Revalidation:
1 year after implementation

FPM Newsletter special edition
Summer 2014

Editorial

Dr Asad Khan
Editor of the Newsletter
Advocacy Committee

Welcome to the Summer edition of your newsletter.

Our current issue contains some interesting articles on revalidation from various perspectives, angles and viewpoints. Revalidation, as most of us know, is a process by which doctors licensed to practice are required to demonstrate, on a regular basis, that they are up to date and fit to practise. Although currently a UK process, the principles, philosophies, learnings and processes of revalidation can be applied anywhere.

In this newsletter, Dr Susan Bews, the Responsible Officer for the FPM, shares her experiences of the first year of revalidation. I am sure, after reading her interesting article, readers will appreciate the valuable work done by the Faculty in creating a system and supporting framework for this important exercise. Dr Sharon McCullough reflects on her appraisal experiences in a thought provoking manner. Lucy Pavesi, who was among the first cohort of FPM members to go through revalidation, talks about the process from an appraisee's viewpoint. Revalidation perspectives and issues from within a pharmaceutical company designated body are brilliantly highlighted by Danie du Plessis. If you are an international doctor preparing to revalidate, you will find practical tips and guidance from Piotr Krzeski very useful. Swati Bhat highlights the importance of this process from a doctor undergoing speciality training. And finally, Mike Court talks about our Faculty's revised CPD guidance notes.

Finally as I always say, this is your newsletter. Please feel free to contribute and yes, all suggestions for improvement are warmly welcome. Please contact myself or Ben Cottam in the Faculty office (b.cottam@fpm.org.uk) with your ideas.

A message from the President

Dr Keith Bragman
President
FPM

I am delighted to introduce this edition of the newsletter, dedicated to the topics of revalidation and continuing professional development. As the reader will learn, more than 500 doctors have chosen to revalidate in pharmaceutical medicine using the services of the Faculty. We now have one year's experience to call upon. Not surprisingly many of our members have unique challenges and this reflects the diversity of our speciality. Pharmaceutical medicine is no different to other specialities in internal medicine. Namely we are working to ensure the effective treatment of the patient. Many of our practitioners are remote from the patient. However the responsibility to the patient must remain at the forefront of our efforts. This is demonstrated by your professionalism and efforts to address the daily challenges of the job.

I went through the process of revalidation earlier this year. I soon learnt that I needed to justify my actions and way of thinking. I needed to understand that the universal statements regarding patient care could be interpreted in many ways. Too often we are too busy to allow sufficient time for critical thought. However it shouldn't be a luxury. That discussion with the appraiser made me examine whether what I was doing was indeed useful and relevant to the patient.

In fact revalidation was simply a path to the culmination of continuing professional development. It was a very necessary action to demonstrate my personal and ongoing commitment.

Please do read the newsletter and learn about the experience of the Faculty and why others have revalidated in Pharmaceutical Medicine.

Kind regards,

Keith Bragman MD (Lond) FRCP FRCPath PFPM

FPM Launches Revised CPD Guidance Notes

Dr Mike Court
Professional Standards Committee
FPM

Important for all physicians who are revalidating, all physicians undertaking CPD who are not revalidating and all appraisers

The GMC requires that all doctors undertake appropriate CPD. The Faculty CPD Guidance Notes focus on practical aspects, including what to include in your CPD, how to record it and how to reflect on it. There are useful publications and some Faculty tips on how non-clinical activities of pharmaceutical medicine can map to Good Medical Practice. This rewritten guidance was first issued in October 2013; experience gained and new information gathered has been incorporated into the revision launched in June 2014.

The chair of the Faculty's Professional Standards Committee (PSC), Prof Tim Higenbottam, said "Anyone undertaking CPD, whether they are revalidating or not, will find the advice invaluable and indeed essential in planning and recording their CPD."

FPM Responsible Officer (RO) for revalidation, Dr Susan Bews, said "I encourage all pharmaceutical physicians, whether revalidating through the Faculty or with another designated body, and those who are not revalidating, to read and use this guidance document. For those revalidating it provides clear guidance on a number of aspects of the evidence required, it gives examples and provides additional help for completing an e-Portfolio. Following this guidance should help ensure a satisfactory portfolio of evidence."

Prof Peter Stonier, Faculty PMST Programme Director said: "This is a very good and useful document. It lays out clearly and explains what many of us have come to understand and believe should be the nature of CPD in its many contexts and applications, and now with particular reference to pharmaceutical medicine. It should be widely read, and hopefully in due course it will have some impact outside UK, in Europe and beyond!"

