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Bridging the Gap
Summary Report 2021

*Tackling Differential Attainment
in the Medical Profession*





Tackling Health Inequalities

BIHR

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INSTITUTE FOR HEALTH RESEARCH

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Undertaking Research in Diversity

Equality to Justice

BRIDGING THE GAP

TACKLING DIFFERENTIAL ATTAINMENT IN THE MEDICAL PROFESSION
SUMMARY REPORT

September 2021

INDRANIL CHAKRAVORTY, SUNIL DAGA, SHIVANI SHARMA,
MARTIN FISCHER, SUBARNA CHAKRAVORTY & RAMESH MEHTA

ALLIANCE FOR EQUALITY IN HEALTH PROFESSIONS



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OUR VISION



Vision depicted by Gita Hosdurga, a young student

The British Association for Physicians of Indian Origin (BAPIO) was founded in 1996 as a non-profit organisation to support and give a voice to thousands of doctors from the Indian subcontinent, who dedicate their working lives to the UK National Health Service. BAPIO as an organisation grew to include doctors from across the world and their progeny. At its heart the mission was and remains that of promoting equality and diversity, while supporting doctors to be educators, researchers, leaders and always to provide excellent care to our patients. BAPIO has always believed that we achieve more if we work in collaboration with all. Twenty-five years on we find ourselves reflecting on our journey so far.

The UK society reflects multi-cultural identities, with over 14% of the population identifying with a non-white heritage. This is reflected in the medical professions where the diversity of doctors entering the register has changed, particularly with the balance of gender and the increasing numbers of International Medical Graduates (41%). On the surface, this is a positive story for diversity. However, equity in outcomes, opportunity and workplace inclusion are far from a reality. Seven years on from the landmark BAPIO vs Royal College of General Practitioners ruling in 2014, the differentials are still more pronounced by ethnicity and gender over other protected characteristics.

This, persistent differential attainment across the career cycle has spurred BAPIO to chair the 'Alliance for Equality in Healthcare Professions' (AEHP). In this report (BTG21), we detail the process, outcomes and recommendations from a mammoth effort from the AEHP to bring together multiple stakeholder organisations, training providers, academics, researchers, and grass root doctors across a rigorously designed programme of exploration on the lived experience of DA and associated drivers.

Over 150 professionals have made contributions to this project during last year. Together, we have critically considered what progress has been made and asked honest questions about the changing face of challenges that require intervention to make equity in medical careers a reality.

The NHS Workforce Race Equality Standards and the Medical Race Equality Standards also mark progress in unearthing longstanding disparity. We hope that the outcome of the AEHP is complimentary to these but bolder in scope. We propose a series of actions to support a systematic shift over the next five years that properly values, celebrates and makes use of the talent of the diverse workforce providing medical care in the UK. This is our vision for a fair and just society.

Ramesh Mehta OBE
President



ASPIRING FOR JUSTICE

This was our dream for justice for the BTG21 team. The phenomenon of differential attainment has never been far from the collective heart of the members of BTG21 team. The kernel of the idea of a project to tackle DA may indeed have been born during discussions fueled by the buzz one feels after a successful BAPIO National Conference, as we did in 2019 in London. But, what started as an idea, then rolled on gathering over 150 people with passion, expertise, lived experiences and above all the drive to make a difference to the fellow professional. Then COVID-19 happened to the world and all the skeletons of inequalities came out of proverbial cupboards. This spurred the team on. Our mission - 'To right the wrongs'.

The programme of work comprised of 6 themes with nominated leads who took on the challenge, assembled the expertise, the range of professionals and the resources needed to undertake the rigorous and expansive thematic synthesis. The teams included medical students and professionals across the spectrum, working closely and without hierarchy. Each team worked differently, but several hundred people-hours were invested in reading, debating, analysing and writing the review papers, creating the discussion questions for consensus building workshops and then poring over the thousands of words of transcripts. What was created at the end was a robust evidence base of 88,000 words.

TEAM

The BTG21 Team used mixed methods. We recognised the value of primary research, importantly led by researchers independent to BAPIO. The qualitative research element on lived experience of DA was therefore undertaken by researchers at the University of Hertfordshire. The 'central team' as one of us called the coordinating, facilitating and writing team - were tireless in constructing the meetings, the pre-workshop discussions, the workshops and the post-workshop facilitated debriefs and poring over 88,000 words of text. We have faced many challenges but have never been shy to challenge ourselves. For weekday evenings and almost every other weekend, the whole family (including the dog) were drafted in. Many contributed to the artwork, graphics and editing.

