

Revalidation: a General Medical Council perspective

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Most doctors in the UK are very good doctors who keep themselves up to date because they are highly motivated and committed to doing their best for their patients. In the past this was accepted on trust, but the world has changed. Revalidation is the process by which doctors in the future will confirm that they are up to date and fit to practise.

A *BMJ* editorial accurately foreshadowed a tumultuous decade for doctors: ‘All changed, changed utterly. British medicine will be transformed by the Bristol case’.¹

Until the highly publicised events in children’s heart surgery in Bristol, it had been assumed that doctors would maintain high standards in their profession by self-regulation. However, in Bristol some doctors had been harming patients by working outside their competence while others knew but had remained silent. Self-regulation had been found wanting and the General Medicine Council (GMC) proposed revalidation as a consequence. The idea that evolved within the GMC at that time envisaged a four-layer model of revalidation: the professionalism of the individual; constructive self-assessment within the clinical team; effective clinical governance and quality improvement within the organisation; and, at a national level, the regulator. These principles still stand today.

Revalidation has been a long time coming. The challenge has been to develop a system that is fit for purpose, while being usable by the 218,000 doctors with a licence to practise: revalidation has to work at the front line. The main pillars will be appraisal and multisource feedback (MSF).

Appraisal should be an opportunity to take stock; to reflect on what clinicians are doing to develop their knowledge and skills and what they need to do in the future; to discuss difficulties, personal or organisational, that may be preventing them from performing at their best; and importantly it should be an opportunity for the appraiser to say ‘well done’ to the large numbers of doctors who provide an excellent service, often in challenging circumstances. MSF, or 360-degree feedback, should involve colleagues – not only doctors – and patients and the outcomes should form the basis of a discussion at the appraisal. There may well be outlying views but if there is a trend going in one direction it can be a very useful pointer, either positively or negatively.

A crucial principle is that physicians will be revalidated to do what they do now, not what they once did. And they will be revalidated on what they do that impacts on patients, either directly, for the majority of doctors, or indirectly, for those with a licence who do not see patients. So, for example, a clinical academic doing one clinic a week in a very specialised

branch of medicine with the rest of their time in research would be revalidated on whether they were up to date and fit to do that clinic. Their appraisal, as now, would be jointly administered by the NHS and the university, but their research is of no relevance to the process of revalidation, except in rare instances. Or if they are engaged solely in medical management and do no clinical practice, but take decisions which impact on patient care, they will be expected to show that they adhere to the principles of Good Medical Practice. The GMC is determined to ensure fairness and proportionality in the revalidation process and will be consulting further, in the light of the outcomes of recent pilots, from March 2010.

Determining the knowledge and skills appropriate to doctors who have progressively specialised as their careers have progressed will be challenging. The medical royal colleges are leading that work, with their proposals coming to the GMC for evaluation and ultimate approval. Appraisal will be delivered in and by the NHS and the system is being led by the UK health departments. The GMC is very clear that appraisal must be as free of bureaucracy as possible and are particularly keen to ensure that perfectly good existing systems are not swept aside. There has been much discussion about the costs of revalidation. Our view is that two issues are being conflated. Appraisal should exist in any organisation that is serious about quality improvement and excellence. A well conducted appraisal costs no more in time or money than a bad one and these costs should already be in the NHS system.

Recommendations as to revalidation will be made to the GMC by a responsible officer, usually the medical director. As the name implies, that person will be responsible for the accuracy of the recommendation, but will almost inevitably rely on many others to implement the process, particularly in large organisations. The GMC will have the final say on whether to revalidate a doctor – and, therefore, to challenge any recommendations that seem perverse or which are unsupported by evidence.

The GMC has never considered that the purpose of revalidation is primarily to identify ‘bad apples’. It is primarily to affirm good practice. Clearly, some doctors will be identified who need remediation – as happens now. It is very important that such doctors are identified early in the five-year cycle of revalidation and that remediation begins at that stage.

Revalidation is the biggest change in medical regulation for 150 years – and change brings uncertainty. The GMC recognises the need for timely and effective information and regularly updates the frequently asked questions section of their

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website: www.gmc-uk.org/doctors/licensing/faq_revalidation.asp. Change also brings challenges of implementation, so the GMC is piloting and consulting extensively to ensure that systems work. Revalidation will start in 2011, but not in all specialties or in all parts of the UK at the same time. We will start only where and when we are ready, with progressive phasing-in over the ensuing two to three years.

Reference

- 1 Smith R. All changed, changed utterly. *BMJ* 1998;316:1917–8.

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■ EDITORIALS

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Passive smoking and children's health

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Two generations ago in the UK over half of all men, and nearly half of all women, were smokers. Offering a cigarette to a visitor or guest was considered polite. Government health ministers smoked at their desks. Smoking in public, at work or in the home was normal behaviour, and clouding of indoor environments with tobacco smoke was commonplace.

With the publication of the first reports by Doll and Hill on the association between tobacco and lung cancer, and particularly after the publication of the Royal College of Physicians (RCP) report (*Smoking and health*) in 1962, the prevalence of smoking began to fall but it remained widespread in public.^{1–3} As time passed, however, increasing recognition that exposure to tobacco smoke in the atmosphere (variously referred to as passive smoking, environmental tobacco smoke and second-hand smoke) constituted a health hazard as well as a nuisance led to restrictions on smoking in a range of public places. By the year 2000 nearly half of the UK population worked in smoke-free environments, and the recent passage of smoke-free legislation throughout the UK now means that enclosed public and work places are required by law to be smoke free.⁴ However, passive smoking remains a significant health hazard as a result of exposure in the home, which in 2003 caused nearly 11,000 deaths among adults in the UK.⁵ The impact of second-hand smoke on the health of the approximately two million children who are currently exposed to passive smoke in the home, however, has not been established.

The 1992 RCP report *Smoking and the young* summarised the impacts of smoking on children at a time when much of the evidence of harm was still only just beginning to emerge.⁶ A new

report from the RCP, *Passive smoking and children*, has therefore been produced to review this evidence again, and to quantify the effect of second-hand smoke on children's health. There were two main drivers in producing the report – firstly, the need to update the epidemiological estimates of harm to children from passive smoking, including relative risks, hospital admissions and general practice (GP) attendances and, secondly, to identify policy areas to reduce exposure in the future. The new report presents systematic reviews and meta-analyses of the major health effects of passive smoking in children, and estimates that exposure causes about 20,000 cases of lower respiratory tract infections, 120,000 cases of middle ear disease, at least 22,000 cases of wheeze and asthma, 200 cases of bacterial meningitis and 40 sudden infant deaths in UK children each year. This burden of disease results in over 300,000 UK GP consultations, around 9,500 admissions to hospital each year, and a significant cost to the NHS – an estimated £9.7 million to primary care, £13.6 million on hospital admissions and £4 million on asthma drugs. It also estimates that around 23,000 children become regular smokers by the age of 15 as a result of exposure to smoking by their parents. The impact of this influence on the future health of these individuals is potentially catastrophic.

All of this morbidity and mortality, and cost to the NHS, is completely avoidable. Since most exposure of children to passive smoke occurs as a result of parental smoking in the home, there are two simple means of preventing exposure: firstly, to encourage as many parents as possible to quit smoking, and secondly, to encourage those who cannot or will not quit to make their homes smoke free. Unlike smoking in enclosed public places, however, smoking in the home cannot be prevented through legislation; instead, a comprehensive strategy is needed to reduce the prevalence of adult smoking and promote smoke-free homes.

Reducing smoking prevalence requires sustained increases in the real price of tobacco, further reduction in smuggling and

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