Has Credentialing a role in the regulation of Postgraduate Medical Education and Training?

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 Credentialing is... an objective evaluation of a subject's current licensure, training or experience, competence, and ability to provide particular services or perform particular procedures.
Credentialing is an umbrella term referring to the various means employed to designate that individuals or organizations have **met or exceeded established standards**.
The MSc award includes the research dissertation and corresponds to 180 credits. The Diploma corresponds to 120 credits and the Certificate to 60 credits.

**Module example (15 credits):**
Evidence-based Child Health: assessed by 3-hour unseen examination. Mandatory for Certificate, Diploma and MSc

**Module example (60 credits):**
Research project: assessed through dissertation of 8000-10000 words (including five credits from the viva voce exam at the end of the MSc course)
The Expert Panel on Credentialing was charged to create a standardized framework that healthcare facilities might utilize during initial credentialing and re-credentialing. This includes a broad array of methods, such as evaluation of patient outcomes through case reviews, analysis of data, review of accomplishments, complaints, certifications, and other competency assessments as recommended by specialty boards, professional societies, or regulatory agencies.
Credentialing for surgical practice

Any basis for credentialing must be seen to be objective, reproducible, credible, validated and appropriate. In order to do this we must:

• Agree standards
• Decide on a framework for assessment
• Determine methodology
• Select appropriate methods for each individual
• Judge performance objectively
• Manage the strategy
• Evaluate the results
Credentialing is primarily perceived as a protective mechanism against poor performance, but it should also be seen as encouraging development and building up an individual's portfolio.
The use of ultrasonography, traditionally performed by radiologists, is becoming increasingly widespread in emergency medicine.

This article discusses training and credentialing guidelines, paths to becoming credentialed in emergency sonography, and quality assurance issues.
There are four key factors that have prompted the development of the concept of credentialing:

- The general appetite for more information about the status and competence of doctors
- The changing nature of healthcare delivery
- The need to ensure that postgraduate medical training equips doctors to best care for patients now and in the future, and that this training can be shown to enable doctors to be fit for this purpose
- The need to promote doctors’ continuing professional development.
Registering specialist credentials would enable recording of competences acquired throughout a doctor’s specialist career and not just at the award of a CCT.

Specialist credentialing might be used to reflect the increasing modularisation of specialist training and the more flexible training opportunities that will be necessary because of the changing demographics of the medical profession.

Credentialing would provide a way of giving formal recognition to the additional training undertaken and qualifications acquired by doctors. The recording of that additional training would make the expertise of specialists more easily recognised and the register more transparent.

Specialist credentials would enable the recognition of specialist competences in fields of practice for which it is not possible to obtain a CCT and where regulation has been identified as weak.

Credentialing offers a more agile means of responding to developments in medicine than is possible through the recognition of CCT specialties. It should be possible in principle to extend the principle of credentialing to apply to general practitioners with special interests.
‘In partnership with the medical profession, in particular the Royal Colleges and the professional regulators, we will develop plans to introduce modular credentialing for the medical workforce over the coming decade.

This means the formal accreditation of capabilities at defined points within the medical career pathway that takes into account knowledge, capabilities, behaviour, attitudes and experience.’
Meetings involving Royal Colleges, regulators and Department of Health (DH) officials

**Recommendation 2**

No changes to medical training should be introduced without consultation and engagement with stakeholders (including the public, trainees, employers and the professions), piloting and assessment of the impact of change.

**Recommendation 3**

Any proposals for modular credentialing must be compatible with the recommendations made by Medical Education England on the future structure of training and agreed by the Devolved Administrations.
Working definition

“A credential is a marker of attainment of competences (which include knowledge and skills) in a defined area of practice, at a level that would allow the holder of the credential to practise with a limited level of direct supervision in that area of practice.”
Credentialing would help to demonstrate and support the maintenance of standards of specialty doctors who had developed competence in discrete areas of specialty practice.

There may be regulatory value in this in terms of public and employer reassurance. There may also be a related value in terms of giving better recognition to specialty doctors and their training needs.
Service posts and Credentialing

Some doctors may choose to step sideways from their training before achieving specialist registration and perform service roles. Their abilities will vary considerably and employers, colleagues, patients and the public need to be able to recognise their level of safe practice.

Thus a mechanism to record the expertise doctors have achieved needs to be developed. The same might usefully apply to doctors who have performed additional training since completing their specialty training.
“Employers favour a modular approach to postgraduate medical training built around care pathways that provide recognised ‘credentialing’ to support doctors’ development over a range of flexible career routes”

“Employers want to enable specialty doctors and their trust equivalents to gain recognition for the knowledge, skills and experience they acquire throughout their careers”

“There is strong support for the development of a standardised system of recognition, or ‘credentialing’, which would, in time, support doctors to better evidence their skills when applying for entry to the specialist register via the CESR route and achieve greater autonomy of practice where their competence has been accredited”
“a new intermediate step between Foundation and specialist registration. The curricula would be designed to ensure training to a level commensurate with a doctor providing a meaningful service contribution”

“demonstrably qualified to practise with a limited level of direct supervision”

“providing a workforce more responsive to changing service needs and enhancing choice and opportunity for doctors in their careers”

“medical career structures must be mapped across each administration to balance UK-wide strategy and single-country needs”
Consistency of overall approach will be important in order to achieve a coherent outcome.

