Revalidation in Practice

Shaping the future development of revalidation

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The views expressed in this report are those of the participants and the authors and do not necessarily reflect those of the Health Foundation.
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Executive Summary

Introduction

Revalidation represents the most significant revision of medical regulation since the 1858 Medical Act. It transforms the GMC’s registration system from a historical record of qualifications gained to an on-going evaluation of competence that provides assurance of clinical standards to the public. So, both in terms of policy and practice, revalidation has enormous implications for medical culture, patient care, the development of medical professionalism and the professional identity of individual doctors.

Over a decade of debate and a further two years of piloting across 10 pilot sites in England prior to full implementation is testimony to the significance of revalidation as a major policy change. Revalidation became a professional reality on 3rd December 2012 with full implementation.

This report provides a timely and important perspective in this significant emerging debate. It discusses the perceptions of those involved in appraisal at all levels as it feeds into revalidation.

Methods

Annual appraisal is at the core of revalidation. It is therefore vital to understand this central, yet traditionally confidential activity if an understanding of revalidation is to be achieved.

The research took place in Cornwall, Devon and Plymouth Healthcare Trusts between September 2011 and March 2013 as the first wave of doctors were revalidated. We recruited a total of 25 participants. Recruitment was not easy. In Cornwall especially, we found hostility at times to the research in the context of the recent challenging revalidation pilot, proposed changes to NHS pensions and advanced discussions about the Health and Social Care Act. However we ultimately collected an immensely rich set of primary data and a sufficient sample to demonstrate the effectiveness of our methods and to produce findings that reinforce the need for an expanded study.

We video recorded 7 appraisals across primary, secondary and community care settings to provide unique insights into the process. The data gathered was used to prompt lines of questioning for both the appraisers and appraisees in 18 follow up in-depth interviews. In
order to contextualise these micro-interactions of the individual appraisals within the wider system of revalidation we also interviewed 4 Responsible Officers (RO), a regional GMC Employer Liaison Officer and a primary care revalidation administrative lead. We analysed the research data in two main phases. Firstly, using activity theory as an analytic heuristic to explore, describe and understand revalidation, and its role as part of a wider clinical ‘system’. Secondly, applying discourse analysis to interpret any dominant cultural narratives and competing practices as they interact and (re)shape this system.

Core findings

We found, a significant amount of uncertainty among our participants as to whether revalidation would achieve its aims, either at the level of improving and celebrating individual medical practice or at the wider level of assuring public confidence in the profession as a whole. Anxiety was a common thread that ran through the three overarching, but not mutually exclusive, themes that we identified through the research: Professional identities; Evidence of practice; Appraisal for revalidation.

Professional identities

We found group identities to be very strong not just in terms of specialism, as you would expect, but also the more subtle distinctions based on generational lines. Generation is cited as a key marker of difference in the profession’s attitude towards and preparedness for revalidation. This needs to be carefully considered to ensure that a crude notion of generation does not become a driver for future interventions and that medical education fully prepares doctors for the new professional landscape.

There was a perception among doctors that as a group they were the ‘type’ of people who found it difficult to ask for help. One of the benefits of revalidation, it was suggested, was that problems could be picked up earlier, support needs identified and help sought before a problem became a crisis.

There was confusion about the operationalization of remediation, with particular concerns in primary care about the potential financial and collegiate impact on GP practices if the practice was required to fund remediation for individual doctors.
Professional identity in relation to professional integrity was also highlighted in relation to the evidence required for revalidation. Two key findings were the anxieties raised around the potential for evidence to be ‘hidden’ and the reliance on the skill of the appraiser in teasing out issues that either may become concerns in the future or alternatively highlighting good practice that the appraisee had failed to recognise as such.

Appraisal for revalidation

Participants felt very strongly that the appraisal was an intensely personal encounter and as appraisal becomes linked to revalidation there were questions as to who ‘owned’ the appraisal. The pastoral element was particularly stressed by appraisers and appraisees in primary and community care. The pastoral component was less of an issue for doctors in secondary care which suggests a disparity of objectives and process between the different healthcare communities and it mirrors the opinions expressed by the ROs for the different designated bodies in interview.

We observed that the form and content of an appraisal was largely dependent on the appraiser. Such lack of consistency suggests the need for the independent audit of appraisal processes and training to ensure parity and continuity.

Linked to our observation of lack of consistency in the appraisal process and the relative importance of the pastoral element is the concern expressed by participants that revalidation will become the primary driver for appraisal.

Evidence of practice

We found significant differences across Trusts in terms of the suitability, usefulness, availability and format of centrally generated and collated data as evidence for the revalidation portfolio.

The requirement of patient feedback as supporting evidence for revalidation is proving a concern to doctors. Aside from the well-worn arguments about the difficulty of gathering patient feedback by certain specialisms we found more subtle concerns expressed linked to type of patient; for example the elderly, patients with mental health issues and/or addiction.
The role of the patient needs to be clarified and mechanisms for patient feedback need to be reviewed to ensure it is not only equitable but meaningful for both patient and doctor.

There was a general feeling that some form of external regulation was necessary but the extremes of a ‘tick box’ exercise or an overly bureaucratic process, it was felt, would detract from the very medical practice revalidation was meant to support. Many participants were hopeful that as revalidation developed it would prove to be a useful process that would ultimately enhance practice and be beneficial to patients.

Conclusions

Revalidation is a new policy intervention and represents a significant change to medical practice and governance. It will take time to inspire the confidence of individual doctors, the profession and the public. This research, conducted as the first wave of doctors was revalidated and many members of the profession were on ‘high alert’, has provided valuable insights into revalidation in practice and has paved the way for a full scale evaluation of revalidation across the UK. The research has highlighted a number of inconsistencies that will need to be addressed to ensure that revalidation achieves its aims. These include:

- Consistency – consistency in the appraisal ensured by a system of ongoing independent evaluation.
- Appraisal for revalidation – revalidation must neither reduce appraisal to a ‘tick box exercise’ nor expand into an unwieldy bureaucratic system.
- Evidence – more rigorous checks on evidence presented in appraisal in order to help appraiser and responsible officer judgement making.
- Systems - need to be implemented that help doctors to collate the required evidence for the portfolio.
- Patients – patient feedback needs to be equitable and patient involvement in revalidation needs clarification.
- Remediation – processes need clarification as do any financial implications for Trusts and individual doctors
- Revalidation - will need to be monitored as it develops to ensure that it delivers its stated aims
1 Introduction

Revalidation requires that all doctors who work in the UK, whether NHS employees or working in the independent sector, demonstrate that they are ‘fit-to-practise’ medicine on a five yearly appraisal cycle. In this process, appraisers, through the completion of a standardised form, report the outcome of appraisals each year to the local responsible officer (RO). The RO every five years makes one of three recommendations to the GMC; revalidate, defer or concerns about non-engagement. The GMC, as the professional body, then makes the final decision about the individual doctor. Revalidation represents the most significant revision of medical regulation since the 1858 Medical Act as it is the first time doctors have had to undertake any regular professional review of their practice. It transforms the GMC’s registration system from a historical record of qualifications gained to an on-going evaluation of competence that provides assurance of clinical standards to the public. So, both in terms of policy and practice, revalidation has enormous implications for medical culture, patient care, the development of medical professionalism and the professional identity of individual doctors.

Over a decade of debate and a further two years of piloting across 10 pilot sites in England\(^1\) prior to full implementation is testimony to the significance of revalidation as a major policy change. Finally on 19\(^{th}\) October 2012 Jeremy Hunt, UK Secretary of State for Health announced the commencement of revalidation which then started on 3\(^{rd}\) December 2012.

Since then the GMC have reported, in a recent press release responding to the Revalidation Support Team’s report on the progress of revalidation in the UK\(^2\) that “20,490 doctors had revalidated as of 10 October 2013” and they expected that by the end of 2013 up to 30,000 UK doctors will have revalidated. Moving forward they expected to revalidate about a fifth of licensed doctors between April 2013 and the end of March 2014, the majority of licensed doctors by the end of March 2016 and all remaining licensed doctors by the end of March

\(^1\) http://www.revalidationsupport.nhs.uk/files/DE0270-00-DH-MedRev-Summary_Report_FINAL.pdf

\(^2\) RST Organisational Readiness Self-Assessment (ORSA) Report 2012-13
A report on implementation indicators for revalidation in England as at 31 March 2013
2018. On a monthly basis, the GMC plan to release revalidation figures on their website in the near future.

Revalidation in the field requires consultants, GPs, Trust and Specialist Associate/Staff Grade doctors, and trainees, to collect ‘evidence’ of practice against the four domains of the GMC appraisal structure: General information; Keeping up to date; Review of practice; Feedback on practice. The revalidation process is not uniform across the UK but each of the devolved countries has signed up to a set of principles. In England ePortfolio’s are formulated against the Revalidation Support Team’s (RST) Medical Appraisal Guide (MAG), many now provided by private companies, although the Royal College of General Practitioners (RCGP) provide their members with a bespoke ePortfolio. Scotland has a ‘one-stop’ Scottish Online Appraisal Resource (SOAR), as does Wales with their Medical Appraisal & Revalidation System (MARS). Clinical governance is made up of generic data such as complaints and sick leave, and more specific data such as mortality or infection rates. Appraisal documentation includes colleague and patient feedback, clinical governance data and personal development plans. ‘Revalidation activity’ is therefore centred on this appraisal process. So for the first time doctors will be required to collate data against a framework linked to a national re-licensing scheme.

The research we have undertaken with support from The Health Foundation is therefore timely and provides an important perspective in this significant emerging debate. The research is unique in that it provides an evaluation of the landscape prior to and then directly into the launch of revalidation.

The research discussed in this report focusses on Stage 2 of a comprehensive programme of research to understand revalidation in all its complexity. Stage One: Revalidation in Policy, set out to clarify the ‘meaning’ of revalidation through discourse analysis of interviews with key policymakers. This stage, stage Two: Revalidation in Practice, seeks to assess its impact on clinicians and clinical practice, and examine contemporary attitudes/experiences of medical professionalism. Finally, Stage Three: Revalidation and Patient and Public

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Involvement (PPI) will analyse the role of PPI in revalidation and its operationalization. The overall programme is summarised in Appendix 1.

2 Background to the research

“Revalidation is unique in that it is national, compulsory, involves all doctors regardless of position or training and is linked to the potentially performance moderating process of appraisal”5.

As Stage 1 of our research has demonstrated, revalidation has been and remains a contentious policy6. It is part of a raft of changes to medical policy and practice that will have a fundamental impact on health service provision and practice; including sweeping NHS reforms announced under the current coalition government and changes to public service pensions. It is important to acknowledge that revalidation, and consequently research in connection with it, sits within a wider context of reform.

Little is known about the role of professional regulation in terms of its actual impact on practice in the long term. Relicensure, a process in North America similar to the UK’s revalidation, is well established7 - and to a lesser extent in Australasia8. The evaluation of programmes is vital to ensure that the programmes are achieving what they set out to do and that they are constantly being developed and improved9. A diverse research literature exists on different aspects of the revalidation process however there is no comprehensive up-to-date evidence synthesis on each aspect of the revalidation process. With the


introduction of revalidation in the UK comes a unique opportunity to explore its implementation, in terms of best practice and to undertake a deeper analysis to provide new insights into a new regulation and new professionalism\textsuperscript{10}.

