Education and debate

Is the BMA a 21st century organisation?

Nizam Mamode

The BMA is out of touch with its members and in urgent need of reform, according to a former senior member. In an accompanying article the BMA's chairman of council argues that change is well under way

I heard many complaints about the BMA during the eight years I was a senior member. Most of these complaints have been unjustified, and I have often suggested that although the BMA may need to change, it is best done from within. However, earlier this year I decided to criticise the BMA publicly. My criticisms can be considered in three categories:

- The BMA does not spend members' money wisely
- It does not represent members' interests adequately
- It is institutionally racist.

The BMA has emphatically denied all these claims.

Members' money

Until I made the fact public, probably fewer than 50 of the BMA's 125 000 members were aware that it recompenses senior members for loss of private practice while working for the association. The reason so few people knew this is that the committee which decides the payments does not publish its minutes; although the sums paid are published, the reasons for these awards are not. In 2003, the BMA spent £478 459 (£720 000, \$870 000) compensating 25 council members,¹ 54% more than the amount paid out the previous year, but nobody officially knows what the money is paid for. This lack of transparency is

unacceptable in a modern trade union, and clearly transparency is essential to prevent corruption. The amount that members can claim is not capped, although a cap is to be introduced eventually as part of an ongoing review by the compensation committee. Over the past three years, the highest single compensation payment was £55 670.

Compensating members of a professional organisation for money foregone is unusual. The Law Society, for example, pays compensation only to the president, the vice president, and deputy vice president, with the money going direct to those individuals' firms. Other council members have to be satisfied with out of pocket expenses. Similar rules apply at the Royal College of Nursing, while the Royal College of Surgeons and Royal College of Psychiatrists reimburse only expenses.

Representation

The second way the BMA fails members is that it does not represent them adequately. This is reflected in the fact that of 57 seats in the recent elections for council, 21 were unopposed. Several elections had to be rearranged because there were no candidates. These ought to be damning statistics, but they are not new. Many places at the annual representatives meeting are also likely to be uncontested, although the BMA says it has no information on this. The local union structure (the divisions) is widely accepted within BMA House as being moribund.

Turnout at BMA council elections has been steadily dropping for the past 10 years, with only 21% of members bothering to vote for the 2004-6 intake. This represents a 5% drop on 1994 figures. Turnout may be falling in elections outside the BMA as well, but the past few years have seen tremendous changes in the NHS and the introduction of new contracts for two thirds of the membership. In this context, electoral apathy is of great concern and seems to reflect the disconnection and disenchantment that many doctors feel. Although the BMA regularly conducts market research to find out what members think of it, these data are for internal purposes only and are not published.

The BMA is highly influential and has campaigned successfully on many issues. Yet its members still do not

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BMJ 2004;329:161-4

The BMA in full flow: debating the establishment of the NHS in 1948

see it as leading opinion, rather as reacting to government initiatives. Even its defence of the NHS was lukewarm,² partly because of the strong influence of the private practice lobby within the BMA. This dissociation from the membership reached its climax when an overwhelming majority of consultants and specialist registrars rejected the new consultant contract negotiated by the BMA in 2002, prompting the resignation of several senior members. The BMA has recently conducted an internal assessment of the debacle,³ but unsurprisingly its conclusions are anodyne. For example, a key message is the need for "full consultation and involvement of grass roots opinion in defining the objective of the negotiation so that there is understanding and buy-in to the nature of the change proposed."

Having led negotiations for both the junior doctors' contract and the revised consultants' contract, I have witnessed a culture in which relationships with Department of Health officials are developed over the years and a desire not to rock the boat predominates. In this context, it is no surprise that almost every chair of council in recent years has received a major political honour on retirement.

Institutional racism

Perhaps the most violently denied criticism is that of institutional racism within the BMA. The secretary said recently, "The BMA denies accusations of racism."⁴ The pattern of events almost uncannily mirrors those of the Lawrence inquiry, which has become a benchmark for race relations in this country. Individual doctors have complained for many years about discriminatory attitudes by the BMA, just as many members of the public complained about the Metropolitan Police. In both cases the response has been characterised by a combination of denial or dismissal of a few "rotten apples." Lord Scarman stated in 1981, "Institutional racism does not exist in Britain."⁵ Yet the Metropolitan Police now accepts that institutional racism continues to exist within the force and has pointed out that most national organisations in the United Kingdom are probably institutionally racist. Recently, the Royal College of Psychiatrists accepted institutional racism within the NHS and within itself.⁶ The BMA, while continuing to publish tracts about racism in the wider health service, stands out as almost the only organisation denying that it is institutionally racist.

The Lawrence inquiry defined institutional racism:

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 detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.⁷

The BMA hierarchy has repeatedly demanded evidence to substantiate claims of institutional racism (again similar to the police before the Lawrence inquiry). In March, the BMA lost an appeal against a racial discrimination ruling in which they were ordered to pay £814 877 compensation to an Asian surgeon. This is the largest award ever in a racial discrimination case and has now cost the BMA over £1m. A Manchester tribunal in 2002 had ruled that the BMA was guilty of indirect race discrimination in

refusing to support race discrimination claims by its members against royal colleges, postgraduate deans, or the specialist training authorities. Rajendra Chaudhary, who had sought the BMA's help after the medical training authorities had failed to recognise aspects of his training, is now unable to work owing to stress related psychiatric illness.

