PERSONAL REFLECTIONS ON WORKING AS A COUNCIL MEMBER AT THE GMC

INTRODUCTION

Some friends at BAPIO (British Association of Physicians of Indian Origin) have asked me to share my experiences of serving on the General Medical Council (GMC) and hence this paper.

GETTING ON BOARD

I was appointed to the Council in 2009 for a four year term (extendable for another term, but more about that later) and it was a highlight of my career. Although I had served briefly with the Faculty of Public Health (my professional body) and the British Medical Association earlier I was not fully engaged there, and whilst enjoying the benefits of such bodies I also felt that of necessity these organisations had to be protective of their members' interests. On the other hand I wanted to be a part of an organisation where the public and patients interests came before (not instead of, though) professional interests, and the GMC fitted that bill for me. During the early 2000s I had served on the GMC's Fitness to Practise (FTP) Panels and I suppose to some extent that may have helped in my selection, although how one ends up (or not, as often happens to International Medical Graduates (IMGs)) in certain positions in the UK remains a mystery to me! But I am grateful to Sir Graeme Catto for giving me the opportunity.

When I joined the GMC I had certain aspirations. My wish list included changes in the FTP procedures; as a previous FTP panellist and as a medical director I was very frustrated with the GMC procedures which took too long, had unexplained variations and in my view considered cases which were best dealt with locally. "Localising the GMC" and creating a seamless system, from local to national level, was the way forward. I wanted the GMC to be the custodian/leader of the system, but not be the first port of call for complaints about doctors except in some important instances.

My second wish was for better regulation of medical education. I had been involved in setting up the Hull York Medical School (HYMS) and then moved to Manchester and I noticed considerable differences between the

'Greenfield' approach at HYMS with the ability to design a more fit for purpose community oriented curriculum and ring fencing of funding with joint governance between the universities and the NHS, for example, to the 'Brownfield' situation in Manchester where there were concerns about public health input into medical education and limited student placements in general practice for example.

I was also passionate about reducing fees for doctors, whether for annual retention or exams. Although I personally had benefitted from the large salary increases for consultants I was very mindful that the situation had changed for new doctors, not only were salaries lower, there were fewer jobs and increasing student debt and there was the need to pay for various exams and professional societies.

Surprisingly, one thing that was not really on my agenda when I joined the GMC was equality and diversity and especially racial discrimination!

MY OBSERVATIONS ON THE WORK DURING 2009-12

So, what do I think of my time?

The Organisation

Of course, the 2009-2012 term was a historic one since we finally managed to secure the necessary legislation for revalidation (and I was amongst the first doctors to revalidate in Dec 2012), something that had been on the cards for many years, and had a very challenging birth. Apart from this controversial, and in my view much needed, initiative, there were reforms in almost all the functions from changes to the most visible work of the GMC: the FTP procedures, to changes in how medical education is to be organised and regulated, to a revision of the 'Bible' Good Medical Practice (GMP), to guidance on various issues affecting doctors, and finally the adoption of IT to streamline its business including introduction of my GMC and moving more functions out of London to Manchester, for example.

Not all of these changes are yet fully embedded and it will be a while before we see the benefits. Thus, the introduction of Employer and Regional Liaison Advisers to promote better engagement with the range of stakeholders and support the FTP changes should result in more informed policy making and fairer, speedier and costs-effective resolutions of cases. These are also very timely developments given the start of revalidation, for example. Whether what has been started will come to fruition and whether the GMC will be fit for purpose given the ongoing reorganisation of the NHS in England (we need to note that the GMC is a UK regulator, and not just for England) especially in the 'Post-Mid Staffs' world and in the light of the economic pressures only time will tell. I personally believe that within the NHS we have much to do to make regulation work for patients and professionals. In the early days of the Council we used to talk about a four level- Individual, Team, Organisation and National - approach to regulation. Revalidation is focussed on the individual and much more is needed to align GMC with the work of the systems regulators: the CQC and Monitor in England, and other professional regulators such as the Nursing and Midwifery Council for example, to ensure that all levels are properly covered and joined up, and we do not end up holding doctors alone responsible. I seriously worry about the focus being on individuals and especially when this can lead to tragedies (see my views on this matter at http://www.hsj.co.uk/opinion/columnists/staff-should-beprotected- from-never-events-too/5052598.article).

