in working patterns, and funding for study leave.

In preparing for appraisal we must therefore think carefully about the evidence we present (our portfolios), and about our personal and professional development over the next time period. The organisation should consider who is best to perform the appraisal interviews, what information the appraiser requires beforehand, and guidance on what to include in the agreed outcome statement. Details of who keeps the statement, and which members of the organisation are allowed to see the public outcome from individual doctors, need to be agreed before an appraisal system starts.

For appraisal to work

- all parties must have confidence in the quality of the appraisal system
- appraisers must have the necessary skills
- there must be processes in place to manage the outcomes
- conflict of roles for management should be avoided

Revalidation is a process of assessment – a judgement of whether a doctor is or is not fit to practice. It is not therefore inherently supportive or developmental. The criteria on which revalidation is denied must be explained to a doctor, so that he or she may work to address the deficit or alter the nature of their practice in order to avoid areas where practice is substandard. But it is the processes leading up to revalidation that should be supportive and developmental.

Part of the appraisal interview will involve a joint review of the content of the revalidation portfolio. However, the appraiser is not there to assess another clinician's portfolio, their purpose is to explore the appraisee's interpretation of the data, identify blind spots, and encourage reflection. If the appraiser acts in judgement of the appraisee's portfolio, doctors may feel inhibited in raising concerns during the appraisal because they fear that the information might be used against them at the revalidation point. Consultants appear more reluctant to assess, rather than appraise, colleagues. It has been suggested that revalidation might rely on 'successful appraisals'. Much more training will be needed if we are to assess our colleagues, and robust external quality control will be vital. Assessment of colleagues is likely to mitigate against creating an open, innovative culture where excellence will flourish.

In preparing for appraisal we must therefore think carefully about the evidence we present (our portfolios), and about our personal and professional development...

Neither appraisal nor revalidation are designed to cope with individual clinical incidents. Evidence of dangerous practice must be dealt with promptly and effectively – using an annual review process is unlikely to achieve this. If a clinical incident arises which suggests dangerous practice the matter should be dealt with promptly within a line management framework. An assessment has been made and, in a supportive culture, a formative interview will consider the problem in the light of the doctor's overall performance and learning/development needs will be identified. Although the skills needed to conduct such an interview will similar to those required for appraisal the purpose of this interview is to focus on the immediate changes required to prevent a reoccurrence; this is not appraisal. The learning needs that emerge from a critical incident and the progress made towards meeting these needs should be picked up as part of the annual appraisal process.

With skilled, trained appraisers, our experience is that appraisal is very helpful. There are advantages in offering a choice of appraiser. If one's appraisal is done by someone who does not have line management responsibility then it is vital that systems are in place to respond to the outcomes identified in the appraisal.

Revalidation	Appraisal
everyone achieves minimum standard	maximum for everyone
all aspects of performance reviewed	concentrates on strengths and weaknesses
reviews the past	review past and plan the future review of job plan and PDP
enforcement of outcomes	enabling rather than enforcing – *but* evidence of appraisal is required for revalidation
external quality control	

Quality Assurance

Successful appraisal is the key to making revalidation work. Through appraisal doctors will face revalidation confident that the evidence compiled for their portfolios is complete and reflects their professional development. It is therefore important to identify who is to be responsible for the quality assurance of appraisal. If this is to be a role of the Commission for Health Improvement, this should be made explicit.

The General Medical Council (GMC) will have an obligation to monitor quality control regionally and nationally, as they do with the oversight of education provided by Medical Schools.

The revalidation portfolio will be submitted for review and those doctors who are deemed to be a cause for concern will be referred the GMC's Fitness to Practice procedures, with three possible routes. These will be 'Acting to protect patients'.

At this point for those few doctors whose professional performance is questioned, a referral to the performance procedures will lead to a more rigorous assessment that will identify those doctors who fail to reach an acceptable standard.

Where the portfolio reveals failure of ethical or moral standards, the referral will be to the Professional Conduct Committee.

Doctors whose performance is compromised by their health will be referred to the Health procedures.

This will be a very small minority of the total and will therefore inevitably be concerned with the 'bottom cut off' and its ability to provide early warning of potentially failing doctors. The vast majority of doctors have nothing to fear from revalidation. These processes are more about improving and developing doctors professionally than about proving us to be better (or worse) than our colleagues.

References

1 *Scally G Donaldson LJ Clinical Governance and the drive for quality improvement in the new NHS in England BMJ 1998 317 61-5*

2 *Appraising doctors and dentists in training SCOPME Nov 1996*