The findings made it clear that the surgeon's problems were not just from an individual but were systematic. The award included £5000 aggravated damages because the tribunal found the BMA's conduct was "high-handed throughout" and amounted to "institutional denial." Subsequently, the BMA paid £130 000 in an out of court settlement with a further group of members who were pursuing racism claims against it.

Several other legal cases are now in progress against the BMA. These are mostly cases where doctors have been successful in winning racism claims against their employer or other body after the BMA has refused support. Currently, the 51% rule is applied in BMA House—that is, that the organisation will not support any claims of racial discrimination by a member unless there is at least a 51% chance of success in an employment tribunal. This may seem reasonable, but perhaps should again be considered in the context of the Metropolitan Police. Since the Lawrence inquiry, police officers have a duty to give serious consideration to all claims of racially motivated crime. I would argue that the BMA should at least give serious consideration to doctors who allege racism by NHS organisations, even (or perhaps especially) if this is difficult to prove. Although it may be easy to play the race card, unless a union takes such claims seriously and supports its members, it is guilty of institutional racism.

Another example of failing ethnic minority members involves trust grade doctors. Only 130 known BMA members are on trust grades (about 0.1% of the membership), yet these doctors are usually from ethnic minorities. It is difficult to know how many trust grade doctors there are, but a recent study found 430 such posts advertised over four weeks,⁸ suggesting that several thousand posts exist across the country. The BMA seems unable or reluctant to recruit these doctors, yet they remain one of the most exploited groups.

Under the 2002 Race Relations Act, public sector bodies have a duty to carry out monitoring of ethnic minority representation on its committees. Commendably, the BMA does this. Yet I have never seen the results of such monitoring, far less any action taken. Despite the fact that one third of doctors in the NHS are from ethnic minorities, they represent only a few per cent of the inner BMA. Six years ago, the BMA said: "Although many organisations and medical schools collect data on ethnicity... few of them actually publish the results in a meaningful way [and] even though data might be collected, nothing is being done to monitor the figures and effect change."⁹ Unfortunately, the BMA now lags behind many of those organisations it has criticised.

Next steps for the BMA

As Macpherson made clear, the first step towards change is recognition that there is a problem.⁷ Many of us are waiting to hear that recognition. The BMA

Summary points

The BMA is serving its members poorly

Large and increasing sums are spent compensating council members for loss of private earnings

Poor voting turnout and a lack of candidates for council elections are symptomatic of members' disenchantment

The BMA denies the existence of institutional racism but represents doctors from ethnic minorities poorly

urgently needs to reform. To do this it first needs to acknowledge the problems. An alternative to the current compensation system needs to be introduced quickly. Radical steps to reconnect with the member-

ship and revitalise the political process are necessary. A more active role in leading opinion and fighting for change is essential. The BMA needs to take steps to attract and recruit ethnic minority doctors, to fight their causes, and to be seen as an inclusive and democratic organisation. Without these steps it will fail.

Competing interests: NM has received a payment from the compensation committee while working part time.

- 1 BMA *Annual report of council*, 2003. London: BMA, 2003. www.bma.org.uk/ap.nsf/Content/AnnRepCoun03 (accessed 24 June 2004).
- 2 BMA Health Policy and Economic Research Unit. *Healthcare funding review*. London: BMA, 2002. [www.bma.org.uk/ap.nsf/650f3ee0d0fb990fca25692100069854/80256b140033ce0780256b50004e1cf4/\\$FILE/healthcare%20funding.pdf](http://www.bma.org.uk/ap.nsf/650f3ee0d0fb990fca25692100069854/80256b140033ce0780256b50004e1cf4/$FILE/healthcare%20funding.pdf) (accessed 24 June 2004).
- 3 BMA. Learning the lessons (unpublished).
- 4 BMA returns fire over allegations. *Hospital Doctor* 2004 Feb 12:28-9.
- 5 Scarman, Lord. *The Brixton disorders 10-12 April 1981*. London: HMSO, 1981.
- 6 Gould M. Report accuses NHS of institutional racism. *BMJ* 2004;328:367.
- 7 Macpherson W. *The Stephen Lawrence inquiry*. London: Stationery Office, 1999.
- 8 Dosani S, Schroter S, Macdonald R, Connor J. Recruitment of doctors to non-standard grades in the NHS: analysis of job advertisements and survey of advertisers. *BMJ* 2003;327:961-4.
- 9 BMA. *The future of our doctors: a conference on racial equality in the NHS*. London: BMA, 1998:9.

BMA's response

James Johnson

By raising important issues about representation and accountability in the BMA earlier this year, Nizam Mamode has done the BMA a service. Any member organisation representing an important professional grouping ought to be able to show that it is fully responsive to the needs and concerns of members whenever it is challenged, especially from within.