I have been closely involved with this project from the beginning, and for me there are several main highlights. The guidance (in Section 6) contains lots of ideas on things that constitute CPD and I would be willing to bet that every reader will see something that they hadn't thought of before. Section 8 offers practical advice on how to reflect on your learning; 'I learnt a lot' isn't enough, but it is still not difficult to highlight personal learnings in just a paragraph or two. The jewel in the crown for me, though, is the so-called 'Framework' (Appendix 1) which draws on several published guidance documents that cover the range of our practice in pharmaceutical medicine to help relate everyone's CPD to the different domains of Good Medical Practice. For pharmaceutical medicine, for example, patients include not only those participating in research studies but can also include the patients who are eventually prescribed our medicines, while many references to 'patients' in GMP are also applicable to colleagues and others with whom we interact in during the course of our work. There is also new, helpful advice on how to use audit for educational purposes (and how not to use it) as this has been a source of considerable confusion to date. Added to this, there is a useful table describing evidence requirements for CPD and two very helpful flow charts demonstrating the CPD process for revalidating doctors and non-revalidating doctors alike.

Some further points in the revised guidance notes which members may have missed are:

- The Faculty provides support for pharmaceutical physicians undertaking CPD regardless of whether or not they are undertaking revalidation and whether or not they are members of the Faculty.
- A CPD activity does not need to be a specific learning/teaching event but can be any of an infinite number of activities which provide an opportunity to learn. This includes for example informal learning, which can arise in day-to-day work.
- All doctors should have an annual personal development plan (PDP) which must be discussed and agreed with an appraiser or mentor.
- All pieces of CPD must have personalised reflective notes/commentary which, in most cases, will need to be only one or two paragraphs long.
- Recording CPD credits and the '50 credits requirement' is now optional, though should remain usual practice for physicians who are not revalidating. (PReP will generate an annual report for these doctors if they use it for recording their CPD).
- All CPD participants can self-accredit relevant activities.
- Employers are responsible for providing CPD support for doctors working for them.

All Faculty members are encouraged to print off a copy and use these new guidance notes to help with their CPD. Please also share them with pharmaceutical physicians who are not members of the Faculty. They can be accessed at https://www.fpm.org.uk/revalidationcpd/CPD/cpd_guidance_june_2014

First year of revalidation - Responsible Officer perspective

Dr Susan Bews
Responsible Officer
FPM

Ten years plus in gestation and now the first year of revalidation is over! The Faculty has over 500 doctors revalidating, we have established an appraisal system from scratch, I have submitted the required number of recommendations to the GMC, and we have lived to tell the tale. For me personally it has included two appraisals and a positive recommendation (relief!). So, a successful first year.

The facts above belie the amount of work involved and the support I have had from so many parties; Faculty staff, the board, outside bodies such as the GMC, NHS England and of course appraisers and appraisees. The encouragement and commitment from so many has been fantastic.

For many doctors there has been a need this year to make a decision about retaining their licence. Having worked hard through medical school to achieve this recognition it cannot be easy to make this decision even for those who are working abroad or are in the UK but do not need their licence as they are perhaps retired. It does appear that the very considerable support we have given to those doctors has been appreciated.

For those of us who are retaining our licences and revalidating we have all had to face the challenge of what evidence to use, how to present it, and worry about whether it will be enough. We held a number of seminars to provide guidance on this and our guidance developed as we gained experience. However for those who had very early revalidation dates there was little or no precedent and yet most were able to produce excellent, well thought through portfolios with solid demonstration of all the requirements. I have great respect for those appraisers who undertook appraisals without the experience of having had one themselves – as was necessary at the beginning. That must have been quite daunting as they were expected to be instant experts.

I have also been so pleased to see the time and effort that most appraisees have given to supporting revalidation and to hear and read of the value that they have gained from their appraisals. In many instances it has been a symbiotic gain for both parties. There has generally been a high standard of evidence in portfolios, with a commitment to both the principles of good medical practice and to ensuring and evaluating that their medical practice is good. For many it is obvious that in their everyday work they seek excellence as a routine.

