



Sushruta Journal of Health Policy & Opinion

OPINION

Does the treatment of minority doctors by the UK regulator demonstrate Institutional Racism?

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ARTICLE INFORMATION

Article History:

Submitted: 17 06 2021

Published: 19 06 2021

Revised: 20 06 2021

Keywords:

Institutional racism, Regulator, The General Medical Council

Digital Object Identifier:

<https://doi.org/10.38192/14.2.9>

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ABSTRACT

In June 2021, an Employment Tribunal, accepted the claim from the complainant that the UK regulator, the General Medical Council may have discriminated against a doctor on the basis of his race, ethnicity or religion in their processes and outcomes.¹ This is perhaps the first time that such a claim of discrimination on the basis of race, ethnicity or religion has been passed in the UK, hence this is hailed as a 'landmark judgement'. It is not the first time that doctors have claimed that GMC and its processes demonstrate institutional racism.² The Kline report described the existence of 'In groups and out groups' determined by qualifications (including by country and within the UK by medical school) and ethnicity (including within BME populations). They found that members of ingroups can receive favourable treatment and those in out groups are at risk of bias and stereotyping.³ Amitabha Banerjee, wrote in the BMJ, that overt and covert racism within the medical profession is rarely talked about but existed then, and still unfortunately exists now, albeit to a lesser extent, to this day.⁴ The case of Hadiza Bawa-Garba, a Paediatric trainee who was struck off the register by the GMC on negligence and then subsequently restored demonstrated discrimination in the processes, as the duty White consultant did not face any disciplinary process. Complaints are more likely to be against BAME doctors, and when they proceed to the regulator or the law courts, they are more likely to lead to more serious punitive measures and guilty verdicts.⁵⁻⁷

The debate on whether GMC's processes were unfair, discriminatory and racist started in 1996.⁸ However, even in 2003, the GMC council has debated the issues of institutional racism and expressed its commitment to fairness⁹ but little progress has been made even 2 decades later. In its submission to the William's review in 2018, BAPIO had recommended that 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.¹⁰ In relation to the differential outcomes for doctors from minority ethnic backgrounds in examinations, assessments, recruitment, the GMC is committed to ensuring that pathways through medical education and training are valid, fair and justified.¹¹

The world including the NHS is changing. The Care Quality Commission (CQC) has issued an open statement, together with the NHS Race and Health Observatory, Nursing and Midwifery Council (NMC) and the GMC, calling on healthcare leaders to ensure that health and care staff across the country are protected from racism or any other form of discrimination. The statement demonstrates a collective commitment to work together to tackle racism, bias and inequalities within the healthcare system, calling on healthcare leaders



to ensure that policies and processes are fair, inclusive and in line with the Equality Act 2010. The GMC set “ambitious” targets to address specific areas within medical the profession to address entrenched bias and racial discrimination, which it believes requires “sustained focus and for healthcare regulators be aligned on this commitment”. Dame Clare Marx, the chairperson of the GMC UK, reiterated her commitment to creating robust processes which were fair, transparent and just in dealing with all doctors, offer speedy resolutions/ outcomes of cases, offer sensitivity and support to doctors under investigation. She committed the GMC to facilitate change across the system.¹² The NHS has been working to close this gap by adopting national targets in formal disciplinary investigations between White and BAME staff.¹³ There is more visibility of the work of overseas doctors and issues of racism are being more openly debated.

There has been progress, but if we want to attract the best doctors in the world to the NHS, we have to create an environment where those doctors will be treated fairly and without discrimination. In his Blog following a recent meeting with the GMC in Scotland on equality, diversity and inclusion, Mr Zamvar explores the feedback he has received from his colleagues and issues a wake-up call to the profession.

Blog

A few weeks ago, I was asked to present the views from the profession at a meeting hosted by the General Medical Council in Scotland on Equality, Diversity, and Inclusion (EDI) issues affecting doctors from minority and ethnic backgrounds. I collected the views of doctors via social networks regarding their experience and view on the EDI aspects of the regulator, their processes and the outcomes of fitness to practice investigations.

