and fit to practise, and it would have been pointless to press ahead without first dealing with the doubts that have been raised. I have therefore supported postponement. But confidence can be fragile. It will not have been helped by some of the reporting in the aftermath of the inquiry and the spinning going on around it. In public life you get used to that, and to some people reaching conclusions on the basis of anecdotes. The solid evidence from our consultation should not be overlooked. It showed widespread support in the UK and abroad for our revalidation proposals. Although they can undoubtedly be strengthened, let us not overlook that the UK medical profession has taken the lead by developing revalidation. Nothing in the fifth report detracts from that, and nothing in it undermines the principles that underpin revalidation.

Moving forward

Continuing to debate the past would be unproductive. What counts now is to get revalidation right for the future. The GMC will contribute positively to the review. We see several areas where we can do so. The first is in being more explicit about the evidence that doctors must include in their revalidation folders. Dame Janet has made helpful suggestions that although intended for general practitioners, would apply to most doctors working in a clinical setting—for example, folders should include prescribing data and records of complaints and concerns, information about continuing professional development, the results of audit, and a patient satisfaction questionnaire. We expect that these would be covered within appraisal or through clinical governance systems. The emphasis, I believe, must be on performance in practice.

The GMC also has a role in developing the quality assurance framework. We have already described the characteristics of a GMC approved environment. We expect that most NHS organisations will meet our requirements but some may not. We cannot rely safely on local systems unless explicit quality assurance arrangements are in place, and we need to be more explicit about how they will operate. We also need to be

Summary points

The primary purpose of revalidation is to certify fitness to practise

The Shipman inquiry made recommendations for improving the GMC's revalidation model

The GMC intends to develop explicit requirements for validation and quality assurance

The GMC will also continue to work with others to detect poorly performing doctors and ensure early action

clearer about how, and with what purpose, we will operate random and targeted sampling.

Although revalidation is the affirmation of a positive, we have always said that the GMC must also contribute, with clinical governance systems, to the detection of, and early action on, problem doctors. We need to further develop proposals to make this clearer, and we see a much closer cooperation with employers as the key.

The reformed GMC will continue to force the pace of reform and take whatever steps are necessary to play our part in delivering patient led healthcare and to fulfil our statutory purpose “to protect, promote and maintain the health and safety of the public.”

Contributors and sources: GC has been a member of the GMC since 1994 and has served on its education committee and committee on professional performance. He is also a member of the Council for Healthcare Regulatory Excellence.

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Cardiologists embrace new terminology

Viewed from the plain speaking world of general practice, cardiologists seem to be rivalling dermatologists in developing an ever changing array of terms for conditions they encounter. One particularly disingenuous example recently came my way.

Five years ago, our practice purchased an automated defibrillator. In the six months before its arrival, I had had need of one on two occasions. For five years after its arrival, it stood unused in the corner of an alcove. Until, that is, a 70 year old man attended his Monday morning appointment with our practice nurse to have a sutured finger redressed. Commendably, he had parked half a mile from the surgery and walked briskly across town for some exercise. On entering the waiting room, he collapsed. In a surprisingly calm and

organised manner he was resuscitated by a GP and two nurses, while receptionists marshalled the absorbed onlookers and telephoned for an ambulance. Our defibrillator restored sinus rhythm with its first shock.

The patient was admitted to hospital, transferred to a tertiary centre for insertion of an implantable defibrillator, and discharged. He continues to attend for six monthly review at our practice and remains active and well. A discharge summary followed with the usual delay. The primary diagnosis? Not “Successful out-of-hospital resuscitation” or “VF successfully defibrillated” but rather “Failed sudden cardiac death.”

Crispin Fisher *general practitioner, Marches Surgery, Leominster* (crispin.fisher@nhs.net)