Compensation for loss of earnings

Mr Mamode's first criticism is of the practice of reimbursing members of the BMA Council for demonstrable monetary loss while on association business. As he acknowledges, he has benefited from this arrangement, receiving a payment of £21 900 in 2000. Although he was compensated for losing part of his NHS salary, the BMA's practice has been to compensate members for monetary loss, whether it is from NHS or private practice. The BMA could stop compensation for losses from private practice while continuing to reimburse other sorts of loss, but this would unfairly discriminate against some members, particularly those who work exclusively in the private sector.

It is right that we should consider how, or indeed whether, to reward people for time spent working for their representative association. I have benefited from the BMA's compensation scheme but accept that there are powerful arguments in favour of remunerating doctors for what they do for the association, rather than compensating them for lost earnings.

Every member of the BMA receives a copy of our annual report and accounts, which not only refers explicitly to the compensation committee and its role but also lists by name the recipients of both compensation payments and honoraria.¹ I therefore do not accept accusations of secrecy.

This is proper disclosure, in full compliance with best practice, of the arrangements whereby council members have been remunerated for BMA work. If giving members this information provokes debate, I welcome it because that is the purpose of disclosure. Just such a debate took place at the BMA's annual representative meeting at the end of June. In rejecting the proposition that compensation for lost income (whether or not linked to private practice) should be abandoned, the meeting declined to share Mr Mamode's view. BMA Council will revisit this difficult and contentious issue in October.

Representation and racism

Next Mr Mamode argues that the BMA fails members by not representing them adequately. It is true that, although membership numbers are at an all time high, member engagement is not all we would wish. Like many other democratically based institutions, we are trying to find ways to involve members more fully in our work. I would be glad to hear fresh ideas from Mr Mamode or from any other member on how to tackle the difficult challenge of apathy and lack of engagement.

Perhaps the most serious charge is that of institutional racism. As evidence for this, Mr Mamode points to the litigation against the BMA by ethnic minority members who have claimed for racial discrimination, in particular the widely reported case of Mr Chaudhary. I do not for a moment underestimate the seriousness of this case and its impact both on Mr Chaudhary and on our reputation among ethnic minority doctors.

Two things need to be said about it. Firstly, the BMA, on the strong advice of leading counsel, is

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This year's annual representative meeting

appealing the decision to the Court of Appeal. (It had been given permission to appeal from the Employment Appeal Tribunal). Secondly, Mr Chaudhary's substantive case of discrimination against the secretary of state for health was rejected by an employment tribunal in April this year. Funding for this unsuccessful case was, incidentally, provided by the BMA and represents a small part of a total of over £225 000 that the organisation has expended on legal fees for the various discrimination cases which Mr Chaudhary has conducted against NHS defendants.

If the courts do uphold Mr Chaudhary's claim against the BMA, it would not automatically follow that the BMA is or was institutionally racist. Since the events that led to Mr Chaudhary's case, and the others often linked to it, we have transformed the way in which we offer advice to our members on racial discrimination. All such cases are evaluated by an outside law firm at the BMA's expense, and decisions about which cases to take up are made on their objective (but not, of course, infallible) professional judgment. This new system was put in place in October 2003—well before Mr Mamode raised his concerns earlier this year—and our members' experience of it has been extremely positive. Since then 47 discrimination cases have been accepted

and taken forward on behalf of members. Fourteen of them have been successful and have led to members receiving appreciable awards for damages.

Should we lower the threshold for taking up discrimination cases below the 51% chance of success that is applied to all other tribunal cases? This is a difficult issue, but that threshold does not seem unfairly high. Members may seek legal support from the BMA for a huge variety of reasons, and in some cases their livelihood is at stake. We must ensure that we deploy our funds fairly and effectively. We need a sensible filter to ensure that we do not pursue cases that have little prospect of success, whether the grievance stems from alleged discrimination or another cause. Equally, we need to scrutinise the problems that doctors bring to us to ensure that we are always alive to the possibility that race discrimination may lie at the heart of the difficulty the member has experienced.

As to collective support for ethnic minority doctors, one of the key priorities that I have set for the association next year is the negotiation of a new contract for staff and associated specialists, a segment of the profession in which these doctors are over-represented. We do need to work harder to reflect the interests and concerns of all our members, particularly those from ethnic minorities who are inadequately represented in the BMA's inner councils. A new team now leads our equal opportunities committee: Sam Everington and Aneez Esmail have an unrivalled track record in identifying and confronting discrimination in the NHS. They are the best guarantee that diversity issues—the theme of the recent annual representative meeting in Llandudno—will remain high on the BMA's agenda. It is Mr Mamode's BMA just as much as it is mine, and we need people of his talent and energy not just to tell us where he thinks things are going wrong but to help us put them right.

Competing interests: JJ has been chairman of BMA Council since July 2003. He has previously received payments from the compensation committee for lost private practice income and is currently in receipt of honoraria from the BMA.

1 British Medical Association. *Annual report of BMA Council 2003-4*. London: BMA, 2004:18, 46.

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