Unfair Treatment

The overwhelming opinion amongst most of the BAME (Black, Asian, and Minority Ethnic) doctors was that; a) BAME doctors are more likely to be referred compared to their White colleagues for similar mistakes/incidents/complaints. b) For a similar complaint, for BAME doctors, the processes and the outcomes would be harsher compared to their White colleagues. They gave me examples of where they felt White colleagues had been treated leniently (for which they do not have any complaints, but they did consider why that benefit of the doubt, or that leniency was not afforded to them). Figure 1

¹⁵

Culture Of Fear

I spent many evenings talking to doctors on the phone. Many gave me examples. They told me their own stories, and those of their friends, and acquaintances. One more thing that came out was the fear factor. They were still worried about the system “getting back at them”. This fear was firmly entrenched, something that I felt very difficult to fathom. They wanted me to let people know what they feel, and the general circumstances of the case, but nothing which could identify them. They felt that if they raised issues of racism or unfair discrimination, they would be targeted.

Here are some examples:

- An Anaesthetist from Birmingham who had been suspended from the GMC Register for a year for financial dishonesty had his suspension cut short to allow him to go back to work during the pandemic. [14] While there is nothing wrong with doing this, it is also apparent that some BAME doctors were not afforded the benefit of this leniency.
- I have come across one BAME doctor who was also suspended for a year for financial dishonesty. He also expressed an interest in getting back to work during the pandemic, but was not able to.

Figure 1 shows the case of the same anaesthetist who was able to return to work during the pandemic, because of shortages of anaesthetists. And there are examples of other cases which were turned down. It is indeed a fact that the doctor who had his suspension cut short happened to be a white doctor; whereas all these doctors in the examples above who did not have their suspensions curtailed were BAME doctors. On the face of it, this smacks of injustice. There is no doubt that there will be many other factors at play, and no case is straightforward; but the overall figures justify the strong perception amongst the BAME community that subconsciously race plays an important role.



Index case – Dr XY was a consultant in intensive care medicine and anaesthesia	The Dr was suspended for having been on call for NHS and private hospitals concurrently on numerous occasions (over 30)—misconduct that had potentially endangered patients.	Dr XY a White doctor had their 12-month suspension cut short after their NHS trust wrote to the GMC in response to their guidance * saying that they were needed to help fight the covid-19 pandemic.
Case A Dr AB's name had been erased from the Register as it had been found proved at Medical Professional Tribunal (MPT) that they had accepted work whilst on sick leave.	At the time of application, they had been erased for 4 years and 3 months, with only 9 months before being able to apply for restoration to the register.	Dr AB supplied substantive logs and audits of their work and actions whilst erased, letters of support from colleagues, family and friends, as well as showing their dedication to the medical profession through voluntary work. Their application was refused.
Case B Dr CD's name had been erased in 2018 as they had wrongly written a prescription for a family friend.	The GMC had originally only sought suspension at the MPT.	Alongside their application, Dr CD provided multiple letters of support, references, evidence of courses and Continuing Professional Development (CPD) and testimonials, including one from the Practitioner Health Program recommending their restoration. Their application was refused.
Case C Dr EF's name was erased in 2018 due to a patient complaint which had been made in another country.	They had been maintaining their clinical knowledge and skills through CPD as well as teaching and lecturing other medical professionals and volunteering. Interestingly they are still allowed to practice in the country where the complaint was made, after having being investigated by the local medical council.	Their application was refused.
Case D Dr GH had been suspended in 2020 for misconduct not relating to their clinical skills and that did not endanger patients.	Their request for early review of the suspension was refused by the GMC and they were informed they would have to wait another 2 months until the Interim Outcomes Tribunal (IOT) review.	Their suspension was then revoked at IOT. 2 months later, unnecessarily delaying their return to help throughout the pandemic.
Further to the GMC guidance*, four BME doctors (their cases described briefly Cases A-D) applied to have their sanctions relaxed and/ or revoked so they could support and work for their NHS Trusts during the pandemic. None of them were successful in their application. Cases A to D were supported by extensive logs, recommendations and detailed insightful personal pleadings from the doctors themselves, with the help of defence organisations. The index case refers to a White doctor who's suspension was revoked appropriately by the GMC.		

Figure 2 shows the details of two cases which happened at about the same time.