It is incredible that this mammoth piece of work was done pro bono. If we were to apply standard research costing for a similar type of programme of activity, we estimate the value of the professional time in excess of £150,000. We have come closer as a team, as a family and put our collected views together. For all of this and more, we are grateful to each and every member of the team. We are grateful to our collaborators, our experts, our stakeholders and the healthcare leaders who have supported and joined us - challenging us to be brave and bold.

Indranil Chakravorty

Chair, BAPIO Institute for Health Research

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CENTRAL TEAM

Indranil CHAKRAVORTY, St George's Univ London & U of Hertfordshire

Martin FISCHER, Fischer Associates

Shivani SHARMA, University of Hertfordshire

Subarna CHAKRAVORTY, Kings College Hospital

Sunil DAGA, Leeds Teaching Hospitals

Ramesh MEHTA, President BAPIO

THEME LEADS

Jyothi SRINIVAS, Milton Keynes University Hospital (Recruitment)

Subodh DAVE, University of Bolton (Assessment)

Veena DAGA, Leeds Teaching Hospital (Career Progression)

Anindita ROY, University of Oxford (Research & Academia)

Rakesh PATEL, University of Nottingham (Research & Academia)

Geeta MENON, University of Surrey (Leadership Roles)

Vijay NAYAR, Health Education England (Leadership Roles)

Ananta DAVE, University of Nottingham (Professionalism)

JS BAMRAH, University of Manchester (Professionalism)

RESEARCH

Akhila PANDA (University of Buckingham Med Sch)

Alison FERGUSON (Uni of Buckingham Med Sch)

Anshoo DHELARIA (East & North Herts)

Arvind SHAH (North Middlesex Hosp)

Carlos CURTIS-LOPEZ (University of Manchester)

Catherine Dominic (Bart's & The London)

Chelliah Selvasekar (Christie Hospital, Manchester)

Daniel Robinson (University of Manchester)

Dev Chauhan (The Hillingdon Hospital)

Faisal Hassan (Royal United Hospital, Bath)

Geraldine Sawney (Lister Hospital, Stevenage)

Joydeep Grover (Southmead NHS Trust, Bristol)

Lambrini Theocharidou (Countess Chester Hospital)

Manasi Shirke (Queen's University, Belfast)

Naureen Bhatti (HEE London)

Neeraj Bhala (University of Birmingham)

Rachel Don Bosco (University of Hertfordshire)

TEAM

Robert M Blizzard (HEE York's & Humber)

Rosanna Geddes (Medical Defence Shield)

Roshelle Ramkisson (University of Manchester)

Rupal Shah (HEE London)

Saba Hussein (Sirona Care & Health)

Sahana Rao (Oxford University Hospital)

Saif Sait (Kings College Hospital, London)

Saman Zaman (St Georges University Hospital)

Saraswati Hosdurga (Weston General Hospital)

Sarthak Bahl (Milton Keynes University Hospital)

Satheesh Matthew (Barts Health NHS Trust)

Shevonne Matheiken (Manchester)

Spandana Madabhushi (East & North Herts)

Triya Chakravorty (University of Oxford)

Umakanth Kempanna (Hull Royal Uni Hosp NHS Trust)

Veeresh Patil (Milton Keynes University Hospital)



COLLABORATING ORGANISATIONS

Academy of Medical Royal Colleges
Association of Pakistani Physicians of N Europe
BAME Health Matters
BME Medics
British Indian Doctors Association
British Indian Psychiatrists Association
British Medical Association
Doctors Association of United Kingdom
Health Education England
Health Education England (Global)
Medical Association of Nigerians Across Great Britain (MANSAG)
Medical Defence Shield
Medical Defence Union
Medical Schools Council
Medical Women's Federation
Melanin Medics
Nepali Doctors Association
NHS England & Improvement
Nursing & Midwifery Council
RDME, University College London
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of General Practitioners
Royal College of Nursing & Midwifery
Royal College of Obstetrics & Gynaecology
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians of Edinburgh
Royal College of Physicians of London
Royal College of Psychiatrists
Royal College of Surgeons
Royal Pharmaceutical Society
University of Hertfordshire