Revalidation is a policy driven intervention, but its resulting impact is far from clear. In part this is due to differing stakeholder views about what revalidation is for in terms of the desired weighting of the policy aims during its development: towards regulation (summative) or professionalism (formative). In part it is also due to a lack of clarity about who revalidation will serve since while both positions stress the focus on the doctor/patient relationship in their rhetoric, they only address the likely reality of the doctor/ regulator relationship in respect of policy. The final agreed policy aim of revalidation in the UK, to ensure that doctors are ‘up to date and fit to practise’, conflates the distinction within a single phrase rather than clarifying purpose. Thus the consequences that follow from revalidation cannot be predicated on any assumed benefit to patients or their doctors and will only appear through practice\textsuperscript{11}.

Interventions are complex. It has been shown that while they might bring about intended change, there is always a risk of unintended consequences, some of which may be negative\textsuperscript{12} . There is a body of literature demonstrating the unintended consequences, both positive and negative, of performance management. These unintended consequences are significant because over time they can become significant drivers, and not just products, of the intervention. For example, negative unintended consequences such as increased work stress may lead to more work absence and indeed be detrimental to the health of doctors.


\textsuperscript{11} Archer et al. (2012) Revalidation: in policy \texttt{http://www.revalidationresearch.co.uk/key_documents_info/Stage-One-Report.pdf}

themselves\textsuperscript{13}. Conversely, identifying positive unintended consequences may provide the opportunity to offer evidence-based gateways to better practice.

Therefore revalidation’s influence on healthcare and its consequences for the work of health professionals needs to be explored as the policy is operationalized. Some consequences have been predicted by policy makers. Indeed, the GMC posits revalidation as a regulatory lever that has the potential to drive improvements to both individual practice and the complex systems in which it takes place. By seeking to discover more about the evolving performance management process (revalidation) and its subsequent impact on the personal social contract (professional identity) we will be able to identify predictable but as yet un-verbalised, intended and unintended, consequences of the policy in practice.

Aims

- To understand the impact of revalidation in practice
- To assess the consequences of implementation for the medical profession
- To inform future policy

Objectives

- To identify and explore the practical consequences of revalidation
- To examine and assess potential positive and negative impacts of implementation on:
  - The practical experiences of revalidation
  - Professional identity and the shaping of a new professionalism
- To highlight areas of potential improvement that would benefit from further research

3 Conceptual framework

Acknowledging the politicisation of professional review through revalidation is essential, in that it makes transparent potential challenges from the outset and thus equips participants with the necessary knowledge and methodologies to resolve them. Our research questions are underpinned by the conceptual issues outlined below:

3.1 Perceptions: what are the attitudes and responses of the workforce?
The partial transference of autonomy away from clinicians themselves (self-governance) to the GMC and DH (institutionalised governance) is a clear challenge to professional power. Instances of consensus and resistance, identified by those undergoing revalidation, will help us to gain an idea of how best to proceed constructively, without alienating either party. The aim of our research is to identify and privilege shared discourses, which can act as gateways to consensus - and challenge potential areas of conflict.

3.2 Practice: what are the effects of revalidation on clinicians’ work?
It is important to question why a shift in focus and methods has become necessary - for example, we might ask whose interests are served by revalidation: the medical profession, government, patients, the public, or a combination of the above? We have addressed these questions from the perspective of policy makers in the first stage of the research\(^\text{14}\). This study, however, asks while rhetoric may emphasise particular outcomes, how do the key discourses of revalidation go on to inform practical action in the workplace?

3.3 Appraisal: how can clinician engagement support positive processes and outcomes?
The application of specific criteria and appraisal processes will have real implications for doctors’ career trajectories, via their promotion or remediation. The research examines perceptions through the implementation of revalidation processes. Recording and discussing appraisals will provide research participants with the opportunity to identify clear strategies for using appraisal techniques that maximise transparency, minimise conflict and facilitate beneficial change.

3.4 Professionalism: what does revalidation mean for professional development and identity?
Finally, taking these factors into account, it is clear that revalidation will play an important role in shaping or, more precisely, *reshaping* professionalism in medicine. A sense of professional identity is central to peoples’ occupational experiences, their motivation and self-worth. By anticipating that revalidation will inevitably impact on personal and

\(^\text{14}\) Archer et al. (2012) Revalidation: in policy
http://www.revalidationresearch.co.uk/key_documents_info/Stage-One-Report.pdf
professional identity, the research allows participants to consider how various approaches can be applied to enhance, rather than threaten, a shared sense of professionalism within the workforce.

4 Methodological framework

The research data were analysed in two main phases using a range of established complimentary methodologies. Cultural historical activity theory (CHAT)\(^{15}\), an analytic approach which employs a variety of methods, is frequently adopted by workplace theorists\(^{16}\) including in medicine\(^{17}\), it is used here to explore, describe and understand revalidation, and its role within and as part of a wider clinical ‘system’. These findings are complimented by undertaking discourse analysis to identify and interpret the dominant cultural narratives and competing practices as they interact and (re)shape this system.

Using this combination of methodologies enables us to describe and analyse revalidation as an intervention across the full range of its contexts – from the micro-interaction of the individual appraisal to the macro-interaction with the wider sociocultural matrix – thus assuring both breadth and depth of the research. In addition to being theoretically rigorous this framework has the advantage of recognising agency and the dynamic nature of interactions.

4.1 Cultural Historical Activity Theory

Cultural historical activity theory (CHAT) is relevant to examining revalidation because it provides an accessible and flexible framework with which to identify and examine any contradictions that play out as it has been implemented. The framework offered by Engeström within the CHAT approach is uniquely suited to gaining insights into how wider

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socio-political and economic struggles serve to mediate local practices and subjectivities\textsuperscript{18}. This is important because such changes may represent unintended consequences of action within the activity system.

Engeström set out five principles of CHAT in 2001 which we have used to structure our CHAT analysis.

- **Activity** - An activity system is the unit of analysis in the context of a network
- **Multi-voicedness** - An activity system always contains multiple points of view, traditions and interests.
- **Historicity** – analysis of the activity system and its constituent components and actions over time.
- **Contradictions** – searching for internal contradictions as the driving force behind disturbances, innovation and change in the activity system
- **Transformation** – the potential of the activity system to change through the contradictions will inform our findings and be presented in that section of the report.

CHAT makes visible the structure and dynamics of an activity and can be understood as a set of elements that underpin an integrated conceptual system. It is not a predictive theory. The system, in its most basic form is represented by a triangle following Engeström and is useful for understanding how specific elements work together to shape an activity\textsuperscript{19}. Figure 1 uses Engeström’s triangle model to model appraisal leading to revalidation.


Some definition of the model is required here. Artefacts (or tools) are mediational means, employed by the subject to achieve the object. The object is the central issue to which activity is directed, which leads to an outcome (such as improved practice, patient safety etc.), as a consequence of the activity. The community comprises multiple individuals and/or sub-groups who share the same general object (or are in some way involved in the interactive space of the Subject). The division of labour refers to both the horizontal division of tasks between the members of the community and to the vertical division of power and status. Engeström intended that rules refer to the explicit and implicit regulations, norms and conventions that constrain actions and interactions within the activity system. These rules are both explicit in medical regulation and convention, and implicit in professional and institutional culture. The distinction between the object and outcome of the activity system
is important. The outcome is the purpose for which the object is used. However, it needs to be recognised that different members of the community will interpret the object in different ways and bring their own meaning and intentions to the object of the activity.

4.2 Discourse analysis
The study also undertakes a systematic analysis of the discourses that shape the revalidation strategies as they are played out in practice, in order to assess its impact on professional activity.

Discourse as we apply it to revalidation has three dimensions: language (used to describe and communicate the ideas and practices of revalidation), practice (the actions involved therein) and institution (the formal social and cultural organisation of the ideas or practices, dictated by revalidation and the experience and identity of clinicians professionally validated in this way). We examine these as complex phenomena that are supported or negated by their cultural and political contexts.

Our analyses are used to illuminate the details of revalidation, highlighting differences between various emerging subject positions, and the discursive practices they inform. We examined these with the goal of isolating any misunderstandings and barriers that may impede the process. The findings of our discourse analysis are used in combination with CHAT to address our broader research aims of illuminating the processes and impacts of revalidation. These approaches will capture examples of best practice in order to provide evidence that can be used to inform future implementation strategies. This will be based upon identifying opportunities for consensual change, modelling gateways to positive working practices, and capturing the strategies that facilitate a strengthened sense of professionalism within the workforce.

5 Methods
Since appraisal is the focus of revalidation activity in doctors’ professional lives, data from appraisals formed the cornerstone of our research. Appraisals were videoed to provide unique insights into the process and the data gathered was used to prompt lines of questioning for both appraisers and appraisees in follow up in-depth interviews. In order to contextualise these micro-interactions of the individual appraisals within the wider system
of revalidation we also interviewed Responsible Officers and the GMC Employer Liaison Officers.

5.1 Research ethics
We secured ethical approval for the research through NRES on 2nd September 2011 followed by local R&D permissions for Cornwall and the Isles of Scilly. An amendment to our NRES permission did not need to be secured to extend the research into Plymouth and Devon as we were extending the study to other NHS sites. However, we were required to secure local R&D permissions. Potential participants were provided with a project information sheet and consent form. Copies of the documentation are included as Appendix 2.

5.2 Data collection
The key element of data was the recording of the normally private appraisal; needing the consent of both the appraiser and appraisee. Only by recording the appraisal would we be able to tailor prompt questions to individual appraisees and appraisers at follow-up interviews around the key areas of the presentation and evaluation of evidence. The videoing of appraisals would also facilitate comparisons, between different appraisers and across the Trusts. Within a fortnight of the appraisal an interview with the appraisee was arranged, with the appraiser being interviewed following the recording of their last appraisal. We interviewed the geographically related ROs and ELAs separately to gather an understanding of the wider system of revalidation.

At the beginning of each interview participants were invited to draw what revalidation meant to them and to describe their drawing. This method of data collection is consistent with that described by Guillemin, whereby ‘the use of an integrated approach that involves the use of both visual and word-based research methods offers a way of exploring both the multiplicity and complexity that is the base of much social research interested in human experience’ 20. The drawing element was not compulsory, however in previous research we have found it to be an extremely useful exercise as an ‘ice breaker’ at the beginning of an interview on a challenging and personal subject in addition to the data it provides.

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5.3 Recruitment
Support for the research in Cornwall was secured from the three ROs who volunteered to promote the research to colleagues (primarily appraisers) in their designated bodies. However, they cautioned us at the outset that in their opinion the experience of pilots in Cornwall would deter participation in our research. Cornwall and the Scilly Isles had been part of the 2010 GMC revalidation pilots with all doctors in all healthcare sectors involved in the pilot.

Through the ROs we were given the opportunity to present our research at community and primary care lead appraiser meetings with the aim of spring-boarding recruitment. However, we met with considerable apathy and hostility from the majority of appraisers who appointed themselves as ‘gatekeepers’. We became caught in a ‘top down model’ that made it difficult to find a way to talk to the appraisees directly. Our most successful recruitment of appraisees was through one secondary care appraiser in Cornwall who contrary to his colleagues acted as a ‘champion’ for the research. This individual, who is a keen advocate of revalidation, actively encouraged their appraisees to participate and this has implications for future research. Firstly, it suggests that supporters of the policy are more likely to participate and encourage others to do so, rather than detractors taking the opportunity to criticise the process (as we originally assumed). Secondly, it suggests a level of co-operation and trust between appraiser and appraisee. It should therefore be noted that the enthusiasm of our ‘champion’, while it progressed recruitment also created a potential bias in the research.

