Chapter 1 Summary of British Cardiovascular Society’s Proposals

The British Cardiovascular Society has discussed and reviewed potential standards and mechanisms for revalidation for cardiologists in the United Kingdom on many occasions in 2008. The proposals here are the outcome of these extensive discussions and reviews, including several Executive, Board and Council meetings, and a one-day workshop during 2008. This paper is intended for a consultation with the membership of the Society, as well as for wider consultation with the cardiovascular community in the United Kingdom and elsewhere. Our proposals could also be used for discussion as a model for revalidation of cardiologists in Europe.

The British Cardiovascular Society proposes that revalidation of cardiologists should be undertaken in the following domains:

1. Knowledge based assessment:
   We propose that a formative demonstration of knowledge of the core and/or subspecialty curriculum should be demonstrated. The format would be formative (incorrect answers from the respondent would be explained with a correct answer), and the basic structure would be designed to ensure a breadth of knowledge across the subject in a Curriculum directed fashion. There would be a core knowledge requirement for general or acute cardiologists, and specific sub-specialty knowledge requirements for sub-specialists.

2. Skills based assessment:
   We propose cardiologists would use one or more of four potential levels in the hierarchy of assessments to demonstrate their competency in clinical skills:
   A. National Quality & Outcomes;
   B. National accreditation systems;
   C. Local Quality Improvement Program;
   D. Personal reflective logbook of procedures.

3. Demonstration of Professional Behaviour:
   **Essential requirements:**
   A. Details of current medical practice;
   B. Demonstration of annual Continuous Professional Development (CPD) activities over the five year revalidation cycle;
   C. Demonstrate involvement in clinical teams - Multi-source feedback (360° process), patient feedback (for example patient satisfaction surveys, etc);
   D. Demonstrate national audit and quality improvement - evidence of participation in national audits applicable to their practice; and evidence of participation in national quality control and improvement programs, applicable to their practice.
   E. Evidence of equality and diversity training
   **Voluntary requirements:**
   F. Intellectual participation and development (when undertaken);
   G. Leadership and managerial roles;
   H. Other professional work.
Chapter 2  Overview of governing bodies’ work

2.1  Department of Health plans

The report “Medical Revalidation – Principles and Next Steps” was published in July 2008 by
the Chief Medical Officer for England’s Working Group.¹

The Purpose of Revalidation

The purpose of revalidation is to ensure that licensed doctors remain up to date and continue to be
fit to practise. Revalidation has three elements:

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

Revalidation also:

• gives further focus and energy to doctors’ desire to keep up to date and improve their
  practice, through continuous professional development and reflective practice;
• aims to sustain and enhance public confidence in the profession as a whole by
  providing periodic assurance that doctors continue to be fit to practise;
• provides a process through which doctors who may fall short of professional standards
  in some respects can be supported in addressing them;
• acts as a driver for local clinical governance processes to provide the opportunity for a
  doctor to demonstrate they reach acceptable standards, to allow informed judgements
  about individual performance;
• identifies the small proportion of professionals who are unable to remedy significant
  shortfalls in their standards of practice and remove them from the register of doctors;
• lets the voice of patients and colleagues be brought in to reflective practice and the
  assessment and development of doctors’ practice; and
• is one of several mechanisms for improving the quality and reducing the risks of patient
  care, all of which must act in concert.

The report “Medical Revalidation – Principles and Next Steps” states that in shaping the way
forward, there are several key principles. These are that revalidation in the United Kingdom:

• must support doctors in meeting their personal and professional commitment to
  continually sustaining and developing their skills;
• should include within it a strong element of patient and carer participation and
  evaluation;
• should be seen primarily as supportive, focussed on raising standards, not a
  disciplinary mechanism to deal with the small proportion of doctors who may cause
  concern;
must include remediation and rehabilitation as essential elements of the process for the very few who struggle to revalidate, giving them help wherever possible

should be a continuing process, not an event every five years, so that problems can be identified and resolved quickly and effectively;

should avoid bureaucracy, add value and provide a reasonable level of reassurance to colleagues, employers, patients and the public;

should be introduced incrementally through piloting to ensure that it works well;

should provide reasonably consistent assurance of standards across the United Kingdom, whatever the practice model;

should be based on evidence drawn from local practice, with robust systems of clinical governance to support it; and

will depend on the quality, consistency and nature of appraisal to ensure the confidence of patients and doctors.

