CMO's report on revalidation

In the aftermath of the Shipman Inquiry's fifth report, the Chief Medical Officer for England, Sir Liam Donaldson, had an unenviable task in producing a report on patient safety, revalidation and the functions and structure of the General Medical Council (GMC) that would engage a general public exercised by the circumstances it reviewed, a bemused government and a UK medical profession showing a loss of confidence. His 44 recommendations deserve careful consideration but, alongside those that will be generally welcomed, others bear more careful scrutiny during the 4-month period of consultation.

Our patients should welcome the emphasis on increased public safety and the Royal College of General Practitioners will recognise many of its responses to Donaldson’s Call for Ideas in his final recommendations, and will welcome the pivotal role for it that he proposes in their delivery. Even with a rigorous approach, there will always be variations of standards within a range and the public must accept that even if that variation is narrowed, by definition, the performance of 50% of all 'good' doctors will be 'below average'. Donaldson proposes examining a number of domains of performance, but any test of a reasonable level of knowledge must take into account not only that range of normal achievement, but also the different ways that doctors at different stages of their careers codify their knowledge. The young doctor can produce long lists of differential diagnoses, whereas older doctors, relying on long experience, not only know what they do not know, but know where to find the answer. The trick will be to bridge both variables with a method capable of withstanding legal challenge.

A 'rigorous approach' may possibly ignore any debate over revalidation's core purpose. Some believe that a recertification process is one that should summatively guarantee quality practice. Others advocate that it should involve appraisals that are intrinsically more formative but with a summative endpoint: in effect, a foundation stone that clarifies the meaning of registration with incremental enhancements that would steadily move the mean of the bell distribution curve of quality to the right. Donaldson describes the former, but he concedes that there is an alternative view and he seems to forget that in 2004 Dame Janet Smith believed that the Department(s) of Health were fully signed up to the latter.

In general terms, however, the RCGP will welcome an approach that more explicitly sets a standard for practice that will better reassure our patients, but recertification or revalidation aside, some of the remaining recommendations of this report are more controversial, especially among doctors.

Donaldson's most surprising and unevindenced proposal is to transfer the responsibility for undergraduate medical education away from a well-resourced, experienced and widely respected GMC Education Committee, overseeing medical education across an entire medical career, to a Postgraduate Medical Education and Training Board (PMETB), already struggling with an existing remit that is limited to the training years. He seems to have ignored powerful arguments to do exactly the opposite and park PMETB's remit under the wing of a GMC that has a track record with Tomorrow's Doctors, existing alliances with the Academy of Medical Royal Colleges over the educational continuum and the necessary personnel.

Donaldson's recommendations to abandon elected medical GMC members will unsettle those doctors who believe that GMC policy should be informed by doctors still working at the coalface, and that the profession should maintain its right to elect a proportion of the medical majority that will remain. Reverting to appointed members will only retain the confidence of doctors if previous perceptions of regulation by grandees remote from everyday practice are avoided. As the chairman of the Governance Working Group that produced the composition and balance of the current GMC membership, in office only since July 2003, I comment only that this structure has barely had time to bed in, and judgement upon its effectiveness is perhaps premature.

Doctors are perhaps most alarmed that their livelihoods and reputations could be compromised on the basis of the civil standard of proof that Donaldson suggests should be deployed in fitness to practise cases. The GMC already investigates complaints on that test, but the potential drastic penalties upon conviction surely demand a higher level of proof than probability. The rigour he proposes for recertification sits uneasily with this recommendation: the phrase ‘balance of probabilities’ does not resonate with the word ‘rigour’.

There are, however, three other major issues with Donaldson's proposals that will exercise patients and government as well as doctors before November.

The first is to do with the accountability of the GMC as the medical regulator. Under Donaldson, the GMC will retain one core responsibility — the keeping of the medical register. One must ask how realistic it is to discharge that duty if the job of ensuring the competence and basic medical education of entrants to that register is removed to another body. Similarly, if adjudication of fitness to practise cases is to be carried out by a new, separate tribunal, how can the GMC effectively maintain the standard of its register if the decisions to remove doctors from it, or their quality control, are not its responsibility? Arm's-length, European Union legally-compliant fitness to practise decisions presently inform ethical standards, undergraduate education and registration under the same organisational umbrella and the loss of such a virtual circle would not be in the interests of best regulation. In the middle ground are those cases that Donaldson wishes to be subject to remedial and supportive action through locally-based GMC affiliates. These new officials would effectively carry out the duties of existing trust medical directors but, in the future, would be badged, franchised and trained by the GMC centrally, but with many of their decisions overseen by yet another, separate, national body.