Potential participants cited the recording of the appraisal as a deterrent to participation. Such potentially invasive research methods, particularly when the subject is highly emotive, are challenging and can prove limiting to the research. However, since appraisal is at the heart of revalidation we believed that, in order to fully understand the process, direct recording of appraisal was necessary. Even if the sample was ultimately small it would still provide valuable insights not available in any other way.

The challenges of recruitment were discussed with The Health Foundation and with their agreement (and appropriate ethical approval) we extended our catchment area to include Plymouth and the community settings in Devon.
Once the research was extended into Devon we used our contacts in the medical school to distribute information about our research to discrete groups. As with recruitment through the Cornwall ROs we were again acting through a third party and not able to engage with appraisees directly. It is therefore impossible to know how many potential participants across Cornwall, Plymouth and Devon were aware of the research and exactly how the invitation to participate was framed.

Although we did not achieve our initial recruitment target of 43 participants the table below shows that we successfully engaged 25 participants in the research. We recorded 7 appraisals representing a cross section of the profession and undertook 24 interviews. Figure 2 below is an extract from our recruitment spreadsheet.
Data management

All the data pertaining to individual participants were created as ‘sets’ in NVivo (a qualitative data management and analysis computer software package). The most comprehensive set of data for an individual in this study included audio and/or video files of the appraisal and interview, a drawing, transcripts of the appraisal and the interview.

The sets are then coded as individual ‘cases’ in order to assign gender, role and location ‘attributes’ to each participant. ‘Attribute coding’ is the first level of coding that provides a

<table>
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<tr>
<td>RO (secondary care)</td>
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<td>yes</td>
</tr>
<tr>
<td>RO (community care)</td>
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<td>yes</td>
</tr>
<tr>
<td>RO (primary care)</td>
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<td>yes</td>
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<td>Appraiser 2 (secondary care: wards)</td>
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<td>Appraiser 4 (secondary care: labs)</td>
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<td>yes</td>
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<tr>
<td>Appraiser 5 (community care)</td>
<td>n/a</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Appraisee 1 (secondary care: wards)</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Appraisee 2 (secondary care: theatre)</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Appraisee 3 (secondary care: theatre)</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Appraisee 4 (secondary care: wards)</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Appraisee 5 (secondary care: theatre)</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Appraisee 6 (secondary care: theatre)</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Appraisee 7 (community care)</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Appraisee 8 (primary care)</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Appraisee 9 (primary care)</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Appraisee 10 (primary care)</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Appraisee 11 (primary care)</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Appraisee 12 (primary care)</td>
<td>yes</td>
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<td>yes</td>
</tr>
<tr>
<td>Appraisee 13 (primary care)</td>
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<td>no</td>
</tr>
<tr>
<td>Appraisee 14 (primary care)</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

**Fig. 2** Summary of participants

5.4 Data management

All the data pertaining to individual participants were created as ‘sets’ in NVivo (a qualitative data management and analysis computer software package). The most comprehensive set of data for an individual in this study included audio and/or video files of the appraisal and interview, a drawing, transcripts of the appraisal and the interview.

The sets are then coded as individual ‘cases’ in order to assign gender, role and location ‘attributes’ to each participant. ‘Attribute coding’ is the first level of coding that provides a
basic description of the data and is particularly useful for studies with a variety of data. Setting attributes also allows the data to be ‘cut’ in a variety of ways for analysis and comparison between attribute determined groups.

The attributes we assigned to each individual were: gender, NHS Trust (primary, secondary, community) and role in revalidation (RO, Appraiser, Appraisee).

The 11 ‘primary codes’ were agreed by the team once the fieldwork had begun. We used a ‘holistic coding’ method in order “to ‘chunk’ the text into broad topic areas, as a first step to seeing what is there.”

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All data were coded at this initial level before being split into descriptive secondary and tertiary sub-codes to enable more detailed analysis. Again, where appropriate, we repeated the categories used in Stage 1 for a more detailed future comparison of commonality and differences. (A full list of codes and sub-codes is shown in Appendix 3)

5.5 Anonymity

We used a letter and number code to identify participants that would map onto the attribute coding in NVivo. The purpose of this was to:

- Ensure anonymity with a small cohort in a restricted geographical area
- Use a system that could easily incorporate other participants should the research be extended to include other areas

<table>
<thead>
<tr>
<th>Location</th>
<th>Trust</th>
<th>Role</th>
<th>Gender</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cornwall - 0</td>
<td>PCT - PC</td>
<td>RO - RO</td>
<td>Male – M</td>
<td></td>
</tr>
<tr>
<td>Plymouth - 1</td>
<td>SCT - SC</td>
<td>Appraiser - AER</td>
<td>Female – F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CCT - CC</td>
<td>Appraisee - AEE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For example the 1st male GP appraisee from Cornwall participating in the research would be identified as – 0/PC/AEE/M/1

In the case of secondary care we added L, W or T (labs, theatre or wards) to indicate the broad area of their work

Fig. 4 Anonymisation of participants

6 Analysis

Cultural Historical Activity and discourse analysis are used in combination to analyse the data. By working through Engeström’s triangular model we teased out the separate elements of the process to understand where potential tensions (Engeström’s Contradictions) might arise. Citing Il’enkov (1977) Engeström argues that “A contradiction is
a historically accumulated dynamic tension between opposing forces in an activity system”\textsuperscript{23}: indeed in practice it is often almost impossible to separate the ‘tools’ from the power relations embedded in them. It should be noted that since revalidation is a relatively new activity system \textit{Contradictions} are likely to be prevalent as different intentions are brought to bear in a new and as yet undefined system.

The dovetailing of discourse analysis with CHAT is therefore appropriate, since discourse analysis describes the power/knowledge dialectic and power at work in the \textit{Contradictions}. The discursive analysis was informed by the thematic coding of interviews and appraisals, but contextualised with the components of the CHAT model. Discourse analysis enables us to better understand the narratives underpinning revalidation as it is played out and posit their influence on the relative, success and effectiveness of revalidation.

\textbf{6.1 Thematic coding}

The thematic coding of the data identified the most common themes and this highlighted the significance of specific issues. In Figure 5 the ten most significant themes that emerged from the interviews are shown with the number of separate sources (interviews) that identified them.

For example we found through the thematic coding of the interview transcripts, that our participants were not overly burdened by the history of revalidation. Although 14 interviewees cited Harold Shipman as a driver for revalidation he was simply nominated as a rallying point without the underlying discourse of traditional self-regulation being discussed.

Neither were the pilots referred to in any significant way in the interviews which was surprising considering that during the recruitment phase we were told by the ROs and Appraisers from Cornwall that the experience of the pilots was still very raw (9 references were coded against ‘Pilot’ across 6 interview transcripts, 3 of which were transcripts of RO interviews).

NVivo enables searches for key individual words and phrases. For example the phrase ‘tick box’ was used by 13 interviewees a total of 74 times, strongly suggesting that the reductive idea of a ‘tick box’ is a dominant trope within revalidation.

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**Fig. 5 Common themes identified through coding**
NVivo ascribes numerical values to incidence against individual codes. From this we can compare and contrast the most important themes across all or parts of the data. For example the most significant themes evidenced through the primary codes from the RO interviews were ‘People’ (60) and ‘Challenges’ (56). Interestingly ‘Processes’ (41) were understood by the ROs to be significantly more relevant to revalidation in practice than ‘Politics’ (27). Whereas for appraisers the most significant themes identified were ‘Revalidation and Appraisal’ (117), ‘People’ (94) with ‘Challenges’, ‘Processes’ and ‘Systems’ of equal importance (46).

6.2 CHAT

The exercise of modelling the appraisal cycle leading to revalidation as an activity system testified to the complexity of the activity since it was often difficult to demarcate between the separate elements. For example, The Artefacts are intertwined with the purposes they are put to in this activity system – so understanding how and why the Artefacts are used is crucial to identify how the Object and the Outcome are being interpreted.

6.2.1 Multi-voicedness

An activity system is always a community of multiple points of view, histories and interests. The Community in this model is extremely broad: potentially including every doctor in the UK, their patients and the non-clinical workforce who support the delivery of healthcare. The Division of labour in an activity creates different positions for the participants who carry their own diverse histories, and the activity system itself carries multiple layers and strands of history engraved in its artefacts, rules and conventions.

Our interviewees were not unanimous in their evaluation of the division of labour.

The GMC employer liaison officer we interviewed stated:

I think something that is really key and a lot of the time gets overlooked is actually it’s on the individual doctor, you know they are a professional, they are in a privileged profession and they have to take responsibility for their own revalidation ... make sure they’re engaging in appraisal, doing their CPD, gathering patient and colleague feedback, and actually learning from those experiences and taking that forward over a period of time. There’s lots of other key players obviously but for me it’s, I think you can’t separate it from the individual doctor, it’s ultimately their responsibility to keep the privilege of being on the register. GMCELOM1
The appraisees interviewed generally felt that the majority of the work lay with them and their appraiser, with the RO having a minimal ‘sign off’ role. The appraisers however acknowledged the role of the RO not only in ‘signing off’, but also in overseeing the process and disseminating information. In this appraisees and appraisers are only acknowledging those functions of the RO role that immediately relate to them. Whereas the RO regulations in England are more extensive, requiring ROs for example to maintain an up to date list of doctors connected to their designated bodies and since 2013 to ensure that the doctors they are responsible for ‘have sufficient knowledge of the English language necessary for the work to be performed in a safe and competent manner’

There is a tacit understanding that revalidation is for patients, yet the patient voice in the process is limited to providing feedback. Several of our participants discussed their concerns about the restrictive nature of the current ‘patient feedback forms’ in terms of equity.

One GP identified another set of voices with the potential to intervene in the doctor/patient relationship, who, “with the best will in the world” act as gatekeepers to feedback and hence part of the revalidation process:

Also I am absolutely sure that my receptionists select out the patients. ... They do it with the best will in the world, but if you’re having a bad day and running late, they probably don’t give out the forms and if somebody comes in who is intoxicated, which a lot of my patients are, or angry or maybe has learning difficulties or something like that they just wouldn’t give them a form. I am sure they do it like that. They wait until you’re having a good day and everything is quiet and calm and then they give out the forms. ... I am sure that they select them or they leave out difficult people. 1PACEEF6

6.2.2 Historicity
For Engeström ‘Historicity’ is both the local and the global history of an activity system. It allows for the passage of time around a given activity and the components of its system. Any activity system is not self-sufficient and needs to be seen in relation to other activity systems in order to realise the deeper structure of each component. Figure 6 shows the relationship of other key activity systems and discourses to each component of the Appraisal Activity system.

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Fig. 6 External discourses and activity systems relevant to components of our activity system

The external discourses and activity systems shown in the diagram are by no means exhaustive. For example, we could have included the planned health reforms as an activity system since they coincided with our research and anecdotally have been associated with increased levels of anxiety. These external systems and discourses are not static. For example at the time of our research Clinical Commissioning Groups were not part of the medical landscape, however they are now set to have a considerable impact on the commissioning of medical care and may have a role in revalidation as part of the PPI agenda.