Similarly, the changes in the provider landscape, with more shift of services to the community settings and introduction of 'for-profit' providers (indeed the FTs also fit this category), over-production of doctors in the UK, and UK medical schools seeking foreign collaborations are also uncharted waters. Suffice to say that the new Council won't be standing still yet!

As most of my colleagues know I have been a supporter of the GMC – I am sure that I speak for many IMGs when I say that we wished our 'parent' countries had such an institution. Indeed I did encourage exchanges between the Medical Council of India and the General Medical Council. Few years ago, especially after the Harold Shipman case and other failures, there were serious concerns whether the GMC would survive. The previous Council (under Sir Graeme Catto and Finlay Scott)

were credited with saving it (sic). Our job was to build on their legacy – although looming revalidation and the merger of PMETB and the GMC (to bring the whole education pathway under one umbrella) meant that the GMC was not yet completely safe! Despite at times challenging situations, both of these came to pass and I am proud to have served on the Council during this historic time.

As its regulator, the GMC is never going to be friends with the medical profession- and there remains uneasy truce between the professional bodies and employers and the GMC. However, it was pleasing to see increasing 'respect' for the GMC because of better engagement on important matters, and listening to the wider stakeholders. I am, however, personally uncomfortable with the notion, expressed by some, that only lay people can protect the interests of patients. I think that this is doing disservice to the commitment and dedication of large numbers of doctors, and I hope that there will be a good balance between protecting patients and supporting doctors at the GMC.

The quality of work done by the GMC staff throughout has been of high standard, and I have been impressed with the calibre and commitment shown. They have also coped with the 'almost' avalanche of reforms and obviously the move to Manchester affected some staff members personally. If only we were always so blessed with good staff in our day jobs (sic) was a feeling shared by others also. On the other hand, the staff enjoy very good terms and conditions, and have been sheltered from the harsh economic reality of the NHS and wider society. I know that some people have commented on these including questioning the fact that the GMC offers private healthcare cover. This was one area where I 'failed' to convince my colleagues about the need to align the GMC with the NHS terms and conditions- it is a matter of public record that I voted against the (amount of) fees to be paid to the Chairman and new Council members, and which I found unacceptable.

The Council

As regards the Council itself (I must admit I found the terminology confusing. The 'Council' is the traditional 'Board' and to have to say that I am on the Council of the General Medical Council seemed bizarre!), even now, many doctors do not realise that 2009 was the first time that Council members were selected, by the Appointments Commission, and not elected by doctors, and there were equal numbers of medical and lay members. It was therefore a ground breaking start and there was intense speculation about how the model would work. Was this the end of the medical leadership at the GMC with still some scope for self-regulation? Will we end up with a lay chairman? Will we end up in two camps: medical and lay etc? As it happened Professor (since Knighted) Peter Rubin became the Chairman and we managed not to be split along medical or lay lines. And we did good work and managed to introduce a range of much needed reforms.

But would we have passed the 'Good Medical Practice' test – of respect, valuing others and team working – as a Council? Were we an exemplar of good governance? Was there a danger of not walking the talk? Of course, all boards have tensions, with not everyone feeling equally valued or getting opportunities to contribute fully or personally develop. And it would have been surprising if these issues did not feature in the Council also. I was perhaps well prepared for some of these tensions (although I always find them distasteful and I have trouble with what happens with the divide and rule/ autocratic approaches, sadly, seen in some boards), having been on NHS boards for a long time. Such tensions are inherent in the workings of powerful organisations and with very

senior people, and should be seen as 'character building' experiences (sic), and a necessary part of one's development as a leader.

Readers may want to see my general observations on management and leadership in the NHS at this site (http://www.fmlm.ac.uk/sites/default/files/uploads/docs/resources/RMadhok%20NHS%20Leadership.pdf) , and as can be seen I would want to encourage more doctors, and especially IMGs, to seek and take up these challenging roles.

