Mechanisms of revalidation

In last month's edition of the Journal, Glyn Elwyn gave an overview[1] of Mike Pringle's 2005 John Fry Fellowship Lecture.[2] Pringle outlines the history of the General Medical Council's (GMC) plans for revalidation, the GMC's current thinking around revalidation, associated concerns expressed in the fifth report of the Shipman Inquiry,[3] his concerns about the current state of revalidation and, finally, some options on the way forward. Elwyn also provided an eloquent summary of his own interpretation of the persisting concerns around appraisal.

Pringle describes his disagreement with the GMC's position on revalidation and articulates thinking that is not all that dissimilar to the GMC's. Even more difficult to follow is the reconciliation between his definition of revalidation and his own options for delivery.

Although Pringle interprets the legislation (that refers to revalidation as 'evaluation of a medical practitioner's fitness to practice') as focusing solely on the absence of unfitness to practice, he quickly reverts to the GMC's early and continuing notion of the demonstration of positive attributes and not the identification of poor performance. One exception is 'certification of meeting local standards for clinical governance and that there are no local concerns', an aspect of raising and acting upon local concerns about a doctor's performance. The GMC includes this as the local clinical governance sign-off.

In recognising that appraisal was never intended to detect poor performance, we have evidence that some doctors' appraisals are deferred due to the detection of local concerns about performance.

Pringle's main suggestions for a mechanism of revalidation are about demonstration of positive attributes. His bullet points (see Box 1) are largely drawn from the Royal College of General Practitioners' *Criteria, Standards and Evidence for Revalidation of General Practitioners*.[4] The public and the profession can be reassured that these are not new ideas. They are already imbedded in the culture that is building around clinical governance and appraisal. A quick examination of where we are highlights how the majority of these criteria are already included in the existing processes (Box 1).

At intervals Pringle appears very keen on the use of lay inspection of all doctors' folders. Despite recognising this as impractical, his final analysis requires all folders to be assessed by colleagues and lay individuals at least once. He implies that this is the only way of securing lay involvement in the revalidation of doctors. Leaving aside the issues of practicality and cost-effectiveness, I would suggest that other issues need to be considered.

Consideration of folders is best undertaken by those who know the doctor's practice locally, and have access to the necessary expertise and data to analyse and understand the results of audit and clinical governance data.

Lay involvement in groups is not the only way of securing patient involvement in revalidation. The GMC's guidance recommends the use of patient feedback questionnaires for all doctors. Lay involvement in quality assurance of both appraisal and clinical governance adds value.

Pringle believes that:

'Clinical governance will, in time, become a very useful keystone in revalidation. But either alone or with annual appraisal, clinical governance is

Box 1. Main suggestions for a mechanism of revalidation.[2]

Suggestion	Current situation
A statement of what the doctor does	This is already present in the standard appraisal documentation for NHS and private sector doctors; locums and substantive post holders, in all four of the UK devolved administration
Evidence that the doctor is fit practise those activities, including:	
• Certification of having effectively taken part in appraisal	Part of GMC's existing plan
• Certification of meeting local standards for clinical governance and that there are no local concerns	Part of GMC's existing plan
• The results from case-based and conventional audits	Easily and often already incorporated into advice on completing appraisal documentation
• The doctor's reflective continuing professional development within an annual personal development plan	Already an existing part of appraisal and its link to continuing professional development
• The views of patients and colleagues (360 degree assessment) including complaints and their outcome	Ongoing work by GMC and some medical Royal Colleges to develop questionnaires in this context
• Certification of technical skills required for the doctor's role (such as communication skills, medical records keeping and cardiopulmonary resuscitation)[a]	Can easily be incorporated into either appraisal or clinical governance where appropriate. There is a danger of creating a new industry around this particular point and further clarity is required as to validity and reliability of such certificates if they are to be considered.
• Self-certification of health and probity	Specific wording already provided by the GMC guidance on revalidation
• Other speciality specific evidence as required	This could be advised by the appropriate Royal Colleges

[a]*This is the only aspect of Professor Pringle's suggestions that is not already covered by existing guidance.*

not, and will never be, a revalidation methodology that is fit for purpose.

My reasons are as follows. The application of clinical governance in the NHS is still variable and its presence outside the NHS is even more erratic ..."[2]

Although I recognise that appraisal and clinical governance are inconsistent in their methodologies and delivery in different parts of the UK, much of this relates to organisational discrepancies. The fact that they are not yet fit for purpose is not a reason to discard these two complimentary and powerful tools as having the potential to be reliable mechanisms for delivering a positive demonstration of individual doctors' fitness to practise.

Pringle argues that we do not need revalidation if local processes become this effective, thus failing to recognise the positive impact that I believe the GMC's current model of revalidation will have on enhancing the quality and consistency of appraisal and clinical governance. Existing tools, thus enhanced and quality assured, can provide powerful statements about individual doctors and the environments within which the vast majority of doctors will be exercising their licences to practice.

Elwyn's article recognises that there is an ongoing debate about the constitution of revalidation.[1] Pringle's lecture and the fifth Shipman Inquiry report appear, to me, to do more to enhance the GMC's position than to detract from it.

