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LET'S TAKE A VOTE ON REVALIDATION

The news that revalidation pilots were to be extended by a further year, and the whole process subject to a cost-benefit analysis was a source of delight to many. It also provides a golden opportunity for the profession to take stock of what frontline doctors really think about the idea.

Whenever a change is proposed to the status quo, there are a number of key questions that need to be asked.

First, what is wrong with the current state of affairs or can it be improved upon? Second, what is to be achieved by the new set of measures. Finally, how will it be achieved?

At present, GPs are subject to an annual appraisal. Their clinical work has never been more closely scrutinised: QOF, PCT prescribing advisors, patient surveys, and significant event analyses. Our colleagues read records of our consultations on a daily basis, so we enjoy continuous peer review. As GPs, we of course have the ultimate scrutineer sitting with us in our consulting rooms: the individual patient, who will return to see us time and time again, forcing us to confront our failures as well as rejoicing in our successes.

Given this, are we to believe that there is a significant cohort of GPs who are 'under-performing'? Half of all GPs will of course be 'below average', but how many are significantly and consistently failing in their professional practice? It cannot be as high as the 5 to 14% anticipated to fail revalidation.

Others have argued that it is important the profession is seen to be doing the right thing, in order to restore public confidence. This rather implies that the public do not trust us, despite evidence to the contrary. Two years after Shipman was found guilty, a MORI poll revealed that doctors were the most trusted professionals.[1] The public, at least, were able to recognise that Shipman was a lone serial killer, and not reflective of the profession as whole.

Will revalidation reduce the risk of another medical serial killer? Almost certainly not — as many commentators have pointed out, Shipman would probably have sailed through the revalidation process.

If the process is not robust enough to weed out the exceptionally small number of the truly inadequate from the rest without imposing an undue burden on the majority, if there is no problem with public trust, and if it will not eliminate mass murderers from the ranks, then what it is it for?

The third question, of how revalidation is to be achieved is equally critical. The same survey[1] that revealed high public trust, also found that 61% of the public thought that doctors spent too much time doing paperwork. Where is the evidence that multi-source feedback or patient satisfaction questionnaires will lead to better, more competent doctors? In already challenging areas with difficult patient populations, it may in fact have the opposite effect of demoralising hard-working practitioners.

So we have a chance, a brief window of opportunity for the profession to unite behind the banner of the College. We must rise up against the spectre of revalidation, which undermines our professionalism and will force many of our most experienced colleagues into early retirement.

The College is the only realistic outlet for the voice of GPs, and as such it has a heavy burden of responsibility to represent us. The College cannot afford to become estranged from its members; and for the sake of the profession, the members must not become disenfranchised with the College.

So let's do the democratic thing and take a vote on revalidation. If the ordinary, jobbing members of the College decide revalidation should go ahead, then we naysayers have a duty to stop complaining and engage with the process; if not, then revalidation should be laid to rest.

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REFERENCE

1. The Public's Trust in Doctors Rises. MORI on behalf of the British Medical Association, 2002; **14 June**: http://www.ipsos-mori.com/researchpublications/researcharchive/poll.aspx?oItemId=967 (accessed 14 Jun 2010).

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