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3 **Analysis**
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5 # Appraisal and revalidation for UK doctors - time to assess the evidence
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KEY MESSAGES

- **Appraisal is the product of two determining discourses: regulation and professionalism. It aims to respond to distinct, often competing priorities which require different processes.**
- **There is currently little evidence of appraisal achieving its objectives which range from assuring a doctor's fitness to practise and performance management, to driving personal and professional development whilst providing coaching, mentoring and pastoral care.**
- **The pause of appraisal and revalidation during the pandemic offers an opportunity for clarification of its purpose. This should be followed by research to identify the appropriate intervention tools and outcomes, measurement of intended and unintended consequences, and evaluation of cost-effectiveness.**

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28
29 **Contributors and sources**
30 The authors worked together on the initial manuscript and revisions and all shared in the
31 design, literature review, and drafting of the manuscript. VTB is a GP and an appraiser and
32 has been involved in research on the design and evaluation of complex interventions and
33 their effect on professional behaviour. MM is a GP and honorary fellow of the Centre for

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VTB is the guarantor of the article.

Conflicts of Interest

We have read and understood BMJ policy on declaration of interests and have the following interests to declare: VTB is a GP appraiser. MM has previously written of her concerns about appraisal. All have to undergo appraisal as part of revalidation. There are no other potential conflicts of interest.

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Patient and Public Involvement

This analysis did not involve patients or the public in its design or reporting.

Appraisal and revalidation - time to assess the evidence

Introduction

The pause of appraisal and revalidation during the pandemic offers an opportunity for critical thinking on their purpose and cost-effectiveness and for redesign of their processes argue Victoria Tzortziou Brown and colleagues.

The General Medical Council (GMC) has taken a more flexible approach to regulation during the COVID-19 pandemic, with revalidation and appraisals largely suspended to allow doctors to focus on clinical safety and workload.[1] With reinstatement planned, we argue for urgent clarification of their purpose, an evidence-based approach for their implementation and ongoing evaluation.

Medical revalidation and appraisal

Revalidation practices vary widely amongst countries in the absence of a unified agreement surrounding its definition, mechanisms and appropriate design.[2] Some countries have no formal process in place [3] while others heavily rely on evidence of continuing medical education.[2]

The GMC is the first regulator in the world to implement a compulsory and comprehensive revalidation process[4] for over 335,000 doctors on its register.[5] According to the GMC, revalidation 'gives your patients confidence that you're up to date'.[6] A cost and benefit analysis in 2012 showed that, in England alone, revalidation would cost the NHS nearly £1billion over a ten-year period. [7] The expected benefits included: increased public trust and confidence in doctors, improved patient safety and quality of care, reduced costs of support for underperforming doctors, reduced malpractice and litigation costs, better information about care quality and positive cultural change in the medical profession [8] but there is no evidence these have materialised.

Appraisal is the only route to revalidation and must contain supporting information under six defined categories: continuing professional development, quality improvement activity, significant events, feedback from patients and colleagues, and complaints and compliments.[9] Most doctors (97%) revalidate through annual appraisals and a five-yearly recommendation to the GMC from their responsible officer, based on the outputs from their appraisals. [9]

There is an ongoing tension on whether the mode of revalidation and its key component, appraisal, should be summative (a pass/fail test against a defined standard), or formative (a

flexible, informative exchange of information). [10, 11, 12] This tension results from unclear articulation of what problem appraisal is trying to solve whilst responding to numerous stakeholders with competing priorities.[13]

The current roles of appraisal can include a combination of assuring a doctor`s fitness to practise, performance management, personal and professional development and providing coaching, mentoring, pastoral care and support. This panoply of undertakings means appraisal has become a mini industry, with numerous personnel planning, overseeing, recording, or performing appraisal, and commercial and membership organisations offering tools to complete it. In the absence of a clear and consistent aim of appraisal, we evaluate each of these purported purposes.

Appraisal and assurance of fitness to practise

The White Paper on medical regulation[14] proposed that appraisal should remain central to the revalidation process with a greater emphasis on summative aspects 'which confirm that a doctor has objectively met the standards expected'. However, there is no relevant research and evidence on what tools, data and processes can objectively demonstrate these minimum expected standards.