Some overarching principles for all types of credentialing are needed. For example,

- Possession of a credential should signify attainment of a standard commensurate with practise with a limited level of direct supervision
- A credential must be in a sufficiently broad area of practice that it would not restrict workforce flexibility or quickly become obsolete (therefore avoiding procedure-specific credentialing)
- A credential must not compete with a recognised sub-specialty field.
The purpose of the Credentialing Steering Group (CSG) is to facilitate the coherent development of proposals for credentialing across all stages of doctors’ careers, and to provide information on work and progress to the Board, Council, Academy, four Departments of Health and other key interest groups.

The work will be developmental in nature and the aim will be to consider the outcomes of initial exploratory work by autumn 2009 and for wide consideration prior to potential implementation in part or whole, making use of pilots where applicable.
Membership of the CSG

CSG comprises members drawn from the key interest groups:

PMETB, GMC, Four Depts of Health, AoMRC (including trainees), COPMeD (Vicky Osgood, Mike Watson), BMA (including specialty doctors, trainees and consultants), NHS employers, Workforce Director, MEE, patients and the public.
Functions of the CSG

Establish the overarching principles for the development of credentialing that apply across all work streams.

Provide a strategic direction for the project work on Progression through training and Supporting revalidation credentialing.

Take delivery and agree plans for the work streams, including the scope of the work, outputs, milestones, piloting and timetable.

Oversee the progress of the work streams.

Provide information on work and progress to the key interest groups, the regulators and the four Departments of Health.

Identify and agree issues where decisions by key interest groups, the regulators, and the four Departments of Health will be required. DH (E) will have specific reporting as agreed between PMETB and DH (E).
Agreed initial workstreams

‘Progression through training’ work stream (chaired by PMETB), including practice where no formal recognition exists.

‘Supporting revalidation’ work stream (chaired by GMC), for specialists including GPs with special interests and specialty doctors. The links with recertification mean that this falls within the remit of the Continued Practice Board.
Agreed initial workstreams

‘Progression through training’ work stream (chaired by PMETB), including practice where no formal recognition exists. Four areas have been identified for further initial consideration – Legal/Forensic, Musculoskeletal, Breast disease, Cosmetic surgery.

The review of CCT curricula and subspecialty curricula currently ongoing by PMETB provides an opportunity for the medical Royal Colleges to identify progression through CCT training more clearly. For some this includes discrete modules within their curricula, which could have the potential to be credentialed.
Agreed initial workstreams

‘Supporting revalidation’ work stream (chaired by GMC, within the remit of the Continued Practice Board), for specialists, including specialty doctors and GPs with special interests.

Revalidation will transform the register from an historical record of doctors who are qualified to practise, to a contemporary statement of their continuing fitness to practise. This workstream will consider

(a) the potential of credentialing to support more effective regulation within the specialty doctor career structure, and examine how such credentialing might relate to specialist training; and

(b) the recognition of increased expertise within highly specialised fields of practice, and how this could be used to support revalidation of these doctors.
DH literature review

The literature supports credentialing in demonstrating and supporting the maintenance of standards of doctors who had developed competence in discrete areas of specialty practice. In addition, there may be regulatory value in this in terms of public and employer reassurance. There may also be a related value in terms of giving better recognition to specialty doctors and their training needs.

There is evidence supporting the role of credentialing in the granting of clinical privileges in a procedure specific way e.g. the Canadian process of credentialing endoscopic procedures. This is particularly useful where procedures cross traditional specialty boundaries.
The literature suggests that there is an urgent need for recognition of competence attained in discrete areas of practice not covered by either CCTs or by PMETB recognised sub-specialty training e.g. remote and rural medicine, cosmetic surgery etc.

Credentialing may help to facilitate movement of trainees in and out of training programmes at the appropriate level, and give greater flexibility to professionals (and employers) to move between specialty training programmes, whilst having their capabilities and learning properly recognised.

Credentialing is also useful in supporting effective workforce planning and the aims of the NHS Next Stage Review, namely improved knowledge of the skill sets available and through a more flexible workforce that can develop approved and recognised skills more rapidly to meet changing service needs.
The strategic review of the regulation of medical education and training being led by Lord Patel at the request of the GMC and PMETB will almost certainly have an interest in the regulatory implications of credentialing.

Any work on credentialing will need to be tied into the review.
Where next?

Reports of the 2 workstreams to the CSG (Feb 2010).

Consideration at final PMETB meeting (March 2010) and report back to DH(E). This will complete all agreed work.

Further consideration after merger by GMC Postgraduate Board, Continued Practice Board (and Council).

Wider issues –
future of sub-specialties
future medical career structures
regulation of CPD for doctors in career posts
distributed regulation (“agreed common standards, set by a lead regulator, used to regulate practice regardless of original professional registration – eg podiatric surgery”)