One of the many privileges of my role as RO has been the opportunity to meet with or correspond with so many doctors in the pharmaceutical industry. It has been a real pleasure. Another privilege is to review the evidence in the portfolios and read about the very varied work you do. Some of the evidence that is used is fascinating. It has been very interesting to see how evidence from very varied roles can meet the requirements of revalidation. Perhaps not surprisingly as we work in an innovative industry, everyday activities have been used, reviewed or evaluated in innovative but appropriate ways to meet the GMC requirements, most noticeably with quality improvement activities.

Annual appraisal and a revalidation cycle are becoming part of the normal pattern for pharmaceutical physicians. This first year has clearly demonstrated that those working in our industry can demonstrate their competencies and fitness to practice in the same way as any other doctor. We have shown we can achieve the required standards set by our regulator. Thank you to all who have contributed in so many ways to this to make it possible.

My first appraiser year: what I've learned

Dr Sharon McCullough
Consultant Pharmaceutical Physician
Zygian Limited

This time last year I'd completed my appraiser training, just been assigned my first appraisee and was fretting about how to conduct the appraisal. A year on and with a number of appraisals now completed (including my own) I think I've learned a lot. My reflection below explains.

What have I done?

Over the past year, I've liaised with the FPM revalidation team, made contact with appraisees, offered advice about the process to those who asked, recommended the FPM appraisee workshops to everyone, booked numerous Regus meeting rooms (great value!), negotiated the e-Portfolio, reviewed appraisal input forms and supporting information, met appraisees and learned about their practice, asked some questions, helped to devise personal development plans (PDPs), and written up appraisal output forms. I've attended two appraiser network meetings. I've also run an informal survey which looked at how appraisers complete the on-line 'paperwork'.

Why has it been a useful experience?

From an educational 'life-long learning' perspective, I think the revalidation appraisal is an important opportunity for pharmaceutical physicians to take stock of what they're doing and check they're happy with their professional journey. Any involvement in that process is valuable. But I've been incredibly impressed with the insights into their work that appraisees have allowed me: the high standard of activity; the concern for patient safety in every part of the business; the thoughtfully constructed portfolios; the level of professionalism and the willingness to 'just get on with it' (in relation to both the 'day job' and the appraisal process). Seeing what other people are doing and their approach to their work and their revalidation is a very useful benchmark to help me maintain my own practice.

So what have I learned?

I've certainly discovered something new about how our industry works from every appraisal that I've done. I've also learned that there is a wide variety of approaches to the e-Portfolio, evidence, and reflection from both appraisees and appraisers, but from personal observation and the output of the appraiser survey these are mostly reasonable and justifiable. I've also discovered that there is really no need for me to worry about how to conduct an appraisal since that's not a role I need to assume. Unlike the traditional workplace appraisal performed within a 'boss:subordinate' relationship, and often uncomfortably focused solely on achievement of objectives, I've found the revalidation appraisal to be a refreshing 'peer:peer' conversation exploring how professional practice is realised in the workplace. My role is to facilitate the discussion and act as an objective witness. With no prescribed curriculum and no pedagogic relationship between the appraiser and the appraisee, I've also found that the revalidation appraisal is very different to the educational appraisal of PMST, even though they both deal with professional development.

What next?

I hope to get some feedback from appraisees and the RO after the next round of appraisals. Also, I'll try to use my understanding of the differences between the PMST and revalidation appraisal processes to make the transition smoother for new appraisees who have completed PMST. Most of

all though, I would really like to see if there is any way that some of the great work that is being described in revalidation appraisals could somehow be collected and promoted, allowing us to demonstrate to the industry, the wider medical community and beyond what a varied, important and professional job pharmaceutical physicians are doing in the workplace every day.

Appraiser training and networks update

Susan Paterson, Professional Development Administrator, FPM

The training of appraisers for the Faculty designated body has been taking place on a regular basis since January 2013. Whilst some of the newly-trained appraisers have undertaken company appraisals previously, the Faculty was aware that the introduction of revalidation with medical appraisal as its core would be a very different experience. Feedback following the training days indicated that the formation of an appraiser network could be a very valuable resource. The consensus was that networking could be both on a formal basis, such as events hosted by the Faculty and informal e.g. via social media organised by the appraisers themselves.

In response to this feedback, the Faculty has undertaken two networking evenings, to date in November 2013 and May 2014.

These events have been facilitated by the Faculty Responsible Officer, Dr Susan Bews, with the main focus being upon individual appraisers presenting examples of their personal experiences of appraisals to the group and opening discussions on how to address issues arising and subsequently how to incorporate learning outcomes into best practice. These discussions have been supported by guidance from Dr Bews.