Malcolm Lewis

REFERENCES

1. Elwyn G. Revalidation: cracks at first, now chasms. *Br J Gen Pract* 2005; **55:** 562.
2. Pringle M. *Revalidation of doctors: the credibility challenge. John Fry Fellowship Lecture.* London: The Nuffield Trust, 2005.
3. The Shipman Inquiry. Safeguarding patients: lessons from the past, proposals for the future. London, TSO, 2004. http://www.the-shipman-inquiry.org.uk/fifthreport.asp (accessed 14 Jul 2004).
4. Royal College of General Practitioners. *Criteria, standards and evidence for revalidation* (revised). RCGP: London, 2004.

Flora medica
Richard Lehman

From the journals, June—July 2005

***New Eng J Med* Vols 352/353**

2477 Borderline gestational diabetes, with peak sugars <11, is worth taking seriously. This trial found better maternal and fetal outcomes with tight control than with usual care.

2508 The first case report of an unvaccinated patient who survived rabies, albeit with residual disability: she was put into coma and given antiviral drugs until her own immune system took over.

2571 Spooky pictures of the Marburg and Ebola viruses which emerge from the African forests to kill scores of people, partly because of poor health practices.

2598 News of a monoclonal antibody capable of stopping the autoimmune destruction of insulin-producing cells — early days, but exciting.

2721 All you need to know about the cheap, easily manufactured recreational drug γ-hydroxybutyric acid (GHB) — addictive and dangerous, especially taken with alcohol. For other clubbing drugs, see *Lancet* (2137).

***Lancet* Vols 365/366**

2024 Back pain is mostly better after a month, with no difference in this trial between physiotherapy and a brief pain-management programme.

2041 The ubiquitous Epstein-Barr virus is associated with nasopharyngeal cancer in South East China.

2098 Two big cohort studies (see 29 below) drive home the message that transient ischaemic attacks (TIAs) need to be considered as medical emergencies in the same way as unstable angina.

2179 Endovascular repair of abdominal aneurysms proves to have the same mortality as the big bloody open operation.

2201 Sad dads are bad for lads: fathers who get postnatal depression have adverse effects on their children, especially boys.

29 The Oxford ABCD score for risk assessment in TIA — A for age, B for blood pressure, C for clinical features, and D for duration.

37 If you don't treat conjunctivitis, it gets better by day 7, whether it's viral or bacterial. Even at day 3, there was little difference between chloramphenicol drops and placebo.

***JAMA* Vols 293/294**

2865 A big meta-analysis trying to decide whether we should be taking a selective or blanket approach to early invasive treatment for acute coronary syndromes. No clear answer, as there is a higher immediate mortality from early intervention, balanced by better long-term outcomes.

3003 Triple vaccine for all adults? This study proves that it is safe and immunogenic, and may eliminate the 25% of persistent coughs caused by pertussis.

3029 An important study from British primary care examining outcomes in acute uncomplicated lower respiratory infections in healthy adults, randomised to antibiotic, no antibiotic, or delayed antibiotic. There was no significant difference.

Other Journals

Arch Intern Med (**165:** 1246) reports that a milky diet seems to reduce premenstrual syndrome. To avoid hypertension, lose weight: data from Framingham on page 1298 showing that dropping a stone in middle age reduces the risk by over 30%. For treating hypertension, ALLHAT comes out in favour of thiazides, even in diabetes or impaired glucose tolerance (page 1401), and a systematic review of 27 trials (page 1410) confirms equivalence among drug classes. *Ann Intern Med* (**142**) ends June with a supplement looking at the challenges faced by systematic reviewers in a wide spread of topic areas, including complementary and alternative medicine. A trial of acupuncture for fibromyalgia found, once again, that sham treatment works as well as real (**143:** 10). The Chinese population probably derives greater benefit from soy beans than from needles — a study from the People's Republic (**143:** 1) demonstrates a drop in blood pressure. By contrast, a sham-controlled trial of acupuncture in *Obstet Gynecol* (**106:** 138) finds that it may help women with overactive bladders. *Arch Dis Childhood* (**90:** 733) reviews the role of cystography in 108 children who had a urinary tract infection in the first year of life, and found that this unpleasant investigation has little value. The message of *Mayo Clin Proc* (**80:** 728) is to avoid long-haul flights before major surgery: they increase your risk of venous thromboembolism. *Med Humanit* (**31:** 23) brings a robust defence of evidence-based medicine: 'EBM is a necessary condition for clinical freedom, not a threat to it.' Just as some dogs look like their owners, some journals resemble their subjects. The *Journal of Individual Differences* contains a quirky scattering of topics; the *International Journal of Obesity* keeps gets fatter; and the *Journal of Near-Death Studies* has not appeared since Fall 2004, prompting fears that it may have crossed to the Other Side.

Plant of the Month: *Hydrangea sargentiana*
If you have a big damp shady space, this handsome hairy giant will reward you with mauve-blue lacecap flowers, whatever your soil.