COMMENTARY ONE: Revalidation Cannot be Left to the GMC Alone

John Moorehead
Director of Operations and Company Secretary at ASGBI

The author of this article is quite correct in suggesting that considerable doubts exist around the whole issue of revalidation and that many doctors remain unconvinced about the appraisal process. However, some of the comments in this paper will do nothing to assuage the concerns of many in the profession. To suggest that *"only the optimistic can claim efforts to tackle the quality of doctors is in better shape"* is a remark with little foundation. What evidence is there that there is a significant problem with medical practice in the UK? Yes, there will always be the very occasional poor performer, but existing mechanisms have already proved adequate at weeding them out. The author's throw away remarks are on a par to those of a junior health official who recently wanted to highlight that 50% of doctors are below average. I think that most doctors are struggling to see how revalidation will do anything other than waste a considerable amount of time and money. An unarguable step forward? I think not. The author should also be aware that teamwork and patient involvement existed long before the concept of revalidation was ever thought of. The comments of the quoted "medical director" strike me as those of a well-balanced manager with a chip on both shoulders, irritated by the fact that no "club" would have him. To suggest that we have to wait for the five-yearly revalidation process before poor performance can be identified is utter nonsense. All the surgical units that I am familiar with have regular and robust audit meetings. These, along with weekly MDTs, have the potential to flag up performance issues very quickly. I know of no surgeons who would either tolerate or condone poor clinical practice. Revalidation will add nothing to what we already do.

COMMENTARY TWO: Revalidation Cannot be Left to the GMC Alone

Nicholas Markham
Director of Informatics at ASGBI

I think McLellan has got it about right. Success depends on engagement and enthusiasm, neither of which will be likely overflowing in abundance. There are going to be real teething issues, as well as a great deal of apathy and resentment, but like most faits accomplis, kicking against the pricks will ultimately prove to be fruitless.

We know this that legislation is coming, and there are some indisputable facts:

1. We want to see the best possible standards in medical practice.
2. Bad practice should be rooted out.
3. Underperforming doctors need identifying and thence, if possible, retraining.
4. The public need maximal confidence in doctors and the way medical services are provided.
5. Doctors' skills, interests and performance can become stale over time.

The process will take years to mature. It will take almost as long for the process to have real teeth, and allow poor performers to be reliably and consistently identified, and then remediated. The robustness of the annual appraisal will need considerably beefing up as, at present, it is invariably little more than a tick-box exercise, and revalidation cannot be allowed to inherit this trait.

The evidence needed to inform will vary from specialty to specialty – for surgeons, their morbidity/mortality, cost effectiveness, records of complaints and some multisource feedback, are the most obvious.

So, yet another piece of regulation/legislation – call it what you will – with which we have to contend with these days. I must try not to be so sceptical; maybe it really will make a significant difference.

Perhaps the greatest personal worry I have is that I suspect I suffer from 'Imposter Syndrome' - having a fear that the process will reveal me for what I really am; not an apparently minimally successful surgeon, but an utter fraud. Should I jump before I'm pushed?

COMMENTARY THREE: Revalidation Cannot be Left to the GMC Alone

David Rew
Director of Communications at ASGBI

A license to surgical professional practice is based upon accumulated trust. Credits for that trust accumulate incrementally, in the passage from school into undergraduate medical training; from medical school into basic professional training, and so on up the ladder to consultant status. At all stages during training, there are checks and balances on an individual's competence, integrity, behaviour and safety, which validate that trust.

At consultant level, these checks and balances, if anything, intensify. The individual surgeon carries a substantial burden of responsibility for his or her every action. He or she is under continual scrutiny by patients, ward, theatre and outpatient staff, administrators, family, friends and others. Perhaps the most potent form of scrutiny is peer observation. It does not take long for a reputation to become established or undermined by word of mouth in any professional community, or for concerns to emerge about aspects of an individual consultant surgeon's practice.

Over the past decade, reporting, appraisal, risk and complaints systems, and the policies that underwrite them, have been progressively refined in every NHS and independent hospital. The days have long gone when consultants had the authority to override managements and concerns, or to act imperiously and contemptuously in the face of evidence of their own incompetence or malpractice. In a well run hospital, where there is good communication and trust between clinical and administrative colleagues, informal lines of communication will help anticipate and address many issues before they escalate into serious harm to patients or to the reputation of the hospital. Indeed, such is the sensitivity around these issues that many "course corrections" and local disciplinary actions are exercised effectively, quietly and with little overt disturbance.

Of course, seen from the perspectives of senior management and the DoH hierarchy, a large modern hospital can be a frightening place in terms of risk containment. Cosy, clubbable contacts and informal information networks begin to break down when you employ 500 consultants at all stages in their careers, in a technically complex system where new procedures and methodologies are regularly introduced; where younger consultants are being appointed with significantly less clinical experience at the coal face than once was the case; and where senior consultants are entitled by law to work into their late 60s.

Formal appraisal systems have much to offer organisations and appraisees. They provide an opportunity for regular reflection on practice in a supportive environment, and an excuse to collate documentation on one's professional life into a folder on an annual basis. Given the importance now attached to the annual appraisal process, it is a matter of some surprise to me that some 20% of the 400+ consultants in my own institution have allegedly not had such an appraisal in the past five years.

Consultants feel under considerable administrative pressure at present, with requirements to engage in annual job planning, local and enhanced appraisal, reflective writing and Stat and Mand training (50 Shades of Health and Safety), all of which are significant distractions from clinical work. Throw in time and emotional energy expended in dealing with the complaints culture, and fears of the GMC elephant lurking in the professional waiting room, and it is small wonder that some colleagues fold or withdraw from voluntary participation in the appraisal process entirely.

And so to GMC-directed revalidation. It is already clear that this will produce a very substantial increase in workload, both for appraisers and appraisees, which will carry massive time costs and penalties for a system which is already under considerable pressure, and where the state of the nation's finances may yet oblige substantial cuts in funding for the health services. One cannot help but wonder what practical return will be secured for this call upon precious resources, when strengthening and enforcement of the current local reporting and appraisal systems would go a long way to teasing out potential problems at source.

I have a further concern on a matter which I believe will ultimately and rightly come to be tested in the courts. It relates to the enormous powers invested in the Reporting Officers, who will generally be medical directors of NHS Trusts. Given the anxieties felt by many members of the profession about revalidation, it is essential that Reporting Officers are seen to be independent of GMC pressures, which are ultimately political. They must carry the confidence and trust of those who they are revalidating.

Unfortunately, Reporting Officers carry a double indemnity. They lack true independence, in that they are both (generally) employees of the NHS Trust whose employees they are revalidating. They are also directly answerable to the GMC through their own revalidation and through the innate command structure of the health system. While the best reporting officers will approach the process with absolute integrity, there will be huge scope for deliberate or inadvertent prejudice in a system which may be perceived as fundamentally illiberal by those who have studied history and the working of autocracies.

Clearly, surgeons should take the lead in engaging with the revalidation process, in helping make it work as intended, and in helping make the concept of enhanced appraisal fit for purpose in one form or another. It remains to be seen whether GMC-directed revalidation in its present form will secure the aims which have been set with it, or whether it will collapse under the weight of additional bureaucracy and of the inconsistencies which it is likely to generate. I look forward to discussing this piece of reflective writing with my Reporting Officer in the Autumn of 2013.

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