GMC AND RACE

As regards the issue of racial discrimination, my views on this have already been published (http://bapio.co.uk/images/file/Prof%20Madhok%20GMC%20speech%2019%209%2012.pdf). Although I was very aware of the concerns expressed by BME doctors, and having faced direct discrimination in the NHS, I personally was not on a crusade for the reasons I described in the foreword to the book that we had published in Manchester. However, part way during my Council term I started becoming increasingly concerned, especially as I had been asked to become the Chairman of BAPIO by then where I repeatedly came across examples of discrimination and stories of how the NHS was failing to utilise the talent and leadership potential of BME doctors. I also then started chairing the CLN- REAL initiative which showed that the problem went beyond doctors. I therefore become convinced that we had much work to do to promote race equality in the NHS and within the GMC and that we could use the GMC's position as the leader of the system to influence others also. As it happened, I was then asked to work with another Council member, Sally Hawkins, to look at race/ethnicity issues and the work of the GMC. We also linked up with Iqbal Singh who chaired the GMC's E & D Committee. This issue then took up a lot of my time, and I find it ironic that my period/role came to be defined in terms of being the crusader for racial equality at the GMC especially as I do value all other aspects of equality and diversity, and in any case believe that there is a lot more to the GMC's work where I have, could have, contributed.

Anyway, I think we started some initiatives to promote race equality and I can only hope that the GMC will continue to lead by example and make progress as I am very concerned that things have started going backwards in the NHS. There is still a lot to do including becoming more proactive, as the recent RCGP CSA exam issue shows for example where the disparities in the pass rates between IMG/BME and local trainees had been known to the Establishment for some time and yet no serious action was being taken. Although we won't be at the new Council, both, Iqbal and I have been asked to stay on and co-chair the GMC-BME Forum.

WHAT NEXT FOR ME

Finally, the question asked of me is why I am not on the new Council. Although when we were appointed in 2009, we were eligible for another term, the 'rules' changed as it was decided to reduce the size of the Council to 12 (rather than 24) members. Some people have pointed out that none of the three BME doctors on the last Council have featured in the new one. I can not speak for Iqbal and Johann and obviously with only 12 places (instead of 24) there was bound to be competition. It is hard for BME doctors to reach certain positions – INDIGO (BAPIO's discussion forum) identified the Faculty of Medical Leadership and Management and the King's Fund as two organisations bereft of any BME members at their top levels recently, for example. The sad part is

that even when we do get there we have to start again – getting to the next level requires further struggle; a case of glass ceiling after glass ceiling. After making it to the Council I found that having any meaningful senior roles/positions in the GMC management and governance arrangements and to personally develop further was a challenge.

In my case, I decided not to apply for another term for many reasons including the increasing awareness of the tension between the 'Establishment' and 'Activism'. The Establishment, by its very nature, wants to preserve the status quo whilst activists challenge things. Having been a part of the Establishment (in NHS management and the GMC) for over two decades, and whilst being proud of some of the achievements I realised that change is slow, and sometimes one has to go outside of the Establishment to move things along, or at least try. I felt that I had done as much as I could have within the GMC under the circumstances and could add more value from outside by doing both, helping to implement reforms such as for revalidation/FTP changes and by being a commentator/lobbyist.

I am pleased, and honoured, that the BAPIO Executive led by Ramesh Mehta has asked me to continue as Chairman for a second term. I realise that there is a lot to do to make IMGs, and all clinicians, feel supported in the NHS – I would like the Establishment to work with (to use the Darzi phrase of Co-Development) and not against doctors. Most doctors do not feel supported presently, and as a society we are in danger of proving William Carlos Williams right; he described doctors as "one upon whom we set our hopes when ill and our dogs when well"!

Perhaps in time (I am still young) and under different circumstances I may join the establishment again! For now, I wish the new Council members well and would encourage BME, and indeed all doctors, to join in whatever capacity they can- there are many ways they can contribute to the work of the GMC and the wider system of medical regulation and education. It can be challenging but it is also very rewarding work.

DECLARATION

The views expressed here are personal. I am conscious that it is unusual to write such reflections, and some people may take the view that it is not the done thing. My response is that I wish more people did share their reflections

in the spirit of learning and to help others contemplating taking on such roles. I certainly have done it in that spirit and if I have given any offence then I apologise. I am grateful for the fellowship and support of many Council members and the staff.

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http://www.bapio.co.uk/news_detail.php?id=80