interventions for problems such as depression anxiety, eating disorders, and schizophrenia has received much recent attention and is now clearly a health service priority. However, even with a sizable increase in current resources it will be hard to meet the potential demand. The expansion of training in the technique to professionals whose work is not exclusively focused on mental health problems seems a logical development. The health visitors who took part in the study enjoyed the training and delivery of the intervention and they found the techniques they had learned transferable to their other work. The use of a manual ensured standardised treatment, and alongside training, supervision, and case review, provided a robust model of service delivery. Development of alternative strategies for delivering CBT — such as supported self-help[18] or computerised[19] approaches — might merit further research and could further expand our therapeutic options.

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Regulation: appraisal alone is not enough

Until now, the ultimate goal of medical training has been to achieve the right to independent medical practice. The prime benefit of this has been the professional ability of a doctor to think, speak, and act objectively, purely in the interest of clinical benefit, and free from corporate constraint. The noxious side effect has been a litany of medical scandals, well documented elsewhere, where doctors, both misguided and malicious, have become the agents of harm. The challenge for a new regulatory process is to eliminate the latter while preserving the former.

The introduction of appraisal for all NHS doctors was an excellent first step in addressing this challenge for several reasons. Firstly, it is a universal process following a standard format. Secondly, it has broadened the remit of professional development to include all aspects of good medical practice, not just maintenance of knowledge. And thirdly, it has begun with the premise that most doctors are diligent and honest, and will voluntarily bring the important issues to their appraisal.

This is not to say that appraisal has solved the problem. Although universal, there is inconsistent implementation. The dawning of realisation that professional development goes beyond knowledge has been slow, so that there remain too few learning resources around subjects such as teamwork and probity. And, partly because we choose what we present in appraisal by way of evidence, and partly because at its heart appraisal is a developmental activity, there remains the question of how we assure that individual doctors meet acceptable standards of practice.

These contradictions are part of the reason why researchers such as Colthart *et al* end up with the results they have.[1] In a postal survey to which 671 GPs responded, 47% thought that appraisal had altered their educational activity. Asked about the value of appraisal, around 40% reported their perception that appraisal is valuable, around 40% that the value is marginal, and the remainder that it has no value. Appraisal has the potential to succeed, but also to fail. The optimists see the former, the sceptics the latter.

This divergence of opinion is healthy. The sceptics should consider the optimists' view that the process is worth further development and the optimists should recognise the gaps that appraisal fails to address. Both groups need to accept that, valuable as the

supportive and confidential aspects of appraisal are, there need to be elements of scrutiny and public demonstration of competence for a regulatory process to be effective and credible. Whether these elements occur within the appraisal or in parallel clinical governance processes outside the appraisal, they must be present.

The government white paper on regulation[2] has provided an important point at which to examine the appraisal process so as to consider how it needs to develop, and what other processes need to be placed alongside it, for regulation to work. Some of these things are clear, some less so. Appraisal needs to be standardised, and its implementation audited, to show the level of consistency being achieved. Key items of evidence submitted for appraisal must be agreed, spelled out, and produced by the doctor for the appraisal to proceed. Linked to this, organisations must align their clinical governance processes towards producing information that is relevant not just to surgeries, departments and teams, but to individuals, so the doctor can produce evidence for appraisal relating to their individual performance. Clearly, it will be a challenge for organisations to support the process and to make it manageable for doctors to complete in a way that adds to, not distracts from, their clinical role. All of this needs to happen not just in the context of one specialty or location, but for all doctors, whatever the nature of their employment, in all four countries of the UK.

The most fundamental change, however, is not one of these, sizeable and challenging though they are. The critical shift required relates to our attitude towards our traditional professional aspiration of independent medical practice. Our collective fear of relinquishing independence is perhaps the strongest reason why better regulation in the form of revalidation has not already occurred. We believe that measurement of performance such as it exists at present is inadequate. We fear that by being measured we will be judged and either found wanting or coerced into activities we do not want to undertake. Altruistically, and legitimately, we fear that this will ultimately harm patients because they will have lost their independent voice. Selfishly, and unacceptably, we fear loss of status and power. Independent practice has served the profession and the population well despite the disasters that have occurred — the dilemma lies in not knowing whether relinquishing independence will ultimately help or harm.

The answer is that it depends on what we replace independent practice with. If we revert to a subordinate, dependent state, everyone will lose. We would be better not to change. However, if we can envisage something higher than independence to move towards, this may justify the risk of making a change.

Our new aspiration should be for interdependent, not independent, medical practice.[3] An independent doctor stands alone and proud; an interdependent doctor is entwined with their teams, organisation, and patients. An independent doctor acts as an unchallengeable font of knowledge; an interdependent doctor is a bridge between a patient and all aspects of their care, continually informing, counseling, negotiating, and advocating, in as many different directions as it takes to serve the patient's best interests. An independent doctor lays claim to the moral high ground; an interdependent doctor shares it.

Shifting to a culture of interdependence will have a subtle but profound effect on how we embrace regulation. The interdependent doctor continually seeks out perspectives other than their own, to be sure, rather than make assumptions about, the motives of others. This sharing of perspectives allows the building of trust between the organisation and the individual, which is what will allow the gradual unpicking of the blame culture, so well recognised in the NHS. Because interdependence requires multilateral integrity and trust, instead of fearing retribution for failing measures, we will develop confidence in the fair and tolerant ability of our organisation to identify where variations within measures are acceptable. Therefore, instead of viewing scrutiny as oppressive and intrusive, we will see it simply as a step towards better understanding of how we work. As we become more open and confident, the organisation will perceive less defensiveness, and also begin to develop a better understanding of the pressures on clinicians that prevent improvement on measures. We will begin to address performance issues with the organisation outside appraisal, and receive support in return for engaging with scrutiny. This, in turn, will reduce the pressure on appraisers to 'assess performance' in the appraisal interview, allowing appraisal to fulfill its precious function as a confidential forum for facilitated self-reflection,[4] while at the same time providing an annual punctuation mark in the overall regulatory process.

As it is in medicine, so it is in life. The issue is societal; the choice personal. The highest levels of organisation, the GMC, the NHS, colleges, and society itself will continue to try to move the profession towards where they collectively think we should be, so as to be safer and better. Individually, unless we are motivated to change, then rather like a patient coerced to take a statin without being convinced of the benefit, the process will be one of continued ambivalence, sporadic conflict, and stuttering points of activity, ultimately unsatisfying, wasteful, and possibly harmful. The risk: if we do change, and get it wrong, then everyone will lose, society and the profession both. The prize: if we get it right, the rewards could be remarkable. The era of 'independent medical practice' may come to be seen as an unfortunate one of 'unsupported medical practice', and people may wonder why we did not move to interdependent (and supported) medical practice sooner.

And so here we are. Appraisal alone will not be enough for regulation. We will be measured. We can resist, in the hope of preserving independence, or succumb, reverting from independence to dependence. Or we can choose a new aspiration. The choice is personal. Interdependence: the decision is ours.

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