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Revalidation is the answer

To one question—but many more remain

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Revalidation is the current focus of attention in the unending examination of the roles, rights, and responsibilities of professions. On behalf of the public, governments may permit and sometimes encourage groups with special skills to have a monopoly in providing services. When the public is not in a good position to judge the quality of a service, the training, qualifications, and codes of ethics and behaviour of a self regulated profession have traditionally provided the desired protection. However, these structural characteristics of a profession are no longer enough to reassure a less deferential and better informed public. This is true for all professions and for all developed countries. So it is against this background that moves towards revalidation of doctors in the United Kingdom should be seen.

Societies now expect evidence of the effectiveness of services and of the continuing competence of individual practitioners. The introduction of clinical governance within organisations and revalidation for individuals has been the first step to meeting this expectation in health care in the UK. For many doctors these terms have, as yet, little concrete meaning. The General Medical Council aims to change that by introducing revalidation for all doctors in the UK by 2002 within a healthcare system that will become increasingly transparent about the quality of services.

British medicine is coming rather late to accepting revalidation. As the articles in this issue show (pp 1180-92),[1–5] other countries have already gained substantial experience in implementing different approaches to maintaining professional credentials. Within the UK nursing and dentistry are also well ahead of doctors.[6 7] As with early initiatives in Australia,[3] however, nurses and dentists are relying on the provision of evidence of participation in formal and informal continuing education. The licensing bodies, professional organisations, employers, and, presumably, patients in Canada, the Netherlands, and the United States are seeking to go beyond this educational proxy for continuing competence by including methods of examining the performance of clinicians.

Not surprisingly, Norcini reports formidable difficulties in the US in devising rigorous and fair assessment methods that rely on patient outcome measures.[2] Such measures are now used routinely in many American health care systems to provide performance profiles for doctors, but case mix differences and problems in attributing outcomes to individuals in a team setting have impeded the use of patient outcome data for recertification.

As a sweeping generalisation, assessment has so far relied on the exam in the US and on the examiner in Europe. These traditions are now converging.[2 5] In the Netherlands for all doctors and in the US for some specialties, peer review of performance is an important element of revalidation. In both countries national clinical guidelines are used to shape the assessment.

The international trend to revalidation for doctors shows that its adoption in the UK is not simply a reaction to recent high profile cases of professional misconduct, though these may have influenced the timing of the GMC's decision to embark on revalidation. It is seen as the current answer to the question: How can the profession reassure patients that doctors remain competent? Other questions remain: What else should revalidation be trying to achieve? Will it actually improve patient care? Will it enhance the continuing professional development of doctors? In a recent lecture Van der Vleuten described the inevitable educational reaction to every assessment action[8]: for the person being assessed, the assessment is the educational curriculum. Will revalidation subvert continuing professional development by forcing doctors to concentrate only on what is to be measured?

The GMC's revalidation steering group has been ambitious and imaginative in defining the process of revalidation. It has firmly linked revalidation to registration. Recertification (the term most commonly used in other countries) and revalidation are therefore synonymous. The GMC has also decided on local delivery of the system based on national standards and puts its faith in a combination of local peer review and transparency for the public, employers, and the profession. Four subgroups are devising the processes for specialists, general practitioners, public health doctors, and doctors in training; on p 1180 Southgate and Pringle describe the progress made in general practice.[1] An outline system will be formulated by next May so that the GMC can consult on it, with the aim of deciding the final strategy by May 2001 and beginning implementation from the end of 2001.

Revalidation will undoubtedly be introduced. Undoubtedly, too, it will have a profound effect on the practice of medicine in the UK. Hard questions remain—not least over the logistical problems. Over 100 000 doctors will have to be assessed, with many also acting as assessors. Will the multiplicity of local review procedures required for different branches of

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the profession be able to withstand legal challenge? For example, how will the many non-principals working in general practice show their continuing competence? The GMC has so far set its face against formal examinations, but for some groups this would be a sensible option.

In fulfilling its primary responsibility to protect patients the GMC will add revalidation to its existing regulatory powers. It will require intelligence and hard work to translate the principle of revalidation into a process that stimulates the continuing professional development of doctors but does not become an empty chore that diverts clinicians' time and energy from caring for patients.