The Faculty Responsible Officer has provided feedback to the appraisers on her perspective of the portfolios reviewed to date.

The GMC perspective on revalidation was provided by Mrs Ingrid Southorn (GMC Employer Liaison Advisor) who addressed the May meeting. The role of the ELA involves advising designated bodies, such as the Faculty, on how to address some of the more complex issues relating to revalidation. Meetings with the ELA take place regularly and also afford the opportunity for the Faculty to be updated on revalidation progress within the GMC.

Feedback from the appraiser network events suggests that this is a useful resource and a valuable learning opportunity.

Revalidation through the FPM – appraisee point of view

Dr Lucy Pavesi
Senior Medical Adviser, Safety Surveillance & Analysis
Procter & Gamble

I was among the first cohort of FPM members to go through revalidation – my appraisal was in September 2013 and I successfully revalidated in November. Here are my thoughts on how it went…

With regard to preparing for my appraisal, all I can say is that I'm glad I'm used to documenting and saving stuff! I should explain that my main role as a pharmaceutical physician is European Qualified Person for Pharmacovigilance, so 'inspection-readiness' and 'audit trails' are the name of the game! This stood me in good stead for the delights of the PReP system, where you have to be able to upload multiple documents as supporting evidence for your activities covering the GMC Good Medical Practice domains and attributes.

In fairness, I soon got used to navigating my way around the electronic system. One thing I learned (the hard way) though, is that it's best to add items to the PReP system gradually over time, rather than several at once. This is because you soon get frustrated having to enter (mandatory) 'start' and 'end' dates for each activity or document, with its description. This detailed information becomes more difficult to trace and recall once a few weeks have passed since completion. Also, even after my appraisal, I still cannot answer the question 'How many documents/activities is enough?' I guess the general rule is that you need at least one item of supporting evidence for each GMC attribute, and it's fine to have more for some attributes than others. Another frustrating aspect of using the PReP system is that it asks for your reflections and learnings from each activity across two separate data fields, so my input here became rather repetitious. Overall the whole process of adding evidence items is quite time-consuming even if you have suitable documentation to hand.

In terms of understanding the GMC domains and attributes, the various guidance documents issued by the GMC and FPM were helpful. The main challenge for pharmaceutical physicians is addressing the more 'patient-orientated' attributes when most of us have little or no direct contact with patients. My closest involvement is in terms of handling adverse event reports from patients and writing safety labelling and information leaflets. You have to think creatively about how you can show that your work covers these areas. To this end, I found the FPM seminar on revalidation useful. It provided good practical advice. For example in interpreting the attributes as they relate to pharmaceutical physicians, and on what constitutes a quality improvement activity.

Finally, in terms of the appraisal itself, once I had got through the rather tedious process of completing the pre-appraisal documents in PReP, I actually found this to be enjoyable and much more helpful than I had perhaps anticipated. My appraiser had been able to review my supporting evidence in the system ahead of our meeting, so we had time for a good discussion about my personal development plan. It was really beneficial to be able to give this some thought with the help of the fresh perspective and objective view point of an independent appraiser.

Revalidation in a pharmaceutical company designated body

Dr Danie du Plessis
SVP, International Medical, R&D Chief Medical Office
GSK

It was with some degree of trepidation that the time for revalidation became fact. A friend once said there is no emotion worse than uncertainty, and to some degree this was the case during the time before and soon after revalidation became reality. Many of us had some idea what it was about but were not quite sure what would be expected.

We are fortunate to have our own responsible officer in the company (GSK) who has gone to great lengths to get a number of us trained as appraisers. To be honest, my initial thoughts when asked to be an appraiser was that it would be quite easy and straightforward given that we are used to doing performance appraisals in a work setting. However, the devil, as always, is in the detail. I remember reading the documents before doing my first appraisal and thinking: wow, this is much more specific and detailed in practice than I thought it would be.

By the third appraisal it was also clear that we will always have huge variation between individuals in this process and that as appraisers we will need to be aligned to have a common quality standard. Fortunately there were some great examples of reflective notes (amongst other things) that we could easily and quickly share as best practice.

The next surprise came with preparing for my own appraisal. There is of course truth in 'see one, do one, teach one'. With the benefit of hindsight, I think all appraisers should have gone through their own appraisal first to truly understand what is involved, what the expectations are, how the system works, how to upload documents, and to generally appreciate some of the detail first hand.