The Medical Board of Australia dropped the term 'revalidation' and uses a 'Professional performance framework' proactively identifying doctors at risk of performing poorly, with strengthened assessment and management of medical practitioners with multiple substantiated complaints.[15]

The existing appraisal process in the UK has a strong focus on collecting, recording and reflecting on supporting information. However, written reflection is not necessarily translated into ongoing reflective practice[16] and there is no robust evidence to show that appraisal improves safety, patient outcomes or gives patients confidence in doctors.[17] Even if some patients believe appraisal guarantees an up to date and fit to practise doctor, this is not an evidenced outcome and may result in false reassurance. The process is often seen by doctors as onerous and bureaucratic.[18] Accordingly, appraisal and revalidation were largely suspended during the COVID-19 pandemic 'to free up capacity to maintain essential care'.[19] Retired doctors were automatically re-registered with the GMC and told they did not have to engage with revalidation.[20]

Appraisal and performance management

128 Another summative role of appraisal, especially in hospital settings, is performance
129 management. According to NHS England's Revalidation Support Team, medical appraisals
130 may be used to ensure doctors are working in line with the priorities and requirements of the
131 organisation in which they practise.[21]
132
133 The Review Body on Doctors' and Dentists' Remuneration goes further by recommending
134 linking pay progression to achievements assessed at appraisal.[22] The incorporation of job
135 planning, performance reviews and pay progression within the appraisal process introduces
136 inherent conflicts of interests and challenges around appraisal confidentiality,[13] whereby
137 health service managers may wish access to confidential appraisal folders. Doctors may be
138 asked to include evidence of mandatory training, an organisational but not GMC
139 requirement, adding to confusion and conflict.[23] Further, the role of the responsible officer is
140 often held by a senior clinician/head of service within the organisation, a potential conflict, as
141 the appraisee may want to raise contractual, safety or management concerns but is reliant
142 on the responsible officer for registration, and hence income.
143
144 Performance management in general is poorly underpinned by evidence.[24] A rapid evidence
145 assessment [25] by the Chartered Institute of Personnel and Development showed that while
146 appraisal can contribute towards performance, there is considerable variation and often it
147 has no effect or even worsens performance. The review suggested that performance
148 management should be continuous and not a discrete process occasionally revisited, and
149 recommended separating developmental performance issues from administrative ones, as
150 they involve different types of professional behaviour. [25]
151
152 **Appraisal, learning and professional development**
153 A formative element of appraisal is continuous professional development (CPD). Appraisal
154 is meant to help doctors identify, reflect on and plan to address their educational needs.[26]
155 However, reliance on formal annual assessment of learning needs risks turning learning
156 from a reflexive and responsive process into a narrow and fixed one.[27]
157
158 There is little causal evidence linking the appraisal process and improvement in practice.[28]
159 A systematic review of multi-source feedback found limited evidence of benefit over
160 professional behaviour.[29] A 2014 NHS Revalidation Support Team report summarizing
161 research on the impact of medical revalidation [30] found that only a quarter of doctors
162 reported they changed their clinical practice as a result of their last appraisal. According to a
163 cross sectional GP survey, less than half reported that appraisal enhanced learning or
164 improved practice, and just over half said that it encouraged CPD.[28] Findings are often

165 based on self-reported, subjective assessments on the impact of appraisal and results can
166 vary widely. For example, feedback in 2019 using the NHS England Medical Appraisal Policy
167 questionnaire, found that 91% of doctors agreed that appraisal was useful for promoting
168 quality improvement [31] but only 34% responded 'yes' to this question in the 2017 Royal
169 College of General Practitioners` survey. [31]
170
171 Appraisal provides a means to document practice but may not necessarily improve it. Some
172 doctors identify negative impacts on practice and professional autonomy.[16] According to a
173 survey of over 1000 UK GPs and trainees in 2017 '70% stated that summative, written
174 reflection is a time-consuming, box-ticking exercise which distracts from other learning.' [18]
175 Another study reiterated the perception of a tick-box process which creates the impression of
176 accountability [32] adding that doubts over the value of appraisal, or lack of trust, mean it is
177 more likely to be regarded as purely procedural.
178
179 **Appraisal and professional coaching/mentoring**
180 Appraisal may go beyond identifying learning needs and agreeing CPD plans. It is
181 sometimes seen as opportunity for medical professionals to reflect on careers, consider
182 aspirations and develop potential. Appraisal may thus adopt elements of career coaching
183 and mentoring. However, these rely on the development of a trusting relationship over time
184 rather than a single annual encounter, and both depend on confidentiality, an unconditional
185 positive regard for the client and a non-judgmental approach.[33] Most organised mentoring
186 schemes attempt matching of mentees with mentors.[34] Such conditions are not possible in
187 the existing appraisal process and therefore, although coaching and mentoring are
188 increasingly advocated within the NHS, such interventions, if effective, should occur outside
189 the appraisal process.
190
191 **Appraisal, life coaching and wellbeing**
192 A relatively new appraisal role is life coaching, which explores issues such as work-life
193 balance, 'wellbeing' and pastoral care.[31, 35] The GMC`s report Caring for doctors Caring for
194 patients [36] recognises that organisations which prioritise staff wellbeing provide better quality
195 of care, see higher levels of patient satisfaction, and retain more of their workforce. The
196 GMC has committed to working with relevant stakeholders towards improving doctors'
197 working lives. However, it is unclear how appraisal can meaningfully contribute towards
198 wellbeing.
199
200 The appraisee is expected to use their own judgement when making health declarations. If a
201 health concern is identified during an appraisal, the matter is addressed within other

