Part 1 – INTRODUCTION

1. In the course of this inquiry, a woman doctor said to me that *'I just want to be proud of my trade union'*. I hope that this Report will help to make the BMA a better place to work, and that it will allow it to carry on the vital work it does in improving and safeguarding both doctors and patients, and in highlighting issues affecting public health. As the doctors' trade union, it is responsible for negotiating doctors' NHS contracts; for improving learning, and education; and for prompting and leading debate on ethical, scientific and public health matters through its research and publications. Its role is to speak up for doctors; in September, it sprang to the defence of Dr David Nicholl, who had been insulted by the Leader of the House of Commons for pointing out the dangers of a No-Deal Brexit. The Chair of Council has also spoken widely about those dangers in terms of both staffing and the availability of medicines, and the BMA has made its voice heard on issues such as cuts to NHS funding and services, as well as global health issues such as alcoholism and obesity. Doctors get involved with the BMA to make things better, not as their day job; as they become more senior, they lose money through their commitment to the work done there. It is their union, not just an association of members. Its staff work tirelessly to help the BMA achieve its aims. It is important that the atmosphere is conducive to making this happen, and that people are attracted to join in its work, are respected when they are doing that work, and feel sufficiently valued not to be driven out.

2. The BMA commissioned this Report after publication of an article in *GP Online* on 1 April 2019 written by two members of its General Practitioners Committee (*GPC*), Dr Zoe Norris and Dr Katie Bramall-Stainer. The article, and subsequent interviews they gave to national newspapers, detailed what they described as *'the dark dinosaur-infested depths of the world of GP politics'*. They complained about being called '*naughty'* and '*naughty girls'* by their colleagues. GPC was portrayed as '*misogynist'*,

with some male doctors ignoring and disrespecting their female committee colleagues, making sexist remarks, and talking about breast size. They also alleged:

> *'There is a widespread feeling that [disciplinary] systems are in place to protect establishment hierarchies and individuals who are an accepted part of the furniture, while rooting out those who challenge the status quo'.*

3. The BMA promised to hold an investigation. It was decided that this should be carried out by someone entirely independent, and who had neither appeared for nor against the organisation. It invited applications from individuals who met this criterion; it interviewed shortlisted candidates, and I was appointed in June 2019 to prepare this report.

4. My terms of reference were provided to me in June 2019.

> ***1. Overall purpose of appointment***
> *The purpose of your appointment is to conduct a confidential and legally privileged investigation into allegations of sexism and sexual harassment by members of the BMA's GP committee. You are required to establish the extent to which the allegations are substantiated and in the event of substantiation to make recommendations for any changes needed to address this ("the Purpose").*
>
> ***2. Aims of the Inquiry***
> *In furtherance of the Purpose the investigator is expected to:*
>
> - *Investigate the allegations made by members of the BMA GP committee, as reported in the media during the week of 1 April 2019, in relation to sexism and sexual harassment in the BMA.*
> - *To assess the BMA's actions taken on any reported incidents on sexism or sexual harassment since the BMA' new July 2017 code of conduct and disciplinary procedure started, and to assess reasons why individuals may not have not reported incidents.*
> - *To identify any specific incidents that should be scrutinised under the BMA's code of conduct processes and have not already been so.*
> - *To assess the current degree of sexism/gender inequality in the BMA, including comparisons with other organisations or sectors.*

- *To assess the BMA's work and policies in promoting gender equality as part of its EDI programme.*
- *To assess any organisational or systemic factors in the BMA that fail to promote gender equality.*
- *To make specific recommendations to address and prevent sexism or sexual harassment in the BMA, drawing upon examples of best practice.*

3. Scope of the Inquiry

The independent investigation will:

- *consider the experiences of BMA members and staff covering sexism and sexual harassment during their interactions on BMA business.*
- *be open to confidential feedback from all BMA members and staff on the matters within its purview*
- *include seeking feedback from those who have made complaints in the media as well as those who have responded to the statements that the BMA has already made to the press and membership.*
- *when considering feedback on individual incidents, consider whether the code of conduct and disciplinary procedure in place at the time were used. The press reports refer to attitudes among members to these processes and so it is important to understand members' experience of them and, if they chose not to use them, why this was so.*
- *identify any individual incidents of sexual discrimination and/or harassment of any identified individual/individuals which appear to fall short of the standards of behaviour expected of members so the BMA may confidentially address and manage those incidents through the appropriate processes set out in the BMA's Articles and Bye-laws.*

4. Areas out of scope of the Inquiry

The review will not be an investigation of any incidents or complaints which do not relate to BMA member and staff's experiences of sexual discrimination, or other unacceptable behaviours related to gender during their interactions with BMA members.

5. Outputs of the Inquiry

- *The investigation will produce a written report outlining the feedback received by members and staff and an assessment of the alleged sexist behaviours. This must be delivered in accordance with the delivery requirements described in section 6 below.*

- *The report will provide an assessment of whether incidents were reported and whether these were dealt with appropriately under the BMA's existing code of conduct and disciplinary procedures (including any revisions supplied prior to or during the Inquiry). The report will also make recommendations regarding whether any amendments to these procedures are necessary (and taking into account any revisions to this supplied to you prior to or during the Inquiry).*
- *The report will identify recommendations for systemic and cultural changes to address and prevent sexism or sexual harassment in line with the BMA's commitment to EDI.*
- *The recommendations of the report may be shared externally (at the BMA's discretion) and should form a stand-alone section of the report.*
- *The report will report confidentially on any specific incidents involving identifiable individuals who have been alleged to and may have behaved in an improper manner so BMA may manage this through the appropriate processes including as set out in the BMA's Articles and Bye-laws.*

5. I was called to the Bar in 1979, and took silk in 2009; for many years, I have specialised in the field of employment, and in particular, in discrimination, victimisation, whistleblowing, and equal pay. Over that time, I have acted for both employees and employers. I have appeared for and against police forces, banks, large international companies, and small employers, in all sorts of the claims described above. In the early part of 2019, I appeared for an employer defending allegations of sexual harassment, sex discrimination and whistleblowing, and then for an employee making allegations of sexual harassment, sex discrimination and whistleblowing.