STAKEHOLDERS



CONTRIBUTORS

Abdel R Moataz, Egyptian Doctors Assoc, UK
Abhishek Gupta, Student
Adelina McLeod, RCPedin, TMC
Aishnine Benjamin, BMA EIC Committee
Ala Szczepura, Univ of Coventry
Alison Johns, CEO, Advance Health Education
Amanda Howe RCGP President
Amit Kochhar, BMA SAS Committee
Andrew Elder, President, RCP Edin
Andrew Foster, CEO, NHS Leadership Academy
Andrew Goddard RCP London, President
Andrew Morris, CEO, NHS E/I
Andrew Foster, CEO
Andy Lewington, Kidney Research UK
Aneez Esmail, Univ of Manchester, UK
Angharad Davies, Royal College of Pathologists
Anjali Prinja, Imperial College London
Ann Griffin, Dir, Research Dept MedEd, UCL
Annapurna Pandravada, University of Glasgow
Anshoo Dhalaria, Paediatrician, Lead for LEDs
Anthea Mowat, Medical Women's Federation, UK
Anton Emmanuel, Head, NHS RHO
Anushka Aubeelack specialty doctor
Ashok Poduval, Sherwood Forest Hospitals
Asya Mussad, Faculty of Med Leadership & Mgmt
Atef El-Kholy, Egyptians Doctors Association
Balakrishnan R Nair, Univ of Newcastle, Australia
Baroness Dido Harding, NI Health Protection
Bernard Chang, President Royal College of Ophth
Biju Simon, University of Leicester
Blake Dobson, General Medical Council, UK
Camilla Kingdon President, RCPCH
Carol Woodhams, University of Surrey
Caroline Curtin, Barking, Havering & Redbridge Trust
Chaand Nagpaul, Chair, British Medical Association
Cherian George, Radiologist, UHNM
Chetna Modi, NHS Leadership Academy
Chitra Joseph (Research fellow)
Clare Gerada DBE, NHS Practitioner Health
Clare Owen, Medical Schools Council
Colin Melville, General Medical Council UK
Colleen McGregor, Trainee HEE Thames Valley
David Cruz Walma (PhD student)
David Sellu, Surgeon
Davinder Sandhu, Past PG Dean, Univ Bristol
Deena Iskander, Academic Clinical Lecturer
Deepak Rao, Associate MD London
Dinesh Bhugra, Kent & Medway Medical School
Farica Patel, St George's University Hospital
Fatima Sulaiman, Blood Cancer UK
Faye Gishen, University College London
Fiona Bishop, Associate Dean, HEE
Fiona Godlee, Chief Editor British Medical Journal
Fiona O'Sullivan (HoS, Ophthalmology, HEE KSS)
Gabrielle Finn, University of Manchester
Geoff Smith, Geoff PG Dean, HEE South West
Habib Naqvi MBE, Chair, NHS Race & Health Obs
Hannah Barham-Brown, BMA Council Member
Hannah Sharpe (PhD student)
Harish Bhandari, Leeds Teaching Hospitals, UK
Harveen Brar (UG applying for Med)
Hatim Abdulhussein, Trainee Doctor
Heidi Johansen-Berg, St Edmunds Hall
Helen Rowntree, Blood Cancer, UK
Helen Stokes-Lampard, Chair, AoMRC
Hilary Cass, ex-President of RCPCH
Husam Elbana, James Cook Univ Hospital
Iqbal Singh OBE, Healthcare Commission
Ivy Glavee, Dentist, London
Jacqueline Stevenson, University of Leeds
Jagtar Singh OBE, Chair Coventry & Warwickshire
Jahangir Alom Trainee- Widening participation
Jane Cannon, General Medical Council UK
Jane Dacre DBE, University College London
Jeeves Wijesuriya, BMA JDC
Jenny Vaughan, Doctors in Distress UK
Joanne Harris, Dean, Univ Bucks Med Sch
John Brecknell, DME Queen's Hospital,
John Chisholm, Medical Ethicist
John Drew, NHS E/I
John Launer, Innovation, HEE Primary Care
John Norcini, FAIMER, Philadelphia, USA
Julie Thacker, Univ Exeter (MSC)
Justin Bice, University of Leicester
Kailash Chand, Retd Chair of BMA NW
Kantappa Gajanan, Chair of BAPIO SAS forum