2.2 General Medical Council plans

The General Medical Council has published a paper on “The role of the GMC, the Academy of Medical Royal Colleges, Royal Colleges and Faculties in the framework for revalidation: Propositions for Revalidation”.

Proposition 1: There is a clear need to minimise burdens and avoid duplication. As a starting point, revalidation should be viewed as a single set of processes, with two potential outcomes – relicensing and, for those on the Specialist Register or GP Register, recertification.

Proposition 2: The purpose of recertification is to demonstrate that doctors on the Specialist Register or the GP Register continue to meet the particular standards that apply to their medical specialty or area of practice.

Proposition 3: In working on the form that recertification might take for individual doctors within specialties, the following principles should apply:

a. Recertification, including the standards and processes, devised by the Medical Royal Colleges and Faculties, and Specialist Associations, and approved by the GMC, must command the confidence of the GMC’s four key interest groups - patients and the public; the profession; the NHS and other healthcare providers; and the medical schools and Medical Royal Colleges.

b. Individual Medical Royal Colleges and Faculties, and Specialist Associations, should consider how doctors can best gather evidence for their specialty. The GMC and the Academy will have a role in ensuring appropriate consistency across specialties. The GMC will only approve proposals that comply with its principles.

c. Medical Royal Colleges and Faculties, and Specialist Associations, will be responsible for defining the standards appropriate to a specialty or area of practice and the methods used to assess them. Evidence should be drawn from a range of sources and activities, which may include appraisal structured on Good Medical Practice, multi-source feedback from colleagues and patients, clinical audit, simulator tests, knowledge tests, continuing professional development or observation of practice.

d. Appropriate standards, assessment schemes, arrangements for monitoring and delivery, and quality assurance must be in place before a recertification scheme is approved by the GMC.

e. Decision making processes and procedures for recertification must be fair, objective, transparent, and free from unfair discrimination.

f. Doctors will not need to be members of Colleges to undertake recertification.

g. As far as practicable, recertification of doctors on the Specialist Register or GP Register will coincide with relicensing. That is, where possible, there should be one process with two
Proposition 4: The standards for remaining on the Specialist Register and the GP Register will be the same as the standards currently required for entry to those registers. However, the range of competencies and evidence to be demonstrated for recertification will relate to the doctor’s actual practice.

Process of revalidation
The Health and Social Care Act 2007-08 became law with Royal Assent on 21 July 2008. This legislation introduces a local “Responsible Officer” (section 119) in each healthcare organisation who has the responsibility for:

a. conferring on the responsible officer for a designated body (= “healthcare organisation”) responsibilities relating to the evaluation of the fitness to practise of medical practitioners having a prescribed connection with that body, and

b. requiring a responsible officer for a designated body to co-operate with the General Medical Council, any of its committees, or any persons authorised by the General Council, in connection with the exercise by any of them of functions under Part 3A or 5 of this Act.

It is expected that a local Responsible Officer would be accountable for the local process of revalidation of doctors in that healthcare organisation, based on standards advised by the GMC, Royal Colleges or Specialist Associations. It is expected that the local Responsible Officer will review revalidation portfolios of individual licensed doctors every five years to advise revalidation to the GMC, or referral to regional GMC Affiliates or national GMC offices.

It is envisaged that the British Cardiovascular Society will advise on appropriate standards and mechanisms for recertification of cardiologists, including sub-specialist cardiologists. If individual cardiologists have questions or uncertainty about their revalidation, local sources of advice could include colleague cardiologists in their healthcare organisation, their clinical director, or the local Network Service Advisor of the British Cardiovascular Society.

Where the local Responsible Officer has uncertainty about revalidation of individual cardiologists, or proposes referral to regional GMC Affiliates or national GMC offices, then formal, independent, professional, specialist advice will obviously be required. The British Cardiovascular Society will establish processes and mechanisms to identify and propose independent, disinterested cardiologists in the relevant sub-specialty but outside the region who can provide advice, assessment, or propose remediation either to individual cardiologists, or to the regional GMC Affiliates or the national GMC office (or if agreed to both parties). The Peer Review process of the British Cardiovascular Society already has a long-established mechanism and process for identifying independent, disinterested cardiologists outside of the relevant region, which could also be used for this purpose. The sub-specialist Affiliated Groups of the British Cardiovascular Society are likely to have a similar role.

