high value that it will encourage participation by physicians exempted by the grandfather clause, who represent about one-third of all certified internal medicine physicians. The hope is that these physicians will voluntarily seek an MOC credential designation because of the value it provides. The secure examination is the most rigorous part of the MOC process and is linked to evidence of better outcomes. The examination is designed to evaluate the synthesis of information and clinical judgment. Secure examinations are rigorously developed and tested using elaborate psychometric standards and are reviewed by ABIM test committees and directors for clinical relevance. The Board plans to intensify its efforts to develop methods and metrics to assess professionalism, communications and interpersonal skills, systems-based practice, practice-based learning, and improvement. The ABIM is going to great lengths to consider how MOC can be more relevant to clinical practice, as physicians enhance skills in areas in which they have experience, but in which they may have no formal training.

The ACC and ABIM are working together to make MOC activities value-added and to enrich the cardiology-specific educational opportunities. We hope to collaborate with BCS colleagues in sharing best practices for MOC/Revalidation. The backbone of our approach has been to emphasize appropriate balance in the assessment of the key areas of knowledge, skills, and professionalism. Like the BCS, we believe that the best interests of the public are served by a continuous knowledge assurance process as opposed to a periodic knowledge assessment. For further discussion, I can be reached via email at john .harold@cshs.org. ■

Revalidation for Cardiologists in the United Kingdom

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Physicians in the United States are familiar with Board Certification and Maintenance of Certification. There is no similar regulation of medical practice in Europe after specialist training is completed. The United Kingdom will shortly introduce a Revalidation for Doctors program to demonstrate and confirm that licensed doctors practice according to the General Medical Council's (GMC) generic standards (relicensing) and that specialists practice according to the standards for their specialty (recertification). The intent of Medical Revalidation is for the process to be supportive rather than punitive and to include patient and clinician involvement. The result should raise standards and include remediation and rehabilitation. Revalidation should be a continuing process, not an event, and should ensure consistent standards across practices, be based on evidence from local practice, and depend on the quality of local appraisal.

Revalidation for physicians in the United Kingdom will be based on structured annual appraisal, with 5 satisfactory consecutive appraisals leading to revalidation. The framework for appraisal of generic medical practice is based on *Good Medical Practice,* a publication with standards set forth by the GMC. The GMC has agreed that the standards for remaining on the Specialist Register will be the same as those currently required for entry to this register. However, the range of

competencies to be demonstrated for recertification will relate to the physician's actual practice, rather than to his or her original training. The process leading to Medical Revalidation will be overseen by a local Responsible Officer who will be accountable by law to maintain a liaison between the local health care organization and the GMC and to implement Revalidation.

Our British Cardiovascular Society (BCS) proposals for Revalidation for Cardiologists have evolved from workshops, discussion groups, consultations, and feedback from the past 2 years. We are finalizing our proposals for publication on our Web site, and for the introduction of Revalidation for Cardiologists in 2011. The BCS proposes that Revalidation for Cardiologists should be undertaken in 3 domains linked to the individual cardiologist's work practice or job plan: knowledge, skills, and professional behavior.

Knowledge Assessment

General cardiologists undertaking unselected, acute, inpatient, adult, on-call cardiology, general in-patient adult cardiology ward rounds, or unselected adult cardiology outpatient clinics should demonstrate general knowledge of the cardiovascular curriculum in a span of 5 years that is equivalent to any 25 of the 38 chapters of the European Society of Cardiology (ESC) *Textbook of Cardiovascular Medicine*. This textbook follows the learning framework defined by the Core Syllabus in Cardiovascular Medicine and is supported by multimedia resources. There is an automated online Multiple Choice Question (MCQ) assessment. If a cardiologist undertakes exclusive subspecialty practice according to his or her clinical practice or job plan, he or she should demonstrate specific subspecialty knowledge from the relevant chapters of the ESC *Textbook of Cardiovascular Medicine*.

Alternatively, cardiologists may demonstrate knowledge from other sources accredited by the European Board for Accreditation in Cardiology (EBAC). These could include MCQs from sources such as the Education in Heart series, ESC Guidelines, Web courses, journal articles, Web casts, and online case discussions. Whatever the source used, a similar demonstration of knowledge would be required in terms of EBAC credits awarded in 5 years. A record of online learning and assessment activities and credits would be maintained. These would be downloadable to the cardiologist's personal Revalidation Portfolio.

Skills Assessment

Individual practice job plans or procedural activities undertaken should be linked to the demonstration of competency in clinical skills. Cardiologists should provide evidence of competency in their clinical skills by using 1 of 4 potential levels in the hierarchy of assessment: national audit systems of quality and outcomes; national accreditation systems; structured, continuous, local, quality-improvement programs; or a personal reflective logbook of procedures. These data would not include any individual or identifiable patient records.

The Essential Professional Requirements for Revalidation, which are mainly required for appraisal and relicensing, are as follows: details of current medical practice, evidence and record of Continuing Professional Development, involvement in clinical teams (eg, multisource feedback), participation in national audit and quality improvement, and evidence of equality and diversity training.

There are several advantages to the educational, as opposed to regulatory, approach proposed by the BCS. The foundation of the revalidation is based on core and subspecialty training in cardiology. Knowledge-based assessment is linked with assessment of procedure competency, and the demonstration of knowledge and skills and competencies is linked to the individual clinical practice or job plan. In addition, the proposals will allow the credentialing of individual clinicians in procedures and with health care organizations. This approach has the potential to serve as a generic system for revalidation for cardiologists in Europe.

It is expected that local Responsible Officers will be appointed by health care organizations in the United Kingdom in 2010, with the first wave of revalidation for doctors taking place in 2011. The BCS hopes that we will have a pilot Web-based system ready for trial in early 2010, and we would pilot revalidation for cardiologists later in 2010. If successful, cardiologists will be ready for the first Medical Revalidations for physicians in the United Kingdom in 2011. For more information, please visit our Web site at http://www.bcs.com. My email address is dhackett@globalnet.co.uk. ■