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It is increasingly accepted that the completion of undergraduate medical education is only the first step in a process of life long learning for physicians. At its simplest, life long learning involves participation in continuing medical education (CME), designed to keep physicians up-to-date on clinical developments and medical knowledge. The broader concept of continuing professional development (CPD) includes CME along with the development of personal, social and managerial skills. More demanding methods incorporate other tools such as peer review, external evaluation and practice inspection. The outcome of these processes may be recertification or relicensure, although this is rarely the case in Europe.

Few countries require that physicians demonstrate explicitly that they remain fit to practice. The term 'revalidation' was coined by the General Medical Council (GMC) in the United Kingdom (UK), where it was defined as an "evaluation of a medical practitioner's fitness to practise".[1] Although this definition focuses on assessment, it is recognized that the process leading up to it should be formative, encouraging professional development as well as identifying those unfit to practice. Revalidation is thus one element within a larger system that has three objectives:

- to provide a system of professional accountability;
- to ensure that basic standards of care do not fall below acceptable standards; and
- to promote continuing improvements in quality of care.[2]

Drawing on a recently published policy brief and article[3,4] we discuss contextual factors influencing the choice of approach to revalidation, potential policy approaches, evidence relating to the different technical methods and some implementation options.

Policy context

One important factor contributing to concerns about life long learning in Europe is the European ExPeRT (external peer review techniques) project funded by the European Commission between 1996 and 1999. It identified four main external peer review models aimed at measuring the quality of service management and delivery: health care accreditation; the International Organization for Standardization ISO 9000 standards (accreditation standards initially designed for industry, but since applied to health care in radiology, laboratory systems and quality systems in clinical departments); the European Foundation for Quality Management Excellence Model (a self-assessment framework for applying external review to achieve quality standards); and *visitatie*, which is Dutch for 'visitation' or peer review-based schemes.[5] The ExPeRT team argued that within Europe convergence of quality assurance models is feasible, but depends upon the willingness of governments, health service providers, health care quality professionals and organizations to come together and adopt certain policy

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recommendations.[5] This consensus, in turn, requires complementing technical analysis with a more thorough policy analysis of power relations in European health systems.

Indeed, the potential to implement different quality assurance models varies among countries, reflecting the balance of power between the different stakeholders. For example, as mentioned in the case study on England in this issue, high-profile enquiries into situations where the behaviour of physicians has fallen short of expected standards have been used by politicians to strengthen government regulation of professionals. The case study on Germany suggests that in other countries, patients may be less questioning of physician competence, creating less demand for explicit accountability mechanisms. A further factor contributing to concerns about life long learning is increasing evidence of the scale of medical errors.[6] Although most involve broader system failures, they have contributed to concerns about physician competence.

Underpinning these developments is a growing recognition of the rapid pace of change in medicine and the way that skills and knowledge of medical professionals can erode over time. In a systematic review of the relation between experience and quality of care, 32 of 62 studies (52%) reported an association between decreasing performance and increasing years in practice for all outcomes assessed. This suggests that older doctors and those who have been practising for many years have less factual knowledge, are less likely to adhere to appropriate standards of care, and may also have poorer patient outcomes.[7]

A further dimension relates to the right to free movement by health professionals and patients. A number of high profile cases have placed the movement of patients within the European Union (EU) firmly on the political agenda. Somewhat less attention has been paid to the movement of health professionals. Professional mobility is based on the mutual recognition of professional qualifications, which assumes that someone registered to practise in one Member State remains competent to do so in all others. This is consistent with the principle of free movement enshrined in successive European Treaties; barriers should, therefore, be no more than absolutely necessary. This has led to calls for greater coherence internationally on how doctors are trained, registered and continually assessed. There is, however, surprizingly little understanding of how doctors are continually assessed in different Member States, who the regulators are, what methods of regulation are used, and how they are implemented.

Potential policy approaches

Whilst methods are still evolving in most of Europe and there is no obviously superior approach, there might be considerable unrealized scope to learn from the experience of countries with more developed systems of ensuring life long learning. A study of the experiences of New Zealand, Canada and the UK[8] has divided models for assessing continuing competence into two broad categories: the learning model and the assessment model, with the latter subdivided in to four further typologies. The models are summarized here and their current application in Europe has been noted.[3,4]

Learning model

Programmes under this model usually reward attendance at formal CME activities, self-assessment of learning needs, patient feedback, academic activities, and audits. Most are based on a continuous quality improvement concept. This model seeks to improve clinical competence but does not identify poorly performing physicians. Most countries in Europe employ this model, some in combination with other models.

Assessment model

The assessment of the practicing physician emphasizes performance as well as competence, and thus corresponds more closely with the idea of revalidation. Assessment tools have been adapted from those used in undergraduate and vocational education for the specific purpose of assessing the performance of practicing physicians. These include, for example, the interview, case-based oral examinations, record reviews, peer ratings, patient satisfaction questionnaires, and observing patient encounters. Four separate types of assessment were distinguished (Table 1)

Effectiveness of different methods

A major difficulty with ensuring fitness to practice is the lack of evidence on screening methods for physician assessment. In particular, reviews of evidence on the effectiveness of audit and feedback,[9] self-assessment,[10] multi-source feedback[11] and patient-reported outcome measures[12] reveal that while they can be effective in improving professional practice and quality of care processes, little is known about whether they improve patient health outcomes and whether they are cost effective. The evidence on CME and CPD[13] and recertification[14] suggests these methods can improve patient health outcomes, but again reliable cost effectiveness data is largely absent.