Possible national timetable:1 above

- Late 2008: pilot of GMC Responsible Officers (local);
- Late 2008 to early 2009: pilot of GMC Affiliates (regional);
- Late 2009: GMC issues licences to practice to registered doctors;
- 2010: Pilot recertification – perhaps for certain categories of doctors (for example by region or by country, by speciality or field of practice, by grade of doctor, or in primary or secondary care, etc);
- 2010-2012: Roll-out of first cycle of full revalidations.
Chapter 3  BCS Detailed Proposals

Re-licensing of doctors

The General Medical Council has published a Draft Framework for Appraisal and Assessment derived from “Good Medical Practice”\(^5,6\). This draft framework proposes generic standards, and sources of evidence for individual doctors, required to meet the standards of Good Medical Practice. It is expected that much of the information will be collected and reviewed as part of individual appraisal.

It is expected (depending on legislation) that the first round of licenses to practice will be issued to individual registered doctors by the GMC from late 2009. All licensed doctors will then be subject to future revalidation. It is planned that re-licensing as part of revalidation will be based on the demonstration of satisfactory appraisal.

The British Cardiovascular Society proposes that the information required for relicensing is collected and maintained in a personal revalidation folder or portfolio, alongside information collected and maintained for recertification of cardiologists.

Re-certification of cardiologists

The challenge for a successful revalidation process is to identify relevant methods by which doctors may demonstrate continuing clinical competence. Curricula provide an educational template with dynamic content, onto which domains of evidence, and respective formal methods of assessment, may be mapped. Conventionally, the educational structure of Curricula is threefold:

- Knowledge
- Skills
- Professionalism

The European Board for the Speciality of Cardiology (EBSC – a joint Committee of the European Society of Cardiology (ESC) and European Union of Medical Specialties (UEMS)) proposes to develop a portal or web site to a personal revalidation folder or portfolio, in which qualified Cardiologists can demonstrate evidence of continuing competency in Knowledge, Skills and Professionalism. The core and subspecialty curricula for cardiology trainees in the UK are almost identical with that of the EBSC.

This principle which applies to the general cardiologist may also be applied to the cardiology subspecialties.

3.1 Knowledge based assessments

For revalidation of cardiologists in the UK, BCS propose that formative demonstration of knowledge of the core and/or subspecialty curriculum should be demonstrated.

It is proposed that revalidation for Knowledge should largely lie within the formative use of multiple choice questions generated with respect to European Board for Accreditation in Cardiology (EBAC) approved ESC educational content (ESC Text Book, ESC Guidelines, journal articles, Education in Heart series, conference web casts and case discussions). Educational content would be available through the portal with multiple choice questions used to assure that the material had been read with due care, attention and concentration. Whilst the format would be largely formative – incorrect answers from the respondent would be explained with a correct answer, the basic structure would be designed to ensure a breadth of reading across the subject in a Curriculum directed fashion.

There would be the option of a final summative use of MCQs, with random selection of the questions covering the breadth of the educational content. A “pass mark” such as 9 out of 12 as currently employed in the “equality and diversity” accreditation web site, could be employed.
It would be expected that cardiologists undertaking general and acute cardiology practice should demonstrate their knowledge base across the core spectrum of the cardiology curriculum. Cardiologists undertaking specific sub-specialty practice in one or more sub-specialties should demonstrate their knowledge in those specific areas of the cardiology curriculum – for example in specific chapters of the curriculum. The specific breadth of knowledge that should be demonstrated could be linked to the specific responsibilities contained in an individual clinician’s job plan.

