Revalidation: cracks at first, now chasms

On 8 June 2005, Professor Mike Pringle gave the 2005 John Fry Fellowship Lecture, organised by the Nuffield Trust in London. He called it ‘Revalidation of doctors: the credibility challenge’. The audience was, in sections, invited and alert, great and good, knighted and elevated, yet some were fidgety and irritated. At the end, we were all stunned in part, taken aback at times, but on the whole most were impressed, I think, at the candour and grasp of the issues. Mike gave a stirring account of the history, the twists and the turns, the Bristol and the Shipman, the international developments, the current stand off, and drew his argument to a close with a round of 10 bullets that ricocheted among the canapés. He asked us to consider, in disarming clarity, what, in his view, and maybe the view of many more, the true aim of the most important test facing the medical profession is to be, when all is said and done. It’s to sort out goats and sheep. Lets stop pretending otherwise.

At this point, best to recap, as he did, that the General Medical Council (GMC) had at first proposed that revalidation should assess doctors using a portfolio of evidence, based on standards, with lay involvement and with an understanding that the onus was on doctors to establish that they were ‘up to date’ and ‘fit to practice’. He reported that the GMC’s position had shifted significantly around 2001 to the view that taking part in five appraisals was going to be sufficient; a process that was subsequently augmented by the addition of a local clinical governance review. In this shift, lay involvement in the process had been downsized significantly.

Dame Janet Smith’s Shipman Inquiry Report declared that this model of revalidation was ‘not fit for purpose’. The GMC when considering the report on the 15 December 2004 decided to uphold their conceptualisation of revalidation; essentially to ‘tough it out’. The Department of Health meeting on the same morning decided that revalidation should not be allowed to proceed as formulated. A few days later, a review was announced by the Chief Medical Officer. We await the results of the review.

This crack, this disagreement between the existing GMC view and those who feel that revalidation as set out cannot accomplish its stated aims, is now in great danger of leading to a chasm in which many will find themselves adrift as this issue gets played out more and more vociferously between institutions, Royal Colleges and government. At the heart is the debate about the overall purpose of revalidation. Professor Pringle, like many others, argues that to truly protect the public, revalidation has to address poor performance as well as provide a mechanism for the episodic assessment of all doctors. Failure to address the need to weed out those doctors who are ‘not fit’ to practice is to retract into paternalism, a protective professional attitude that he argues is not sustainable. It is, he contends, a serious problem if the GMC continues to hold the line that revalidation is about confirming safety of practice rather than use a screening tool, ‘that taking part in five appraisals was going to be sufficient; a process that was subsequently augmented by the addition of a local clinical governance review. In this shift, lay involvement in the process had been downsized significantly.‘

Elements of the audience were clearly uncomfortable with this message. Many of the Royal Colleges support the GMC’s current approach to revalidation or have undeclared positions. The RCGP has within it voices such as Pringle1 and Lakhani,2 who challenge the GMC’s standpoint and wish to see a standards-based portfolio of evidence put back on the agenda, yet concede that the exact nature of many of the assessment methods have yet to be determined. They are careful, however, not to suggest that their views represent the College.

There is, of course, an assumption in all this that it is necessary to give everyone the same test rather than use a screening tool, although of course screening has its own set of problems. It also clear that having tools accurate and sharp enough to cut out poor performance, however defined, will be yet another hurdle. Making sure that people can use such tools in a consistently skilful way is another challenge. The complexity and economics of this gargantuan task were not addressed. But these are implementation issues: there is no clarity as yet about what is to be implemented.

Here then is the stuff of drama: powerful people at loggerheads about principles, with nothing less than the regulation of professional practice at stake. The Chief Medical Officer will of course be taking soundings, and his recommendations will reverberate in this policy vacuum. It was an important event and in the last analysis, some were surprised when Professor Pringle did not put forward what seemed to be a potential conclusion to his analysis. A number of people in the audience, particularly patients, were left wondering that if revalidation is really about ‘protecting patients’, as well as supporting doctors, and if the GMC is finding it ‘all a bit difficult’, then perhaps the time has come for another institution entirely. That might be a step too far for those concerned — but who knows what a newly elected government might do.

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REFERENCES