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## Viewpoint

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### GMC AFFILIATES

*'General Medical Council affiliates will be clinicians of high standing, having credibility with, and the support of, doctors, managers and their patients. It is important that this role is carried out by a clinician in active practice. It should be seen as both a professional duty and a mark of distinction for doctors to undertake this role at some point in their career. Its prestige and importance should be reflected in reward schemes for doctors.'*

So runs the rubric below the second recommendation in the CMO's recent report *Good Doctors, Safer Patients*.[1] The affiliate's job description includes:

- taking the lead role in dealing with fitness to practice cases locally;
- reporting 'recorded concerns' to the GMC;
- discussing if required 'recorded concerns' with a new national committee;
- offering to meet complainants;
- deciding whether any issues have been resolved satisfactorily;
- agreeing with doctors approaching retirement whether they should continue practising;
- collating information about a doctor as part of the re-licensing process; and
- providing a report to a new organisation or employer when a doctor changes jobs.

The CMO's report contains 44 recommendations, covering under-performance, appraisals, revalidation, medical education, public information and the governance of the GMC. Thirteen of the recommendations relate directly or indirectly to the work of the proposed GMC affiliates. Does this role add anything to existing arrangements?

Over the last 5 years I have helped establish the procedures whereby PCTs handle what is usually called a 'cause for concern' in general practice. The 2001 Health and Social Care Act sets out the legal framework whereby PCTs admit or remove doctors on their Performers Lists. Currently any GP can be suspended by their PCT pending investigation or removed on the grounds of poor clinical performance, fraud or after decisions made by the GMC or the courts.

These powers are invested in the Responsible Board Member, often the PCT's Director of Primary Care. Such a person however does not work in isolation. Most PCTs have evolved a two-tier process for handling concerns. A small initial advisory group, including the GP Clinical Governance lead, decides whether the problem can be handled at a low level, or, if more serious, referred to a reference group (usually a sub group of the PCT Board).

The Shropshire GP Performance Review Panel has considered 16 cases in the last 4 years. Most are discussed informally and anonymously. The purpose is to support and advise the initial advisory group. On two occasions cases have been considered formally with the doctor present. The panel assessed risk and considered that, although serious, referral to the GMC was not indicated. Programmes of education and mentoring were set up, in both cases, successfully. Referral to the GMC is a lengthy and stressful process whatever the outcome and handling cases locally is always preferable whenever possible. When local processes are seen as supportive rather than punitive, GPs are more likely to report concerns about partners or locums. This is a remarkable change from only a few years ago when problems were ignored or swept under the carpet. GP clinical governance leads can be proud of their role in this success story. The GMC itself has recognised the value of such arrangements by passing an increasing number of reported concerns to PCTs for investigation and management.

It is therefore surprising that the CMO does not clarify the relationship of the proposed GMC affiliate to existing arrangements as provided for under both the Health & Social Care Act 2001 and those to be introduced as part of the government's response to the Fourth Shipman Report.[2] This requires PCTs to appoint an Accountable Officer, usually a senior manager with a clinical background, to monitor the use of controlled drugs and abnormal prescribing patterns by GPs. Such an officer is to be supported by an advisory group and a decision-making panel, both of which will have input from an active clinician.

Instead, the new post of GMC affiliate appears to be operating in a vacuum. The report recommends their creation but does not expand on the thinking behind this. It does not say whether other professions or their regulatory bodies have developed such posts here or abroad. More importantly, it does not clarify who will employ them nor lines of accountability. Until it can be demonstrated what value these new posts add to existing arrangements, it is hard to believe that GPs or consultants will apply for a position which seems professionally isolated and more like performance manager than senior statesman.


**Anthony Rathbone**


### REFERENCES


1. Chief Medical Officer. *Good doctors, safer patients*. London: Department of Health, 2006.
2. Department of Health. *Safer management of controlled drugs: (1) Guidance on strengthened governance arrangements.* London: Department of Health, 2006.