6. Although I have never acted for or against the BMA, I am also experienced in cases concerning the NHS. I acted for the claimants in the test case to determine whether *Agenda for Change,* the NHS pay and grading scheme, complied with the laws on equal pay,[1] and (separately) for NHS whistleblowers Jenny Fecitt and Maya Yassaie.

[1] The employment tribunal held that it did comply – there was no appeal.

I have acted for NHS Trusts, defending claims of discrimination, victimisation, whistleblowing and unfair dismissal. I have also acted for thousands of equal pay claimants against local authorities, including Birmingham City Council and Glasgow City Council. Last year, I published a textbook on equal pay and the gender pay gap.

7. I declare one interest, as I did when I was interviewed for this role – my father was a GP who worked in the NHS from its inception for over thirty years until he retired because of ill health.

8. The Resolution Process, set up under the Code of Conduct, and the principles known as *Living Our Values,* set out how a doctor should be investigated when a complaint has been made – this can be done either formally or informally. This report is not a disciplinary investigation under that Process. With the exception of Dr Zoe Norris and Dr Katie Bramall-Stainer, whose experiences are well documented in the media, I have not named names in this Report; doctors and staff came forward and spoke to me in confidence, and they were assured that I would not pass on information identifying them unless they authorised me to do so. I decided to set up my own email address dr.investigation@cloisters.com, so that I could be contacted without witnesses going through the BMA.[2] I also wrote to every BMA member and BMA member of staff, inviting them to come and speak to me about their experience of sexual harassment and sex discrimination, as well as any experience of the Resolution Process, and a second copy of the letter was sent out towards the end of the inquiry; I was being contacted even in late September. I have not given the BMA the names of those who contacted me, or identified to them who told me what. I first let witnesses tell me whatever they wanted to tell me, rather than my asking them pointed questions, although I then clarified and explored matters with them. They also described experiences which other people had told them, although I have been careful about using this information without it being corroborated by other people's accounts. However, I heard the same sort of experience many times over. I have also received emails from some who did not want to speak to me, but who

[2] This did not mean 'doctor investigation', but simply reflected my initials and the investigation, something a number of respondents did not realise.

wanted to tell me of their personal experiences, good or bad, or to make observations; I followed up some of these emails with queries of my own. I have examined documents from the Resolution Process files held by the Corporate Development team, including the Code and the Process, as well as messages on listservers, the method used by the BMA for email correspondence around individual groups or committees, and the PowerPoint presentation given to Council when the process was rolled out in 2017.

9. I heard in person from eighty-two men and women who contacted me – about one fifth of those were members of staff, and over half of those who spoke to me were female. As I have said, I also received emails from other doctors and members of staff. Not all of them had experienced sex discrimination or sexual harassment, and some said they had never seen it; or there was some sex discrimination, but not on any grand scale; or there was some sex discrimination, but it was only one of the problems in the BMA.

10. I spoke at length to Orla Tierney, who conducted a review of the Resolution Process, and who made recommendations for changes to it to ensure that it was seen to be independent; these became effective from September 2019.

11. This Report is therefore my assessment of problems about sex discrimination, sexual harassment, and bullying within the BMA, based upon what I have learned. I have not made adjudications on specific allegations of sex discrimination and sexual harassment, as I was not in a position to do so; in some cases, I did not have the names of the alleged perpetrators, and I could not have done so in some cases without breaking the confidentiality of the informant. Where I have come across matters that I believe should be pursued, I have encouraged those affected to pursue that complaint, and I have offered them support in doing so. In some cases, with the consent of the complainant, I have investigated what happened with a complaint that had been made, or chased it if it had not been pursued, or where, as in one case, it seems to have been caught up in another process, and not dealt with at all. Some women did not want to come forward if it meant giving their names, but they did

want me to know what had happened to them, and I listened to their concerns, and factored them into my conclusions.

12. This report is not about various issues that some people would have liked it to be about. That is because those issues are not within my remit. I have however had to consider the issue of bullying, because it sometimes has not been possible to determine the reason for the less favourable treatment complained of, and whether it was because of sex, or because of some other reason, or a combination of those reasons. Its effect, however, has been equally upsetting.

13. I hope that this Report will focus attention within the BMA on the damaging elements of its discriminatory culture, including the (limited) instances of sexual harassment. The latter is undoubtedly far more headline-grabbing than the former, but that should not detract from the genuine complaints of the persistent undermining and undervaluing of some women doctors and staff, together with a corrosive and combative culture of '*I'm right, and you're wrong, and I know best, and you don't know what you're talking about'.* That atmosphere is inimical to any happy organisation and to successful and collegiate working.

14. Above all, I hope that this report will encourage some BMA members to change their own behaviour. The primary responsibility is theirs. The BMA is not a club; it is a workplace, where dedicated doctors and equally dedicated staff come together to try and improve the working lives of doctors, the treatment of patients, the NHS, and the health of the nation. Learned behaviours, discriminatory views, sexual harassment, and patrician attitudes, are unacceptable. Equally the BMA should not tolerate this behaviour in others and should call it out, put in place systems to train members to reduce poor behaviour and to tackle it with fair conduct processes.