So the second cycle has now started. Some of the challenges include checking for continuity from the first assessment, specifically as it relates to identified development areas. The second cycle should ideally also see more focus on the part of the appraisees rather than try and capture everything they do. The one thing that I personally still struggle with is the discipline to do quick reflective notes on an ongoing basis and making it an everyday habit of reflection.

Although only applicable for those of us maintaining a licence to practise with the GMC, I still find the internal performance appraisal and the revalidation appraisal somewhat disconnected. The GMC and the company evaluate different things. I wonder how we can combine the two evaluations in a sensible and efficient way from a documentation perspective as there is an overlap of 'how' we get things done – if not for GMC at least for the company? I also wonder if it would make sense to try and get timings for pharmaceutical physicians aligned for midyear or end of the year company appraisals. And of course translating what clinical patient interaction means for us in the industry remains a challenge for most.

Although practice makes perfect, both as appraisee and as appraiser, we need to plan appropriately to do this well as it does take quite a bit of time to get right.

Revalidation – thoughts from an internationally-based doctor

Dr Piotr Krzeski
Medical Director
Medpace

Why I decided to revalidate

The United Kingdom is one of few EU countries which formally recognises pharmaceutical medicine as a medical specialty. In Poland there is no such recognition and pharmaceutical physicians are denied a medical licence to practise. For myself, I feel that GMC registration and the UK licence to practise enables me to maintain connection to a professional body and maintain acknowledgment of my medical qualifications.

Steps I took to revalidate

Ensuring engagement of employer:

The revalidation process takes time and requires financial commitment. It is best served when the employer recognises the need and supports the efforts. It may be challenging in non-UK organisations that are not familiar with it. Upon registration with the Faculty as my designated body I had to complete a number of documents (the revalidation pack) including the revalidation agreement with a statement from my employer.

A special international practice form with its attachments for additional information is required from non-UK doctors. For employed pharmaceutical physicians these include a description of the organisational structure and reporting arrangements relevant to the doctor's role, the arrangements for performance monitoring and review, the organisational disciplinary policy and procedures relevant to fitness to practise. You will also be expected to provide a description of complaints policies and procedures relevant to medical practice, including complaints from clients, patients and public. Information will be required on external quality frameworks or codes of practice relevant to the doctor's role and how findings are reported as well as the doctor's current standing with local medical regulators in the country where the doctor is registered and practises.

Most of the required information fell under my employer's SOPs and policies; being confidential this did not need to be presented in full, but briefly described (up to a single page) in general terms with reference to the internal documents.

The e-Portfolio and PReP

I took time to acquaint myself with the system. It is likely to be my repository of collected evidence for the rest of my professional life so it was a worthwhile investment. The e-portfolio requires early input on the scope of work. The scope of work will include the list of current roles and responsibilities within the employing organisation as well as any roles undertaken outside of main employment. My job description from the employer proved to be a useful document to start with. I complemented it with the part-time roles that I fulfil voluntarily (e.g. teaching medical students or observing courses for the Faculty).

In revalidation much emphasis is put on quality improvement activities. A lot of what pharmaceutical physicians do in our practice has quality improvement at its roots. For example medical monitors act to improve quality of clinical research when providing Good Clinical Practice advice. I implemented short feedback questionnaires after my presentations which I then complemented with reflection on

the results to include as a quality improvement activity. Voluntary work was also a great piece of evidence. The work I did for the Faculty (as a course observer) complemented my supporting information as a quality improvement activity.

Getting in touch with my appraiser:

My appraiser helped me through the revalidation process. It was worthwhile getting in touch early (although allocation took time) and setting the appraisal meeting date. This helped with planning and making travel arrangements as the meeting needed to take place in the UK. Three weeks prior to my appraisal meeting I had a very helpful teleconference with my appraiser during which some last minute advice was shared. At that time I had my supporting information uploaded and prepared in the e-Portfolio but some reflective learning notes needed additional elaboration.

The appraisal meeting:

The meeting with the appraiser gave me the opportunity to provide live commentary to the rather tedious task of collecting and filing the documents in the e-Portfolio. This was the time to answer questions on why I thought a particular piece of evidence supported what it was meant to support, provide a personal perspective to my responsibilities and how I felt they were addressed in my daily work in line with the GMC requirements. Importantly it is also the opportunity to discuss the achievements and plans for the future both to address revalidation issues, if any, but also career development.

