What can we learn from the Manjula Arora case?

Compassion, curiosity, and cultural competency can go a long way in organisations which are open to listening and re-assessing.

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The diversity of the medical profession has never been greater—42 per cent of doctors in the NHS are of black and minority ethnic origin in a workforce heavily reliant on international medical graduates (IMGs). Almost two-thirds of doctors joining the UK medical register are from ethnic minority groups.

So when Manjula Arora, a locum, was given a month’s suspension over whether or not she was promised office equipment, the consternation was instant, and palpable. At its heart, this issue hinged on a legal test around dishonesty which was wrongly applied. Had that test been applied correctly, the allegation against Arora would never have made it to a tribunal, preventing a great deal of anxiety.

This week the General Medical Council (GMC) has published a review of the case which we co-chaired. We hope that our review of the Arora case will encourage modern regulation which is compassionate, caring, and fair. It is our belief that we can make cases such as this into “never events.”

Our review makes a series of recommendations, from greater consistency in managing concerns so that “local first” (managing concerns at a local level rather than referral to the GMC) becomes the default, to more rigorous investigation plans and case assurance.

But crucially we also call for greater levels of cultural competency to better understand the professionals working in our health services.

The NHS remains a beacon of diversity but is lacking on inclusion. Sadly, the feeling persists that our health system is not a level playing field for staff of all backgrounds. The GMC can be a leader in changing this perception if it develops greater insight into the experiences of the doctors it regulates, so that misunderstandings are not compounded by mistakes.

The GMC must show greater compassion in its interactions with doctors, patients, and referrers. We know that investigations are hugely stressful for doctors and can have a lasting effect on their mental or physical wellbeing. The need for support is sometimes even more important at the end of tribunal hearings than during the process itself.

Regulators should judge their success not by how many cases they handle, but how they support local systems towards local resolution and remediation, and how good practice is shared and standards are continually improved. That is where compassion will benefit not just doctors and regulators, but also patients and employers.

It should be noted that the GMC is making some positive contributions already. The GMC invited this review, after hearing the concerns raised about the case. Through its outreach teams it delivers sessions to acclimatise new doctors to UK medical practice helping integrate into the NHS and community. It could do even more through using Responsible Officers to support local resolution to avoid unnecessary referrals. If and when the UK government undertakes reform of its legislation, the GMC will be better able to dispose of fitness to practise concerns consensually.

Until then, the GMC and the wider health service must engender a culture of curiosity in how it fulfils its statutory duties and treats those doctors who come into its orbit. We believe that the GMC is committed to embedding equality in its processes and in the health service; now it must use its influence to follow through on that commitment.

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