Will GP revalidation make things better or worse?

Question: what revalidation policy will produce quality practice and also prevent another Shipman? Answer: policy that makes practitioners unafraid to question the status quo. Shipman could have passed tests for medical competence. It was someone unafraid to ask 'why do so many of your patients die?' that found him out. Similarly, a quality practitioner is unafraid to go beyond a superficial medical diagnosis and patiently, persistently, gently, explore deeper, hidden things. Revalidation must lead to an environment where supportive asking of uncomfortable questions becomes the norm.

At an individual level, I am describing a reflective practitioner[1] who uses qualitative as well as quantitative methods of inquiry. This practitioner recognises that what is known at a superficial level is never the whole story, and is always fishing for surprises.

At an organisational level, I am describing a learning organisation[2] that teaches all staff the habit of learning from and with each other, and puts in place learning spaces, systems and feedback loops that help to translate individual learning into whole-organisation learning.

At the level of the whole system, I am describing a learning community,[3] wherein people from different backgrounds develop trusted relationships that encourage friendly, not punitive, exploration of new ideas.

There is a wealth of knowledge about how to develop reflective practitioners, learning organisations and learning communities. Policy for revalidation could learn from this.

Argyris and Schon[4] describe three distinct types of learning that are simultaneously required in a learning organisation:

1) Single-loop learning relates to quantitative, positivist approaches to inquiry that leave the underlying assumptions of the status quo intact.

2) Double-loop learning relates to qualitative, critical theory approaches to inquiry that question these assumptions.

3) Deutero-learning, or 'learning how to learn', relates to participatory, constructivist approaches to inquiry that generates new knowledge through creative dialogue between different people.

Single-loop learning thinks in simple, linear and controlling ways. On its own it leads to defensive reasoning.[4] This is good at maintaining the status quo and achieving short-term goals. However, it also encourages 'top-down', simplistic, 'black and white' solutions that cannot deal with the complexity inherent to most situations. Also, it is a dominant feature throughout the health service, including general practice. Overly emphasising this in revalidation will encourage further defensive behaviour — the opposite of what is needed. It is a self-evident fact that if a practitioner is made to feel vulnerable, accused or overly scrutinised, they will be less prepared to risk, increasingly pass responsibility to others, avoid exploration of deeper aspects of a patient's health, and retreat into the safe territory of evidence-based protocols, applying them with inappropriate rigidity. Whole person care, job satisfaction and health service costs will all suffer as a consequence.

Double-loop learning carefully considers the complexity and context of a situation — it encourages humility, active listening, and openness to new interpretations. Deutero-learning recognises that genuinely new knowledge is co-created — it encourages team-working, systems-thinking and inter-disciplinary participation in learning and inquiry. Together, these forms of learning lead to a heightened ability to identify and solve problems (which addresses the fear of another Shipman), build trusted relationships (which facilitates asking uncomfortable question) and lead to more effective learning (thereby increasing competence, quality and job satisfaction). They are less concerned with controlling others, and more about enabling them to see bigger pictures, and helping them to feel that they belong. Their systematic use would result in a smarter and cheaper approach to quality. However their use may also feel unfamiliar or 'risky'. It may seem overly hands-off to those whose preference is to directly control the behaviour of others, and overly complex to those who expect simple, single solutions.

So how can these theories be applied to policy for revalidation?

1. Revalidation should be seen as only one component of an integrated strategy to encourage good questioning, learning and quality throughout the career of a GP. Other closely related aspects are appraisal, participation in audit and research, organisational development, teaching, service monitoring, and participation in local innovation and inter-disciplinary learning sets. All of these things should be made relevant to each other within ongoing cycles of life-long learning. Appraisal and revalidation can be considered to be different stages in these cycles. Each individual would develop their own cycles to include things that fit best with their overall development. Part of the revalidation process could be an examination of its coherence.

2. Special attention may be required for any practitioner whose performance causes concern. This can be at any stage of the cycle, including revalidation. However, the emphasis at all stages should not be on 'passing' or 'failing', but on meaningfully engaging in a pursuit for quality and personal development. This requires that

facilitators, managers, teachers and leaders know how to make primary care a learning and nurturing environment.

3. Learning and revalidation of individual practitioners cannot be totally divorced from learning and validation of the general practice organisation and the Primary Care Trust. PCT visits to assess the Quality and Outcomes Framework of a practice could become a key point in this cycle where diverse aspects of the practitioner, practice and locality stories can be considered together.

4. Multiple windows into practitioner behaviour and learning are useful, built up into a portfolio and largely under practitioner control. The mentor/appraiser/facilitator should be able to help the practitioner to use this in an empowering way to describe their own life story, rather than as an onerous burden of accountability. Different and innovative windows should be encouraged, including audio and video analysis, peer consultation audit, 360° appraisal, knowledge questionnaires, audit and research projects, written papers, significant events, student teaching and leadership of team-learning. These should be presented not as defensive posturing, but as proud celebration of personal growth.