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1 Southgate L, Pringle M. revalidation in the United Kingdom: general principles based on experience in general practice. *BMJ* 1999;319:1180-3.
2 Norcini JJ. Recertification in the United States. *BMJ* 1999;319:1183-5.
3 Newble D, Paget N, McLaren B. Revalidation in Australia and New Zealand: approach of Royal Australasian College of Physicians. *BMJ* 1999;319:1185-8.
4 Dauphinee WD. Revalidation of doctors in Canada. *BMJ* 1999;319: 1188-90.
5 Swinkels JA. Reregistration of medical specialists in the Netherlands. *BMJ* 1999;319:1191-2.
6 United Kingdom Central Council for Nursing, Midwifery, and Health Visiting. *Standards for post-registration education and practice*. London: UKCCN, 1995.
7 General Dental Council. *Reaccreditation and recertification for the dental profession*. London: GDC, 1997.
8 Lord Cohen Lecture. www.educ.unimaas.nl/lord-cohen-lecture.htm (accessed 25 October 1999).

Dangerous people with severe personality disorder

British proposals for managing them are glaringly wrong—and unethical

This summer the British Department of Health and the Home Office jointly issued a paper on *Managing Dangerous People with Severe Personality Disorder*.[1] The paper was apparently "based on the results of extensive informal discussions" and sets out the government's policy objectives in dealing with what the paper calls the "dangerous severely personality disordered." The paper avoids descending into the apparently unending debate over what is, or is not, a personality disorder and to what extent personality disorders are treatable and attempts to cut through the gordian knot with what presumably are intended as straightforward and practical proposals for action. If only it were that simple.

This government "framework for the future" proposes legal powers for detaining indefinitely people with dangerous severe personality disorder. Specialists, including psychiatrists, are to be employed both to better identify people with dangerous severe personality disorder and to develop "approaches to detention and management." Finally a comprehensive programme of research is to be established to support development of policy and practice. The proposals make a point of insisting that "indeterminate detention will be authorised *only* on the basis of evidence from an intensive specialist assessment" (my italics).

There are people whose antisocial and self damaging behaviours are at least in part a product of abiding character traits such as impulsivity and suspiciousness combined with abnormalities of mental state, including instability of mood and dissociative symptoms. Such distressed and disturbed individuals currently attract little interest from mental health professionals and even less from those who fund services. Clinical experience suggests, however, that such disorders can be improved, if not cured, even if research has failed to pinpoint the best therapeutic approaches. Severely personality disordered individuals are overrepresented among recidivist offenders, though such disorders do not inevitably lead to serious offending; nor are serious offenders drawn exclusively from their ranks.

Crime and violence are major political issues. Surveys indicate growing public support for more punitive approaches to offenders,[2] and populist governments around the world, be they left, right, or third way leaning, fall over themselves to respond to law and order agendas. In England and Wales section 2 of the Crimes (Sentencing) Act already provides for discretionary life sentences for those convicted a second time for serious violence or a sexual offence. The courts have, however, shown a signal lack of enthusiasm for imposing such sentences, frustrating the government's carceral enthusiasms. The proposals set out in this document openly acknowledge the hope that the judicial reluctance to sentence on the basis of predicted future behaviour will be reduced if courts are provided with medical evidence that offenders have dangerous severe personality disorder.

What is wrong then with proposals that promise far greater resources for a relatively ignored group of mentally disordered people and at the same time hold out the prospect of increased community safety? If dangerousness was really a characteristic of some personality disordered individuals rather than a characteristic of some acts by some of them; if the proposed special centres, with their multidisciplinary teams armed with "batteries of standardised procedures," could reliably recognise dangerous severe personality disorder; if these proposals were really about providing care and treatment for the personality disordered; and if health professionals were really judges and jailers charged with maintaining public order, then perhaps these proposals would be worth taking seriously. But none of these assumptions holds true.

Enthusiastic advocates exist for actuarial methods of predicting future criminality, and some place considerable theoretical emphasis on the contribution of personality.[3 4] In practice, however, the probability of future offending is predicted most effectively by past offending.[5] Variables such as being a substance abuser or having a history of being abused as a child, have significant, if less consistent, associations with increased

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