Letters

- Revalidation of Canadian physicians

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We commend Wendy Levinson for her provocative suggestions regarding revalidation of Canadian physicians.[1] We also applaud *CMAJ* for publishing views that are more demanding and supportive of meaningful external verification of Canadian physicians' ongoing competence than those of the Canadian Medical Association.

We agree with much of what Levinson has advocated, specifically the call for a revalidation process for all physicians implemented by the provincial medical regulatory bodies and the call for an external assessment of physician performance. Indeed, valid methodology to measure the actual performance of physicians in practice is the Holy Grail sought by medical regulators.

As noted in the editorial, a number of jurisdictions have mandated or will mandate participation in 1 of the 2 national maintenance of certification programs. Two jurisdictions, Alberta and Nova Scotia, also require all physicians to undergo regular multisource feedback reviews from patients (if applicable), colleagues and coworkers. Rather than an "alternative approach," as suggested by Levinson, Alberta's Physician Achievement Review program is an integral component of the Alberta college's revalidation strategy. Although it is a quality-improvement program, 20% of physicians undergoing this review will be flagged for follow-up, and 1 out of 5 of those (about 4% of the total) will undergo a formal peer review of their practice.

In addition, Levinson argues that the process is "only feasible for primary care and larger specialties" when in fact Physician Achievement Review tools have been created, used and validated for primary care, medical specialties, surgical specialties, episodic care (e.g., emergency and walk-in practices), anesthesia, laboratory medicine and diagnostic imaging. Very few physicians are not captured by the Physician Achievement Review process. Results from our implementation of each set of Physician Achievement Review tools have been published in peer-reviewed journals.[2,3]

In other jurisdictions, peer review of physician practice is a prominent component of quality assurance. Many provincial medical regulators operate accreditation programs for laboratories, diagnostic imaging and other diagnostic modalities. These programs not only capture and review the policies and procedures but also involve direct inspection of the facilities where physicians provide services as well as review outcomes.

In addition, many medical regulators either operate, or have access to, prescribing or dispensing information on a limited or broader scale. Such information can prove useful as a screen into what physicians are doing in practice. The Collège des Médecins du Québec has used prescribing data very effectively in monitoring, intervening in and improving the practices of physicians in that province. We look upon the analysis of databases, such as those for prescribing, as offering a real opportunity to create affordable, proactive, valid and reliable tools to assist in providing the kind of external oversight that Levinson recommends.

Notwithstanding the many activities we employ to ensure that our members are performing to an acceptable standard, we recognize that the currently available tools are not sufficient to ensure that every physician remains competent. We therefore heartily support Levinson's call for more research to understand the relation between revalidation and quality of care in practice and to explore the most effective methods to assess physician performance.

Although examinations can measure a physician's knowledge base, they do not measure how a physician actually performs in practice. Thus, although we are less sure of the value of examinations in pursuit of this goal (and nor are physicians in our jurisdictions), we strongly support adding methods to our toolbox that have been proven successful. Evidence-based regulation should be our mantra as we move to achieve the very important ends that Levinson advocates and that our public demands.

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Competing interests: None declared.

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We thank Wendy Levinson for promoting the principle that physicians individually and the medical profession collectively must be accountable for sustaining and enhancing physicians' knowledge, skills, attitudes and competencies over a lifetime of practice and that these processes must be transparent.[1] In 2005, the Council of the Royal College of Physicians and Surgeons of Canada established lifelong learning as the professional ethic for all fellows. The Maintenance of Certification program has promoted and supported this mandate by establishing high standards for group learning, self-learning and practice and performance assessment strategies and by requiring fellows to plan, implement, document and defend, where required, their process of learning and the outcomes achieved that

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contributed to the quality of their professional practice. Participation in continuing professional development activities alone is an inadequate marker of learning, and learning divorced from improvements in competence, performance and health outcomes is an inadequate metric for any continuing professional development system committed to improving the quality of professional practice.

We disagree with Levinson about the foundation upon which accountability should be based. Rather than promoting the development of a testing culture that is based on summative examinations, the Royal College of Physicians and Surgeons of Canada is advocating for the creation of a learning culture characterized by practice reflection, inquiry, peer review and rigorous formative assessments of knowledge (through self-assessment programs), competence (through simulations) and performance (through practice reviews) that reflect the entire spectrum of roles and competencies associated with the CanMEDS framework. Because recertification examinations cannot realistically be tailored to an individual specialist's scope of practice and provide limited feedback to promote learning and improvement, we have rejected the inclusion of recertification examinations as a mandatory requirement of the Maintenance of Certification program. We applaud the Federation of Medical Regulatory Authorities of Canada's inclusion of "formative" as 1 of the 5 principles of revalidation.[2]

We are in the midst of an exciting but challenging cultural shift in continuing professional development. At the Royal College of Physicians and Surgeons of Canada, we remain committed to enhancing the rigour, accountability and transparency of our continuing professional development system to promote lifelong learning and to enhance the quality and safety of care, thereby contributing to the health of Canadians.

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The Canadian Medical Association has long recognized the need for physicians to engage in lifelong learning to maintain the quality of clinical care. Although Wendy Levinson is to be commended for endorsing the principle of lifelong learning, the Canadian Medical Association cannot agree with her suggestions on how best to achieve it.[1]

The editorial largely ignores the peer-review process that the provincial licensing bodies have been running for a quarter century. Ontario was a pioneer and its work has been cited in the world literature as such; Alberta has added a number of innovations, including interviews with staff, colleagues and patients. Under these programs it is mandatory that physicians allow physician assessors into their practice to review their charts and question their approaches to diagnosis and the management of patient care. The process is designed to educate rather than punish.

Most physicians would agree that the acquisition of continuing medical education credits and participation in peer-review programs are important to ensuring competence. There is, however, little if any research to prove that examinations assess practitioners appropriately. The article by Tamblyn and colleagues[2] cited by Levinson is often referred to precisely because there is almost no other such evidence, certainly not enough for the type of systematic review we would demand if a clinical intervention were to become recommended practice. There is a wealth of research showing good continuing medical education to be effective in enhancing quality of care.

A simple focus on a recertification process that is based on passing a test misses the key issue. The real challenge is to show that new knowledge gained by physicians is leading to positive changes in practices and better patient care. Self-reported measures are currently the only cost-effective way to demonstrate such changes; the cost of external audits would be prohibitive.

Bringing about change in practice is the final frontier. To ensure that better training leads to better patient outcomes, we need a concerted collaboration between physician organizations and governments to make the best possible learning opportunities available to physicians.

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The author responds:

There is general agreement that any system of revalidation should ideally measure the competence of physicians in each of the CanMEDS roles and the actual performance of physicians in their daily practice. As suggested by Trevor Theman and colleagues, Craig Campbell, and Robert Ouellet, a robust revalidation system should incorporate multiple assessment tools: self-assessment of knowledge, practice reviews done by peers, simulation testing of skills and feedback from patients and peers. We all agree that a broad array of tools is needed to assess physicians' competence; ideally, each tool would measure a different aspect of physicians' skills. However, all of the letter writers are against the use of an examination.

How then can we measure physicians' knowledge? Patients want a physician who is up to date on the most recent advances in their field and they think that physicians should periodically take a test. However, physicians argue vehemently that they do not need a test for a variety of reasons: they keep

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