3.2 **Skills based assessment**

The British Cardiovascular Society proposes that clinicians demonstrate competency in their clinical skills by using one of four potential levels in the hierarchy of assessment:

A. National Quality & Outcomes
B. National accreditation systems
C. Local Quality Improvement Program
D. Personal reflective logbook of procedures

Individual job plans or procedural activities of clinicians should be linked to the demonstration of competency in clinical skills using one of these potential methods of assessment. In the longer term, assessment using National Quality & Outcomes, or National accreditation systems, is more likely to systematically drive up demonstration of quality of procedural skills, compared with local Quality Improvement Programs or personal logbooks.

A. **National Quality and Outcomes**

Existing systems:

The Central Cardiac Audit Database provides national secure and encrypted data collection systems with national audits of procedures and conditions. These include (and are professionally led by):

- Adult Cardiac Surgery incorporating the UK Heart Valve Register (Society of Cardiovascular & Thoracic Surgeons);
- Adult Percutaneous Cardiac Interventions (British Cardiovascular Intervention Society);
- National Infarct Angioplasty Project (Dept of Health & British Cardiovascular Society);
- Myocardial Infarction National Audit Project (MINAP – Royal College of Physicians);
- Cardiac Rhythm Management – Devices and Intervention (Heart Rhythm UK);
- Heart Failure (British Society of Heart Failure);
- Cardiac Rehabilitation (British Association for Cardiac Rehabilitation & British Heart Foundation);
- Rehabilitation for Survivors of Major Arrhythmia or Sudden Cardiac Death (British Heart Foundation);
- Congenital Heart Disease Surgery and Intervention (Society of Cardiovascular & Thoracic Surgeons & British Congenital Cardiac Association);
- Sudden Arrhythmic Death Syndrome (Dept of Health);
- Pulmonary Hypertension (Pulmonary Hypertension Association).

Individual clinicians should be able to download a summary of their personal caseload and procedures, with agreed and relevant quality and outcomes measures. This data would not include any individual or identifiable patient records. This summary for each year, and for the five year revalidation cycle, should be entered into their personal revalidation portfolio. Ideally, this summary data should be electronically transmitted by secure means directly into their personal revalidation portfolio.

Individual audits and subspecialty professional organizations should agree the appropriate data items to include in a summary of an individual clinician’s activity and outcomes.
Project development:

In order to develop assessment of quality and outcomes measures for individual clinicians, BCS has joined with the Royal College of Surgeons in a joint project to examine the principles and criteria for the development of outcomes-based "clinical dashboards" (a broad measure of outcomes resulting in a "balanced scorecard") that will provide reliable, validated information on performance, and play a vital role in the use of outcomes as a source of evidence for recertification. ‘Clinical dashboards’ is a relatively new term by which is meant an easily accessible method of presenting complex outcomes information to the appropriate audience. Application for funding for developing and piloting this project from the Academy of Royal Medical Colleges is being sought.

This project is taking a disease-specific approach (ischaemic heart disease - incorporating the work of general physicians, cardiologists and cardiac surgeons) to facilitate the measurement of performance of individual clinicians and the wider multi-professional teams in which they work. The project will examine how information about clinical outcomes can be extracted from routinely collected data sources and presented in an accessible manner in order to reduce administrative burden and strengthen the engagement of clinicians with local data collection and analysis.

B. National Accreditation Systems

Personal accreditation systems:

The British Society of Echocardiography (BSE) provides accreditation of individuals in specific echocardiographic techniques using written and practical assessments. This is renewable every five years. BSE accreditation has become the de facto standard for independent practice in specific echocardiographic techniques:

- Transthoracic echocardiography
- Trans-oesophageal echocardiography
- Community echocardiography
- (Echocardiography departments)

Departmental accreditation systems:

It is also proposed that if a specific service (for example a hospital echocardiography service) has received formal departmental accreditation through a professionally led accreditation exercise within the last five years, then all those cardiologists undertaking the specific procedures in that service could receive accreditation for revalidation purposes of their procedural skills.

C. Local Quality Improvement Program

Specific cardiology services should have or develop a regular quality improvement process.