What I learned

Systematic work is key. An early review of what is required helps in collecting the supporting evidence as it accumulates, which saves hours of archive folder browsing.

In the end the revalidation process turned out not to be just for maintaining the UK licence to practise. I truly appreciated the added value of reflection on my daily work. It brought to life the aspects of my personal and professional development that would have otherwise gotten buried in the other priorities and gone unnoticed. By itself this could help me improve as a pharmaceutical physician and ultimately … this is what revalidation is about.

Trainee revalidation

Dr Swati Bhat
Medical Assessor
MHRA

All doctors who hold a licence to practise with the GMC, which will include doctors in training (trainees), must revalidate. For pharmaceutical physicians enrolled on the Pharmaceutical Medicine Specialty Training (PMST) programme this means 1) collecting evidence demonstrating their achievement of the competencies set out in the 'Specialty Training Curriculum for Pharmaceutical Medicine, August 2010' (the PMST curriculum), 2) having regular meetings with their educational supervisors to discuss their progress and training needs, 3) submitting self-declarations about their professional conduct and scope of practise, and 4) attending the Annual Review of Competence Progression (ARCP), which is held on a yearly basis and acts as the trainee's annual appraisal. The Postgraduate Dean, who is also the responsible officer for trainees, will submit a recommendation to the GMC advising if the trainee is fit to practise and can continue to hold a licence to practise. The GMC decides whether to revalidate a doctor. The Postgraduate Dean will normally submit a recommendation to the GMC every five years (if training lasts longer) and also at the point that a trainee is eligible for a CCT. Thereafter it will be a five-yearly process.

For a trainee the most important part of the revalidation process is the collection of evidence, which will help the Educational Supervisor as well as the ARCP panel to assess the trainee's appropriate progress through the PMST programme. This demonstrates that the trainee remains up to date and fit to practise in accordance with GMP.

The evidence relates to the six types of information as required by the GMC and some examples are mentioned in the table below:

Categories	**Examples of evidence for trainees**
Continuing professional development	Project-based Discussion, Pharmaceutical Medicine Assessment Tool, Diploma in Pharmaceutical Medicine, attendance at meetings including reflection on the learning gained
Quality improvement activity	Project-based Discussion, Pharmaceutical Medicine Assessment Tool
Significant events	Reflective log
Feedback from colleagues	Colleague Feedback Report
Feedback from patients	Patient Feedback Report
Review of complaints and compliments	Reflective log, Trainee Form R

The above evidence is all related to those needed to demonstrate achievement of the competencies set out in the PMST curriculum. The evidence has to be electronically recorded in the trainee's individual training e-Portfolio. There are templates for each of the above. In addition there is the possibility of adding other evidence through the documents that can be added in the individual library and then linking it to the appropriate item/s.

Each trainee's individual circumstances will influence the number and type of evidence used to demonstrate the achievement of competencies. Initially it can be quite daunting to understand the type of evidence that is required and the best way to present it. However advice from the educational supervisors and other trainee colleagues, along with the Faculty guidance, can be very helpful. This will enable each individual to develop their own method of presenting evidence on the e-portfolio.

Gaining these skills to collect and present evidence in an electronic format will be helpful even after the training ends, as this activity will be necessary for the duration of a pharmaceutical physician's professional life. The platform for collecting the evidence for the annual appraisals required as part of the revalidation process may be different in different Trusts or different specialties but the principles are likely to be similar.

On a personal note, I found the above process a bit difficult at the beginning as I was uncertain of the best way to present the evidence. However once I had some experience it was much easier. Critical comments from my educational supervisors and looking at the examples on the Faculty's website helped me to refine my presentation of evidence. I am confident that this will stand me in good stead even post training.

Every project undertaken and every incidence, whether good or bad, encountered during one's professional practice can be a learning experience. Selecting the most appropriate example and presenting it effectively is the challenge.

Trainees must declare information about all work that they have undertaken as a medical practitioner since their last ARCP including any medical practice that falls outside of their training programme. This information will normally be entered in the trainee Form R (Part B), and their employers' completed 'Scope of Practice' form. The organisation where the trainee is undertaking PMST will also have to submit an 'Employer's Trainee Report' (also known as the 'Collective Exit Report'), which the deanery sends twice a year to all the employing organisations of the trainee and the 'Concerns and Investigations Report', where any concerns and their resolution should be detailed.

To conclude, during training other than the routine training requirements, there are no extra requirements for preparing for revalidation and the process is quite streamlined.

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