Our participants recognised revalidation as part of a broader regulatory picture. In particular comparisons were made between extant appraisal processes and appraisal for revalidation.
With the general feeling being that the pastoral elements of current appraisal processes, which were seen as extremely beneficial and important, risked being lost if appraisal predicated on the discourse of professionalism became secondary to regulatory discourses. Appraisal as a professional as well as a pastoral conversation was particularly noted by primary and community care doctors, indeed both these groups emphasised the existing support networks with colleagues. One community care practitioner (OCCAEM1) emphatically opposed revalidation largely on the grounds that the systems in place locally in his specialism, he felt, already provided more than sufficient checks and balances. Indeed he opined that revalidation was potentially detrimental in that its regulatory function could deter doctors from taking “protected risks” which would have financial cost as well as professional implications around individual patients’ trust.

but at the end of the day we need to be at the cusp, taking risks. We are expected to, especially consultants, we are expected to make decisions when others fear to make them. Simple as that. ... So you can pull back and play safe. Think hang on, why should I put myself out in the limb? Why should I do that extra bit? Why should I think about trying somebody in the community? Why should I try to treat them in community, when I can just get them into hospital? It’s that perception. That might be the way forward, sectioning them, it might be something, it might be a sensible option, but for the individual that might break their particular relationship with you. ... I think it can impact on their relationships, particularly in the field in which we work. It can be an impact on resources, because admissions is so costly, which is not something which, managing somebody in a community is a lot cheaper than managing someone in hospital, but if I say somebody is high risk and it’s – it’s a fine balance. 0CCAEEM1

This concern was echoed by a secondary care RO who felt that the revalidation could potentially prove to be a check on progressive medicine:

Patients require professionals who are able to make difficult judgements in risky situations. Is what patients need. And if bureaucratic systems stop them doing that out of fear, I think that would be harmful to patients. 0SCROM1

6.2.3 Primary Contradictions
For Engeström, contradictions are the drivers of innovation and change in the activity system. He argues that contradictions are cumulative internal and external structural tensions within and between activity systems, and often reference historical precedent and other activity systems. Those that reside in each component of the system he calls ‘primary
contradictions’ and we can list the specifics of these against the components of our activity system.

<table>
<thead>
<tr>
<th>PRIMARY CONTRADICTIONS</th>
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</thead>
<tbody>
<tr>
<td><strong>Component of Activity System</strong></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Subject</strong></td>
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<td><strong>Object</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Artefact (tools)</strong></td>
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<tr>
<td><strong>Rules</strong></td>
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<tr>
<td></td>
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<tr>
<td><strong>Community</strong></td>
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<td></td>
</tr>
</tbody>
</table>
Division of labour

- Layers of responsibility
- Division of labour and accountability not always clear or uniform
- Collation of evidence
- May require additional layers i.e. admin and HR support
- Power invested in ‘actors’

Fig. 7 Examples of Primary Contradictions in the Appraisal activity system

The most immediately obvious contradiction concerns the Activity itself, since in leading to revalidation, appraisal needs to be both a summative and formative process. This tension has been cited as one of the biggest challenges that appraisal systems must contend with.²⁵ Outside the context of CHAT, appraisal has been described as a ‘contradictory tool’ in the sense that while the contradiction between summative and formative may affect the appraisee, it also presents a problem for the appraiser: “the appraiser needs to be both a disciplinary judge and a helpful counsellor, but this could also be construed as a dilemma.”²⁶ Eades and Simmons (2004) also emphasise the two different approaches of appraisal, those of assessment and development. They write that a “longstanding performance appraisal dilemma is the weighting to be given to performance assessment compared to performance development – especially as these ‘judge’ and ‘helper’ roles imply different philosophies, process and levels of openness in appraisal.”²⁷ This contradiction in terms of aims and purposes as played out in practice was recognised by all our interviewees. For example:

I see [appraisal] as more trying to support the person, provide them with feedback to change their behaviour. ... [revalidation] ... I see it more as an assurance for the world outside that this person is a good chap, or chapess. ¹SCLAERM¹:

²⁵ http://www.appraisalandrevalidationevidence.com/resources/scharr_gp_appraisal$5B1$5D.pdf


As a fundamental contradiction it becomes embedded within every component of the activity at some point. For example a primary care appraisee with experience as an appraiser observed in relation to pastoral support that might “pick up problems before they become problems”:

I think there are some good things about revalidation in terms of sort of making people a bit more systematic, and making them think about more about what they have to do, but I think that it is going too far that way and I think the preventative thing is being knocked out, and you can see that in the tools we have to use and the approach that sadly some people are taking. 1PCAEEF5

The maintenance of a delicate balance between revalidation’s formative and summative aspects was key to the majority of our participants with the general feeling that should revalidation assume a full regulatory function and become a ‘tick box’ exercise it would serve no one. One secondary care RO made a clear distinction between these two aspects and felt that as revalidation matured a clear distinction would be made between the formative and summative elements:

So an appraisal isn’t a cosy chat, we’re talking about whatever you want to talk about. It should be challenging. ... professional appraisals may need to have a professional element, but they should be challenging, they must be challenging otherwise you call them mentoring. So what appraisal is becoming is more of an appraisal and less of a mentoring system and I think what needs to happen as that change matures, is that people need to take mentoring more seriously, organisations and employers do, to give doctors the outlet to have a confidential chat and then seek support. ... I think appraisal is being dragged kicking and screaming from a cosy chat to an element of regulation. Appraisers are being dragged, to a certain extent kicking and screaming, into that role and I think some will be uncomfortable and will leave and will go and will be seeking to set up mentoring systems. 0SCROM1

Aside from the overarching formative/summative contradiction contained within the Activity there are other primary contradictions that are not unique to individual components. For example, evidence in various forms, including clinical data, patient feedback and complaints, was an area of concern to our interviewees for a number of different reasons and therefore is represented in different components of the CHAT system.

Division of labour and Tools both present ‘evidence’ as an internal contradiction but again for different reasons. Evidence forms a contradiction in The Division of Labour in relation to who is responsible/able to collect that evidence and process it. Whereas, evidence in Tools
relates to the form of that evidence and the systems/processes for its collection and presentation. A connection is created between them through the Rules which determine the power relations embedded in the access to/the use of/ and the efficacy of the Tools.

By using CHAT we were able to understand how the Community works through the Rules to establish the power hierarchy in the Division of labour by determining the form of the Object. The more components within an activity system that contain a specific element, i.e. ‘evidence’, the more significant to the whole system that element becomes and the greater its potential to effect change becomes.

6.2.4 Secondary Contradictions
Secondary contradictions appear between the components of an activity system, they are indicated in Figure 8 by solid arrows.

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**Fig. 8 Secondary Contradictions**

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Secondary contradictions were clearly identified by our participants. Taking secondary contradictions pertaining to the subject by way of an example we can see how these are recognised as being played out in practice.

For example, in the Subject/Artefact contradiction one GP (Subject) recognised that patient feedback as evidence (Artefact) was potentially flawed:

> Am I going to choose the patient that doesn’t like me? No, of course I’m not. I’m going to choose the patients that think the sun shines out of my bottom. They will be the one’s filling in the forms if I have a say-so in that. ... – is that meaningful? 0PCAEFF2

If it is impossible to create the necessary Artefacts to achieve the Object (revalidation), the Subject may need to supplement, re-design or abandon the Artefact. One secondary care appraiser recognised that for appraisees to collect clinical data there was “a particular problem with that here because of the way that the hospital collects data” (1SCLAERM). Therefore hospital systems are likely to impact on the success of the Object (revalidation).

As the above example demonstrates there is often more than one secondary contradiction between components. In the relation between the Subject and the Object, the Subject (doctors) needs to work to maintain the Object in a form that is relevant. This appraisee, for example, recognised that should revalidation reduce appraisal to a purely summative exercise then it would cease to be relevant to individual doctors.

> It depends on how creative and human the appraisers are going to be; if they’re going to be box ticking bureaucrats then yes, we’ll have lost a valuable method of formative education. 1PCEAEFF7

The doctor is referring to the underlying formative/summative contradiction at the heart of the activity. We identified the attendant risk of the Activity becoming a contested site with members of the Community seeking to determine the Object in a number of interviews. In this typical example the interviewee expresses confidence in the extant systems ability to achieve the Outcome, namely increased public confidence and the assurance that doctors are ‘up to date and fit to practise medicine’:

> Cardiac surgery, more than any other specialty in the land has already gone through an immense process of introspection. We are the most closely scrutinised individual practitioners of any branch of medicine. So, no, this won’t make a blind bit of difference. 1SCEESM3
The *Rules* both act on the *Subject* and are in turn acted out by the *Subject*. The less specific the *Rules* become the more scope for certain *Subject’s* to capitalise on their inherent contradictions.

I think you might weed out someone who isn’t performing, you know perhaps their operation rate success rate isn’t as good as it should be, um or um, or a doctor who has a lot of complaints against them for example, those sort of things can be lit up but I still think lots of potentially dangerous practices can slip under the net because at the moment you’re just relying on the evidence that you get in an appraisal and that evidence is generated by the doctor who you’re appraising, and they could bring anything, they could bring stuff that’s completely made up and I would have no way of checking that. **OSCAERSF1**

The subject position and ‘status’ of the *Subject* determines the *Rules* applied. In the above quotation the appraiser is suggesting that a hierarchical power balance between the appraiser and appraisee is not clear, with the appraiser reliant on the honesty of the appraisee to make a judgement. This may be particularly relevant where the appraiser is not in the appraisee’s specialism.

### 6.3 Discourse

Appraisal leading to revalidation does not occur in a vacuum. There is an emerging body of literature discussing the changing face of medical regulation in the context of wider socio/cultural change and the impact of this on the profession and medical identities\(^\text{28}\), and indeed many of our participants recognised this wider context:

I think revalidation is something which actually moving into the future, doctors for years and years and years have been seen to be their own judges and jury, and in any modern world we wouldn’t accept that from almost any other profession. We’ve got away with it as a profession because by and large we’re highly respected, and by and large we are acting in a way that does demonstrate that we have patients’ interested at heart, the difficulty we’ve got of course is that as society becomes more customer-focussed and more challenging that’s going to be put to the test, and revalidation is one way to actually meet those challenges. **01PCROM1**

Any analysis of revalidation therefore needs to be understood against the backdrop of these changing professional and regulatory discourses.

6.3.1 Language

I suppose I think of it largely as a hurdle, that’s an Olympic hurdle. Um and perhaps the appraisal is like a small hurdle which you have to jump over five times. And eventually getting to more of a pole-vault sort of hurdle. That makes it sound very negative and very um ticking a box sort of thing and there is more to it than that obviously, um so perhaps the hurdle would be more of a sort of opportunity for reflection and looking at practice but I’ve got no idea how I would draw that. ... each year you would be reflecting and reviewing your practice and you’d have to use last year’s reflection to reflect on that and you know, just so it yeah, each one would be sort of doing this and then doing this and doing this [referring to drawing], lots of circles sort of going back to the beginning and then each time perhaps getting a bit better and higher. OSCAF1

The metaphors used by our interviewees are employed as a rhetorical device in arguing both promotion and critique of revalidation. Whether employed consciously or not, they have resonance for the interviewees and thus provide insights into the structuring of their perceptions.

George Lakoff and Mark Johnson have stressed the fundamental role of metaphors in the communication of ideas, the construction of cultural engagement with concepts and the structuring of our patterns of thought29. However their cognitive linguistic approach tends to ignore the contextual specificity of language which in this case we felt to be highly relevant.

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Therefore we adopted a more discursive approach by focusing on metaphors as units of language used within specific conversations rather than simply as an organising principle\textsuperscript{30}.

The metaphor of revalidation as a journey was a dominant one not only in the interviews but also in the drawings which predominantly used arrows and lines either to visualize the idea of movement or as a map. Even when the journey was strewn with obstacles, as in the visualisation above, there is still a sense of progression.

The metaphors relating to movement in a direction were split into metaphors that expressed the discourses of formative and summative assessment. The formative part of the process (appraisal) was expressed through ideas of moving forward. Perhaps moving along a spiral rather than a direct line, but progressing nevertheless. The summative part of the process (revalidation) was seen as an end point.