BAME Doctors: Double Whammy

- | | |
|--|---|
| <ul style="list-style-type: none"> • White Anaesthetist (Birmingham) • Financial Dishonesty • One year Suspension (Decreased) • Dishonesty affected Private and NHS Hospital • No Clinical Issues • Kept NHS Job | <ul style="list-style-type: none"> • BAME Doctor (UK) • Financial Dishonesty • One year Suspension (Not Decreased) • Dishonesty only in Private Hospital • No Clinical Issues • Dismissed from NHS Job* |
|--|---|

Source of Info: GMC Website

Source of Info: GMC Website
Source of Info: * Personal Correspondence

The anaesthetist in question (a BAME doctor) who was suspended for a year from the Register, also lost his job at the NHS hospital where he worked. His suspension period is now finished, he is back on the GMC Register, but he is doing locum jobs up and down the country now. The anaesthetist from Birmingham (a White doctor) on the other hand, not only had his job kept for him, but also had his suspension period curtailed. Going through the details of the cases (as available in the public domain), the first doctor was BAME, he was involved in financial dishonesty only involving the private hospital, and not the NHS hospital; but he lost his NHS job. I must stress

that there were no issues about his clinical practice at all. On the other hand, the anaesthetist from Birmingham, was involved in financial dishonesty which involved both the private hospital, and the NHS hospitals. But he kept his NHS job. I also came across the fact that in the same hospital where the BAME doctor was dismissed from his job, a White doctor had been suspended from the GMC Register for sexual misconduct. After his period of suspension ended, he went back to his job in the hospital. He had a lot of support from the management, and his colleagues when he came back, and this helped his rehabilitation.



Does This Differential Treatment Arise From Racism?

There are multiple levels at which BAME doctors find themselves at a disadvantage. I found one more example of a doctor who had his suspension curtailed due to the pandemic. He was a GP from England. Again, he was not a BAME doctor. The Tribunal decision included a statement;

“The MPT observed that the public interest would not be served by removing a “highly valued academic and clinical practitioner out of practice for a disproportionate amount of time”.

If a doctor is of average competence, why can't he have his suspension term reduced? I have examined several tribunal decisions on the GMC website. These terms “exemplary”, “highly-valued” are very subjective. And more often than not, the use of this language favours certain groups (read White) more than others (read BAME).

After I had sent out messages on various social networks asking for opinions about the GMC processes, and perceptions about fairness; I only got negative responses. I also wanted to hear from those who felt that they had confidence they would be treated fairly. So I sent out another message. I specifically asked for opinions from those who felt they had confidence that they would be treated fairly.

And I received no response from anyone who said that they consider the GMC to be fair. Not one single person said that to me. The most positive comment I received was

“It is a good that ‘they’ (i.e. the GMC) realise there is a bias, and it is positive that they want to address it”.

A wake up call

I would therefore urge the GMC to organise a survey specifically dealing with EDI issues, so that the messages that I am bringing via this article, come to you directly from the frontline. And the survey should be designed in such a manner that it encourages people to be candid in their opinions. British Association of physicians of Indian Origin (BAPIO) would be willing to be a partner in this.

Causes For Discrimination

I also spoke to a number of my White colleagues about their perceptions about GMC referrals, and the processes; and why they felt BAME doctors were more likely to be referred.

Here are some of the comments from White colleagues.

- “Trusts hit on weak people, and they flinch away from who they perceive as a powerful person”
- Another comment came from a senior cardiac surgeon from England, who is mentoring an Indian Radiologist who has been referred to the GMC, for something that in his opinion is so minor, that he considers it outrageous that it has even reached the GMC. He said he is aware of other White colleagues who committed far worse misdemeanours and never even got close to a proper process, leave alone a referral to the GMC.
- *“Everybody deserves a second chance. To me it feels that more often than not, at the first slip-up, a*

BAME doctor may find himself referred to the GMC”

The data suggests that a higher proportion of BAME compared to White doctors are referred to the GMC by their employers. The GMC should insist on documentation of advice, support, and a paper trail of what the Trust had done to nip the problem earlier on. And more importantly, GMC must ask the Trust, have similar (or nearly similar) incidences happened with other doctors (or specifically White doctors) in the past, and if they were not referred to the GMC, how were they dealt with internally.

Insight

Another issue that has caught my attention, and which I feel negatively affects BAME doctors is the issue of exhibiting insight. In all the tribunal decisions, important consideration is given to the fact that the doctor has shown insight. Here are two examples from the GMC Website.