15. I am grateful to those who gave up their time to speak to me; to the Corporate Development Team, who answered my enquiries, and were very co-operative; and to Orla Tierney, who kindly discussed the Resolution Process with me.

DAPHNE ROMNEY QC

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15 October 2019

Part 2 – INTERPRETATION AND GLOSSARY

16. In this report, I have used the following abbreviations and terms:

The Act	The Equality Act 2010
ARM	Annual Representatives Meeting (BMA)
BAME	Black, Asian, and Minority Ethnic
BMA	The British Medical Association
Chair of Council	The elected Chair of the BMA Council, the most senior of the Chief Officers
Chief Officers	The elected senior posts of the Chair of Council, the President, the Treasurer, and the Chair of the Representative Board
The Code	The BMA Code of Conduct known as '*Living Our Values*'
Corporate Development	The BMA department with responsibility for enforcing the BMA Resolution Process
Council	The elected governing body of the BMA
Doctors	Members of the BMA, including medical student members
GPC	General Practitioners Committee, used interchangeably to refer to GPC UK and GPC England, unless specifically stated
JDC	Junior Doctors Committee
Members of staff	Employees of the BMA
Partners	GPs who are partners in their own practices
PCP	Policy, Criterion or Practice, a term used in discrimination law to refer to an apparently neutral policy criterion or practice applied by an employer but which has a disparate effect on a group of persons with a protected characteristic
Representative Body	The Representative Body of the BMA
Resolution Process	The BMA disciplinary procedure enforcing the Code
SASC	Staff, Associate Specialists and Specialty doctors Committee
Sessionals	GPs who are employed for a paid fixed number of weekly Sessions, or as locums

Definition of sex discrimination

17. Sex is one of the nine protected characteristics in the Act. Direct discrimination, which may be conscious or unconscious, cannot be justified in law, and the motive for the less favourable treatment is irrelevant. To establish direct discrimination, the claimant must show that he or she has been treated less favourably than the employer has treated a real comparator, or would treat a hypothetical comparator.

18. Indirect discrimination is defined in section 19 of the Act – in summary it is where a PCP has a disparate impact on a group with a protected characteristic. For example, where work hours impact on women with childcare responsibilities; or where there is a minimum height restriction, which impacts upon women and some ethnic minorities. In such cases, it is for the respondent to provide objective justification for the PCP and to show that it is proportionate, in other words that indirect discrimination is no more than is reasonably necessary to achieve a legitimate aim.

19. As a trade union, the BMA falls under section 57 of the Act, which means that it must not discriminate, harass or victimise its members. As an employer, it must not discriminate against, harass, or victimise its employees. In addition, at common law, any employer owes its employees an implied duty not to act in such a way as to breach the mutual duty of trust and confidence implied into every contract of employment, and a common law duty to safeguard their health and safety.

Definition of Sexual Harassment

20. Sexual harassment is defined in section 26 of the Act

> *(1) A person (A) harasses another (B) if—*
> *A engages in unwanted conduct related to a relevant protected characteristic, and*
> *the conduct has the purpose or effect of—*
> *(i) violating B's dignity, or*
> *(ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.*
> *(2) A also harasses B if—*
> *A engages in unwanted conduct of a sexual nature, and*
> *the conduct has the purpose or effect referred to in subsection (1)(b).....*

> *(4) In deciding whether conduct has the effect referred to in subsection (1)(b), each of the following must be taken into account—*
> *the perception of B;*
> *the other circumstances of the case;*
> *whether it is reasonable for the conduct to have that effect.*

21. The essence of sexual harassment is that (i) the conduct is of a sexual nature and (ii) the conduct is unwanted.

22. The ACAS Guidance on Sexual Harassment[3] defines it as follows:

> *'Sexual harassment is unwanted conduct of a sexual nature.*
>
> *It has the purpose or effect of violating the dignity of a worker, or creating an intimidating, hostile, degrading, humiliating or offensive environment for them.*
>
> *Something can still be considered sexual harassment even if the alleged harasser didn't mean for it to be. It also doesn't have to be intentionally directed at a specific person.*
>
> *Experiencing sexual harassment is one of the most difficult situations a worker can face.*
>
> *All workers are protected from sexual harassment in the workplace. This applies to one-off incidents and ongoing incidents. This protection comes from both employment law and criminal law, depending on the circumstances involved'.*

23. The definition therefore includes conduct that is offensive and/or degrading and violates someone's dignity. The definition of '*degrading'* in the Oxford English Dictionary is '*causing someone to be resentful, upset or annoyed'.*

24. A single incident can be so serious to amount to sexual harassment. For example, in *Insitu v Heads,*[4] a young manager, the son of the business's owner, greeted a middle aged female employee with the words, '*Hiya Big-tits'.* Each incident has to be judged in the light of the relevant facts.

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[3] https://www.acas.org.uk/index.aspx?articleid=6078

[4] [1995] IRLR 4 – see also *Bracebridge v Derby* [1990] IRLR 3

25. Physical contact, even innocent, can also amount to sexual harassment. Some cultures are more tactile than others, and touching someone's hand or arm is merely a sign of affection. Some people, regardless of their cultural background, are more tactile than others. Of itself, this is not harassment. What however should be borne in mind is that sometimes the recipient of this attention, and particularly where that person is an employee, is put into a difficult position; s/he does not welcome this attention, but is too embarrassed to say so or, in the case of a member of staff, is fearful of speaking up and causing offence, or, even worse, prompting retribution. In general, in the workplace, any form of physical familiarity is to be undertaken with some caution.

26. On the other hand, some uninvited touching is wholly unacceptable, and should be seen as such. This includes touching someone's breasts, bottom or genitals, massaging their shoulders, kissing them on the mouth or nuzzling someone's neck.