One of the key analogies used was ‘ticking boxes’ which came through in the transcripts and the drawings. Regardless of their pro or anti stance on revalidation it was agreed that should the process become a ‘tick-box exercise’ then it would serve no one. Terms like ‘reduced to’, ‘degenerate into’ and ‘become just a’ were used to qualify this potential outcome. The most finite representation was of a hanged man (0CCAEM1)

Inevitably revalidation is shot through with the language of quality assurance and management since these are key discourses underlying wider socio/cultural demands for accountability. The trope of fitness forms a metaphoric link between the individual and the system. Revalidation is repeatedly defined as ensuring doctors are ‘fit to practise’. It is a prominent phrase in the clinical governance lexicon and its use is promoted in the GMC literature. That the idea of fitness is already present and that “up to date and fit-to-practise” has almost taken on the form of a mantra should not obscure the underlying ideology of control and compulsion, but rather alert us to it by its ubiquity. Fitness embraces clinical governance and professional discourses and harnesses them to a set of relational metaphors that have found favour in the vocabulary of management culture and this reflects a growth in managerialism since the 1980s identified by our interviewees.

In the quotation below, our interviewee uses appropriate metaphors to reflect this contextualisation of revalidation. Importantly this participant suggests that the ‘anxiety generated’ is also part of the ‘industry’ of revalidation:

Well I think there’s going to be a lot of anxiety, agitation in the doctors, it’s also going to create a bit of an industry, and industry of revalidation, I don’t know if that’s a good thing or a bad thing but it could be both, but I certainly think there is going to be a lot of bureaucracy attached to it, a lot of time and resources are going to be consumed with this. 1CCAERM1

Another participant referred to revalidation as a ‘rubber stamp’ on a doctors’ practise (OPCAERF1) which like the kite mark (13 references coded over 5 transcripts) as a signifier of a standard, provides a visible and familiar graphic surety. The caduceus suggested by the RO in the visualisation below uses an established medical signifier to imbue the logo with the authority of history.

6.3.2 Practice

It’s the good old British Kite Mark thing, so you can put whatever symbol you want on it, you can have your wiggly snake with the staff on there but there’ definitely something about Kite Marking. Any doctor working anywhere in Britain so that you know that their training and development, they’ve been through a quality assured process. Now inevitably in something as big as the NHS that quality assurance is going to vary and that’s the key challenge in all of
this, there are some other big challenges I would point out but the big key challenge is about how you actually make sure that the process is consistently there. 01PCROM1

Revalidation was not regarded as a magic bullet:

Appraisal is the means by which the doctor actually provides the evidence that the revalidation decision is made on. As a Responsible Officer I would take a view that in the vast majority of doctors an appraisal that is geared up to meet revalidation will be all that’s needed in terms of assurance but there is all sort of other stuff out there which won’t come through the appraisal process and that might be soft intelligence, it might be information that I know about the doctor or I’m fed by others, and at some point I’ll have to make a decision about whether I would happy to have that doctor licensed to practise for the next five years, or whether I’m not, and all of that information won’t necessarily come through appraisal. So I think appraisal is a big chunk of the quality assurance process but it’s not the whole thing. 01PCROM1

While this RO did not think that revalidation would capture everything another RO held a contrasting view that revalidation would capture information that was not captured elsewhere:

Okay I suppose what I think it’s about is thinking a little bit about the sort of swiss cheese approach to kind of governance … there’s all these different processes try and keep the service safe and that perhaps what’s what revalidation is trying to do, is to add the sort of belt and braces to that … there’s lots of processes that go part way … but the revalidation is trying to provide that sort of final seal if you like to keep everybody to keep the patients safe and it’s trying to make up for if you like perhaps the fact that some of these other processes are [pause] have gaps and are imperfect 0CCROF1

These two viewpoints contrast a top down with a bottom up model of regulation in which either will stand or fall depending on the quality and comprehensiveness of the evidence presented and the evidence available.

Evidence was a key concern for our participants, predominantly the appraisees, who expressed concerns about the quantity and quality of evidence required and in secondary care the accuracy of centrally generated data. One key concern was that the self-selection of evidence for the portfolio was potentially open to abuse. In a typical comment

My appraisal is totally based upon what I want to put in it, and I could easily – I’m sorry I don’t know how confidential this is, and I am not saying that I do, but I could miss things out. I could easily just leave something off that I didn’t want to discuss with them. I could leave off a complaint and they wouldn’t even know. Because they ask you to put down your complaints, but they don’t check. 1PCAEEF6
Appraisees agreed that the skills of the appraiser were central to not only having a useful appraisal but also to draw out inferences or gaps in the appraisees data. We witnessed one appraisal where the appraiser drew on the evidence to flag up positives that the appraisee had not recognised in themselves.

It doesn’t look at your performance as a clinician um in any other way than self-reporting and you can put in as much or as little as you want to now it’s for the appraiser then to dig deeper and obviously that is quite a lot of work that needs to be done so [pause] I’m not sure that [pause] it will help the person that is doing well um it’ll help the person that is bumbling along it may not pick up the person who is um um um struggling.

Some interviewees wanted the evidence presented to be more comprehensive and felt short changed if the evidence they presented prior to the appraisal had not been given appropriate consideration or their appraiser did not give them much time.

This year I started well in time and then my appraiser was two months late seeing me. Which is totally – I wasn’t impressed with him as you can tell – he was two months late seeing me and half an hour late on the day. ... I prepare a lot of paperwork – I didn’t get the impression that he had necessarily read it all. ... So he didn’t – hardly at all asked me to sort of justify anything I’d done, or prove anything I’d done. I’ve sort of found this to be the case with previous appraisers as well, with other people, so I feel that you could almost write anything you like and not be challenged on it. ... So I don’t think he asked challenging clinical questions at all actually. ... Very chatty.

Although there is a view that ‘done well, appraisal can be very valuable; done badly it can be superficial, discouraging and demotivating’ 31. The majority of appraisees felt that the appraisal was for their benefit and was strongly linked to their professional identity as a doctor who exhibited professionalism across the whole of their practice, whereas revalidation was for regulatory purposes. The quote below clearly makes the distinction between the processes and their predication on the discourse of professionalism, which we might equate with the private, in contrast to revalidation and the discourse of regulation situated in the public domain.

You’ve got here appraisal, which I regard principally for the appraisee, so we’re thinking about the Good Medical Practice headings, so it’s not performance but it’s about people’s performance in the clinical workplace and the problems they’re having and how they’re actually doing and it varies a lot on different specialities as how they present their performance and what data they bring to it, and there’s do they keep up-to-date, ... Whereas I see that the revalidation is much more about the hospital regulators if you like,
the GMC, having assurance that this person is up to speed, and the general public, I mean it is sort of designed to keep the politicians and the public happy, 1SCLAERM1

One GP suggested that an unintended consequence of appraisal being linked to revalidation might be that appraisers would not want to continue in that role.

I think the other unintended consequence is how appraisers might view it and most appraisers are in this job because they believe in this developmental bit of it, that’s the bit they believe in and enjoy and the other unintended consequence might be that appraisers start dropping out of it, because checking whether people have the right evidence and only being able to work with the information that appraisers give you will become less and less interesting, but also if appraisers feel that they are being checked up on more and have to report more and feel less safe and feel that if they pick up a problem and feel that they have dealt with it effectively, but that appraisee has problems later on, will they be held responsible? The responsibility of the appraiser I think hasn’t really been made clear, and while it’s a formative developmental process that’s fine because you still can, but is there a risk in the future that somebody will say, the appraiser knew about that, look I’ve seen the form and why didn’t the appraiser address it and they have now killed somebody and will that have an effect either in the way the appraiser works with the doctor, or people will just decide that they don’t want to do it anymore. [pause] Does that make sense? 1PCAEEF5

One surgeon we interviewed had already made the decision not to continue to be an appraiser, stating “I’m happy to be an appraiser, but I’m not going to be a revalidator” and giving their reasons:

Well the implications are completely different. So as opposed to just being a friendly discussion to help someone develop in their appraisal, is now going to become an assessment, and I’m not an assessor of my colleagues. I’m not – I am an examiner for postgraduate medicine and I am heavily involved with undergraduate education, so I’m quite comfortable with assessment, but I am not comfortable with assessing my colleagues, in this role. ... It’s too early to say what I think about the process because it hasn’t even started yet, but I think – the whole thing is based around the mistrust of doctors and I don’t really want to be a part of it, to be honest. 1SCAEESM3.

For one participant the issue of confidentiality and the lifetime of appraisal data were important:

Nobody can guarantee to me that everything that goes on an electronic site is confidential ... we’ve moved from an appraisal which is a meeting between you and your appraiser with revalidation where somebody else has to have a view to recommend you for revalidation and there are some things, there was in that interview, where I’m happy to show my appraiser but I would not be happy to put on an electronic site for who knows to see, because it’s confidential. 1SCAEESF2
When I think about revalidation is something like a chessboard. and then you put your various pieces, so we’ll just call them x, y, z, but they could be kings, queens and stuff. So what I feel about revalidation is actually you’ve got a grid and you’ve got all your different pieces which make up your different Medical specialities. The different types of doctors that are out there, and but, and they’ve also got their different routes across the board, however, the ultimate objective is the same which is to get to the other end of the board and I suppose intimately checkmate GMCELOM1

Using the metaphor of a game of strategy the GMC employer liaison officer, perhaps more than anyone else recognised that doctors are not a homogenous group. Revalidation is a single system to regulate doctors and as such it cuts across the boundaries of medical identities. Our participants identified two boundaries in particular that related to specific types of group identity, namely specialism and generation.

In the chessboard metaphor there is not only an acceptance of difference between specialisms but also the implicit acknowledgement of power differences between ‘pieces’ and different ways of achieving the required end (revalidation).

There was a strong sense of identity across the Trusts and alignment with individual doctors’ Royal Colleges.
Although revalidation is part of the GMC’s regulatory structure the websites of the individual Royal Colleges provide their members with advice and templates that can be used in revalidation. This reinforces the institutional structure of medicine and speaks to the distribution of power within the profession. In one example relating to patient feedback one appraisee recognised that there were definite roles for the Royal Colleges in revalidation:

I mean radiologists will be looking at x-rays and they don’t see the patient. They won’t be dealing with a patient the way a surgeon does. So there’s whole pockets where this idea of everyone has to have patient feedback for revalidation just, you know the colleges need to be really heavily involved in what this actually means. I think the anaesthetists are on the case but I can’t comment on the others. SCAEESF2

There were varying opinions as to the appropriateness of being appraised by an appraiser who did not share the appraisee’s specialist knowledge. For example:

I’ve appraised a couple of people who aren’t in my speciality and actually for them it was a lot easier to keep some of their outcome stuff cos they’re frontline clinicians, so in terms of some of the things that appear on Dr Foster and things, it’s very easy for them to keep some of that. But yeah they said they found it very useful being appraised by someone outside their speciality. SCAEESF2:

And there was also the acknowledgement that revalidation was not a mature process and would need time to develop:

Yeah and when you are appraising somebody of a completely different speciality and you’re talking to them about their, you know, CPD, I don’t really know what CPD a specialist thyroid surgeon needs to do. I just rely on what he tells me he needs to do, but perhaps another surgeon would be able to challenge more, so I think it’s probably a good combination to do some outward and some within, yeah. ... I think you’ve got to be pragmatic, we’re only just starting off and again fifteen years down the line probably have a much more robust mechanism for changing appraiser specialities. OSCAERF1

Linked to the development of revalidation over time was the mobilisation by our participants of ‘generation’ in their formation of medical identities through the stated assumption that there was a generational divide between those doctors who would embrace, or at least accept revalidation, and those who would not.

