Dear Editors

We are grateful to those who responded to our analysis. We were equally perplexed as Dr Goh[1] with the references used by Caesar et al[2] to support their arguments. The studies quoted do not provide objective evidence on the benefits of appraisal and revalidation for doctors and patients. In fact, Archer et al [3] in their independent evaluation, reported that: "we found no significant changes in a number of quantitative measures of quality before and after the introduction of revalidation for a variety of condition/procedure groups. We did find that the likelihood of consultant medical staff leaving the workforce increased significantly." The researchers concluded that: "on the basis of current evidence, we cannot demonstrate that medical revalidation as implemented is a cost-effective policy intervention."

The responses confirm the existing confusion on the purpose and process of appraisal, as stated in our analysis. If the new focus of appraisal is on providing a confidential space to those needing it during the pandemic, [2] then perhaps it should be voluntary and separate to revalidation, because NHSE confirms an "explicit link between appraisal, revalidation and clinical governance, necessitating and justifying the sharing of appraisal documentation" with staff, the GMC and courts as needed. [4,5]

The BMA`s Annual Representative Meeting voted that "the pause in appraisal and revalidation had not resulted in any detriment to patient safety or standards of care" and "demanded an independent audit of the processes involved to examine any alleged benefits and detrimental effects." [6] The meeting quoted that "the time demands of revalidation were equal to 390,000 days of patient appointments, or 1,775 full-time equivalent GPs."[6] The Department of Health's own impact assessment from 2012 predicted the costs conservatively at £1 billion over 10 years. [3] At a time of crisis and in the absence of evidence on benefits, we have a duty to our colleagues and our patients to question the ethics of diverting resources from frontline clinical practice and examine the alternatives.

---

[1] https://www.bmj.com/content/370/bmj.m3415/rr-10
[2] https://www.bmj.com/content/370/bmj.m3415/rr-7
[3] Archer J, Bloor K, Bojke C, Boyd A, Bryce M, Ferguson J et al. Evaluating the development of medical revalidation in England and its impact on organisational performance and medical practice: overview report [Internet]. Alliancembs.manchester.ac.uk. 2018 [cited 15 June 2020]. Available from: https://www.alliancembs.manchester.ac.uk/research/health/Portals/0/Docs/development-impact-medical-revalidation-report.pdf
[4] Medical Appraisal Documentation Access Statement, NHS England, 2016 [cited 9 October 2020] Available from: https://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/01/medical-appraisal-access-stmnt-v1.0.pdf
[5] NHS England ROAN information sheet 8: Confidentiality of reflections for appraisal [cited 9 October 2020] Available from: https://www.england.nhs.uk/medical-revalidation/ro/info-docs/roan-information-sheets/confidentiality-of-reflections-for-appraisal/
[6] Neil Hallows. Reduce time required for revalidation, say doctors. BMA [cited 9 October 2020] Available from: https://www.bma.org.uk/news-and-opinion/reduce-time-required-for-revalidation-say-doctors