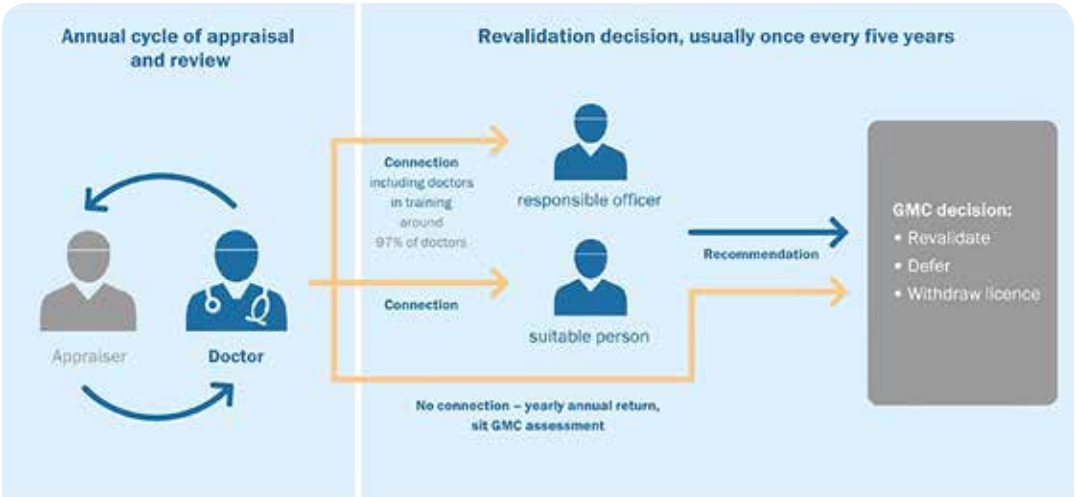
Increasingly, this evidence will have been recorded in electronic repository, which can then be shared and reviewed by the appraiser. Designated bodies have a duty to ensure well trained, supported and remunerated appraisers are available for the volume of connected doctors. Working within the GMC guidelines and locally agreed processes, the appraiser will review the evidence and challenge the doctor on their practice. This will formulate a personal development plan (PDP), which encourages emphasis on an area for improvement or professional enhancement.

The basis of revalidation then follows that review of the annual appraisal output, and progress against the agreed PDP forms the basis for a decision regarding recommendation. The GMC bestows and renews a doctor's licence to practice, but relies heavily on the Responsible Officer and their appraisers to make that decision.

Overall, revalidation is a relatively low benchmark, requiring collation of evidence of day-to-day practice, and a reflection upon this evidence. Much of the process is formative, with the summative approach of testing having thus far been avoided. Inherent within the process is a repeated test of probity, whether that be the formal declaration of health, or the checks and balances created by the flow of information between agencies.

The evidence from Professor Burke's article is that revalidation is beginning to improve internal communication and quality improvement locally.

Orthopaedics as a profession must work together to ensure that we continue to demonstrate leadership on data collection and the interrogation and implementation into practice of outcomes data. Consequent to this is the current preference to resist the professionally damaging and often misleading publication of low-quality surgeon level data in the public domain, which offers little benefit to any party. This position can only be justified and defended if individuals utilise the opportunity afforded them by appraisal, to openly discuss and reflect upon their data and employ practice changes to continually improve as a doctor and offer benefit to patients. ■



Revalidation process (GMC).