across different professions and seeing that standards are maintained throughout that commissioning process, he says. "But we have a separate set of responsibilities around the standards in medical education in particular and seeing that those are actually applied in practice on the ground."

Revalidation

One of the GMC's big projects over the past 15 years has been revalidation, the five yearly process by which licensed doctors are required to demonstrate to the regulator that they are up to date and fit to practise.

One of the key benefits of revalidation, says Mr Dickson, is that the yearly appraisal process inherent in the system will identify and support struggling doctors earlier, before things get to the point where they might need to be referred to a fitness to practise panel. "Secondly, and equally importantly, I hope that it will encourage and support self reflection and reflection within teams, on 'how well are we doing,' 'what are the data around our practice,' and so on," he adds. Another benefit is that revalidation will essentially force employers to introduce formal clinical governance and appraisal systems.

"Over the past 10 years, although clinical governance has become embedded in the health service, it has not become embedded in a uniform way; the quality of clinical governance varies between institutions," he says. "One of the things I hope revalidation will do—and I think there's some evidence that it's already doing—is act as a catalyst to encourage organisations to put in place proper clinical governance. And proper clinical governance means that the doctors within that institution are able to access supporting information, they are able to reflect on what other colleagues and what their patients think about their practice, they have access to data about their own performance, they're able to reflect on that performance, and so forth."

There are concerns that compiling this supporting information—evidence that doctors are required to provide to prove they're staying up to date—could be unduly onerous for doctors. The first round of revalidation pilots found that doctors undergoing the yearly strengthened appraisal that underlies revalidation were spending an additional 4-10 hours collating information and preparing for their appraisal, and 61% agreed that they had to put too much time into the process.[4] "I think inevitably there will be people in the profession who think this is an extra burden; I've got an awful lot on at the moment, why am I having to do this extra thing?" says Mr Dickson. "I hope that the value of it will be seen over time, and it will only be seen over time if doctors themselves and the organisations in which they work embrace this in a positive way. Appraisal is something that is now pretty common in medicine, and we're attempting to strengthen it but not to make it overly burdensome, and I think getting that balance is absolutely right."

Niall Dickson on . . . responsible officers for revalidation

"I certainly would not want one responsible officer sitting in the National Commissioning Board who's responsible for all general practitioners. That would be utterly ludicrous, and I don't think for a minute that [the government] will suggest that. Nevertheless, if they sit within the ambit of the board but are down at regional level and then are overseeing a process below that, fine.

"For us it's important that the responsible officer is not at too low a level within the organisation, as it were, so that they are not compromised in terms of the responsibilities that they have. But they also need, of course, to understand the systems that they're overseeing, so they can't be so remote as not to understand what it is that they're responsible for. We're still waiting for proposals, and the areas that we've been concerned about are, first of all, primary care, and, secondly, doctors in training. The deans at the moment are the figures who are responsible officers for trainees. We want whoever replaces the deans—and it may be deans in another form or with a different name—to have that responsibility, that very important responsibility, for trainees."

- Read more about the role of responsible officers at http://careers.bmj.com/careers/advice/view-article.html?id=20002862.

Some fears have been raised in the past as to how doctors who don't work in standard NHS structures, such as locums and doctors in private practice, will be able to take part in revalidation. However, these issues are not "insuperable," says Mr Dickson, and pilots are under way to investigate how to make sure that groups of doctors who are hard to reach have everything they need to conduct revalidation.[5] "For some of these groups of doctors the challenge is greater, but actually the prize is probably greater as well," he adds. "We need to have a system that's flexible enough so that all doctors can do this regardless of where and how they practise. So we will have that in place." Every doctor, irrespective of how they practise, should be able to find a responsible officer, he says. Locum agencies, for example, will become designated organisations with a responsible officer, as will private practice groups such as the Independent Doctors Federation. "So I think there are ways round some of these more exotic—if I could use that word—sort of careers," he says. "We just have to make sure in a commonsense way we have systems that support them and enable them to demonstrate that they are competent and fit to practise."

Originally pencilled in for 2010, the roll out of revalidation has now been pushed back to the end of 2012, after the health secretary, Andrew Lansley, said that the GMC needed more time "to develop a clearer understanding of the costs, benefits, and practicalities of implementation."[6] Nevertheless, Mr Dickson is confident that the system will be ready to go in 2012, although it won't be a "big bang" introduction.

"We're still heading towards what we hope will be the beginning of the roll out, which is late 2012, towards the end of next year. That is subject to the secretary of state in the UK government switching on the legislation, and we are confident that we will have in place within the GMC the necessary administrative arrangements to enable that to happen," he says. "But we recognise that there's still some way to go in that, and even by late 2012 I don't think we're expecting perfection throughout the whole system."

Fitness to practise

Perhaps the GMC's highest profile role, and also the role possibly of most relevance to the careers of practising doctors, is its regulation of doctors' fitness to practise. The organisation can step in and put limits on doctors' practice, or even strike them off the medical register, if they fall short of its high standards on clinical competence, ethics, and professionalism. Last year the GMC received 7153 complaints about fitness to practise, 63% of which were from members of the public.[7] Only 3540 complaints, around half, were investigated by the regulator, with the remainder thrown out, raising the concern that many of the issues that get through to the organisation are irrelevant, trivial, or potentially vexatious.