Allowing patients to choose the ethnicity of attending doctors is institutional racism

A hospital accepted the request that care should be delivered only by a white doctor. **Nadeem Moghal** reflects

On 22 April 1993 the black teenager Stephen Lawrence was murdered by a gang of people, some of whom were finally convicted in 2012. The deficiencies in the police investigation led to the Stephen Lawrence Inquiry, known widely as the Macpherson report, which defined the phrase "institutional racism" as "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people."[1]

This concept continues to be debated, particularly by police services, the focus of the Macpherson report. The definition is intricate, nuanced, and an advance in our understanding of our society. It is relevant to every organisation, private and public. It is a definition against which individual and organisational behaviours can be tested and healthcare services are no exception. NHS organisations have equality and diversity policies in place to comply with the law, and related mandatory training. Yet neither policies nor training were enough in a situation I experienced. This happened in this millennium in a hospital where I used to work. No names are needed because this is about how organisations might mature to understand and use the concept defined by Macpherson.

The story is that the parents of a child patient refused to have care delivered by black or other minority ethnic doctors; the request was phrased a touch more colourfully. The patient needed the specialist expertise available in tertiary hospitals. The clinical director concluded that because of the nature of the disease and the clinical need of the patient, the parents' choice would be enabled. Attendance at the clinic was planned to ensure that the patient saw one particular white British doctor.

The clinical team, which included doctors of South Asian origin, knew of this arrangement. On one occasion the patient seemed to be acutely ill, forcing the white doctor to check who was working in the assessment unit before deciding to see the patient because of the diversity of staff on the unit at the time. The arrangement continued for more than a year. There was an assumption that the rest of the clinical team accepted this arrangement on the grounds of clinical need. However, when the arrangement was revealed to others outside the specific service in question, as a supposed example of good decision making in a difficult situation, the reactions ranged from "this is no different from a female patient requesting a female doctor" to "this is the first time in my professional career I have felt defined and judged by my ethnic origin rather than my professional capability."

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After a difficult process, including requests for a reversal of the decision (including from me), which unexpectedly led to a board level inquiry, the medical director told the family that care would be provided by staff regardless of their ethnicity. The family relented.

What can we conclude? There are limits to patient choice. Seniority and senior leadership does not necessarily confer a failsafe moral compass. Our colleagues can unwittingly make decisions that damage other colleagues. And when racists are confronted they may ultimately relent.

But might this have been a moment in the organisation's history when it behaved in an institutionally racist way? The decision to enable racist parents to determine who was to deliver their child's care based on ethnicity was to effectuate the racist views of a racist. That does not necessarily make the people who gave effect to the racists' views racist themselves. But such conduct could be seen, when reflecting back on Macpherson's definition, as symptomatic of "the collective failure of an organisation to provide an appropriate and professional service," not to the patient but to fellow colleagues, "because of their colour, culture, or ethnic origin." Can institutional racism be seen or detected in the decision making processes that enabled the arrangement?

Does the decision reveal "attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness"? The key word is "unwitting" but the impact that such thoughtlessness has can be considerable. In this case, enabling the racist can be seen to have "disadvantaged minority ethnic people"—professional colleagues of minority ethnic origin not only in the particular specialty in question but throughout the organisation.

Any organisation might find it hard to accept that it had behaved in an institutionally racist way but the Macpherson definition allows an understanding and creates an opportunity to strengthen the policies of public and private institutions, adding to diversity training, with the aim to make the enabling of racist choices a never event. This type of enabling has happened before,[2] and will happen again unless leaders grasp the definition and provide the right narrative.

The right outcome was eventually reached because of the courage and tenacity of those—including me—who stayed the course, but it was a difficult journey professionally and personally. I will always believe that what had gone on was a worthy subject for internal whistleblowing. The key lesson is that immediately confronting and standing up to racists rather than enabling them must be the first step to building equitable organisations. Organisations and especially their leaders must learn; Stephen Lawrence has much to teach us all.

