Whither revalidation now?

The *Fifth Report* of the Shipman Inquiry[1] and the government's immediate response, setting up a review under Sir Liam Donaldson, have left the whole concept of revalidation in a state of suspended animation. There is currently a danger that a sense of inertia descends over the profession and that Dame Janet Smith's criticisms of the General Medical Council's (GMC's) proposals give oxygen to those with alternative agendas.

Those proposals would have seen the introduction of a GMC process on 1 April 2005 that was arrived at after a long, difficult, but ultimately successful, consultation that involved government, patient interests and all sections of the profession. Sir Liam's review must not lose sight of the considerable agreement that had been achieved over the greatest proposed change to medical regulation since 1858.

Sir Donald Irvine has been quoted as stating that the original concept of revalidation has been watered down[2] and senior members of the RCGP Council seem to be suggesting that they have the answers to Dame Janet's criticisms. But are those perceived deficiencies real or imagined?

It surely cannot be the case that Harold Shipman was the norm rather than a unique aberration within the UK medical profession. If that were so, a system to 'weed out' potential homicidal maniacs among our ranks would be entirely necessary. If, on the other hand, a more reasoned approach to the probity of a learned profession holds sway, an approach that finds comfort from any test of public opinion, one must ask what we are trying to achieve. The answer must be to produce change to regulation that is commensurate with the problem and, at the same time as avoiding complacency, to recognise Dame Janet's compelling conclusion that whatever multisystem failure allowed Harold Shipman to murder, he could not have escaped detection so long had he not been a doctor.

Most professionals believe that reflective practice and keeping up to date are reliable tools in the prevention of potential dysfunction, allowing diagnosis and treatment of deficiencies in practice at the earliest opportunity in a context of increased scrutiny of values and performance, as measured against *Good Medical Practice*.[3] This method concentrates on performance, which subsumes competence, while recognising that the converse does not necessarily hold true.

The licence to practise will mean that doctors will offer evidence for both educational appraisal and clinical governance scrutiny, systems that together positively affirm good practice as well as identifying 'bad apples'. An educational appraisal that is not brought to a grinding halt by serious concerns for patient safety is implicitly 'a tick in the box', especially when complemented by a clinical governance certificate issued after a more directed and rigorous examination of available evidence based upon credible and effective local arrangements.

The granting of that clinical governance certificate will rightly fall to NHS and other employing authorities, but will be supplemented by random GMC quality assurance of the systems in place.

All this was agreed for implementation in April. Agreed by a willing profession well before the shocking discovery of a Shipman in its midst. Agreed by a responsible government that believes in effective medical regulation. Agreed by a public rightly concerned that continued registration depended only upon sending an annual cheque from a recognisable address and by avoiding very serious complaints.

The words 'rigour', 'inspection', 'tests of knowledge and performance', 'assessment' and 'regulation' are now gaining currency. The idea of local panels carefully examining each doctor's individual revalidation folder every 5 years has been resuscitated (implying some 30 000 committee decisions a year). A profession already regulated by contract, by registration, by clinical governance, by NHS complaints procedures, by the criminal and civil law, and by medical royal colleges and competent authorities, now possibly faces yet more hurdles, but at what potential cost?

The UK has a shortage of doctors and what it needs least is an intrusive system of regulation and inspection that inappropriately withdraws licences to practise and at the same time ties up the clinical time of many others to administer a complicated process. What it does need are two things. First, an effective local system that is capable of acting upon evidence of seriously impaired practice immediately, not every 5 years. Second, at national level, a revalidation system that assures that every licensed doctor is up to date and fit to practise as judged against verifiable evidence. These are the very aims of the system now being re-examined.

Sir Liam has a heavy responsibility. He will have to sift through the three volumes of the *Fifth Report*, to consult widely and to test and, if necessary, adapt a process that had already been signed off by all interested parties including the departments of health in all four countries of the UK. He has to find a middle way between the public's concern and its desire for a health service that treats patients quickly and competently. In the meantime, doctors have to expect that some form of revalidation will be introduced based on verifiable evidence, and it must maintain impetus in the name of being a responsible profession worthy of regulating itself in partnership with the public.

For its part, the GMC must avoid complacency and be responsive and co-operative, but equally not lose sight of the fact that its temporarily shelved plans secured widespread support based on careful consultation. Revalidation was never going to be perfect at the first

throw, no new process ever can be, but it has to start somewhere.

Internationally, the GMC revalidation proposals were seen as well ahead of the game and were awaited with congratulatory expectation. Unless sense prevails we could soon see the loss of a world-leading innovation and, at any one time, half the nation's doctors travelling up the M6 in order to assess the remainder with consequences on service delivery that all parties should seek to avoid.

BRIAN KEIGHLEY

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Roger Neighbour

Rotten apples

First and last, it is to the patients and families who suffered at the hands of the abominable Harold Shipman to whom we all — professionals and policy-makers, individually and corporately — owe a duty of care. That said, there is a sense in which we doctors too are Shipman's victims. We too are experiencing the normal sequence of feelings after profound trauma: shock, denial, despair, grief, anger, guilt, blame, and (eventually) being able to move on. As with a personal bereavement, the greatest loyalty we can show the departed is to enrich our own continuing lives with their legacy.

At College Council on 12 February, every shade of this emotional palette was in evidence. We were profoundly touched to hear a GP from Hyde describe the distress felt by Shipman's professional neighbours on learning that, while conducting themselves in no way differently from the vast majority of other GPs with no reason to suspect a colleague of the most egregious crimes, they found themselves, in hindsight and by implication, accused of sins of omission. We were equally moved by Brian Keighley's evident anguish, having devoted a working lifetime to the pursuit of personal and compassionate care, at having his motives and competence as a member of the GMC impugned by Dame Janet's Inquiry. And while the RCGP has emerged from the Inquiry relatively honourably, we in turn find there is a danger that the College's measured and systematic advocacy of ever-higher standards of practice might be highjacked to serve the pressing agenda of detecting the rottenest of rotten apples.

But detecting rotten apples *has* to be a priority for a profession that wishes to make a credible case for self-regulation. A system of revalidation that, while spotting an apple just on the turn, risks missing one so rotten as to cause damage on Shipman's scale, is simply untenable. And not just damage on Shipman's scale. The GMC's proposals pre-Dame Janet, much as we might wish them to have been adequate, were more appropriate to a golf club's membership committee than to a profession where — granted that most of its members are honest and competent — an unacceptable rump is nonetheless letting us all down. We need to remember that the thrust of Dame Janet's criticism was not that we failed to spot the once-in-a-millennium villain, but rather that the early warning systems that might have spotted rogues as well as villains, outliers as well as psychopaths, were, frankly, not fit for purpose. We have to concede that a small minority of GPs are less than acceptably competent, less than acceptably up to date, less than acceptably professional. A system of revalidation that assumes we all take pride in self-reflective improvement through appraisal, and that the absence of clinical governance evidence of incompetence is positive evidence of competence, will, sooner or later, fail. It may not fail on a Shipmanesque scale, but fail it will; and those failures will do avoidable damage to patients.

So what is to be done? The GMC's proposals were, as Brian reminds us, a world-leading innovation. But we can do even better. Sir Liam Donaldson has, as Brian observes, a heavy responsibility. And we must help him discharge it. Wisdom and humility are needed. We must neither over-react nor under-react. We must all try to rise above personal hurt and parochial ambition. We need to be rational and unemotional. We need to be proud of our professional traditions, yet humble in the face of our shortcomings. Where there is evidence of what will lead to improvement, we must be persuaded by it.

The ghosts of Shipman's victims are entitled to no less.