For example, recommendations in the British Society of Echocardiography departmental accreditation guidelines include:

- Weekly meetings to examine challenging or difficult cases;
- At least four specific and formal quality control meetings per year with blind over-reading of studies;
- All staff should attend at least 50% of the meetings;
- A written or electronic documented record of these formal quality control meetings should be maintained, including the names of attendees, and the issues addressed, and plans for continuous quality improvement. This documentation should be adapted for access by individual clinicians for their revalidation portfolios, and for the Responsible Officer of the healthcare organisation.
For example, the Sussex Cardiac Centre has a formal monthly system of peer review:

- Every month 1 in 10 cases are reviewed by a committee of three (two experienced interventionists and one cardiothoracic surgeon);
- A systematic review is undertaken of the anatomy, the technology used, the strategy, and outcome. Case notes can be reviewed to provide further detail if necessary.
- Each month, the 3 member committee meets to review the cases chosen at random by the audit co-ordinator. In an average month 12-15 cases will be reviewed. All interventionists will have at least one case discussed per month. Cases performed by the committee members for that month will not be included.
- A feedback form for each case will be given to the individual operator, and all forms will be kept. A report will be presented at each Cardiac Network meeting.

A documented record of these formal quality improvement programs must be available to individuals for their revalidation portfolios, and to the Responsible Officer of the healthcare organisation. Cardiology subspecialties could define the appropriate frequencies, attendances, contents and processes of a multidisciplinary team meeting, for example when reviewing revascularisation procedures. There should be locally defined systems in Quality Improvement Programs whereby all individual clinicians undertaking procedures have their practice reviewed, for example random selection of cases to include all operators.

The lack of a local Quality Improvement Program should not disadvantage individual clinicians in demonstrating their continuing competence in clinical skills. If there is no local Quality Improvement Program, individual clinicians can use a reflective logbook of cases or summary of their activity as described below.

D. Personal reflective logbook of procedures

For specific procedures, a logbook of cases performed by, or under the direct charge and responsibility of, the individual specialist should be maintained. Evidence of reflective practice should be provided. Summary data for each year, and for the five year revalidation cycle, should be entered into the individual clinician revalidation portfolio.

This logbook should be maintained in an electronic record with the appropriate security and confidentiality requirements. The data should ideally be derived and extrapolated from existing databases and using existing data collection systems. For revalidation, this data would have to be made anonymous by removing any patient identification data, and appropriately encrypted for any transmission outside of NHS secure systems, for example to an EBSC / ESC web portal.

Dr Foster Intelligence provides an individual "Clinician Outcomes and Benchmarking" to support consultants in improving the quality of patient care. The data are derived from the Hospital Episode Statistics in England, and can be used to describe volume, activity and patterns of care for individual consultants. This data could be used by individual consultants to summarise their clinical activity and patterns of care each year, and over the five year revalidation cycle, by downloading the information into their personal revalidation portfolios. However, the Royal College of Physicians has published a report in 2006 stating that Hospital Episode Statistics data are not accurate enough to be used for monitoring the performance of individual physicians.

Summary of skills based assessments

Requirements for demonstration of continuing competency of clinical skills:

Individual cardiologists must provide evidence of continuing competency of their clinical skills in specific procedures using one (or more) of the above mechanisms. Individual specialist quality and outcomes measures using a "clinical dashboard" derived from existing national data sources would provide the highest level of assurance of maintenance of competency of clinical skills. If such systems are not available or yet developed for specific procedures, then individual specialists should have formal personal or service accreditation, or demonstrate evidence of participation in
departmental or regional quality improvement processes, or produce a personal reflective logbook of procedures.

3.3 **Professional Behaviour:**

Cardiologists should provide specific evidence of their professional activities and behaviour.

**Essential professional requirements for revalidation:**
(Mainly required for appraisal and relicensing.)

A. Details of current medical practice

- **Personal details:**
  - Registered name; registered address;
  - Main professional contact address;
  - Main professional contact telephone number;
  - Main professional email contact details;
  - Date of and name of institution granting primary medical qualification;
  - GMC registration number; date of first registration; date on specialist register;
  - Specialties registered; subspecialties registered;
  - Date(s) of previous appraisals;
  - Date(s) of previous revalidation(s);
  - Registration with GP;
  - Immunization record.

- **Employment details:**
  - Main employer, main place of work;
  - Other employer(s), all other places of work;
  - Date appointed to current post; title of current post;
  - Dates, employers and titles of previous non-training posts.