There was a sense that there was an apparent ‘given’ in medical discourse that older doctors are resistant to formal professional regulation, and to revalidation in particular. Key
to this perception is the view that older doctors regard regulation as a bureaucratic procedure rather than an integral part of the development of a new professional landscape.

Although our participants were from a broad age range they made broadly similar assumptions about generational attitudes to regulation regardless of their own age. In the quotation below, the GP is tacitly acknowledging the swansong of professional autonomy.

I remember when the idea of appraisal and revalidation first came out and I was very much a young GP and older GPs were very much against it, this is an affront on our autonomy,

Generation can be evoked as a source of community by constructing collective identities to which individuals supposedly feel attachments. With a sense of community there is an opening for nostalgia and potentially a loyalty to older work practices\(^{32}\). We certainly found that doctors who had been through a number of appraisals and were in a position to compare and contrast over time expressed concern about the more prescriptive requirements of revalidation.

I sit in the middle of the generations. No one ever says, you’re too young to be a doctor to me anymore. [laughs] but equally I can still see that I have more benefit of technologies and that it’s not as awful as it might be to some a little further down the career path.

The scope of revalidation means that the process will be most efficient online, and the IT skills gap between younger and older doctors was highlighted quite often – with some older doctors confiding that they found IT difficult. The embracing of technology and the ability to be reflective by the ‘new generation’ of doctors was an important part of the generational distinction and it was located in education.

The perception across the age range of participants was that junior doctors were better equipped to answer to the demands of a more regulated practice, not that they were more skilled doctors. This perception has implications for inequality in the workplace as the requirements for successful revalidation become more rigorous. Much was made by participants about how medical education was preparing a new generation of doctors for a more regulated and reflective practice.

In general practice and in community health there was a strong collegiate sense and appraisers and RO’s spoke about the importance of ‘local knowledge’ and ‘soft intelligence’.

This was less marked in secondary care where teams often formed and re-formed. Indeed one RO stated a number of challenges he anticipated including the most pressing challenge of getting an accurate ‘real time’ list of doctors working in the Trust “which has captured the guy who was appointed this morning and the three that retired last week, just knowing who’s there”.

The next challenge is to ensure that the scope of practice, the whole scope of practice is brought to the appraisal. So what I mean by that is if you have a couple of orthopaedic surgeons and they work a day a week in a private hospital, then you need to know about that. And how that’s managed is important for the private hospital and their patients, but also for the R.O, who will be me here. So for orthopods who are doing their work over there, which I’ve got no management jurisdiction over whatsoever, but I’ve got a professional responsibility, so my board’ll think “hang on we’re actually paying for the Duchy’s and they’re our competitors.” So there’s stuff that will be interesting. See what I mean.

The inadequacy of current hospital technologies for the purposes of collecting evidence for revalidation, was cited by a number of participants.

[The data] that the organisation collects information for [is] money and waiting lists and what it sees as its imperative political targets, most of the computing that we’ve got is not set up to make clinician’s lives easier. Or patient’s life for that matter, you know it’s set up to kind of serve the commercial part of the organisation. ... but if you go to your GP’s surgery all the notes are electronic, they’re going to call everything up, call up the results, it’s easy to do. Here the notes are an absolute mess, paper records still, volumes of them, not very well filed, getting worse and worse.

There was a clear perception of significant differences between the Trusts in terms of their data systems. In secondary care there was a perception by appraisees, appraisers and the RO that their Trust lagged behind primary care in this respect. The RO as noted above cited the challenge of even keeping the list of employees up to date.

The person tasked with commissioning a system for primary care was pragmatic about moving to a totally online system simply because of the logistics of trying to maintain and store paper based system. They described the new system they were considering buying into in glowing terms.

Well the beauty of the system we’ve chosen is that no matter where you are in the country you could still input, you still have access to your folders and files and stuff, and also on transfer, so if somebody was going to change performance list and go and work in a
different part of the country and stuff, ... the company will actually facilitate the shifting between performance lists and things of that nature so you know, part of the perks of this system was the support that they gave to GPs that were moving in and out of the area so that was one of the kind of ticks that put them above the others really. 1PCSTMF1

This system facilitates the type of ongoing inputting of data that many doctors described as desirable. With most stating that they needed to be more systematic and organised about collating and saving data towards appraisal throughout the year.

One GP appraiser made a blanket statement about doctors not wanting to ask for help even when their Trust funded a support group called ‘Doctor’s Friends’.

For some reason doctors find it very difficult to seek help and um it is probably a case of it’s fine, it’s manageable, they don’t need to seek help. But yes they find it very difficult to seek help but they have got Doctors’ Friends etc., ... doctors who are being seen by Doctors’ Friends are people who have been referred by other agencies, people referring themselves to Doctors’ Friends I think is a rarity. 0PCAERF1

Another GP (OPCAEEF2) noted that this was changing with junior doctors not being afraid to ask more senior doctors for help.

There was a sense that existing support systems across the Trusts were fit for purpose;

If a problem is found with a doctor, how are they going to address that issue, who’s going to pay for all those issues and then needs to be ceased out, but I can’t understand how different is that process going to be, what we already have now for the appraisals, we have a process, the government just wants to make sure that that same process exists for the revalidation as well. If anything’s going to happen with the revalidation that’s already happening with the appraisals, if there are concerns, if there are issues, those are being picked up. 0PCAERF1

There are already plenty of avenues to take people who are having problems, you know with occupational health and peer support and everything. Some people will always find it difficult to be helped and I don’t think revalidation is going to help them any more than the current processes that are in place. 1SCAEESM3

some people that have been well supported by the Deanery sort of getting back into supervised practice for a while but it’s quite a difficult thing to sort out cos who’s going to do it, how is it going to be funded, where are you going to place the doctors whilst they’re sort of you know having this extra bit of educational stuff and how do you measure, where’s the value, you know how do you measure the output and that’s been well, and how are we going to get an independent sort of person or panel of people to say yep that’s all fine now, I think it’s quite complicated when you get into it and expensive. 0PCAEEM1

There was general agreement across the Trusts and between appraisers and appraisees that remediation as distinct from extant processes was not appropriately thought through. This
may relate to the lack of a central directive. The GMC Employer Liaison officer was quite clear that remediation needed to be organised locally.

you’ve probably heard many people at GMC would say remediation isn’t really for us. ...You know that’s very much I think for the RO, the employing organisation to work through with the individual doctors. My role is advise on whether something meets the GMC threshold and should be referred in or not. Um in terms of obviously you know, we need to be aware that a doctor’s taking remedial action but it’s not really for the GMC to put that in place or to, you know that’s very much a individual responsibility. GMCELOM1

One appraiser mentioned NCAS as having a role at a national level but this was the only mention of the organisation and the appraiser thought they would only look at the most “extreme” cases and did not know who would pay for that.

In response to the direct question “If you’re a doctor who needs additional support, do you end up paying for it or does your practice pay for it?” one GP described the potential knock on effects relating to the economic impact of remediation on small practices and working relationships with colleagues.

That’s a very contentious issue, because already, you’re shelling out for all these courses, and you’re having to get a locum to have the time off. I would, I think that would put a lot of small practice, you know a practice with two or three doctors in it, that would probably bankrupt them. ... We used to be two separate practices in this building here, and we have had merged. And we’ve even had talks about merging with another big practice to make a super-surgery and I think with commissioning and all that we are being drawn together already. I would have thought the number of people needing active retraining would have been quite low, but if you happen to have one of those doctors in your practice, it is going to cause a lot of resentment. Basically, if you’re asking the other fellow partners to subsidize the retraining out of their income, there could potentially be big problems. Given time, they might give people the heave ho, rather than support them through, because it is a very expensive process. ... One would hope if you had a doctor who was under performing to the level that they failed revalidation that their partners would be aware of the situation and would be taking steps to put them back into the alignment that they were failing revalidation. But you never know. Some practice GPs don’t even talk to one another in the corridors. 0PCAEEM3

Across the Trusts it was generally felt that revalidation was an opportunity to “pick up” issues before they became problems. This comment from a secondary care RO is fairly typical:

Employers who can pick up doctors in difficulty quicker, and therefore manage them with less expense and less heartache and less difficulty and less recourse to draconian disciplinary, because I think if you do this right you will pick up people early um and help get them on track early and doctors themselves who are in difficulty should benefit from this immensely. 0SCROM1
7 Findings

Medical revalidation is set to change the way doctors are accountable for their practice. It will impact across the profession from the most junior doctor to the lead consultant. As a universal system it is important that it is equitable across the workforce and supports individual doctors in their professional development.

The contradictions we identified by using the CHAT model enabled us to understand how the separate components of appraisal leading to revalidation interacted. Using the model we were able to identify the tensions between the separate elements that informed our findings.

We found, not unsurprisingly, that there was a significant amount of uncertainty as to whether revalidation would achieve its aims, either at the micro-level of improving and celebrating individual medical practice or at the macro-level of public confidence in the profession as a whole. And this reflects the basic contradiction between the twin aims of revalidation: regulation and professionalism.

Anxiety was the common ground between these public and private facets of revalidation for the doctors. Our participants expressed both personal anxiety about going through revalidation and professional anxiety about revalidation not delivering assurance to the wider public. We found that anxiety was a common thread running through the three overarching, but not mutually exclusive, themes identified through the research: Professional identities; Appraisal for revalidation; Evidence of practice.

7.1 Professional identities

Revalidation will affect all doctors practising in the UK, yet they are not a homogenous group. This can be described as a primary contradiction in the Subject element of the Appraisal activity system. While doctors and their practice varied enormously, we found group identities to be very strong not just in terms of specialism, as you would expect, but also the more subtle distinctions based on generational lines. Generation is cited as a key marker of difference in the professions’ attitude towards and preparedness for revalidation.

The scope of revalidation means that the process will be most efficient online, and the IT skills gap between younger and older doctors was highlighted quite often – with some more
senior doctors confiding that they found IT difficult. The embracing of technology and the ability to be reflective by the ‘new generation’ of doctors was an important part of the generational distinction and it was located in education. The perception across the age range of participants was that junior doctors were better equipped to answer to the demands of a more regulated practice, not that they were more skilled doctors. How we frame generationalism in the medical, or indeed any other workplace, will help to structure responses to generational difference. For example from an organisational point of view reliance on cohort and age-based understandings of generation can have a ‘closure’ effect – it is a simple/common sense way of identifying difference in an organisation – esp. medicine where there is a highly structured chronological career progression, hierarchically arranged jobs and well developed internal labour markets. This needs to be carefully considered in order that generation does not become a proxy for reactionary interventions.

Several interviewees discussed how coping and getting on with the job was a part of medical identity. With many interviewees believing the doctors generally found it difficult to seek or ask for help even when support mechanisms were in place. In part this resistance to help was ascribed to medical training with the acknowledgement that this was changing.

One of the benefits of revalidation, it was suggested, was that problems could be picked up earlier. This would not only benefit the individual doctor but also improve the service for patients and reduce costs in the long term.

There was considerable confusion about the processes in place for remediation. Primary care interviewees were particularly concerned about how it would be funded and the potential impact this could have on both the working arrangements in, and the structure of GP practices.