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REFERENCES

1. Schon DA. *The reflective practitioner.* London: Maurice Temple Smith Ltd, 1983.
2. Senge P. *The Fifth Discipline.* London: Century Hutchinson, 1993.
3. Wenger E. *Communities of practice — learning, meaning, identity.* Cambridge: Cambridge University Press, 1998.
4. Argyris C, Schon DA. *Organizational learning II: theory, method and practice.* Reading, Massachusetts: Addison Wesley, 1996.

Flora medica
Richard Lehman

From the journals, February—March 2005

***N Engl J Med* Vol 352**

655 Given as soon as labour becomes painful, intrathecal fentanyl provides better analgesia than a conventional epidural and a lower rate of caesarean section.

676 Long ago, STD meant Subscriber Trunk Dialling, and VD clinics were advertised in the nation's lavatories. Treating the partner(s) was always the problem: the answer is to give the patient enough antibiotics to share out. The proof lies in reduced rates of reinfection.

692 There are at least four memory systems in the brain, and each has its own location and its own dysfunctions. Read this useful review, though I defy you to remember it all.

757 An effective oral cholera vaccine at last — great news for the developing world.

768 A human herpes virus causes sixth disease — and is given the number six, although for a different reason. It causes roseola, as opposed to slapped cheek syndrome, which is fifth disease. Is there a fourth disease? And what are the other three?

***Lancet* Vol 365**

579 A fascinating and well-illustrated study of out-of-hospital antibiotic prescribing habits in Europe. British GPs are among the most sparing and conservative in choice, while the Dutch prescribe the fewest of all, and the French are the most profligate. Bacterial resistance is only loosely related to prescribing, as the editorial on page 548 explains.

663 You need a cool head to look after sick neonates. Head-cooling helmets (on the baby) improve outcomes in severe and perhaps in moderate neonatal encephalopathy.

755 A trial of FOOD for stroke patients sounds like a good idea, but three pragmatic trials of dietary supplementation after stroke showed little benefit. Enteral (PEG) feeding in dysphagic stroke patients does have some survival benefit, but quality of life is very poor (page 764).

773 A systematic review looks at the benefit of influenza vaccine in children older than 2 years — plenty from one vaccine, less from the other.

855 New macrolide antibiotics like clarithromycin and azithromycin are widely prescribed for chest infections in the US, and their arrival was followed by increases in macrolide-resistant *S. pneumoniae*. But then, following widespread pneumococcal vaccination, rates of resistance began to fall.

879 Sensorineural hearing loss in very young children is usually hereditary, and can be treated with cochlear implants, but in older children it is increasingly caused by personal listening devices. Turn that thing down, it's deafening!

***JAMA* Vol 293**

810 A new urine test for bladder cancer – the nuclear matrix protein NMP22. In male smokers over 60 years, it's slightly better than PSA is for prostate cancer. So, if we need another lousy screening tool for urological cancer in men, here it is.

935 It may be useless for most other things, but surely HRT helps the female urogenital tract? Well, maybe in some situations, but rates of urinary incontinence are actually higher in users.

956 This study used a screening instrument for bipolar disorder that detected it in 10% of patients attending a general medical clinic. Beware making your depressed patients manic, it warns, although lithium for a tenth of the population seems a bit more hazardous.

1082 Why reduce homocysteine (Hcy)? The usual reasons are cardiovascular, but in this Japanese study two Hcy-reducing vitamins were used successfully to reduce hip fractures in stroke victims. They used folate and B12, but to do the job properly, add thiamine, pyridoxine, and perhaps riboflavin. And throw in some vitamin D to strengthen bone and muscle (see *BMJ* 2005; **330:** 524).

Other Journals

Arch Intern Med (**165:** 393) finds that coeliac disease (which raises Hcy) is four times commoner in patients with thin bones. A cost-effectiveness analysis of combined aspirin and clopidogrel in *Ann Intern Med* (**142:** 251) is cautiously in favour of the combination. But on page 260 there is little comfort for the older doctor: a systematic review shows a negative correlation between clinical experience and quality of health care. And on page 310, statins hit another bogey — they are linked to nasal polyps. But things in the nose can help hay fever: *Allergy* (**60:** 529) experimented with prototype nasal filters in the parks of Sydney. *Chest* (**127:** 604) explores the worrying link between paracetamol use and asthma. If you have your left temporal lobe removed, you will find that music can still make you feel happy or sad, but not frightened (*Brain* **128:** 628). A sort of Hitchcockectomy.

Plant of the Month: *Magnolia x veitchii 'Isca'*

If you own a park and don't mind branches falling on people, this is perhaps the ultimate flowering tree, covered in vast, intensely scented goblets.