- **Practice details:**
  - Specialties currently practiced; sub-specialist practices;
  - Job plan or weekly timetable of clinical work;
  - Emergency, out-of-hours and on-call commitments; rota;
  - Out-patient clinics;
  - Theatre or laboratory based practice;
  - In-patient work;
  - Other clinical care;
  - Other regular clinical commitments (for example multidisciplinary revascularisation team meetings, imaging review meetings, etc).

B. Continuing Professional Development

The Academy of Royal Medical Colleges has published principles for Continual Professional Development schemes.\textsuperscript{11}

**Categories of CPD:**

- Clinical or non-clinical
- External, internal or personal

Certificates from the Federation of Royal Colleges of Physicians or similar annual and five yearly CPD records should be provided.
C. Involvement in clinical teams:
- Multi-source feedback (360° process) - it is understood that the General Medical Council is developing specifications and criteria for multi-source feedback systems.\(^{12,13}\)
- Multi-source feedback could be tailored for specific cardiac subspecialties or disease-based clinicians:
  - Specific questions (for example on consent processes for intervention);
  - Specific individuals or team members could be used as raters (for example for cardiac interventionists, feedback raters could be specified to include a cardiac surgeon, and one or more interventional cath lab staff such as a nurse, a radiographer or a physiologist, etc);
  - A specific MSF tool for revalidation of cardiologists could be developed which would satisfy the criteria being developed by the General Medical Council.
- Patient feedback (for example patient satisfaction surveys, etc).

D. National audit and quality improvement:
- All cardiologists should provide evidence of:
  - Participation in national audits applicable to their practice;
  - Participation in national quality control and improvement programs, applicable to their practice.

E. Evidence of equality and diversity training

Voluntary professional components for revalidation:

F. Intellectual participation and development (when undertaken):
- Research – abstracts, presentations, publications;
- Review articles, editorials;
- Formal lectures;
- Guidelines – creation, development, delivery, implementation;
- Audits – undertaken, completed, planned quality improvement, repeated;
- Formal teaching activities.

G. Leadership and managerial roles:
- Local;
- Regional;
- National;
- International.

H. Other professional work:
- Work for regional, national or international organisations;
- Any other professional activities (e.g. committees);
- Courses completed.
Chapter 4  Revalidation of cardiologists – mapping information to the GMC Domains of Good Medical Practice

The General Medical Council has published a Draft Framework for Appraisal and Assessment derived from “Good Medical Practice”. This framework is intended to be used for relicensing and revalidation. It is useful to map the sources and type of evidence provided by cardiologists to the GMC Framework:

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Possible sources of evidence</th>
</tr>
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<tbody>
<tr>
<td><strong>Domain 1 – Knowledge, Skills and Performance</strong></td>
<td></td>
</tr>
<tr>
<td>Maintain your professional performance</td>
<td>Knowledge based assessment (see 3.1) Skills based assessment (see 3.2) Professionalism – CPD (see 3.3B) Professionalism – participation in national audits or quality improvement programs (see 3.3D) Validated feedback (see 3.3C)</td>
</tr>
<tr>
<td>Apply knowledge and experience to practice</td>
<td>Knowledge based assessment (see 3.1) Skills based assessment (see 3.2) Professionalism – CPD (see 3.3B) Professionalism – participation in national audits or quality improvement programs (see 3.3D) Validated feedback (see 3.3C)</td>
</tr>
<tr>
<td>Keep clear, accurate and legible records</td>
<td>Professionalism – participation in national audits or quality improvement programs (see 3.3D) Anonymised records (see 3.2A)</td>
</tr>
<tr>
<td><strong>Domain 2 – Safety and Quality</strong></td>
<td></td>
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<tr>
<td>Put into effect systems to protect patients and improve care</td>
<td>Skills based assessment (see 3.2) Professionalism – participation in national audits or quality improvement programs (see 3.3D) Professionalism – CPD (see 3.3B) Validated feedback (see 3.3C)</td>
</tr>
<tr>
<td>Respond to risks to safety</td>
<td>Professionalism – participation in national audits or quality improvement programs (see 3.3D) Validated feedback (see 3.3C)</td>
</tr>
<tr>
<td>Protect patients and colleagues from any risk posed by your health</td>
<td>Registration with GP (see 3.3A) Immunization record (see 3.3A) Validated feedback (see 3.3C)</td>
</tr>
<tr>
<td><strong>Domain 3 – Communication, Partnership and Teamwork</strong></td>
<td></td>
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<tr>
<td>Communicate effectively</td>
<td>Validated feedback (see 3.3C)</td>
</tr>
<tr>
<td>Work constructively with colleagues and delegate effectively</td>
<td>Validated feedback (see 3.3C)</td>
</tr>
<tr>
<td>Establish and maintain partnerships with patients</td>
<td>Validated feedback (see 3.3C)</td>
</tr>
<tr>
<td><strong>Domain 4 – Maintaining Trust</strong></td>
<td></td>
</tr>
<tr>
<td>Show respect for patients</td>
<td>Validated feedback (see 3.3C) Policy/evidence of ending relationships with patients??</td>
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<tr>
<td>Treat patients and colleagues fairly and without discrimination</td>
<td>Validated feedback (see 3.3C) Professionalism – evidence of equality &amp; diversity training (see 3.3E)</td>
</tr>
<tr>
<td>Act with honesty and integrity</td>
<td>Validated feedback (see 3.3C)</td>
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</table>
Chapter 5  Conclusions: Re-certification of cardiologists