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FROM THE FRONTLINE **Des Spence**

We are all businesspeople now

I was flat broke. At university I spent my summers working as many hours as I could in whatever job I could find. One summer I worked in a large Glasgow pub, pulling pints, remembering rounds, totting up orders in my head, clearing up vomit, cashing up, unblocking urinals, carrying cash to the night safe, and breaking up the occasional fight. At the end of the summer, the brewery's regional manager asked me if I wanted to become a trainee pub manager. I phoned my dad who proffered some well chosen expletives as advice. This work taught me just as much as I learnt at university: businesses work hard to give people good service, and money follows.

General practitioners (GPs) hold contracts with the NHS but are in fact private subcontractors, an arrangement that has existed ever since the formation of the NHS. Some disapprove of this model, feeling that GPs should be salaried, in the same way as our hospital colleagues. Others argue that general practice should be more innovative and flexible. What it does mean is that GPs are paid depending on how we run our own businesses: we are businesspeople, whether we like it or even know it. Concern has been expressed that GPs' profits are excessive.[1] The response is to publish the incomes of individual NHS GPs from 2016.[2] Now openness is a good thing, but I'm a well paid GP so it's also potentially embarrassing for champagne socialists like me.

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Profits increased after 2004, when business restrictions were lifted from general practice. For the first time GPs were allowed to employ other doctors, and so the traditional equitable model of partnership is dying if not already dead. Established models of services are unravelling throughout the NHS, with the private sector awarded 70% of new contracts.[3] There is an unstoppable force towards the corporatisation of general practice.

The only logical way to preserve GP partnerships and doctor ownership is through practice mergers. Smaller practices are already struggling with the burdens of administration and changes in working arrangements; bigger practices with fewer partners and more salaried doctors seem inevitable. Larger practices can employ economies of scale, afford more flexibility, and are more organised and diverse. This future might see ever larger profits for GP partners. But there is another way: John Lewis-style partnerships, with a social charter and a cap on senior partners' wages.

I have decided that it's time give up my column in the *BMJ*, from the end of March. I'm going to concentrate on what I am trained to do—building a doctoring business.

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BMJ BLOG OF THE WEEK **David Wrigley**

How to fast track hospital closures—use clause 118

Like a baby throwing their toys out of a pram, Jeremy Hunt is using the blunt instrument of legislation to hit back at patients and campaigners who beat him in the High Courts over his attempt to close Lewisham Hospital.

Lewisham was a successful, popular, high quality, and solvent London hospital. A neighbouring hospital was in dire straits owing to crippling politically engineered PFI debts, so Jeremy Hunt sent in his officials who decided the answer was to close Lewisham Hospital. No one could understand the logic. This decision immediately angered local clinicians, commissioners, and residents, and a huge and ultimately successful campaign stopped the closure process. It was ruled unlawful by the judge. Mr Hunt subsequently decided to spend thousands of pounds of tax payers money to appeal against this High Court decision—but again he lost.

Jeremy Hunt was not a happy man. In order to stop local people blocking his officials in future cases he decided to add a last minute clause to the care bill currently moving through Parliament. Clause 118 is the number on NHS campaigners' lips. It allows officials to close any English hospital with very little meaningful consultation. Even local council scrutiny processes—often seen as robust and fair—will be sidelined.

Jeremy Hunt's justification for clause 118 is that when a hospital is failing he needs to be able to close it down quickly for "patient safety reasons." Hospitals fail because of poor management in most cases. Managers who have been blinkered by the need to run their institution like a business and chase the money in order to survive.

Shadow Secretary of State for Health Andy Burnham said this legislation should "send a shiver through every community," and he is right. No hospital will be safe in what is rapidly becoming known as the "hospital closure clause." The UK has fewer hospital beds per head of population than almost every other European country (we have 3.0 per 1000 population in 2011, well below the OECD average of 4.8 per 1000). The lack of beds leads to huge pressures in hospitals, and the pressure valve that is A&E will eventually blow. The one useful thing Jeremy Hunt could do would be to use the £3bn NHS surplus that we have to invest in more nurses, more beds in hospitals, and more social care for patients to be transferred safely back into the community.

PETER MARSHALL/DEMOTIX/PA

David Wrigley is a GP in Lancashire and a member of the BMA GP Committee

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