27. Sexual harassment can also be verbal or non-verbal – for example, staring at, or *'talking to'* someone's breasts, or making crude, sexualised, explicit remarks. One of the words employment lawyers most dread is '*banter'*, which is usually the word used in employment claims to justify saying something inappropriate and unpleasant. If both parties to the '*banter'* are happy to indulge in it, all well and good. But if the '*banter'*, in essence, amounts to inappropriate, personal, remarks about someone's body or sex life, and the tone is not reciprocated, it is not *'banter,'* it is sexual harassment. Sometimes, even if there is no protest, or the person who is the subject of the banter appears to join in, it is still unwelcome, but that person feels unable to speak out and to ask for the *'banter'* to stop. Again, the person responsible for the '*banter'* should reflect upon whether the person it is directed to is likely to think it funny, or whether, in truth, this is someone being picked on.

28. The effect of sexual harassment can be cumulative. In *Driskel v Peninsula Services,*[5] the Employment Appeal Tribunal said *'That which in isolation may not amount to*

[5] EAT/ 1120/08

discriminatory detriment may become such if persisted in, notwithstanding objection, vocal or apparent.' In that case, the manager kept up a series of sexual comments, culminating in a demand that the woman wear sexy clothes and a see-through shirt for a promotion interview.

29. If the conduct is (i) sexual and (ii) unwanted, the question is whether it has the purpose or effect of violating the woman's dignity or creating an intimidating, hostile, degrading, humiliating, or offensive environment. That involves considering the elements in section 26(4) of the Act, namely (a) the woman's perception; (b) the other circumstances of the case; and (c) whether it is reasonable for the conduct to be regarded as having that effect. If a woman does not perceive her dignity to have been violated or an adverse environment created for her (the same is of course for a man), then the legal tests are not satisfied.[6]

30. In assessing whether it was reasonable for someone to take offence, it should be remembered that a remark between friends is not the same as a remark made by someone who is not a friend.[7] The Employment Appeal Tribunal has also held that the fact that a woman wears what could be seen as provocative clothing does not mean that she cannot be offended by sexualised words or actions directed to her.[8] Women are not fair game just because they wear revealing clothing and *'she was asking for it'* is not a defence.

Definition of Victimisation

31. Bringing proceedings under the Act, giving evidence on behalf of another person in such proceedings, '*doing any other thing for the purposes of or in connection with the Act,'* or making a complaint that another person has breached the Act are all protected acts under section 27 of the Act. If A does (or is suspected of doing) a protected act, and is then treated less favourably by B because of it, (consciously or unconsciously) that is victimisation and contrary to the Act.

[6] *Pemberton v Inwood* [2018] ICR 1291
[7] See Elias LJ in *Land Registry v Grant* [2011] ICR 1390
[8] See *Wileman v Minilech* [1988] ICR 318

Definition of Bullying and Harassment

32. The Protection from Harassment Act 1997 makes it unlawful for someone to pursue a '*course of conduct*' (which means there has to be more than one incident) which he or she either knows, or ought to know, would amount to harassment (This is in contrast to the statutory definition of harassment for the purposes of the Equality Act 2010, where a single act may be sufficiently serious to constitute harassment). '*Harassment*' can be conduct of different types, but in order to fall in the definition in section 7(2) '*includes alarming the person or causing the person distress*. The standard definition was defined by the Court of Appeal in *Conn v Sunderland City Council,*[9] as conduct which crosses '*the boundary between unattractive or even unreasonable conduct, and conduct which is oppressive and unacceptable.*' An employer can be vicariously liable for the actions of its employees.

33. ACAS defines bullying and harassment together as:

> '*offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. It may be persistent or an isolated incident. It can also occur in written communications, by phone or through email, not just face to face. Whatever form it takes, it is unwarranted and unwelcome to the individual.'*

As with sexual harassment, the essence of the conduct is that it is unwarranted and unwelcome, intimidating, degrading, humiliating or offensive; and again, the intention behind it is irrelevant.

34. Because the effect is unintentional, the perpetrator may be unaware that he or she is doing it, through lack of insight or sheer ignorance. Of course bullies often know exactly what they are doing, and enjoy doing it; some feel entitled to behave as they do because they believe that their conduct is justified. And as has often been pointed out, bullying is often dressed up as something else, for example '*firm management*'

[9] [2007] CA Civ 1492 .

or *'giving direction'*. As has been pointed out,[10] bullying is often excused by others on the grounds that it is not actually bullying but just *'poor management'* or a *'clash of personalities'*, particularly when it would be embarrassing or difficult to call it out for what it is.

[10] See Dame Laura Cox's report into bullying and harassment at the House of Commons, 15 October 2018

Part 3 –FINDINGS

35. I must emphasise that the majority of men in the BMA are not sexist or sexual harassers, and every committee is not riddled with discrimination. There are hundreds of BMA committees, most of which carry out their work perfectly properly. Notably the smaller committees tend to work much better, because people know each other and show more respect for each other's views. The larger Branch of Practice Committees tend to be the ones with the problems.

Sex Discrimination

36. A large number of the women I spoke to, including those who spoke to me about other women whose stories they knew, feel they are undervalued, ignored, and patronised because they are women. This applies to both doctors and members of staff. This is because of an *'old boy's club'* culture for some that lingers on without proper challenge, which treats women as of less importance and ability. As a result, some women are frustrated and resentful at their treatment, and the lack of change within the organisation, and they walk away. Others stay, but they are unhappy, or they lose their enthusiasm, as a result of which they become disheartened and less effective, or they are simply too intimidated or lacking in confidence to make any proper contribution at all.

