Appeal No. C1/2018/0356

IN THE COURT OF APPEAL (CIVIL DIVISION)

ON APPEAL FROM THE HIGH COURT

QUEEN'S BENCH DIVISION

ADMINISTRATIVE COURT

BETWEEN:

DR HADIZA BAWA-GARBA

Appellant

And

GENERAL MEDICAL COUNCIL

Respondent

And

BRITISH MEDICAL ASSOCIATION

First Intervener

And

PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

Second Intervener

And

BRITISH ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN

Third Intervener

INTERVENER'S (BAPIO'S) SUBMISSIONS[1]

References [x] are to the small bundle of documents and authorities lodged with these submissions

Introduction

[1] These submissions are made pursuant to the order of the Master of the Rolls dated 16 July 2018, granting BAPIO permission to intervene on terms that any submissions are limited to 7 pages.

1. BAPIO was established in 1996 to support International Medical Graduates (IMGs). BAPIO is the largest membership organisation for Black and Minority Ethnic (BME) doctors working in the National Health Service (NHS). It provides a voice and support for its members. It also informs policy makers in the NHS, Medical Royal Colleges, and other organisations. BAPIO has extensive experience of the issues affecting BME doctors in the context of their access to registration, employment and professional regulation. BAPIO has brought proceedings in its name in the past, including to address concerns relating to race discrimination impacting on BME doctors (*R (BAPIO Action Limited) v RCGP and GMC* [2014] EWHC 1416 (Admin); *R (BAPIO Action Ltd) v Secretary of State for the Home Department* [2008] UKHL 27, [2008] 1 AC 1003).

Background

2. BAPIO intervenes in this appeal because it is concerned that BME registrants are overrepresented in Fitness to Practise proceedings and that outcomes are disproportionately harsh for certain cohorts of BME registrants.

3. The Respondent's ("GMC's") most recent annual report [1-22] states as follows:

> "Most licensed doctors who were registered to work in the UK between 2012 and 2016 and whose ethnicity we know … fell into one of four groups: white UK graduates (41%), IMGs[2] who are BME (18%), UK graduates who are BME (12%), and white EEA graduates (9%).[3]
> …..
> Between 2012 and 2016 <u>the rate of a doctor being complained about, having a complaint investigated, and receiving a sanction or a warning varied by PMQ and ethnicity</u> and also by register type….
> In terms of the groups of doctors with the highest and lowest rates of complaints:
> - Just under a quarter (23%) of <u>IMG BME GPs were complained about compared with 17% of their UK BME</u> counterparts.
>
> ………..

[2] IMGs (International Medical Graduates) are doctors who gained their primary medical qualification outside the UK, EEA and Switzerland, and who do not have European Community rights to work in the UK.

[3] There are then two much smaller groups: white IMGs (3%) and EEA graduates (excluding the UK) who are BME (1%). The remaining doctors (16%) did not declare their ethnicity. This year, for the first time, the GMC included doctors with unknown ethnicity separately in the analysis (p. 107) [19].

In terms of the rates of sanctions and warnings, overall differences were relatively low between groups of doctors and numbers are low. Care must be taken in drawing too firm conclusions from these data:
……….

- 1.77% of BME EEA doctors on neither the GP nor the Specialist Register and not in training had a sanction or warning and EEA GPs with no recorded ethnicity had a sanction or a warning rate of 1.49%
- BME UK doctors on neither register and not in training also had a relatively high sanction and warning rate (0.93%) as did IMG GPs with no recorded ethnicity (1.36%)."

(*"The State of Medical Education and Practice in the UK"* (2017) GMC, p.107 [19] emphasis added)

4. Thus, (i) BME EEA doctors on neither the GP nor the Specialist Register and not in training disproportionately received a sanction or warning; (ii) BME UK doctors on neither register and not in training had a relatively high sanction and warning rate and (iii) IMG GPs with no recorded ethnicity (though necessarily IMGs are very much more likely to be BME since of those whose ethnicity is known, only 3% of IMGs are white[4]) also had a relatively high sanction and warning rate.

5. Further, in the case of the largest four largest specialities (medicine, surgery, anaesthetics and intensive care medicine, and psychiatry), UK graduates were less likely to receive a sanction or a warning than those who graduated abroad (*"The State of Medical Education and Practice in the UK"* (2017) GMC, p. 109 [21]).

6. Further still, since it acquired the power to appeal in 2015[5] the GMC have brought a disproportionate number of appeals against decisions of the Medical Practitioners Tribunal ("MPT") affecting BME doctors. Thus, the response [24-26] to a Freedom of Information Request [23] made to the GMC demonstrates that of the 25 appeals, concerning 23 doctors, instigated by the GMC against a

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[4] *"The State of Medical Education and Practice in the UK"* (2017) GMC, p.107 [19].

[5] Section 40A, Medical Act 1983 as inserted by the General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015, SI 2015/794).

decision of the MPT since December 2015, 17 of the doctors concerned declared their ethnicity and of those 17, 13 (76.47%) concerned BME doctors.

