

## Commentary: Excellent review scheme for critical incidents but insufficient for revalidation

Mayur Lakhani

I want to consider the potential use of the Scottish Audit of Surgical Mortality (SASM)<sup>1</sup> scheme for revalidation of surgeons. Revalidation is an important policy initiative in the United Kingdom from the medical profession's regulatory body, the General Medical Council.<sup>2</sup> It is aimed at ensuring that doctors remain up to date and fit to practise, and is also a way of restoring and retaining the public's trust in doctors. The policy is in some difficulty, and the government has ordered a review of how revalidation can be made to work.

The Royal College of Surgeons of England and the Senate of Surgery recommend that surgeons include results of clinical outcomes and record of audits (including morbidity and mortality) in their evidence for revalidation.<sup>3</sup> To this end, the SASM scheme, which looks at avoidable deaths, seems to be a potentially valuable contribution to the process.

The SASM scheme can be regarded as a peer review of critical incidents. Peer review is an important component of revalidation. The clinical ownership and engagement in the SASM scheme is striking, and there is evidence of the iterative development of standards. There is also clear evidence of improvement resulting from collaboration between clinicians and hospitals.

The disadvantages are that no benchmark is established because the denominator is not known and outliers would not be detected. The analysis concerns itself with the process of surgical care that involved individual surgeons, teams, and the institution, whereas revalidation is an assessment of the individual doctor concerned.

Although patients are involved at a strategic (board) level, lay involvement does not seem to exist at other levels. Surgeons elect members of the management group; this generic procedure (as used by the GMC) was criticised by Dame Jane Smith in her fifth report on the case of the general practitioner Harold Shipman (who was convicted of killing some of his patients and is thought to have killed hundreds more).<sup>4</sup> Although no evidence exists, this might suggest that the procedure is perceived as a relatively closed process and that it may not meet the modern day requirements of principles of assessment<sup>5</sup>, transparency, and lay involvement.

Revalidation is more than just a record of continuing professional development or taking part in clinical audit. The doctor must also show that his or her clinical performance is not unacceptable—the “patient safety” test. It is significant that participation in SASM is voluntary and that a small number of surgeons do not participate. The reasons for this are not clear, but for the purposes of revalidation a proved and consistent refusal to participate in a national clinical audit scheme focusing on outcomes for surgeons could be a cause for concern.

In conclusion, participation in the critical incident scheme described would be insufficient by itself to revalidate a surgeon. Revalidation should not be its primary purpose. Instead, it is an important and

thoughtful scheme with the potential to develop into a more robust and widespread confidential reporting and learning system to tackle patient safety by focusing on systems improvement.

This is a personal analysis and does not represent a formal view of the Royal College of General Practitioners.

Competing interests: None declared

Royal College of  
General  
Practitioners,  
London SW1 7PU  
Mayur Lakhani  
chairman of council  
MLakhani@rcgp.  
org.uk

- 1 Thompson AM, Stonebridge PA. Building a framework for trust: critical event analysis of deaths in surgical care. *BMJ* 2005;330:1139-42.
- 2 General Medical Council. *Licensing and revalidation formal guidance for doctors (draft)*. London: GMC, 2004.
- 3 Royal College of Surgeons. *Guidance on surgical practice—criteria, standards and evidence*. 2004. [www.rcseng.ac.uk/services/publications/publications/pdf/cse.pdf](http://www.rcseng.ac.uk/services/publications/publications/pdf/cse.pdf) (accessed 12 Apr 2005).
- 4 *Fifth report. Safeguarding patients: lessons from the past—proposals for the future*. Report of the Judicial Inquiry into Harold Shipman. 2004. [www.the-shipman-inquiry.org.uk/home.asp](http://www.the-shipman-inquiry.org.uk/home.asp) (accessed 12 Apr 2005).
- 5 Postgraduate Medical Training Board. *Principles for an assessment system for postgraduate medical training*. 2004. [www.pmetb.org.uk/pmetb/publications/principles.pdf](http://www.pmetb.org.uk/pmetb/publications/principles.pdf) (accessed 12 Apr 2005).

### Corrections and clarifications

#### *Necrotising fasciitis*

An error occurred in the placement of the three photographs accompanying this Clinical Review article by Saiidy Hasham and colleagues (*BMJ* 2005;330:830-3, 9 Apr), with the result that each is accompanied by the wrong caption. The photograph labelled figure 1 should be accompanied by the caption that was used for figure 2 (“Late signs of necrotising fasciitis . . .”); the photograph labelled figure 2 should be accompanied by the caption that was used for figure 3 (“Split thickness skin grafting . . .”); and the photograph labelled figure 3 should be accompanied by the caption that was used for figure 1 (“Young woman presenting with cellulitis . . .”).

#### *Regulator restricts use of SSRIs in children*

This News article by Lynn Eaton (*BMJ* 2005;330:984, 30 Apr) contained two inaccuracies about the drug atomoxetine. The manufacturer, Lilly, points out that we wrongly suggested that atomoxetine is an antidepressant (whereas it has no antidepressant activity). Also, atomoxetine is not associated with an increased incidence of suicide related behaviour (as we implied), although it is associated with an increased risk of hostility (as we stated) and emotional lability.

#### *Interactive case report: Postoperative hypoxia in a woman with Down's syndrome*

The table in the first part of this report by A K Siotia and colleagues (*BMJ* 2005;330:834, 9 Apr) was inadvertently given the wrong title during editing. As the text suggests, the table shows the patient's postoperative (not preoperative) results.

#### *Reader's guide to critical appraisal of cohort studies: 1. Role and design*

At the final page proof stage of this Education and Debate article, some sort of glitch—the cause of which we have yet to fathom—resulted in the first author's name jumping to the end of the authorship line (*BMJ* 2005;330:895-7, 16 Apr). Paula A Rochon (not Jerry H Gurwitz), therefore, is the first (not the last) author of this paper. This has already been changed on [bmj.com](http://bmj.com).