the process is not fit for purpose.\textsuperscript{11–13} In particular there is confusion about whether revalidation is intended to detect poor performance, and if so, whether the process will suffice. Formative appraisal and summative revalidation are seen as uneasy bedfellows.\textsuperscript{11}  
For most doctors the process will entail participation in an appraisal system, which must be aligned with the headings in \textit{Good Medical Practice} and quality assured to the satisfaction of the General Medical Council.\textsuperscript{12} The Council states that such participation will be “a powerful indicator of a doctor’s current fitness to practise,”\textsuperscript{14} but makes no claim that the process will be sensitive (identify poor performance), specific (identify educational needs), valid (reflect actual clinical practice), or reliable (be consistently across cohorts of doctors).\textsuperscript{13} Where there is any doubt doctors will be invited to submit more information and may be subjected to the performance procedures.

Conclusion
It is difficult to escape the conclusion that the purpose of revalidation is as a form of professional regulatory enforcer to ensure the NHS implements appraisal in a designated manner. This may be enough to encourage doctors to develop and to seek help early in case of difficulty. Alternatively, doctors relying for their revalidation on five appraisals might be tempted to set easily achievable objectives in their personal development plans, rather than risking failure to meet a challenge. The problems with this dual purpose have long been recognised.\textsuperscript{15} In Pringle’s view, the most likely outcome is the worst of all worlds, where the developmental and formative nature of appraisal is lost, and where revalidation fails to identify poor performers.\textsuperscript{15}

Whether patients and the government will be satisfied remains to be seen, particularly if (and predictably when) a recently revalidated doctor is found to have been a poor performer. Ultimately it may be more sensible to separate revalidation from appraisal. Doctors themselves could choose the independent route to revalidation,\textsuperscript{16} by submitting other evidence of minimal fitness to practise—appropriate tools are being developed. Or we could move wholesale to such a model (as in Canada), where a screening tool provides feedback on performance to all while identifying the minority of doctors at risk of being poor performers. These doctors are then investigated in more depth.\textsuperscript{13} Patients and others might be more convinced by this.\textsuperscript{12}

Finally, the impact on doctors and patients should not be underestimated. In just over a decade, the NHS has moved from being an organisation based on high trust relationships to one where explicit written down standards, which are monitored, have become the norm for individuals and institutions. Revalidation is part of this increased bureaucratic control being applied to professional self-regulation. It may increase apparent accountability, but may not foster a culture which increases patients’ trust and doctors’ professionalism.\textsuperscript{15}

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8 BMJ. Purpose of revalidation process must be agreed on. BMJ 2003;327:538.
9 BMJ. GMC’s proposals for revalidation would not be acceptable, economical, or fair. BMJ 2000;321:1220.

Corrections and clarifications

\textbf{Decline in mortality, AIDS, and hospital admissions in perinatally HIV-1 infected children in the United Kingdom and Ireland}

Mis-reading of the alignment in table 5 of this paper (table 2 in the abridged version) by D M Gibb and colleagues led us to print the hazard ratios for death and AIDS/death incorrectly for “How the child was identified” (BMJ 2003;327:1019-23). The hazard ratios for “prospectively from birth” and “after birth” should be inverted: the values for children identified after birth are therefore 1, and for children identified prospectively from birth 0.40 (95% confidence interval 0.31 to 0.78) and 0.44 (0.30 to 0.64).

\textbf{ABC of smoking cessation: Nicotine replacement therapy}

\texttext{ The table showing the formulations and availability of nicotine replacement products in this article by Andrew Molyneux contained an error (21 February, pp 434-6). Nicorette nasal spray is licensed as a Pharmacy (P) medicine and is available over the counter at pharmacies; it is not a prescription-only product, as stated in the table.}

\textbf{Effects of low dose ramipril on cardiovascular and renal outcomes in patients with type 2 diabetes and raised excretion of urinary albumin: randomised, double blind, placebo controlled trial (the DIABHYCAR study)}

A wrong reference number persisted to publication of the full version of this article by Michel Marre and colleagues (28 February, pp 459-5). In the fifth paragraph of the Discussion, in the sentence starting “Conversely, only 30% of the diabetic patients ...” the reference for the HOPE and MICRO-HOPE studies should be reference 9 (not 11, as stated). The references in the abridged version are correct.