GMC and the future of revalidation

Patients, professionalism, and revalidation

Donald Irvine

Revalidation is an essential part of professionalism directed at meeting patients' expectations of good care. The GMC must rise to the challenge

This is the third in a series of articles examining regulation of doctors

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Despite substantial efforts to modernise UK medical regulation, the General Medical Council still does not always put patients' safety first. That is Dame Janet Smith's main conclusion in the fifth report of the Shipman inquiry.[1] The approach to implementing revalidation illustrates her point. Although she found that "The foundation for a system of revalidation that would command public confidence had been well laid" by the GMC, it had been seriously weakened by "substantial changes" made recently to the method of implementation "for reasons of expediency." She said that the revised intentions, approved by the Department of Health, would no longer comprise an evaluation of a doctor's fitness to practise. Yet a competent evaluation is what the public had been led to expect and what the law now requires.

In this article I have set licensure and revalidation in the broader context of patient expectations and doctors' professionalism. I consider six linked points that need positive decisions now to help secure a successful outcome (box 1). Much of modern health care is team based, with the doctor one element in a wider system of clinical governance. Nevertheless, everybody knows that a doctor's performance is critical to the quality of the clinical process. Without good doctoring, patient care can never be safe, however comprehensive the supporting systems are. We ignore this basic fact at our peril.

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The Drop of Milk in Belleville: Doctor Variot's Surgery, the Consultation (1903) by Henri Geoffroy

All patients are entitled to a good doctor

All patients want to be looked after by a good doctor.[2–4] This is because they know instinctively that a doctor's decisions and advice about diagnosis and treatment can affect the outcome and possible consequences of illness and may make the difference between life and death. Patients equate "goodness" with up to date medical knowledge and clinical skill, strong ethical standards, and a bedside manner that is empathetic, courteous, and kind. These are fundamental attributes of doctors' professionalism. When patients and their loved ones are preoccupied with illness, they want to take their doctor's professionalism for granted; they want doctors they can trust.

In fact, most patients generally regard their doctors as good and trustworthy.[5 6] However, although patients can judge a doctor's personal qualities, they have to take clinical competence on trust because they cannot assess it satisfactorily. So they rely on medical regulation to ensure both good medical practice and protection from substandard practice.

Patients now know that their unquestioning trust in the regulatory system was not justified. Evidence from patients' complaints, recent GMC fitness to practise cases, surveys of patient experience, and estimates and examples of substandard practice available to Dame Janet's inquiry[1 7] all suggest that an important minority of practising doctors are clinically inadequate, cannot communicate effectively, or cannot relate appropriately to patients. The main reason for this is that doctors and their regulating bodies, through a misplaced sense of professional solidarity, have tolerated such practice because it avoided confronting colleagues. Successive governments colluded.[8] Consequently, patients have been exposed knowingly to risky doctors.

Box 1: Six decisions to ensure successful licensure

- Agree that all patients are entitled to a good doctor
- Make patient centred professionalism a priority
- Accept that GMC's new standards based model for regulating doctors is conceptually sound
- The standards gap must be closed
- Performance assessment is essential for revalidation
- The GMC needs to be properly accountable to parliament

This position is indefensible. So the first decision is to accept that, from now on, patients are entitled to be treated only by good doctors.[9] This applies particularly to specialists, general practitioners, and locums whose practice is unsupervised. There should be no ambiguity about this. Today we know much more about what we mean by good practice and how to distinguish between acceptable and unacceptable practice. Ensuring good doctoring is vital to patients and should be equally important to good doctors, whose collective reputation is inevitably damaged by poorly performing colleagues.

In practical terms this means that all doctors who hold a current GMC licence to practise—not just the conscientious majority—would be required to meet the standards the council says are necessary for good practice. A useful guide to the threshold of goodness would be for doctors, with their insider knowledge, to be confident to entrust the care of their families to anyone holding a validated GMC licence to practise.

Make patient centred professionalism a priority

Professionalism expresses a profession's culture. It should epitomise good practice. It embraces doctors' personal responsibility for their competence and conduct and their collective responsibility for making sure that the medical profession delivers across the board as it is expected to. At its best, professionalism is unsurpassed in delivering high standards of performance, conduct, and service because true professionals are motivated by conscience.

Medicine is in transition from a predominantly doctor oriented culture to a patient centred culture of professional values founded on the principle of patient autonomy.[10] This requires doctors to treat patients with dignity and respect and involve them as fully as they wish in decisions about their medical care. It gives patients a better experience and can improve clinical results.[11 12]

Much of the current culture is sound. However, the profession and the GMC have much to gain from seeing the principles of accountability (transparency, external scrutiny, and the duty to explain[13]) as precious assets rather than a threat. These principles offer the best chance of reducing the blame culture and the associated fear of medical error and of preserving appropriate professional autonomy. This view is supported by the experience of the Food Standards Agency. Its policy of absolute transparency about data, both good and bad, and about the state of knowledge of what can and cannot be done, has strengthened public trust. The implications for open and rigorous revalidation are obvious.