37. Although the original complaints concerned GPC, these problems are not confined to GPC; they arise across the BMA. GPC has a number of particular issues relevant to the differences between Partners and Sessionals, but those doctors who have been heard telling people that this is just a GPC problem are wrong; it is not.

38. Some men continue to address women in demeaning terms, such as *'girls', 'silly girls', 'naughty girls', 'little ladies', 'lady members', 'Madam Chair'* and *'wee lassies'*; they focus on asking them about their children, and how their husbands are coping with their absence, rather than asking them about their achievements, their career aspirations and their views on policy; they demonstrate a lack of respect towards

them, and to their contributions, and tend to ignore or belittle their concerns. Some of that may be unconscious. On the other hand, there are some behaviours that are, and must be obviously understood to be, unacceptable, including shouting, demeaning women, sexual harassment, and bullying. Some of this may be generational, but that does not make it any less offensive.

39. One of the most consistent complaints was what one woman has termed the *'Miss Triggs'* moment. This is a reference to a *Punch* cartoon in 1988 drawn by cartoonist Riana Duncan. A number of people sit around a table; only one woman is present. Her boss says '*That's an excellent idea, Miss Triggs – perhaps one of the men would like to make it'*. Women are consistently made to feel that they are of less importance, and are less capable, than a man**;** for example, **w**hat they say does not carry the same weight, or they are routinely passed over for committee roles, the opportunity to attend certain meetings, or to sit on certain panels, or to have a say in making appointments, or to participate in a particular project; some reported that meetings have taken place in their absence, and decisions made at that those meetings, because they were not notified of those meetings taking place.

40. This also applies to staff. For example, one female member of staff had responsibility for a certain piece of work; but at the meeting discussing it, the male doctors present all addressed themselves to her male colleague. Female staff with university degrees are told to make the tea, or asked whether they want to come and work as a doctor's secretary or P.A; some have been told, *'you have a lot to prove because you're a woman'*.

41. Some Sessionals (more sessional are female than male, although the demographic has changed) have been made to feel that they are not *'real doctors'* because they work part-time or have encountered some hostility from partners on GPC.

Under-representation of women

42. It should be noted that the BMA has never had a woman Chair of Council in its 187-year history. This is in contrast with the Royal College of GPs, which was founded in 1952, which has had three consecutive woman Chairs, the first in 2010. The Royal College of Physicians, which was founded in 1518, elected its first female President in 1989, and had since elected two more in 2002 and 2014. The Royal College of Surgeons of England, established in 1800, had its first female President in 2014; that said, the Royal College of Surgeons in Edinburgh has not yet had a female President. The Royal College of Obstetrics and Gynaecology, which was founded in 1929, had its first female President in 1949, and its second in 2016.

43. Women are under represented on committees. On GPC England, which is one of the largest branch of practice committees, men outnumber women by two to one, although 54% of GPs are now women. The Chair and Deputy Chair, who are both elected, are both male. The other members of the executive, who are appointed and not elected, are one man and one woman. On the Consultants Committee, women make up 25% of the committee, although 37% of consultants are women. The Chair is male; there are three male Deputy Chairs (two of them in a co-chairing arrangement) and one female Deputy Chair. On SASC, men outnumber women by ten to one, although that branch of practice has roughly equal numbers of men and women. The Chair and all three Deputy Chairs are male. The Pensions Committee has only one voting female member out of twelve. The Chair and Deputy Chair are both male. JDC and MSC have a better balance of men and women, a reflection of the fact that more and more women are coming into medicine, and the newly elected chair of JDC is a woman.

44. There should continue to be more active advertising and recruitment campaigns, together with more '*taster days'* to allow women to come into a committee and learn about its workings; this allows them to sharpen the skills, and to identify the knowledge, required to perform effectively, should they be elected.

45. Quotas or minimum numbers should be introduced to permit women to be better represented on committees. Initially this can be for a limited period, which I suggest could be ten years; once better gender balance looks normal, then it will not be an issue. This will be very unpopular, but there has to be some movement to rectify the gender imbalance.

Sexual harassment

46. Sexual harassment is not unique to the BMA or to medicine; like sex discrimination, it is a societal problem. The #MeToo movement showed how women across all industries were assaulted and harassed, but they said nothing. Those who did were briefed against, dismissed as *'mad'* or *'money-grabbing,'* and their careers were damaged.

47. In 2016, the TUC issued its report *'Still Just a Bit of Banter?',* which concluded that 52% of women at work suffered sexual harassment and that 80% of them did not report it.[11] The BBC released two polls in October and November 2017; the first found that 53% of women and 20% of men (37% overall) said they had experienced sexual harassment at work or a place of study, and one in ten of the women who had been harassed said they had been sexually assaulted;[12] the second concluded that 40% of women and 18% of men had been sexually harassed at work, 9% in the previous year alone.[13] These were all considered by the Parliamentary Women and Equalities Committee, chaired by Maria Miller MP, in its report last year.[14] On 18 November 2018, *The Guardian* reported (based on FOI requests) that Government departments had received ninety-five complaints of sexual harassment over the previous three years and 551 complaints in all of bullying and sexual harassment. There have been similar complaints about the conducts of both MPs and male Parliamentary staff towards female Parliamentary staff, considered in recent reports by Dame Laura

[11] *Sexual Harassment in the Workplace 2016,* TUC August 2016
[12] *Sexual Harassment in the Workplace 2017,* survey by ComRes for Radio 5Live October 2017
[13] *Sexual Harassment in the Workplace 2017,* survey by ComRes for BBC November 2017
[14] *Sexual Harassment in the Workplace* Parliament published 18 July 2018

