BME doctors: The state of bias in the NHS and impact of differential sanctions by the GMC

Written Submission to the Williams' review

1. Introduction

"A doctor is one upon whom we set our hopes when ill and our dogs when well"
William Carlos Williams, American poet and paediatrician

The British Association of Physicians of Indian Origin (BAPIO) is pan-UK organisation launched in 1996, initially to support International Medical Graduates but since then with a broader remit of informing policy makers in the National Health Service, the Medical Royal Colleges and other organisations, as well as having a focus on education, training, mentoring and patient safety. Over time, the organisation has grown in stature and influence. It is now supporting BME doctors across the NHS and is the largest organisation of BME doctors with divisions all over the UK.

BAPIO welcomes the initiative by the Secretary of State for Health, England, to review the processes pertaining to Gross Negligence Manslaughter (GNM) in the wake of the High Court verdict on Dr Bawa-Garba. We are also pleased to have had the opportunity to present our concerns and possible solutions. This written submission is to be considered in addition to the oral evidence given to the panel by Dr Ramesh Mehta (President), Dr Joydeep Grover (Medical Director, Medical Defence Shield) and Dr JS Bamrah (Chairman) on the 11th April 2018. We would wish to bring to attention of the panel that BAPIO has the experience to provide a BME perspective better than most organisations because of the evolving work of the organisation over the last two decades.

2. Professor Sir Norman Williams' rapid review - Terms of Reference (ToR)

Whilst we welcome this review, nevertheless BAPIO would like to express regret that the ToR do not cover the key contentious areas for the following reasons:

1. The focus of the review is narrow. Healthcare professionals who have contacted us are sceptic that this will be a lost opportunity if firm recommendations about GNM and the role of the GMC are not adequately dealt with.
2. GNM does not occur in isolation but is part of significant system failures. It is essential that the review takes account of this fact.
3. There is disproportionate effect of GMN on BME healthcare professionals but the ToR have made no reference to this being an essential part of the review.

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However, we were pleased that in the course of giving our oral evidence Professor Sir Norman Williams and other panel members devoted a significant time to taking our submission on a whole range of issues including conscious and unconscious bias in the NHS and GMC, and racial discrimination in the NHS.

3. The NHS and racial discrimination

The majority of doctors registered to practice in the U.K. work within the National Health Service (NHS). In 2017 there were 236,732 doctors on the General Medical Council (GMC) license to practice register, comprising 74,055 Specialists, 59,598 General Practitioners (GPs), 42,631 doctors who not on the specialist register or in training (usually called Specialty and Associate Specialist doctors) and 59,194 trainee doctors[1].

The NHS is heavily reliant on doctors who have qualified overseas, so that a substantial number of all grades of doctors are from a Black and Minority Ethnic (BME) background. Including doctors qualified in the UK, almost 41% in England are BME, with regional variations so that, for example, in the South West of England 18% are BME while the West Midlands has the highest proportion (52%). Across other countries in the U.K. there is a lower preponderance of BME doctors, with Wales having 33%, Scotland 19% and Northern Ireland only 9% of doctors from a non-white background. Unlike other countries in the U.K., Northern Ireland has a high rate of 'keeping its own' with only 14% of its medical workforce deriving their primary medical qualifications from overseas.

Medical workforce planning has been a challenge for decades with various attempts at trying to achieve a better-balanced workforce yielding poor results in the long term. This has resulted, at times, in the NHS experiencing major shortages of doctors, with the emphasis being more on 'draught and famine' rather than 'boom and bust' throughout the recent three or four decades. Policy makers within the NHS and some Medical Royal Colleges have made sporadic attempts at overseas recruitment, quite often offering lucrative deals that are not available to U.K. registered doctors and therefore proving deeply unpopular and divisive, without offering the comfort of a longer-term strategy in managing recruitment and vacancies.

However, the workforce crisis has never been as acute as what we have been experiencing in recent years. Between 2012 and 2017 the number of licensed doctors qualifying from the U.K. increased by over 10,700 while the number of doctors registered from overseas for a similar period reduced by over 6,000[1]. The BME proportion has risen far greater than the proportion of white doctors entering medicine; the ratio has dropped from 1:4 to almost 1:3.

In our oral submission we were frank about the impact of the GMC's failure to support BME doctors particularly those that come from overseas, as well as the inability to address proportionality in applied sanctions. The perception that the NHS is the holy grail of medical training and jobs in hospital and general practice sectors is fast fading. This was certainly the attraction to many of us who arrived with many expectations for our careers and family welfare, but the perception abroad now is one of unfairness in jobs, disproportionality by the GMC and racism in the NHS which has affected recruitment very significantly. The impact of institutional racism in the NHS has been well documented[2,3] though it has not been widely acknowledged by those that inhabit the corridors of institutional power.