202 processes, for example by an Occupational Health assessment, and not within a
203 performance framework. [37] The Academy of Medical Royal Colleges have advised that a
204 once a year intervention is not the right form of support. [38] Furthermore, a qualitative study
205 showed that if appraisal data are used as evidence for revalidation, it can inhibit doctors from
206 openly exploring difficulties or limitations.[39]
207
208 Patients are likely to want to be protected from 'burnt out' doctors and may see appraisal as
209 a way of monitoring or supporting doctors to avoid this. However, the evidence base for
210 interventions aiming to identify and prevent mental health conditions among healthcare
211 professionals is limited [40] and there is no evidence that appraisal can address this. On the
212 contrary, it may take resources away from other services and initiatives. The NHS Staff and
213 Learners' Mental Wellbeing Commission recommended a coordinated approach to promote
214 staff wellbeing including suitable, safe and confidential work spaces where staff can
215 socialise, share and discuss experiences, as well as quick access to proactive occupational
216 health, emotional and psychological support services. [41]
217
218 Not only appraisal may not be the most effective tool for identifying and addressing mental
219 health needs, but some appraisees perceive the process as unhelpful, time consuming and
220 of low value, [18, 42] having a negative impact on morale and burnout and contributing to GPs
221 and consultants leaving the profession.[43, 44] It has been argued that this may be due to the
222 inflexibility and time-consuming nature of appraisal and that women aged between 30 and
223 39 are disproportionately affected. [45]
224
225 **Redesigning appraisal**
226 Appraisal is the product of two determining discourses: regulation and professionalism with
227 different drivers and aims requiring different processes.[10] Despite the at scale mobilisation
228 and engagement of most doctors on the register, the enthusiasm and hard work of
229 appraisers and responsible officers and the efforts to understand its impact and improve its
230 processes,[46] there is currently little objective evidence of appraisal achieving its distinct and
231 often incompatible objectives.
232
233 The pause of appraisal and revalidation during the pandemic offers a unique opportunity for
234 critical thinking and reflection. Clarity of purpose by the government and GMC is the most
235 fundamental priority; [47, 48, 49] followed by defining the processes and outcome measures to
236 evidence change.
237

238 If the primary purpose of revalidation is assuring fitness to practise, it requires clear
239 separation from the other appraisal roles, which should sit outside a GMC mandated system
240 to reduce the risk of conflict and bias. Any redesign should involve patients and the public as
241 key stakeholders if the aim includes improving public trust.[48, 49] UK National Health services,
242 Royal Medical Colleges and professional bodies should assess costs and impacts on
243 workload and workforce.
244
245 There is lack of solid research base on whether it is possible to accurately assess fitness to
246 practise prospectively, and whether appraisal is the most sensitive, specific, valid and
247 reliable tool for this. [49] Other revalidation models should be explored, for example, online
248 self-declarations, clinical audits and data signals which could indicate concerns, but given
249 previous difficulties [50] this may be a 'wicked' problem with no ready solution. We would
250 favour this honesty and the admission that we need to design a new solution, whilst pausing
251 appraisal, in the same way that we would not recommend a costly and unevidenced clinical
252 intervention which might do more harm than good.
253
254
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