Cox[15] and Gemma White QC.[16] This year, the Bakers, Food and Allied Workers Union (BFAWU), representing McDonalds employees in the UK, reported that there had been 1,000 incidents of sexual harassment, although few had resulted in disciplinary action;[17] rather employees had been moved to other restaurants; and Lloyds of London reported 500 witnesses to acts of sexual harassment, one in twelve of the respondents to its survey.[18]

48. There are a very high number of reported incidents of sexual harassment in the NHS. On 24 February 2019, *The Guardian* reported that complaints of bullying and sexual harassment had risen from 404 in 2013/2014 to 585 in 2017/2018, although only a fraction led to dismissal or a disciplinary hearing. In June 2019, Unison published its NHS survey, *'It's Never OK',* which disclosed that the vast majority of those targeted were women (81%) and that the incidents mainly involved perpetrators older than their target (61%), and who were often employed in more powerful roles (37%). Acts of sexual harassment were most often committed by colleagues (54%); a quarter were committed by other workers (24%) and two-fifths (42%) by patients. Nearly a third (31%) of those who had been sexually harassed said it had occurred on a regular basis and more than one in ten (12%) said it occurred weekly or daily.[19]

49. Some older women in the BMA told me that they now felt ashamed they did not speak out earlier; in the NHS thirty years ago, sexual harassment was rife and many women in training to be doctors found themselves under pressure to sleep with a more senior doctor. That is not now the norm in the NHS; but there does seem to be a lingering feeling of entitlement amongst some doctors, particularly towards younger women doctors and female members of staff, which tends to emerge during drunken events, namely conferences and dinners.

[15] Parliamentary Publications 15 October 2018
[16] Parliamentary Publications 15 July 2019
[17] *The Independent* 20 July 2019
[18] *The Financial Times* 24 September 2019
[19] Unison, 18 June 2019

50. I have heard about incidents of sexual harassment, particularly at ARM and other conferences, after excessive consumption of alcohol. This includes being touched inappropriately, lewd and inappropriate sexual remarks directed to, or made about women, invitations or even instructions to accompany a male doctor to his hotel room, staring at a woman's breasts, inappropriate comments about a woman's appearance, and being kissed or hugged. Most of it is not reported because women, both staff and doctors, are too nervous to report it and there seem to be incidents every year. These instances are not widespread, although they are consistent, and they seem to happen every year. The conduct complained of is unacceptable, and in some cases, it exploits the imbalance of power involved between older doctors and younger doctors, or between doctors and the staff who work for them.

51. I have heard some complaints of sexual harassment outside these social events – these are by male doctors towards female staff, mostly unwanted touching and remarks about their appearance. Again, it is rarely called out by other doctors, and the staff themselves are too nervous to report it, either because they fear they may lose their jobs, or because they do not believe that anything would be done about it if they were to report it.

52. Some women doctors told me that they are also shouted at in a particularly aggressive way uniquely directed toward them, or have witnessed other women treated like this, often with a man's face very close to their own. Certain men have been seen only to shout at women, not at men. This experience is both demeaning and frightening for the recipients. Shouting is completely unacceptable in any place of work.

Failure to call out

53. There has been a failure of leadership for too long throughout the BMA in calling out bad behaviour, including sex discrimination, sexual harassment, rudeness and bullying of all kinds. The Chief Officers, Committee Chairs, Members, and Senior Management, must all take responsibility for not doing more to condemn it, and to intervene to stop it; in the case of the BMA leadership, the buck stops with them. It

may be that discriminatory conduct has not registered with them; on the other hand, some doctors have not wanted to alienate their support base, because there is always an election coming up and they want to win it, some of them intent on progressing up the organisational ladder. However, there is both a statutory and a moral duty towards members and a duty towards staff, and that cannot be put second either to personal discomfort or to political expediency.

Bullying generally

54. Sex discrimination and sexual harassment are but two aspects of the problematic culture at the BMA. There is also a culture of intolerance of other views. This is seen in some committees, and on listservers, and it stems from an inability on the part of some doctors to concede that there is a point of view other than their own. Some doctors continue to bully and to harass other doctors and staff for reasons other than sex – sometimes it is '*otherism,'* sometimes it is just bullying and harassment, and sometimes it is a mixture of the two. Whatever it is, it is intolerable, but it has been tolerated and it is poisonous.

55. Medicine is, and always has been, very hierarchical. From the earliest period of their training, doctors have been shouted at, and belittled, by their superiors, and it becomes learned behaviour. Again, that does not make it acceptable. It can make people's lives a misery, and it is distressing for others who see it and hear it, because they fear that it will happen to them; it hardly needs saying that it makes for a very unpleasant working environment. Shouting is not acceptable in a workplace.

56. The treatment of some BMA staff can be unacceptable, including shouting and rudeness from some members. Their work, intelligence and experience are sometimes ignored. The word they most routinely used to describe their workplace to me was '*toxic'*. That is a very damning word and it suggests that there is a problem. I have spoken to at least two staff who have told me that they are leaving, even without a full-time, permanent job to go to, because they are so unhappy. Others will stay, but they are also not happy. One told me:

> *'I started off being proud to work for BMA. Over the past year, I've found myself walking in with dread'.*

Another told me that a member of staff left because she did not feel it appropriate to have to develop resilience in order to stay and withstand bullying from a doctor on her committee.

> *'She'd come to me crying. In the end, she left and said it made her compromise her values as a person, and that she was being told she had to build up resilience to deal with that conduct from members. Why? We use resilience like - 'if you want to progress, you have to develop resilience to deal with them'. That's skewed in the BMA, and it is not like that in other work places. It is making us find ways of dealing with them [the doctors] and then turning that into a skill'.*

Committees

57. Committees are not getting the best from their members. Too many people are deterred from speaking; some committees are too big, and some are also too adversarial. Using the Council Chamber turns committee meetings into quasi-Parliamentary debates instead of fostering discussion and finding solutions. There should be more breakout groups where smaller number of committee members can conduct a proper debate and have their voices heard.