Our analysis of metaphors enabled us to recognise the heightened professional sensitivities engendered by revalidation and thus alerts us to areas that need to be addressed in taking the policy forward. Two key findings were the anxieties raised around the potential for evidence to be ‘hidden’ and the reliance on the skill of the appraiser in teasing out issues that may not be immediately obvious. There was no discussion about possible methods of

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quality assurances for appraisals: simply awareness that the appraiser changed every three years to prevent the relationship becoming ‘too cosy’.

### 7.2 Appraisal for revalidation

Much of the resistance we encountered to participating in the research stemmed from our recording of appraisals. The appraisers (who are also appraisees) who we spoke to as part of the recruitment drive, clearly felt that the appraisal was an intensely personal encounter that it was inappropriate for others to witness even if it was not expected that the appraisal would turn up any issues.

The personal aspect of appraisal was more significant in primary and community care where the appraisers stressed that the appraisal contained an important pastoral element and the process of capture may have a negative impact on the appraisal. The pastoral component was less of an issue for doctors in secondary care which strongly suggests a disparity of objectives and process between the Trusts and it mirrors the opinions expressed by the ROs for the Trusts in interview. It also demonstrates a level of ‘protection’ adopted by the appraisers which deserves further investigation.

Two appraisers refused to consent to appraisals being recorded even when the appraisees were willing to participate and this prompted the question about who ‘owned’ the appraisal.

Although we were not able to video many appraisals we found that the form and content of an appraisal was largely dependent on the appraiser. We witnessed appraisals taking place in busy hospital offices, we were told of appraisals scheduled to take place in people’s homes, sometimes they took place in front of computers and were written up simultaneously, others had more of a conversational format and were written up later from notes taken. Timings of appraisals varied from between 20 min to 2 hours. The secondary care appraisals we witnessed were the shortest lasting on average 45mins. Primary and community care appraisals lasted approximately 2 hours. We only had the opportunity to record one appraisal from primary and one from community care, but in interview other representatives of these groups supported these timings.

Linked to our observation of the different objectives for appraisal across the Trusts is the concern expressed by participants that revalidation could become the driver for appraisal.
Participants suggested several possible impacts that revalidation could have on appraisal, including:

- Appraisals would be less pastoral – either due to the requirements of revalidation or participants being less willing to share any issues that may potentially be detrimental
- Revalidation will drive ‘hard’ data collection and systems and this could be at the expense of ‘soft’ data and there was a risk that practice could become decontextualised
- If revalidation became over bureaucratic then it would detract from the very medical practice it was meant to support by taking doctors away from their patients.

There was a general feeling that some form of external regulation was necessary but there were concerns that revalidation could also undermine the positives of appraisal – no one wanted a ‘tick box’. Those who supported revalidation thought a tick box would diminish it while those who did not support revalidation thought it just added a meaningless and unnecessary layer.

### 7.3 Evidence of practice

We found significant differences across the Trusts in terms of the suitability, usefulness, availability and format of centrally generated and collated data. There was a clear perception that primary care was the most prepared sector with appropriate systems either in place or about to be invested in. Doctors in secondary care in particular felt that they wasted valuable time trying to find evidence and this made the process of collating the evidence very frustrating.

Many appraisees and some appraisers expressed concerns that poor data could be withheld by appraisees and only ‘good’ data presented in the portfolio as evidence of practice, with a secondary care RO stating that the requirement for ‘good’ data was already impacting on some specialities willingness to take on risky procedures. Appraisers and appraisees agreed that trust was a key factor with appraisers needing to trust that appraisees were presenting a true picture of their practice. The RO’s and one appraiser, who had formerly been a Clinical Director, described the value of local knowledge and ‘soft intelligence’ to supplement the evidence gathered for the appraisal by individual doctors. With the pending
changes to the Trust structures they were concerned that they would no longer be privy to this type of intelligence and this could undermine their judgement.

Where the patient featured in revalidation varied, although it was generally agreed that revalidation was for the benefit of patients and to reassure the public – their role in revalidation was however marginalised. Patients contributed evidence (and only some patients) rather than being part of the process.

The requirement of patient feedback as supporting evidence for revalidation is proving a concern to doctors across the sector. There are well worn arguments about the difficulty of gathering meaningful patient feedback for anaesthetists but we found more subtle concerns expressed linked to type of patient rather than medical speciality; for example the elderly, patients with mental health issues and/or addiction.

8 Conclusions

To date we have collected an immensely rich set of primary data through interview and the recording of appraisals. We have also found that the process of the research has given us significant insights into attitudes towards revalidation in practice across all levels/sectors of engagement. We are already witnessing the perceived and some of the actual consequences of appraisal leading to revalidation.

Revalidation will take time to inspire the confidence of individual doctors, the profession and the public. Siting appraisal at the heart of the revalidation process prompted fears that if revalidation became over bureaucratic then it would not only detract from the very medical practice it was meant to support but also fail to support doctors in any meaningful way. Appraisal, although highly valued by doctors is an uneven process and the ownership of the appraisal as it becomes the cornerstone of revalidation is far from clear.

This research, conducted as the first wave of doctors is revalidated has provided valuable insights into revalidation in practice which need to be set sympathetically against the specific and general anxieties expressed by doctors. Through the contradictions identified using the CHAT model the research has highlighted a number of inconsistencies that will
need further research and will need to be addressed to ensure that revalidation achieves its aims.

9 Recommendations

This timely research has provided a number of insights into the appraisal process as it leads into revalidation. The focus of this research has been regional but the findings from this research reinforces the urgent need for a much larger study looking at how good and poor performance is currently identified and managed. An expanded independent study would present the opportunity to identify regional variation over time and establish the generalizability of our findings. Our research methods have proved to be effective, but a larger scale research project should also include a questionnaire to complement the video and interview based data. A questionnaire is a well-established and cost and time effective way of collecting both descriptive personal experience and opinion it would provide a broader range of opinion on appraisal and the introduction of revalidation than interview alone. This extended research should be a longitudinal independent evaluation of appraisal leading to revalidation. The contribution of the participants indicates awareness, on their part, that the appraisal process can be undermined at various stages. As ethnographic studies in other institutions and organisations demonstrate, informal occupational practices often develop to shortcut or circumvent formal rules and procedures. There was no evidence of this from the data but it should be considered and reviewed through independent ongoing evaluation.

There is a need to develop an equitable and consistent standard of appraisal fit for the purposes of revalidation. In order to quality assure appraisal, more rigorous checks on evidence presented in appraisal will help appraiser and RO judgement making. This could potentially include a randomised appraiser selection to supplement/compliment self-selected evidence. It is important not to lose sight of the many positives that doctors agree appraisal brings as it leads into revalidation. There are two key aspects here, firstly that revalidation should not drive appraisal, and secondly that appraisal should neither be reduced to a ‘tick box exercise’ nor expanded into an unwieldy bureaucratic system.

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Remediation is an area of concern to doctors and this mainly seems to stem from a lack of clarity about who pays for what and in what circumstances. The GMC need to issue guidance that clarifies their role and the roles of others, particularly in terms of the cost implications. Research is urgently needed in this area in order to understand how remediation is being addressed in terms of both policy and practice in different areas and settings.

There is a very uneven pattern of data availability and suitability for revalidation across the Trusts. This needs to be rationalised in order to support doctors in the process of gathering evidence. This may mean investment in systems and administrative support in some areas.

Patient feedback needs to be more equitable. This leads to the larger question of clarity in relation to public and patient involvement (PPI) in revalidation, given that a key driver for revalidation was to reassure public confidence in the profession. More innovative ways need to be developed to ensure a wider range of patients are aware of and involved the process of revalidation.
Appendix 1: The 3 stages of research
Appendix 2: Ethics
Copy of approval letter from National Research Ethics Service (NRES)

HNS
National Patient Safety Agency
National Research Ethics Service

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22 September 2011

Dr Julian Archer
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Dear Dr Archer

Study title: What is Revalidation in Practice? Shaping the future development of Revalidation

REC reference: 11/WS/0012

Thank you for your letter of 19 July 2011, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to any NHS sites taking part in the study, subject to management permission being obtained from the NHSE/ECRO office prior to the start of the study (see “Conditions of the favourable opinion” below).
Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covering Letter</td>
<td></td>
<td>04 May 2011</td>
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<tr>
<td>Covering Letter</td>
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<td>19 July 2011</td>
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<tr>
<td>Covering Letter</td>
<td></td>
<td>19 July 2011</td>
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<tr>
<td>Evidence of insurance or indemnity</td>
<td>Ins. cert</td>
<td>02 August 2010</td>
</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
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<td></td>
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<tr>
<td>Investigator CV</td>
<td></td>
<td>06 May 2011</td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td></td>
<td>27 April 2011</td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
<td>1</td>
<td>14 July 2011</td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
<td>1</td>
<td>06 August 2011</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>1.0</td>
<td>27 April 2011</td>
</tr>
<tr>
<td>Participant Consent Form: Consent Form for Participants</td>
<td>2</td>
<td>14 July 2011</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>2</td>
<td>14 July 2011</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>1.0</td>
<td>27 April 2011</td>
</tr>
<tr>
<td>Protocol</td>
<td>1.0</td>
<td>01 November 2010</td>
</tr>
<tr>
<td>REC application</td>
<td>3.1</td>
<td>06 May 2011</td>
</tr>
<tr>
<td>Referees or other scientific critique report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
<td></td>
<td>19 July 2011</td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/SW/0112 Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project

Yours sincerely

ff

Dr Pamela Cairns
Acting Chair

Email: mindy.kaur@nhs.net

Endorsements: List of names and professions of members who were present at the meeting

Copy to: Nick Church, University of Plymouth PCMD
         Ms Pam Baxter, NHS Cornwall & Isles of Scilly PCT

NRES Committee South West - Central Bristol

Attendance at Sub-Committee of the REC meeting on 02 September 2011

Committee Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Present</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Trevor Baswick</td>
<td>Director - SW Medicines, Information &amp; Training</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dr Margrid Schindler</td>
<td>Consultant Senior Lecturer</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
Invitation Letter to Participants Version 1: 09.08.2011

Dear ,

We are writing by way of invitation to ask if you would be kind enough to contribute to our study. We are conducting a programme of enquiry, involving three separate but interlinked studies in order to explore Revalidation. The first project (Stage One: Policy) sets out to clarify the term and reported in June 2011. The second project (Stage Two: Practice) will assess its impact on clinicians, clinical practice, and contemporary attitudes/experiences of medical professionalism. A later third project (Stage Three: Public) will be used to engage the public in an examination of the impact of Revalidation on perceptions of medical professionalism and the relationship between the profession and society.

We hope you will be able to participate in Stage Two: What is Revalidation in Practice? We are asking you to undertake three things taking approximately 2 hours of your time:

1. A one hour focus group as an appraisee or appraiser
2. Allow us to videotape your appraisal (we will set up and take away the equipment but no researcher would be present during the appraisal)
3. A one hour interview using parts of your video to stimulate the conversation

In addition we will interview the Responsible Officer and members of the General Medical Council (GMC), who make the final decision about whether a doctor is fit or not to continue practising.
Transcripts of the appraisal videos will be analysed using conversation analysis and then the whole dataset will undergo activity and discourse analyses. The purpose of this is to generate a comprehensive evidence base from which to support and promote positive (while minimising and modifying negative) consequences of Revalidation. We plan to help shape Revalidation for you as a doctor both locally in terms of what and how things happen for you and your colleagues and ultimately nationally by informing policy.