The longer-term impact of discrimination on our workforce crisis is not to be underestimated. Indeed, negative stereotypes even at an early stage of medical undergraduate study can adversely affect learning[4]. Inevitably, medical recruitment depends on a number of factors such as global dynamics, Brexit, attractive non-medical jobs, etc., and therefore it would be too simple to say that racism is the only factor, but in our view, it is certainly a significant one. Since 2012 there has been an overall fall by 39.6% in recruitment of International Medical Graduates (the bulk of whom are BME) to training posts, a 37% fall in recruitment to substantive jobs from Oceania and a 50% fall in recruitment from South Asia (particularly India and Pakistan), which historically have provided more doctors to the NHS than any other part of the world. As the NHS and organisations within it seek recruitment from overseas, especially the Indian sub-continent through Medical Training Initiatives, it is vital that the prevailing perceptions are tackled effectively. As Ed Peile professor emeritus of medical education, states it is vital that International Medical Graduates do not feel stigmatised in the current system[5].

Recommendation 1: The review must advise the GMC and the NHS to acknowledge the existence and impact of racial discrimination and make concerted efforts to improve this image nationally and abroad.

Recommendation 2: The review panel must recommend to the NHS that training in Equality and Diversity is fit for purpose and not a cursory online package. BAPIO would be willing partners with NHS England and other organisations in devising a competent training programme.

4. Overseas Medical Graduates and the role of bias in disciplinary decisions

The GMC admits that BME doctors are over-represented in the GMC's Fitness to Practice (FtP) procedures. This reflects the fact that BME doctors are more likely to be referred to the GMC by public bodies (such as employers and the police) and cases referred by public bodies are more likely to be investigated and result in sanctions. The numbers are small, but in our view they most certainly show a trend

towards a bias in how the GMC deals with this group of doctors.

The GMC's own audited data (presented at the GMC's BME forum) shows that bias in process exists at every stage of the disciplinary process. BME doctors who are subject to complaints/referrals to the GMC outnumber White doctors by 2.7:2.3, the ratio for complaints investigated is 27:23 respectively, and investigations resulting in sanctions or warnings is 7:4 respectively. BME doctors suffer the double whammy of being put through the complaints processes whether they are indigenous British born or from Overseas, compared to White doctors. The Policy Studies Institute found no evidence of racial bias in their audited sample from 1997-1999, but it established that the main reason for the higher proportion of overseas qualified doctors referred to the PPC was that they accounted for a much higher proportion of complaints received from public bodies. This finding was replicated by the York Economics Consortium in their 2005 study. The Kings ESRC Programme found no evidence of ethnic bias in the GMC's procedures but found that three groups were of high risk vis-à-vis male doctors, overseas qualified doctors and those referred by public bodies, all of which have a preponderance of BME doctors.

One of our members submitted a FOI to the GMC specifically enquiring about its data on ethnicity and sanctions. In response to that, the GMC revealed that at the time of the request, it had instigated 25 appeals about 23 doctors in relation to Medical Practitioner Tribunal Service (MPTS) decisions since it had obtained the power to appeal in December 2015. Of the 16 that have been heard by the High Court, the GMC appeal has been upheld by the High Court in 14 cases.

The ethnicity breakdown of the 23 doctors is below. In some cases the GMC does not hold ethnicity information.

Table 1: Ethnic distribution in appeals against MPTS decisions

Ethnicity	Total
Asian or Asian British	**7**
Black or Black British	**6**
Unspecified	**6**
White	**3**
Other Ethnic Groups	**1**
Number of doctors	**23**

As shown in the table above, 14 out of 23 (61%) in the group that constituted the GMC's appeals against MPTS decisions came from a BME background. Given the

likelihood of the 'Unspecified' category being largely BME it is probable that the proportion is even higher than the 61%.
BAPIO understands that the authority to challenge the decision of MPTS lies with the Chief Executive Officer of the GMC. This is an anomaly in decision making, partly as such major decisions would normally require the rigor and scrutiny of a committee or panel, however small that might be. It also seems bizarre to us that a properly constituted legal panel presided by a judge under the auspices of the GMC has been challenged by its own parent body in the High Court.

Recommendation 3: BAPIO recommends that the GMC urgently reviews the function of MPTS, and we would further recommend that the GMC must lose its authority to overrule its verdict and take a case to the High Court.