58. People are on too many committees, and for too long. I have also heard from those who describe some committee colleagues as just there for a nice day out, all expenses paid, with meal and accommodation expenses, and first class train travel. Some seats on committees never change, and so the behaviour does not change, but is perpetuated. There should be a time limit for consecutive terms on committees.

59. I also recommend that there is a limit to the number of committees people can sit on at the same time – this limits the opportunities of others, and means the same faces are seen all the time. There is a danger that some of them are spreading themselves too thinly.

Living Our Values and the Resolution Process

60. *'Living Our Values'* was incorporated in a Code of Conduct and a disciplinary procedure, now known as the Resolution Process, in 2017. The Code was introduced to deter, and also to deal with, bad behaviours. The Process has been used successfully to resolve many informal complaints, and to resolve some substantial complaints through the formal route, with adjudication by a panel of three doctors. However, the Process has been undermined; this is both because of a perception that it is not effective (because its operation is shrouded in secrecy), and because many perceive its application to be partial, which has deterred them from using it. Others have chosen not to use it because they are frightened of repercussions and, in the case of some staff, of losing their job.

61. Independently of this report, changes have already been made to the Resolution Process, following a report commissioned by the BMA in 2018. An external, independent, support line has been set up as the first port of call for those wanting to bring a complaint, or who are wondering whether, and how, they should do so. The operators of the external support line, after discussion with the complainant, will also make the decision whether the Process should then go forward using the formal or the informal route. If the complaint is to be dealt with on a formal basis, the investigations will be carried out by an independent firm of solicitors, which will also prepare the case for hearing by a panel of three BMA doctors under Article 14 and the Resolution Process. These are recommendations that I would have made in any event; but I have added several of my own, namely moving the administration of the informal process to the Human Resources Department so that staff have to deal with only one BMA department; ensuring that the complainant is given sight of the respondent's witness statements used in formal hearings, together with a chance to reply to them; that a booklet should be made available clearly explaining the complainant's rights so as to manage expectations; that the complainant should be allowed formal support throughout the process without risking being accused of breach of confidentiality; and that the Panel on formal hearings should be composed of BMA members who are not actively involved in central committees. It is also very important that adequate support must be provided to those bringing a complaint

during and after the process, particularly when they are concerned about repercussions.

62. I have noted some very notable positives in the BMA, including a supportive environment for childcare, the development of policies on bullying and harassment, and cultural awareness and assertiveness training for staff to enable them to stand up when bullied. In addition, the organisation now has its first BAME Chair of Council and the Representative Body has now its third woman Chair, who was elected in June 2019; her predecessor was also a woman, her deputy was elected overwhelmingly at the most recent ARM and is also a woman, and she is also BAME. I have also noted the introduction of the new programme *Equality Matters,* which was launched in September 2019. There are opportunities now to make more changes that will make the BMA a better place. A new CEO arrived in July this year who is keen to tackle these issues. I hope that that changes will soon be made.

PART 4- RECOMMENDATIONS

Culture

63. Every member of the BMA must take responsibility for his or her behaviour and moderate it so as not to insult or denigrate other members. This may take a conscious effort. So be it.

64. Members of the BMA should realise that the old hierarchical systems in medicine do not apply in the BMA. All doctors are there as colleagues and should be treated with respect.

65. Respect should also be shown by all genders towards all genders and to their own. This is also the case for those with protected characteristics, and in addition political beliefs.

66. Staff are part of the team and they should be treated with respect. Conversations and interactions should be respectful at all times.

67. Shouting is never acceptable in the workplace.

68. The BMA should consider implementation of best practice for ensuring diversity and gender balance from other organisations, such as the Law Society policies and its own Equality Matters principles.

Calling out

69. Colleagues and staff must be treated with respect – the principal duty should fall on the doctor not to behave badly. However, everyone in the BMA should call out bad behaviour when they see it, whether it is harassment, sexual harassment, discrimination or bullying. It is simply unacceptable for this conduct to go unchecked, particularly if the reason for ignoring it is to avoid alienating the perpetrator in order to secure votes to get onto, or stay on, a committee or to achieve

higher office. That onus is particularly on the Chief Officers, Chairs and Officers of Committees, and Senior Management. Chairs, committee officers and all members should watch for bad behaviour at meetings (or appoint someone to do it on their behalf) and on listserver; should a complaint be made to him or her, it should be dealt with. Bad behaviour should not be tolerated and it should not be rewarded or be excused.

70. Staff must be protected from these behaviours and should be empowered to call it out. Where doctors witness a member of staff being harassed, disrespected or bullied, they should intervene, or report it to the Independent confidential hotline and/or if appropriate to the Chair of Committee.

71. Staff should be trained to be able to have difficult conversations with doctors and with other members of staff.

72. HR policies should be reviewed, including the staff investigation process.

Committees

73. Every committee member in the BMA must undergo training in diversity, equality, anti-bullying, active-bystander and collegiate working through bespoke courses specifically developed for the BMA sourced through an appropriate provider. These courses should not be online courses, where full attention is not always required – to mend the BMA, active participation, commitment and learning is required. There will of course be those who think that they do not need it. Many of those are likely to be the people who need it most. The training should concentrate in particular on the impact that words and actions have on others, and the importance of respecting colleagues.