Regulation and enforcement arrangements

An international review (including Australia, Canada, Finland, the Netherlands, New Zealand and the US) of the regulation of physicians suggests that self-regulation predominates in European and international approaches to ensuring fitness to practise.[15] However, it seems that the so-called Anglo-American model of 'pure' self-regulation has shifted and become one of professionally-led regulation, with forms of co-regulation, or partnership regulation with statutory bodies or payers, becoming more common. This is seen as allowing for greater transparency and stronger accountability to external authorities. In some countries there have been moves to separate the bodies undertaking licensing from those hearing complaints, also reflecting concerns about protectionism. It has been argued that the separation of assessment bodies from other national bodies with advocacy roles is a major advantage for North American certifying bodies.[16] Linked to this is the question of responsibility for enforcement of assessment methods. There is widespread acceptance that this should be transparent but non-punitive, to respect the rights of both patients and physicians, with efforts

Table 1 Types of Assessment

Type	Description	Application
Responsive assessment	Entails the assessment of the performance of practicing physicians only on receipt of a complaint or report of a problem. Therefore, it cannot identify all those who are performing poorly.	Few, if any, countries in Europe rely exclusively on this model.
Periodic assessment for all	Entails a routine full assessment of all domains of competence for all physicians. This could include an assessment of patient outcomes, an evaluation of medical knowledge and judgement (a review of credentials), and the judgements of peers and patients.	This represents a very ambitious, if not unfeasible, approach and is not fully employed in any country in Europe.
Screening assessment for all	Evaluations are made against a set of specific criteria and the assessment aims to identify broader incompetence by focusing on certain quality indicators. Peer ratings, self-assessment questionnaires, and patient questionnaires can be used for screening tests. However, no single simple screening test has been discovered that will reliably, validly, and practically indicate poor performance.	This model has been adopted in Austria, France, Hungary, Ireland, the Netherlands, Slovenia and the United Kingdom.
Screening a high-risk group	Involves identifying a high-risk group for intensive scrutiny. One approach is to use a database to identify outliers in a set of indicators e.g. prescribing or referral patterns. Another is to identify a certain group of doctors who have been shown to have a higher risk of providing lower-quality care e.g. older doctors.	This type of targeting runs the risk of contravening privacy and human rights laws, and may not therefore work in practice and is not commonly used in Europe, although Norway, for example, does require renewal of licenses of physicians aged over 75 and Slovakia and Switzerland of physicians over 70.

focused on professional development and the identification of the few 'bad' physicians.[17]

An important dimension of the health care system that varies considerably across countries and has a major impact on the regulation of professional practice is the availability of information. Well functioning information systems are needed for many forms of audit, linked to valid patient outcome measures. Countries with sophisticated health informatics systems and functioning electronic health records will have an advantage.

Conclusions and implementation considerations

There is a climate favouring some form of continuing assessment of fitness to practice in a number of countries in Europe. However, there are several issues which need to be considered by policy makers.

In terms of the goals of revalidation, most countries recognize the importance of continually improving physician performance and have therefore introduced CME or CPD. However, it is also not clear that any system would, for example, have been able to prevent the emergence of criminal practices by physicians such as Harold Shipman in the UK (see case study). This is especially important given the enormous cost of some systems, making it essential to avoid the diversion of large numbers of physicians into monitoring activities at a time when many countries are facing physician shortages, as well as the possibility of unintended consequences e.g. barriers to innovation. Nevertheless, it is likely that in countries undergoing health sector reforms, typically reflected in the separation of purchaser and provider and the increased managerial role of the government, there will be increasing pressure to develop enhanced quality control mechanisms.

Which actor within the health care system is best suited to take responsibility for assessing physicians' performance is also unclear, although there seems to be consensus that self-regulation is more willingly accepted than government regulation, reducing incentives for opportunistic behaviour and non-compliance. Some commentators have argued that over-zealous regulation could actually erode, rather than increase trust in professionals and public services by reinforcing a culture of suspicion.[18] Perhaps reflecting increased awareness of these issues, forms of co-regulation or partnership regulation between professional and statutory bodies or payers are becoming more common.

It is also important that in situations where physicians are competing, self-regulation does not become a vehicle for personal animosities. These considerations will be especially important in some of the former communist countries where there are many examples of controls on the medical profession being abused during the communist era. A potential solution to these issues is the separation of assessment bodies from other national bodies with advocacy roles, as in the case of North American certifying bodies.[16]

The most effective method of enforcement of physician assessment is also not clear, and a different balance of incentives and penalties is likely to work best in each country. The most severe penalty currently employed is the removal of the

license to practise. A less severe version is the loss of certification, as in the US where certification is not a legal requirement to practise medicine. It should be noted that crucial to the effectiveness of the US system of recertification is that it was introduced only after stepwise evaluation and validation of the assessment methods over a long period of time[16] suggesting that countries considering introducing such a system should proceed gradually.

Importantly, policy makers must consider how to finance life long learning. Many countries have experienced great difficulties with raising the necessary resources to implement even the most basic physician performance policies, such as CPD. A solution to this has been to look to the private sector, specifically the pharmaceutical industry, to support such activities. A potential problem here is that the pharmaceutical industry is then able to drive the agenda in terms of the content of the CDP sessions. In countries where the pharmaceutical industry is a major funder of CPD and other physician performance improvement and assessment programmes, the government should consider establishing an independent regulatory body to set the agenda in line with the needs of the health care system.

Finally, the scarcity of data and information as well as diversity in practices suggest that there is an unmet need for a forum on the regulation of the medical profession, where countries would be required to report on practices, evidence and challenges, with the aim of eventually drawing up European recommendations. At the European Commission level, there was a statement at a 2006 meeting of the High Level Group on Health Services and Medical Care that the group plans to consider "European and global issues of continued professional development (CPD)" but currently a new Directive on health professionals does not appear to be on the agenda.

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