Recommendation 4: The panel must invite the GMC to provide assurance that its processes are subjected to Equality Impact assessments and that action plans are drawn to ensure fairness.

5. Conflict between public facing role of the GMC and MPTS

The legal arm of BAPIO, the Medical Defence Shield, has a strong opinion on this. The contention is that the GMC misuses the principle of 'public faith/trust/confidence in the medical profession' as a ready excuse to prosecute doctors in the MPTS as well as in appealing against MPTS decisions.

When doctors are prosecuted for negligence or misconduct while engaged in their profession the main determinant should be 'patient safety'. There have been numerous instances in which the doctor has been punished for misconduct or negligence for patient safety, has served their suspension or other penalty, made successful attempts to return to the profession only for the GMC to then prosecute them again using the aforesaid principle of public faith/trust/confidence in the profession even when their patient safety concerns have been satisfactorily addressed.

We believe that if a doctors' conduct, while not engaged in their professional duty, is concerning then the test of 'public faith/trust/confidence' is appropriate. However when negligence is determined, then the first and foremost test applied should be that of 'patient safety' and the current system of multiple jeopardy must be changed.

There are concerns that such decisions are taken by the GMC Chief Executive Officer and we remain very concerned that they are often acting on public perception or worse political compulsions instead of the main principal of patient safety.

Recommendation 5: BAPIO recommends that in the event that the panel cannot accede to our demand to remove that GMC's decision to overturn the decision of MPTS then any such decision must be vetted and agreed by an external panel independent of the GMC.

6. Gross Negligence Manslaughter (GNM)

English law is enshrined in the Coroners and Justice Act 2009 enacted by parliament. Whilst the Act reformed voluntary manslaughter it made no changes to involuntary manslaughter which falls into two categories, unlawful act manslaughter and GNM. Cases of medical negligence leading to fatalities fall within the latter.

The review panel will recognise the variability of prosecutors seeking to bring to justice those health professionals who in their estimation have committed fatal medical errors in a negligent manner. Once considered rare, such manslaughter charges have become more common especially in the past decade or two (Table 2). The law as it stands is heavily tilted to punishing individual errors; referral and successful prosecution of healthcare providers under the Corporate Manslaughter and Culpable Homicide Act 2007 are exceedingly uncommon, and in this regard the Review Panel might wish to take note that BAPIO was unsuccessful in inviting the Chief Constable of Leicestershire Constabulary as well as the CPS to show any interest in opening up an investigation into systemic failure following the death of Jack Adcock[6].

Table 2: Number of incidents/convictions in ten-year periods

Cases	1976-1985	1986-1995	1996-2005
Total number of incidents investigated	7	13	40
Total number of individual HCPs investigated	9	13	50
Total number of individual HCPs convicted	1	6	7

Source: Quick O, Jnl of Law and Society[7]

Data on GNM are not centralised or held in any accessible form and therefore it is difficult to be precise about numbers and convictions. It is likely therefore that these are minimum numbers rather than accurate values. We understood that in the last

decade, of the twenty known cases, six of the individuals charged were White, twelve were BME (Jenny Vaughan, personal communication). Of these, all those convicted (seven) were BME though in the case of two (Sellu and Honey Rose) two convictions were overturned on appeal.
Trolling through the literature it seems that the charge of GNM depends very much on the whim of the prosecutors, so that no firm legal guidelines appear to be applied to bring such a charge on the individual health professional, most of whom are doctors. The vagaries of law in this matter are such that there is scope to apply that differential decision on whether or not to prosecute depending on the act of the doctor, whether they are male or female, their ethnicity, etc. as well as to discretionary enforcement of the final verdict.

There is regional variation as the table below shows as well across the United Kingdom (Table 3). The bar for GNM in England and Wales is set at a lower standard than the equivalent charge of Culpable Homicide in Scotland. Therefore a doctor working in England or Wales would be treated differently in Scotland for a similar offence, which appears entirely inconsistent given that the GMC has a UK-wide footprint.