74. There should also be further mandatory training for Committee Chairs as early as possible into their tenure. This bespoke training should develop their skills in managing meetings, including and encouraging all members to participate,

identifying and dealing with bad behaviour, and understanding the basic principles of fairness and equality in making appointments on that committee.

75. Members of committees (including the Chair and members of the Executive) should be subject to periodic feedback (on an anonymous basis) from fellow committee members and staff about their behaviours, along the lines of a 360 appraisal. Seeing what others have written about them may well concentrate the mind, although care should be taken to restrict the dissemination of this information for reasons of GDPR and confidentiality. The Chair or Deputy Chair of the committee should then discuss the document with the doctor concerned and develop the lessons to be learned from it.

76. There should be careful monitoring of appointment practices, ensuring that rather than the tap on the shoulder for a committee role, for projects and so on, everyone is given a chance to apply and objective criteria are drawn up for the role.

77. Meetings should not take place without everyone eligible to be there being invited and notified of the meeting, not afterwards.

78. It would be good for women across the organisation to get together in a BMA Women's group to support and to mentor each other – this should also include staff from each Directorate and it should consider whether it should join the European Women's Lobby.

79. Committees should emulate Council and introduce quotas or minimum numbers of women in order to better reflect the percentages of men and women in each branch of practice. Each committee should set those quotas after consultation with the Organisation Committee. I accept that quotas are very unpopular with some, but years of diversity reports and recruitment attempts have not managed to even out the gender balance on the major committees, particularly on SASC. I regard this as a temporary measure to change the culture; I have suggested ten years hopefully, the balance will change.

80. That said, women have to be encouraged to stand; often when they do, as a GPC Survey showed, they are elected. I recommend that there should be at least two committee seats for those who have not previously been elected, (male or female) on Branch of Practice Committees, in order to allow them to understand how to consolidate a position after their term is up, and to make a name for themselves. Mentoring should be made available as required. There should be more events for talent spotting where newcomers can be told about the committee's work; there should also be a scheme where people can shadow or observe an existing member of the committee to familiarise himself or herself with the way that it works. This practice has been operated in large companies to get a better gender balance, with women who often work in different departments, and who do not know anyone doing that work, can learn about it before applying to become involved. I recommend that the measures suggested in the GPC UK Gender Task Report should be adopted, and in the case of other committees, adapted.

81. Thought should be given to holding meetings around tables rather than in the Council chamber, so that people talk to each other and not at each other; confidence should also be built by more break-out groups.

82. Chairs should be encouraged to call more women, and to emulate the example of GPC and JDC in trying to call a woman to speak first so as to encourage more women to speak.

Limitations on membership of committees

83. Members of committees should be prevented from standing for re-election for that committee after twelve years, unless they hold an executive position. The purpose of this is to allow new members onto the committee. Members may seek re-election to that committee after three years, unless they hold a time limited executive position. Transitional arrangements should be agreed for existing members. I understand that twelve years may seem arbitrary to prepare for and to get an

executive position; any figure would. But it should be more than enough time to make a contribution.

84. BMA Members (other than Chief Officers and others on committees in an ex officio or co-opted position) should be restricted in the number of committees they can sit on, in order to encourage new membership of those committees. This would also allow committee members better to contribute to the committees they do sit on.

GPC and committees generally

85. Consideration should be given to multi-member constituencies for Regional Seats to allow new people to stand for election alongside the existing holders of those seats. The purpose of this is to get more people, including more women, on to GPC and to get rid of the phenomenon of *'X's seat'*.

Listservers

86. All committee listservers should be effectively monitored by assessors with a speedy determination of complaints by both doctors and staff. Staff should never be personally criticised on listserver; if they are, this should be called out and if they so wish, they should be given a right of reply.

Resolution Process

87. Following the implementation of the new external processes for complaints, the administration of the Resolution Process should be moved to the Human Resources Department in order to streamline the function. This will reassure staff, who remain confused about the different routes available for complaints. The arrangements for independent mediation and other informal options fall more appropriately into the work carried out by the HR department.

88. If complaints are made under the Resolution Process, the BMA must ensure that there is adequate support, counselling and protection for the complainant, and

ensure that he or she is not victimised in any way for having made a complaint, whether the complaint succeeds or not.

89. The panel of doctors should be widened to include those not on Council or regular committees to enable respondents and complainants to feel reassured of a fair hearing and to avoid the impression of bias. I take the view that the panel should be wholly composed of doctors who are not regular faces at BMA House, but who are brought in from outside national committees and should not be personally known to the complainant or the respondent to avoid any conflicts of interest; the Resolution Process provides that any member can volunteer to be on the panel, and will receive the appropriate training. There are many members who are not elected members who may sit as magistrates or on GMC panels or who participate in disciplinary procedures at their NHS Trusts. This will improve confidence in the process.

90. If a complaint is made about a doctor, but met by a counter-complaint, it should still be investigated, and, if necessary, taken to a panel even if it is one word against another, should the complainant's case be deemed to be sufficiently compelling. It has become too easy to stymie a complaint by a counter-complaint, and it leaves complainants feeling frustrated and cheated of a remedy.

91. A booklet should be produced which explains in clear language the options under the Resolution Process so that doctors and staff are clear about the options available to them and the circumstances in which a formal hearing will be pursued. This should be easily accessible on the website.

92. Where a complainant wishes her (or his) name to be anonymous, there is a limited amount of investigation that can take place, but enquiries should be made as far as possible – it would usually not however be possible to proceed to a formal disciplinary procedure without the name of the complainant.

93. Conversely, where an anonymous complaint is received, it should be pursued only where the circumstances appear to merit it, and only after all the circumstances have

been considered, including why the complaint has been made anonymously and whether it sent for a malign purpose, for example to denigrate or damage a candidate standing for election.