Interviews and focus groups will focus on your viewpoints and experiences. You will be assured of confidentiality and the right to withdraw at any point. Following the interview, you will be given the opportunity to comment on, or query, any part of the interview process and the use of the resulting data. You will also be notified of the opportunity to check transcriptions for accuracy if you wish. We will combine your interview transcript with that of others and the resulting analysis will inform a report and a series of published papers.

We would be very grateful if you would consider undertaking this research with us. We have attached an information sheet and consent form. If you are happy to proceed then please return a signed consent form to:

Dr Julian Archer, Academic Clinical Lecturer in Medical Education, Peninsula College of Medicine & Dentistry, C408 Portland Square, University of Plymouth Campus, Drake Circus, Plymouth, PL4 8AA

Or electronically to julian.archer@pms.ac.uk

We will then contact you to arrange a convenient time and place to conduct the initial focus group and following interview.

Yours sincerely

Dr Julian Archer, Academic Clinical Lecturer in Medical Education,
Peninsula College of Medicine & Dentistry,
WHAT IS REVALIDATION IN PRACTICE: SHAPING THE FUTURE
DEVELOPMENT OF REVALIDATION

CONSENT FORM FOR PARTICIPANTS VERSION 2: 14.07.2011

I have read the Information Sheet Version 1 27.04.2011 concerning this research 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
2. I am free to withdraw from the project at any time without any disadvantage;
3. the data (video-tapes / audio-tapes and transcripts) will be retained in secure storage;
4. In the event that the line of questioning does develop in such a way that I feel hesitant or uncomfortable I have the right to decline to answer any particular question(s) and may withdraw from the research at any stage without any disadvantage to myself of any kind.
5. should I withdraw from the project then any data relating to me will be withdrawn and destroyed
6. the results of the project may be published but my anonymity will be preserved.
7. if anything was identified as being important in terms of patient safety during the focus groups or interviews (not appraisal), the research team would be obliged to share this information with the appropriate responsible officer. I would be made aware of this.

I agree to take part in this project.

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

..................................................  ..................................................  ............
(Printed name of researcher) (Signature of researcher) (Date)
Copies of approval letters from Community, Primary and Secondary Care Trusts (Cornwall)

Cornwall Partnership NHS

17 October 2011

Dr Julian Archer
Clinical Lecturer in Medical Education
C408 Portland Square
University of Plymouth
Plymouth

Dear Dr Archer

Re: What is Revalidation in Practice? V1

I am pleased to confirm that Dr Richard Laughame, Research and Development Director has reviewed the Trust Research Governance file for your study and is happy to grant approval on behalf of the Royal Cornwall Hospitals Trust subject to the following condition(s):

- All non-trust staff members of staff coming on site must obtain a letter of access before conducting study activities.
- We strongly recommend that all members of the research team undertake regular GCP training.

Research Governance

I would like to take this opportunity to remind you of your responsibilities as a Principal Investigator. These are:

1. Work must be carried out in line with Good Clinical Practice and the Research Governance Framework for Health and Social Services, which details the responsibilities for everyone involved in research.
2. The Data Protection Act 1998 requires you to follow the eight principles of ‘good information handling’
3. To provide information when requested for Trust research governance monitoring and auditing purposes
4. You must be aware of, and comply with, Health and Safety standards in relation to your research

For further information, please contact the Research and Development Directorate or visit [www.dh.gov.uk](http://www.dh.gov.uk)

Approved Documents

The documents reviewed and approved by R&D are as follows:
Adverse Events
Can I remind you that you must immediately report to the Research and Development Directorate any serious adverse event occurring during the study quoting the study reference number.

Outcome and Publications
Please keep the Research and Development Directorate informed of your progress to allow accurate submissions to the Department of Health in our Annual Report. You must also submit to the Research & Development Directorate a final outcome report on completion of your study. If you publish, please send a copy to the Directorate using the address above.

Yours sincerely

Mrs Amanda Dafson
Research Support Officer

cc Susannah Tooth
nick.church@pms.ac.uk
suzanne.nunn@pcmd.ac.uk
Blanca Mills
17 October 2011

Dr Julian Archer
Clinical Lecturer in Medical Education
C408 Portland Square
University of Plymouth
Plymouth

Dear Dr Archer

Re: What is Revalidation in Practice? V1

I am pleased to confirm that I have reviewed the Trust Research Governance file for you study and I am happy to give approval on behalf of the Cornwall & Isles of Scilly Primary Care Trust subject to the following condition(s): -

- All non-trust staff members of staff coming on site must obtain a letter of access before conducting study activities.
- We strongly recommend that all members of the research team undertake regular GCP training.

Research Governance

I would like to take this opportunity to remind you of your responsibilities as a Principal Investigator. These are:

1. Work must be carried out in line with Good Clinical Practice and the Research Governance Framework for Health and Social Services, which details the responsibilities for everyone involved in research
2. The Data Protection Act 1998 requires you to follow the eight principles of ‘good information handling’
3. To provide information when requested for Trust research governance monitoring and auditing purposes
4. You must be aware of, and comply with, Health and Safety standards in relation to your research

For further information, please contact the Research and Development Directorate or visit www.dh.gov.uk

Approved Documents

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Adverse Events
Can I remind you that you must immediately report to the Research and Development Directorate any serious adverse event occurring during the study quoting the study reference number.

Outcome and Publications
Please keep the Research and Development Directorate informed of your progress to allow accurate submissions to the Department of Health in our Annual Report. You must also submit to the Research & Development Directorate a final outcome report on completion of your study. If you publish, please send a copy to the Directorate using the address above.

Yours sincerely,

Jane Royle
Research Governance Lead

cc Susannah Tooth
nick.church@pms.ac.uk
suzanne.nunn@pcmd.ac.uk
Blanca Mills
17 October 2011

Dr Julian Archer
Clinical Lecturer in Medical Education
C408 Portland Square
University of Plymouth
Plymouth

Dear Dr Archer

Re: What is Revalidation in Practice? V1

I am pleased to confirm that Professor Anthony Woolf, Research and Development Director has reviewed the Trust Research Governance file for your study and is happy to grant approval on behalf of the Royal Cornwall Hospitals Trust subject to the following condition(s):-

- All non-trust staff members of staff coming on site must obtain a letter of access before conducting study activities.
- We strongly recommend that all members of the research team undertake regular GCP training.

Research Governance

I would like to take this opportunity to remind you of your responsibilities as a Principal Investigator. These are:

1. Work must be carried out in line with Good Clinical Practice and the Research Governance Framework for Health and Social Services, which details the responsibilities for everyone involved in research
2. The Data Protection Act 1998 requires you to follow the eight principles of ‘good information handling’
3. To provide information when requested for Trust research governance monitoring and auditing purposes
4. You must be aware of, and comply with, Health and Safety standards in relation to your research

For further information, please contact the Research and Development Directorate or visit www.dh.gov.uk

Approved Documents

The documents reviewed and approved by R&D are as follows:
Adverse Events
Can I remind you that you must immediately report to the Research and Development Directorate any serious adverse event occurring during the study quoting the study reference number.

Outcome and Publications
Please keep the Research and Development Directorate informed of your progress to allow accurate submissions to the Department of Health in our Annual Report. You must also submit to the Research & Development Directorate a final outcome report on completion of your study. If you publish, please send a copy to the Directorate using the address above.

Yours sincerely

Mrs Amanda Delson
Research Support Officer

cc  Susannah Tooth
    nick.church@oms.ac.uk
    suzanne.nunn@pcmd.ac.uk
    Blanca Mills
Approval letter from NHS Devon

Dr Julian Archer
Academic Clinical Lecturer in Medical Education
Plymouth Hospitals NHS Trust / PCMD
C408 Portland Square
University of Plymouth Campus
Plymouth
PL4 8AA

Devon, Plymouth and Torbay
NHS Devon
Public Health Directorate
Commissioning Headquarters
County Hall
Topsham Road
EXETER
EX2 4QL

TEL: 01392 267788 (Ext: 7611)

30 April 2012

Study Title: What is Revalidation in Practice? Shaping the future development of Revalidation

REC Reference: 11/SW/0112

Our Reference: PLY099

Dear Dr Archer

I have reviewed the Trust Research Governance file for your study. This letter confirms that the study named above has R&D Approval for the following Trusts, which are members of the Cluster of NHS Devon, Plymouth and Torbay

The conditions of this Trust Approval require you to ensure compliance with the following:

Adverse Events
You must report any serious adverse event occurring during the study quoting the study reference number to the Research and Development department. This requirement is in addition to informing the relevant Ethics Committee.

Outcome and publications
You must also submit a final outcome report on completion of your study to the R&D department. If your study takes longer than a year annual reports on progress will be required. A copy of any publications should be sent to the R & D Department, Admin Block, Mount Gould Hospital, Mount Gould Road, Plymouth, PL4 7QD, for inclusion in our Research Governance file for your study.

Research Governance
Please ensure that:
1. Accrual figures for your study are submitted promptly, as funding is based on activity.
2. Work is carried out in line with the new Research Governance Framework for Health and Social Services, which details the responsibilities for everyone involved in research
3. The eight principles of "good information handling" (The Data Protection Act 1998) are adhered to
4. You are aware of, and comply with, Health and Safety standards in relation to your research.

Please note that this Trust Approval applies to the documents listed below. Any changes and/or amendments must be notified to the R&D Office, whereupon a further letter acknowledging the changes will be issued.
### NHS Plymouth

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol</td>
<td>Version 1</td>
<td>29/03/2012</td>
</tr>
<tr>
<td>Patient information sheet</td>
<td>Version 1</td>
<td>27/04/2012</td>
</tr>
</tbody>
</table>

On behalf of the Cluster of NHS Devon, Plymouth and Torbay, I wish you every success with the study.

Yours sincerely

[Signature]

Dr Jain Lang
Consultant in Public Health, Cluster of NHS Devon, Plymouth and Torbay

Cc [Dr Suzanne Nunn](mailto:Dr.Suzanne.Nunn@plymouth.ac.uk), Research Fellow in Clinical Education, (Peninsula College of Medicine & Dentistry, C507 Portland Square, University of Plymouth Campus, Drake Circus, Plymouth, PL4 8AA)
### Appendix 3: Thematic coding of interview transcripts

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Appraisal and Revalidation</td>
<td>appraisal, 360, CPD, local knowledge, soft intelligence, mentoring, MSF, non-clinical, pastoral</td>
</tr>
<tr>
<td>Attitudes</td>
<td>negative, indifference</td>
</tr>
<tr>
<td>Challenges</td>
<td>administrative support, confidentiality, cost, data, time</td>
</tr>
<tr>
<td>History</td>
<td>professionalism, responsibility</td>
</tr>
<tr>
<td>Identity</td>
<td>analogies, buzz words and phrases, add value, checks and balances, dashboard, fit for purpose, fit to practice, up to date</td>
</tr>
<tr>
<td>Rhetorical strategies</td>
<td>add value, checks and balances, dashboard, fit for purpose, fit to practice, up to date</td>
</tr>
<tr>
<td></td>
<td>metaphors, personal examples, stereotypes</td>
</tr>
</tbody>
</table>

| Standards                            | audit, evidence, IT, IT standards                                       |
People
- appraisee
- appraiser
- doctors
- consultants
- locums
- outliers
- others
- patients
- public
- RO

Pilots
- clinical governance
- conflicts of interest
- NHS reforms

Politics
- accountability
- communication
- 'good medical practice'
- measurement
- regulation
- Fitness to Practice process

Processes
- safety

System
- commercial products
- organisations
- BMA
- DOH
- GMC
- GMC Connect
- individual NHS Trusts
- LMC
- networks
- royal colleges
- RST

performance