7. For the purposes of this appeal, the findings of the *Williams Review* (*"Gross Negligence Manslaughter in Healthcare: the Report of a Rapid Policy Review"* Professor Sir Norman Williams (published on 11 June 2018)) are also relevant. It reported that: "The panel heard that Black, Asian and Minority Ethnic (BAME) registrants are over- represented in the fitness to practise processes of a number of healthcare professional regulators. <u>There is some evidence that this also applies to prosecutions for gross negligence manslaughter</u>, although the numbers of cases are too small from which to draw meaningful conclusions" (*Williams Review*, p.43 [31]). See too: J. Vaughan *"Gross negligence manslaughter and the healthcare professional"* (2016) The Bulletin, RCS, Vol 98, pp60-62 at p62 [136-138 @ 138].

Legal and Policy Framework

8. These submissions are limited to observations on the general legal scheme and legal provisions/case law that, BAPIO anticipates, will not be addressed by the parties to this appeal.

Fitness to Practise Proceedings

9. As the Court will no doubt hear, the General Medical Council (Fitness to Practise) Rules Order of Council 2004 (2204/2608) introduce the following stages for Fitness to Practise proceedings: (i) consideration of an allegation[6] (Rule 4); (ii) investigation (Rule 7); (iii) consideration by the case examiner[7] who may determine whether the allegation should proceed, issue a warning, refer the matter to the investigations committee or refer the matter for determination by a MPT (Rule 8) and (iv) consideration by the GMC investigations committee which may determine whether the allegation should proceed, dispose of it by

[6] Defined at Rule 2.
[7] Appointed for the purposes of exercising the functions of the investigations committee: Rule 2.

issuing a warning or refer the matter for determination by a MPT (Rule 9). Finally, following a decision of the MPT, the GMC may decide to appeal against that decision.[8] At each of these stages, there are disproportionately adverse outcomes for (for certain cohorts, at least, of) BME doctors.

Equality Act 2010

10. The law requires that at each of the stages above, the GMC must comply with the Equality Act 2010 ("EA 2010"), as it itself acknowledges (*"Sanctions Guidance"* (2016[9]), p.7 [127] and *"Sanctions Guidance"* (2018) p.7 [135]).

11. Discrimination by "Qualifications Bodies" (defined by section 54, EA 2010 [33]), including the GMC, is governed by section 53 EA 2010 [32]. Discrimination in, *inter alia*, the imposition of a sanction and/or withdrawal of registration is unlawful (section 53(2)(a) and 54(3), EA 2010 [32-33]).

12. Further, section 149, EA 2010 [34-35] enacts the Public Sector Equality Duty ("PSED") as follows:

> "(1) A public authority must, in the exercise of its functions, have due regard to the need to –
> (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
> (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it,
> (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
> …
> (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to -
> (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;

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[8] A power acquired in 2015: section 40A, Medical Act 1983 (as inserted by the General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015, SI 2015/794).

[9] Applicable at the date of the Medical Practitioners Tribunal decision in the Appellant's case.

> (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it
> …….
> (5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to –
> (a) tackle prejudice, and
> (b) promote understanding.
> …
> (7) The relevant protected characteristics are –
> …..
> race
> …"

13. As can be seen, the PSED includes both *negative* objectives (eliminate discrimination) and *positive* objectives (advance equality/foster good relations). For the principles applicable to the discharge of the PSED, see: *Bracking v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345, [2014] EqLR 60 [67-82], paras 25-6 and *Hotak v Southwark London Borough Council (Equality and Human Rights Commission and others intervening) and A'or* [2016] AC 811, paras 73-75 [83-119]).

14. The GMC is a public authority to which the PSED applies (see Sch 19, EA 2010 [38-52 @44]). The PSED applies to <u>all</u> of the GMC's public functions (specifically its regulatory functions, those being public functions), save those explicitly excluded and none are relevant here (Sch 18, EA 2010 [36-38]). It therefore applies at <u>every</u> stage in Fitness to Practise proceedings (from receipt of an allegation to deciding whether to appeal), both in the development of policy but also in reaching decisions in <u>individual</u> cases (*Pieretti v Enfield London Borough Council* [2010] LGR 944 [53-66]). There is nothing that BAPIO has seen indicating that that duty is complied with, though it should be, in progressing individual allegations through the Fitness to Practise procedures, up to and including decisions of the MPTs and decisions to appeal. The PSED requires focussed and conscientious consideration in an individual case of the

impact of taking a particular course on the equality objectives set out under section 149(1), EA 2010.

15. BAPIO respectfully submits that were the Court in this appeal minded to lay down any principles of general application applicable to GMC Fitness to Practise proceedings/sanctions, regard should be had to the impact of the EA 2010, including the PSED, on the exercise by the GMC of its regulatory functions.

Medical Act 1983

16. BAPIO submits that in determining whether any sanction properly pursues the objective of promoting and maintaining public confidence in the medical profession (Medical Act 1983, section 1 (1B)(b)), account must be taken of the impact on "public confidence" that must follow from a Fitness to Practise regime that apparently produces disproportionately adverse outcomes for BME registrants.

17. Where Fitness to Practise procedures produce negative outcomes for BME registrants, this may indicate that, either BME registrants are subject to overly harsh treatment – a matter which is likely to greatly undermine public confidence – or that non-BME registrants are subject to overly lenient treatment – a matter which is equally likely to undermine public confidence (and which is, additionally, discriminatory).

18. Further, the PSED which applies in carrying out functions in pursuit of the over-arching objective underlines the importance of ensuring that the GMC's Fitness to Practise functions are exercised in way which is consciously non-discriminatory and which promotes equality.

KARON MONAGHAN QC

19 July 2018