Because of the power of role modelling in medicine, the medical schools, supported and resourced by NHS trusts and postgraduate deaneries, need to take the lead in nurturing and delivering strong professionalism in all clinical teachers in their area. If done well, this would transform clinical leadership to the benefit of patient care, the quality of medical education and clinical governance, and doctors' morale.

So the public and the medical profession both have powerful reasons for putting patient centred professionalism at the heart of their vision of medical care. It must assume a top priority in professional life, practice, education, regulation, and research in order to achieve good doctoring for all patients.

Accept that GMC's new model for regulating doctors is conceptually sound

The new UK standards based model for medical licensure was designed to provide the legal framework for putting the principles of patient centred professionalism into practice. The GMC code of practice, *Good Medical Practice,* is the formal expression of that professionalism.[14] Ongoing research is needed to ensure that the standards continue to be founded on an evidence based understanding of patients' needs, expectations, and experience. *Good Medical Practice* is tied to all dimensions of medical licensure and certification and to clinical governance at the workplace. These ties provide the levers necessary for securing compliance from all doctors throughout their careers.

Revalidation is an intrinsic part of licensure and subsumes recertification. Debate is ongoing about whether revalidation is primarily to show good practice and promote improvement or help identify poorly performing doctors. It is all of these (box 2). This model for licensure was accepted by parliament and the profession and endorsed by both the Bristol Royal Infirmary and Shipman inquiries.[1 15] We should not change the basic architecture.

The standards gap must be closed

An unacceptably wide gap remains between what the GMC describes as good medical practice and the much lower level it uses in making decisions about doctors' impaired fitness to practise, particularly about performance issues. Attempts to close the gap were first made through a private member's bill in parliament in the 1980s but were unsuccessful.[8] The GMC made further attempts during my presidency but failed because resistance from the profession was still too strong.[8] Dame Janet saw the low threshold as a serious problem that has to be solved urgently, not least because the fitness to practise procedures are to underpin revalidation.

To help close the gap it is essential for all doctors to accept, as the public does, that the standards in *Good Medical Practice* are for real. They were intended to be

Box 2: Purpose of revalidation

I was appointed a consultant at Great Ormond Street [The Hospital for Sick Children London] in 1969. In that 30 years nobody has given me an opportunity to demonstrate that I am fit to practise and up to date. I would welcome the opportunity to try to show that to the parents of the children I anaesthetise and the children themselves in some cases. I would hope that the [Medical] Register, available 24 hours a day, seven days a week, would be the instrument for doing that. I hope that people will look up the register, and the fact that I am on it will indicate that I am safe to anaesthetise their children.
Professor David Hatch, speaking at GMC conference on revalidation, 10 February 1999.

attainable by any reasonable doctor. They are not aspirational, as those who hanker after minimalism tend to claim.[8]

Getting the baseline right would be helped if each royal college, within the overarching framework of *Good Medical Practice*, developed the detailed criteria, clinical standards, and thresholds for unsupervised good technical practice in their specialty. The Postgraduate Medical Education and Training Board and the GMC need to review and endorse these standards as signifying the satisfactory completion of specialist training and ensure that they are adequately taught and assessed. The GMC should use these same standards and thresholds as the benchmark for revalidation and fitness to practise.

In the United Kingdom, cardiac surgery is the first specialty to be able to show that all of its consultant surgeons are technically good. This is a tremendous step forwards because these surgeons have shown publicly that it is possible to establish baseline good practice across a specialty. Outcomes for individual surgeons were published recently.[16–18] Such data would form an excellent foundation for the clinical element of revalidation of cardiac surgeons.

Performance assessment is essential for revalidation

Revalidation requires an evaluation of a doctor's medical work against *Good Medical Practice*. The basis of the evaluation was originally intended to be a folder of evidence showing a doctor's personal competence and performance, an annual workplace appraisal by a peer, and a five yearly external evaluation of all the evidence by a small group that would include a member of the public.[19] Subsequently, as Dame Janet showed, these proposals were diluted to such an extent that they could not achieve their intended purpose.

The underlying problem, which goes back beyond revalidation to the introduction of the GMC's performance procedures and even earlier attempts to introduce recertification, is established doctors' fear of assessment.[8] This is a nettle that the profession now has to grasp. Revalidation must be based on an assessment of performance. The profession already has good methods that are readily adaptable for the purpose.[20 21] Now is the time to use them. US doctors' experience with specialty board recertification may give reassurance.

But the main help could come from the royal colleges and specialist societies. They already give strong leadership in their specialties. In particular, the introduction of "membership in good standing," founded on continuing professional development and incorporating continuous assessment, could be hugely supportive and provide members with much of the evidence for revalidation.