- “The tribunal was of the view that Dr X has now fully appreciated the gravity of his dishonest conduct, has fully reflected on the findings of the 20XX Tribunal, his dishonesty, and root causes of that behaviour.”
- “The Tribunal agreed with Mr K’s assessment of Dr X’s reflective statement as being exemplary. Taking all of the above into account, the Tribunal was satisfied that Dr X has developed full insight into his misconduct and dishonesty; and that the risk of repetition is very low.”

Doctors from the BAME background, and especially doctors who are not represented will struggle to write a statement, that is likely to satisfy the subjective criteria that Tribunals use. After trawling through numerous tribunal decisions on the GMC Website, I have not come across any tribunal speaking in such terms for the insight exhibited by a BAME doctor. Why not use objective templates, with many of the questions having a tick-box “Yes-No” box, and some pre-determined questions where text can be used. So doctors who wish to use this facility can do so.

Providing “insight” statements requires a degree of mastery over the language. And in this regard, the processes put BAME doctors who do not have English as a first language, at a disadvantage. Therefore the GMC should offer all doctors the opportunity to use pre-formatted templates for providing insight statements. It may be argued that often the best judge of a whether a doctor has gained insight or not is the doctor himself.

No single person in the GMC is racist or holds views that would support discrimination. But the net effect of all the GMC procedures and processes is that the BAME community is negatively affected. This to me is “institutional racism.”

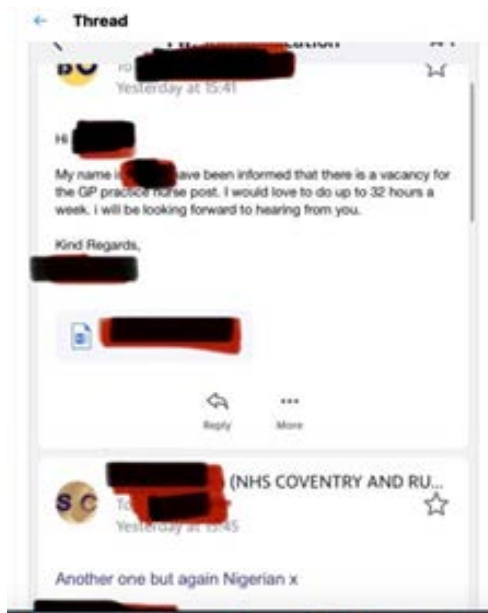
At the 2021 Annual Meeting of the UK Society of Cardiothoracic Surgeons, one of the most popular sessions was one debating the concept of EDI in CT surgery. We discussed the impact of race, and the difficulties faced by women who wish to pursue a career in CT surgery. Simon Kendall, the President of the Society, observed that when the Kennedy report^[16] was being discussed at the English Council, it was



clear that all the female and BAME members of the Council, had humbling stories about what they had experienced in their careers; and his impression was that the White members of the Council were all agreeing with the findings, but always had a “but” at the end.

They would all say,

Figure 3: from Twitter



This Nigerian nurse had expressed an interest in a nursing vacancy. The recruiting agent forwarded this message to another colleague and accidentally also included the applicant. His message read:

“Another one but again Nigerian”. The word *“but”* here makes all the difference. It speaks a lot about the culture in that particular organisation. It not only reflects the views of the person writing that email, it also reflects the views of the person receiving that email, because the writer feels comfortable in using that language.

Solon, a statesman from Athens in the 6th century BC is renowned to have said,

“Justice will only be achieved when those who are not injured by crime feel as indignant as those who are”

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“We agree with all this, but” So the word “but” is a powerful one. It has many negative connotations. I would ask all in positions of power and influence to remove the “but” that they would use at the end of their sentences. Look at the Use of the word “But” in this tweet (Figure 3); that I read on Twitter a few weeks ago.

Benefit Of Justice

Essentially the agenda for achieving EDI will not move forward, neither will change come, until those who are unaffected are as outraged as those who are. Doctors from BAME backgrounds constitute between 25 and 40% of doctors in the UK. There are many disadvantages in a significant proportion of such a large segment of the work-force feeling discriminated against. A culture of defensive behaviours that is the result only impacts negatively on patient-care as well as the wider NHS.

There are huge benefits of having a system that is not only just, but also perceived by its weakest and most disadvantaged members to be fair. It will improve morale, engagement and patient care.

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