Table 3: Prosecutions by region, 2001-2005

Region	Number of incidents	Number of HCPs	Number of convictions
South East	2	3	2
South West	1	1	0
Midlands	3	2	1
North East	3	2	0
NorthWest	7	8	2
Wales	3	5	0
Total	**19**	**21**	**5**

Source: Quick O, Jnl of Law and Society[7]

In our view, since the decision to charge under GNM is made by the CPS it may be beyond the scope of review of the panel to determine where lines must be drawn between the two as the panel is not looking at the 'bar'. However, we would suggest that GNM should only be considered where the CPS is entirely sure that there was a single act or multiple acts by a medical professional which were the acts that led to the death of a patient. The causation should be exclusively describable as the sole act leading to a patients' death. An example of such act would be administration of medication bypassing usual checks, or wrong site surgery by ignoring WHO checklists or safety prompts. Further, in our experience, adverse patient events are almost always linked to failure of systems (the 'Swiss cheese model') where multiple

mistakes line up and safety nets fail either due to poor design, or stresses on the system due to resource constraints.

As such whenever the CPS feels GNM threshold is met, they must always consider if corporate manslaughter is more appropriate rather than charging an individual or individuals where the failure is not wholly attributable to such individual or individuals. Following on from this, the independence of mortality reviews of deaths due to suspected negligence must be ensured. As the hospitals themselves are interested parties, there is an obvious conflict of interest. It would be preferable to have a completely independent body investigate such deaths (like the IPCC for police), and in order that any such system commands the confidence of the public and the profession, there must be an assurance that such reviews are actively kept at a distance and influence of the Trust's Executive Board.

Furthermore, a second tier of expertise should be developed nationally to which complex decisions could be referred to or advice taken on. It would be envisaged that this expert body would be able to guide both the hospitals and CPS in complex cases. Undoubtedly this will be a large piece of work and will need to be resourced.

Recommendation 6: BAPIO recommends the setting up of a combined unit with the CPS and the police, which must investigate all charges of GNM.

Recommendation 7: Such a panel, or in the absence of this the CPS, must compile a register of all cases of GNM so that this is available for audit purposes and any learning that might be derived from this.

Recommendation 8: BAPIO also recommends that any case of GNM must not be dealt with in isolation, and therefore our expectation is that in all cases systemic failures must be considered and healthcare providers, where relevant, are investigated under the Corporate Manslaughter and Homicide Act 2007.

7. Reflection, Openness and Transparency

While recognising the importance of duty of candour and openness of medical professionals in dealing with adverse outcomes, it is also equally important that doctors are not deprived of their legal protections.

Reflections are vital parts of learning, and openness of reporting systems improve patient outcomes. Doctors already have clear responsibility of documenting medical encounters in full and contemporaneously, and various GMC Good Medical Practice guidelines expect very high standards of these. As such, any presumption that reflections would attempt to hide vital information which is not otherwise available is perhaps simplistic. It is very probable that any move to incorporate such personal information into judicial processes will lead to defensive practices and reluctance to be open about genuine mistakes for fear of recrimination.

We were asked as to how reflections may be 'encompassed' – and we would propose that the same principles be applied to reflections as included in 'legal privilege' in effect a right which attaches to the doctor and can be waived. Legal privilege is a fundamental principle of justice, and we feel that if no protection is provided to doctors for reflections, their legal rights may be affected adversely and their ability to comply with GMC Good Medical Practice guidelines may be compromised.

Recommendation 9: Reflections and appraisals must be considered legally privileged and must not be submitted as evidence in GNM trials.

8. Summary

BAPIO welcomes the Secretary of State for Health's review of GNM. There has been widespread concern about the injustice in the Dr Hadiza Bawa-Garba case and other cases of GNM so there is an urgent requirement to ensure that there are significant improvements to a system that is seen by our members as discriminatory, within the judiciary and particularly at the GMC.

It is vital that the medical profession commands confidence in its regulatory body, and we hope that our recommendations, if met, will go some way to creating a more just, equitable and proportionate system which is safer for the patients, and supportive for doctors of all origins.

9. References:

1. The State of medical education and practice in the U.K. General Medical Council (2017) https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk

2. Coker N. Racism in Medicine. An agenda for change. (2001) King's Fund, London

3. Esmail A & Abel P. Is the NHS Institutionally racist? The impact of ethnicity and diversity on doctors' performance and appraisal. British Journal of Health Care Management 2006, Vol 12, No. 10.

4. Woolf K, Cave J, Greenhalgh T, Dacre J. Ethnic stereotypes and the underachievement of UK medical students from ethnic minorities: qualitative study. BMJ 2008; 337: a1220

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6. BAPIO letter to the Chief Constable of Leicestershire Constabulary

Hadiza Bawa-Garba
Police letter.pdf

7. Quick, O. Prosecuting 'Gross' Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service. Wiley publications for Cardiff University: Journal of Law and Society, Vol. 33, No. 3 (Sep., 2006), pp. 421-450

Dated 17/04/2018

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