GMC affiliates would have to fulfil a mixed role as police officer, remediator and examining magistrate, conflicting jobs that most doctors no matter how senior, respected or motivated would find impossible to approach with sustained integrity, especially if they are to be employed locally by health authorities. What is proposed, in effect, is the transfer of the responsibility for failing local NHS clinical governance to a central GMC and, at the same time, introducing an expensive new layer of regulation in the middle of that sandwich. The question remains, however,
how is the GMC to be accountable for a
register when entry, removal and
prescriptions for remedial action are to lie
outside its direct control?

The second issue that raises profound and
unanswered questions is over the
anglocentricity of most of the report’s
proposals. The Health Commission, the
National Patient Safety Agency and its
National Clinical Assessment Service have
responsibilities in Wales, but none in
Northern Ireland or Scotland. Medical
regulation was a function reserved to
Westminster at a time when there was a
cohesive NHS operating within a common
health policy in the four home countries. This
is no longer the case and there may be
questions raised as to whether it is still
appropriate to regulate on a UK basis.

Finally, Donaldson emasculates the
existing medical regulator by annexing its
power to local NHS structures while, at the
same time, denying citizens and patients of
the single most important attribute that
requires its retention as an independent,
vigorous and fearless charitable body. The
GMC is the only organisation that stands
outside a near monopoly employer of
doctors, a near monopoly provider of health
services that, of necessity, ration the extent
of health provision — the government and its
departments of health.

Until now it has been the GMC that has
been the final arbiter of what constitutes
good medical practice, decisions based not
upon that which can be provided within a
treasury budget, but upon what should be
provided in the name of best care. The great
danger of Donaldson’s proposals is that the
standards of medical care, the appointment
of those who decide them and the parameters
upon which doctors will be called to account,
will all reside within the control of the government of the day and its
civil servants. Those of us who believe in a
professionalism mediated by standards
rooted entirely within the public good hold
serious concerns over that proposed shift in
responsibility and accountability.

Good doctors and safer patients are aims
easiest to be desired by all citizens. The
danger of fragmenting the existing structure
of the GMC is that it could unpick its new
cohesion of purpose and policy that naturally
acknowledged the tragedy of Shipman, but
had greater aims than merely the early
discovery of sociopathic criminals among
doctors. Even more dangerous, however, is
that doctors who have been regulated since
1858 in a professional context are, in future,
to be controlled and disciplined through a
contract of employment by reference to
standards, organisations and personnel that,
in the final analysis, owe their power to the
department of health and the patronage of
its secretary of state. Some believe, wrongly
in my view, that the GMC has allowed
professional standards to slip in recent
years: one can only wonder at a view that
doctors would work better, harder and to
higher standards for health service
managers, than the vast majority currently
do because of pride in their profession.

‘British medicine’ is a phrase that has held
credibility across the world for many
generations before 1948 and presently is
well placed to survive the demise of the NHS
as we know it. That certainty is less secure
under some of Sir Liam Donaldson’s more
controversial proposals and we can only
hope that what many see as excess baggage
does not compromise what lies at the
heart of his report — better and safer
medical care.

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Conflict of interest
Elected GMC Medical Member for Scotland,
Chairman, GMC Pension Trustees, Deputy
Treasurer, GMC and UK elected member, RCGP
Council.

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Can early diagnosis and effective
management combat the irresistible
rise of COPD?

My stoical patient in the oxygen clinic was
newly diagnosed with chronic obstructive
pulmonary disease (COPD), having
presented in a coma with severe hypoxia
and hypercapnia. His lungs had been
deteriorating for decades, now the potential
to help him is severely restricted. Such
extreme presentations indicate the problem
of late diagnosis. For a disease where
decline is largely preventable, the sight of
patients dying slowly of COPD should be a
rarity — sadly it is becoming more common.
Despite falling smoking rates, with the
projected rise in the number of older
patients, COPD prevalence is increasing,
and the number of people with COPD
reaching 85 years of age is projected to rise
by nearly 75% by 2025.1 Under-diagnosis
and under-treatment contribute to the
growing burden of human misery and
healthcare costs. We need to know whether
there are effective strategies to stop people
with early disease progressing, and if so,
how to detect the disease early.

The natural history of COPD has been
dominated by the Fletcher–Peto curve
showing accelerated decline in lung
function in susceptible smoker and the
effects of smoking cessation.2 However, it is
not at all clear which patients with early
airways obstruction will progress to more
severe disease. Recent data from Holland
showed that over 5 years, 33 of 399 male