CMO's report on revalidation

In the aftermath of the Shipman Inquiry's fifth report,[1] the Chief Medical Officer for England, Sir Liam Donaldson, had an unenviable task in producing a report[2] 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*[3] 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 variation 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.[4] 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 unevidenced 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*,[5] 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, rations 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 earnestly 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