Appraisal has become a bone of contention. Some people want it to be formative, concerned primarily with personal development and improvement. This is an important function. But it must not be confused with appraisal used in a summative mode, as part of an assessment. Formative and summative appraisal cannot be combined satisfactorily in the same interview. Actually, the profession needs both and should press for that outcome.

Summary points

- The public are entitled to good doctors and will no longer tolerate substandard practice
- Licensure with revalidation provides the framework for ensuring good doctoring
- Done well, revalidation will both protect patients and support doctors
- Revalidation must be based on a fair, objective evaluation of a doctor's practice

The agreement to public involvement in assessment decisions about individual doctors[19] must be restored in full. Patients' organisations saw this as crucial to their trust in licensure. On the question of cost, we should first decide on the methods that will yield the best results. Decisions on optimum cost effectiveness should follow.

The GMC needs to be properly accountable to parliament

Sound licensure requires a strongly proactive GMC that is fearless in confronting vested interests (whether of the profession, government, or employers) which might seek to deflect it from its prime duty of ensuring that all licensed doctors provide a good standard of practice. The public and the profession should insist on this. Revalidation will be the touchstone because it will affect every practising doctor. Therefore, from now on, the real test of the GMC's trustworthiness will be the credibility of the professional standards it sets for revalidation, the robustness of the evidence it is prepared to accept from doctors to show compliance, and the rigour of the evaluation of that evidence.

The GMC needs to be clear that when it delegates elements of the revalidation process to others, it remains accountable for the standard of work carried out in its name. The pitfalls of ambiguous accountability must be avoided.

The GMC, the BMA, and Dame Janet have all said that the GMC should be directly accountable to the public through parliament. I have suggested that a strong all party parliamentary select committee, drawn from both houses and supported by a body like the National Audit Office, should hold all the health regulators, including the Health Commission, to account.[8] External scrutiny of a regulator's documents, with periodic examination of the results in public, would be a powerful and transparent method of keeping regulators up to the mark. These were the methods used by Dame Janet in her inquiry.

Conclusion

The review following the Shipman inquiry provides the profession and its regulators with an opportunity to affirm the public's entitlement to good doctoring for all. Licensure embodying revalidation is the key to achieving this. A positive approach, combining the best

science available with a firm commitment to professionalism and a local management culture supportive of doctors, would be the best way of securing the rigour needed to command public trust and make revalidation feel fair and worth while for doctors.

With that secured, the profession would be in a strong position to join with the public and employers in a new partnership that could transform the outlook for patient centred health care in this country. And that could make for a much happier profession.

Contributors and sources: DI is a former family doctor and was president of the GMC when the 1990s reforms of medical regulation, including revalidation, were first introduced. This article reflects his open commitment to the principles of patient centred health care.

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Ulysses syndrome

What are the two hardest things to do in medicine? To say nothing (or "I don't know") and to do nothing. We have all felt parents' disappointment at the end of a consultation. So, rather than discharge their child, we offer a follow-up appointment, hoping that by then the parents will be more accepting of the situation or that they will be seen by a different doctor. However well meaning our action may be, it medicalises the child's condition: the parents may well feel that their child must have a serious problem because he or she is "under" a specialist.

We might also request another test, and risk inducing "Ulysses syndrome." Ulysses fought in the Trojan war but afterwards took 10 years, with many dangerous and often pointless adventures, before he got back to where he had started. Patients with Ulysses syndrome find themselves caught in a web of further investigations, referrals, and sometimes treatment before finally being recognised as healthy, which they were in the first place. Ulysses syndrome is a side effect of unnecessary and inappropriate investigations or wrong interpretation of results. It was first described 30 years ago,[1] and the number of tests available is now much greater. With greater choice comes greater responsibility and the need for greater discernment. Otherwise we may condemn our patients to a similar odyssey.

When a colleague (A W Coe) and I reviewed the records of children on the waiting list for magnetic resonance imaging of the brain we found that half had not had their head circumference measured, a basic indicator of brain growth. Yet £400 brain scans had been requested, few of which would alter the clinical management and some of which would lead to further referrals and investigations because of results that would turn out to be normal variations.

The upper and lower 2.5% of the normal distribution of results are usually deemed to be abnormal, so 5% of the population are labelled "abnormal" even though they are probably healthy. If you request an unnecessary test in order to please the child's parents and to satisfy your wish to do something, what do you do if the results are slightly outside the normal range? Do you reassure the parents that it is probably a normal variation, or do you suggest repeating the test "to be on the safe side"? Do you admit the child for further investigation? At the very least you have set in train a very anxious time for the parents, further tests on the child, and at least one further outpatient appointment. The worried parents may even arrange for a second opinion, leading to more appointments and investigations on the child. Such needless procedures are a side effect of an unnecessary investigation and uncritical practice.

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