The British Cardiovascular Society proposes that revalidation of cardiologists should encompass the above tripartite assessments of knowledge, skills and professional behaviour.

Advantages of this approach include:
- Educational foundation, based on core and subspecialty curricula;
- Linking knowledge based assessment with assessment of competency in procedures;
- Linking practice with job plan;
- Allows credentialing of individual clinicians in procedures;
- Could be developed as a system for revalidation of cardiologists in Europe.

Possible timetable for BCS:
- Oct-Dec 2008: Consultation with BCS membership and wider UK cardiovascular community;
- Early 2009: define the requirements and content of a revalidation folder or portfolio for UK cardiologists; ensure that appropriate standards, assessment schemes, arrangements for monitoring and delivery, and quality assurance are included; work with EBSC/ESC on a web-based platform for revalidation of cardiologists;
- June 2009 at BCS Annual Scientific Congress: test-run a revalidation exercise for volunteer UK cardiologists using ESC web-based platform;
- Late 2009: pilot revalidation for UK cardiologists;
- 2010: roll out of revalidation for UK cardiologists.

David Hackett  
Vice-President, Clinical Standards Division  
British Cardiovascular Society  
October 2008
Chapter 6 Questions for consultation:

This consultation deadline is 31 December 2008. Do you agree with the British Cardiovascular Society proposed approach to revalidation of UK Cardiologists?

### Overall proposals:

<table>
<thead>
<tr>
<th>1. Revalidation should include the three educational domains of a cardiologist? (Knowledge, Skills and Professionalism)</th>
<th>Please select one response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree, Agree, Disagree, Strongly disagree</td>
<td></td>
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</table>

### Knowledge based assessment:

| 2. There should be a formative assessment of knowledge based on the cardiology curriculum? | Strongly agree, Agree, Disagree, Strongly disagree |
| 3. For general and acute cardiologists, there should be a formative assessment of a breadth of general cardiology knowledge across the general cardiology curriculum? | Strongly agree, Agree, Disagree, Strongly disagree |
| 4. For cardiologists practising in specific subspecialties, there should be a formative assessment of specific knowledge in those subspecialties? | Strongly agree, Agree, Disagree, Strongly disagree |

### Skills based assessment:

| 5. There should be an assessment of procedural skills using one of several different potential methods to demonstrate competency? | Strongly agree, Agree, Disagree, Strongly disagree |

### Other comments (please continue on another sheet if necessary):

Are there any items which should be excluded from revalidation?

Are there any items which have not been included and should be included in revalidation of UK cardiologists?

Any other comments?

You do not have to provide your personal details, but if you are happy to do this please complete the following information:

Name: ___________________________ Position or title: ___________________________

Region of UK: ___________________________

Alternatively, you can forward comments, suggestions, criticisms, etc to:

Dr David Hackett
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9 Fitzroy Square
London, W1T 5HW

By Fax to: 020 7388 0903
By email to: revalidation@bcs.com
References