CONTRIBUTORS

Kate Firth, BMA Policy Analyst, EIC Committee
Kate Gregory, General Medical Council UK
Kate Murnane (Dphil student)
Kate Rush (Medical Director, Bristol)
Katherine Woolf, UCL Medical School
Kheelna Bavalia, Dy MD, NHS E/I, SW London
Lambert Schuwirth, Flinders Univ, Australia
Laura Roberts, HEE, Diversity & Inclusion Lead
Lena Weber (visiting medical student)
Lilian Hunt, EDIS
Lisa Cotterill, NIHR Academy
Mala Rao OBE, NHS Race & Health Observatory
Marianne Griffiths DBE, CEO, Brighton & Sussex Hosp
Marie Gabriel CBE, Chair, NHS Race & Health Obs
Marimoutou Coumarassamy, Notts NHS Trust
Mayur Lakhani, Past President, RCGP
Megan Cosgrove, PhD-UK, now Med_NY
Michael Mulholland, Vice-chair RCGP
Mike Wilkinson, NE Associate Dean for SAS
Mohsin Badat, Clinician scientist
Monica Lakanpaul, University College London
Mumtaz Patel, VP, Global Health, RCP London
Nadeem Moghal, CMO, Independent Health Sector
Nader Francis, University of Bath, UK
Nagina Khan, University of Tauro, Nevada
Natasha Matthews, Faculty of Med Lead & Mgmt
Navaneeth N
Navina Evans DBE, CEO, HEE
Neena Bodasing Lead QA, Keele University
Neena Modi OBE, President, MWF
Nisha Nathwani, DME, L&D Hosp
Nithya Krishnan, Univ Coventry
Olamide Dada, Melanin Medics
Ouseyi Adesalu, King's College Hospital
Pali Hungin, Durham University
Parveen Kumar DBE, QMUL
Patrick Baughan, Advance HE
Prasanth Patel, Univ Hosp of Leicester
Pushpinder Mangat (MD HEI, Wales)
Rachel Davies (Med student)
Radhika Gulati, Medical Student
Raees Lunat, Clinical Fellow, HEE
Rafey Faruqui, Kent & Medway Med Sch
Raj Gupta, BMA Academic Group
Raj Mattu, BAPIO Patient Safety Forum
Rakshitha Pabathi, Medical Student
Rani Bains
Rebecca Barnard, GMC UK
Rishika Sinha, GP
Robert Brunger, Mid-Essex NHS Trust
S Gajanan (SAS Doctor)
Sam Weber, University of Oxford
Samira Anane, BMA rep
Sanjiv Ahluwalia, Reg Dean, HEE, London
Sarah Siddiqui, HEE London, DA Fellow
Sarah Wideman (PhD student)
Sharon Burton, General Medical Council UK
Shevonne Matheiken (ST4 Psychiatry)
Shreya Verma, Medical Student
Simon Gregory, Health Education England
Sonal Kinra, RCGP
Soosan Romel, SAS doctor
Stella Vig, Vice President, RCS London
Stephen Powys, MD, NHS England
Stuart Hood, AMD, MRCPUK
Sue Russell, Cancer Research UK
Sunil Dasan, St George's Univ of London
Taj Hassan, Past-President, RCEM
Terence Stephenson, Sir, Past Chair, GMC, UK
Thomas Charlton, Trainee Doctor
Tinaye Mapako, BMA Students CMTE
TJ Lasoye, DME, Kings College Hosp, London
Tom Baggaley, Assoc Med Res Charities
Toyin Wokoma, Med Assoc Nigeria across GB
Tricia Barlow (Paeds SpR, Disability Lead)
Tricia Campbell Trainee rep, BOTA
Usha Parvathy, U of Newcastle, Australia
Veena Patel, University Hospitals of Leicester
Vidushi Golash, Trainee Doctor
Vijay Kumar, Association of Surgeons UK
Vinita Shekar, SAS Cmte, RC Surgeons England
Waleed Arshad, RCP London/AoMRC SAS Lead
Yaa Achampong (ST5 trainee in O&G)
Yuvaraj Venugopal GP, LNC Rep
Zoe Penn, MD, NHS E/I London, Prof Standards

BRIDGING THE GAP

REPORT

SUMMARY

REPORT



DIFFERENTIAL ATTAINMENT

- Healthcare professionals are among the most respected, valued members in any society- and also the most regulated. It attracts some of the most talented, innovative and resilient individuals who are keen to do good. Respect, job satisfaction and autonomy are fundamental to the experience of any professional, and often valued above financial or material reward. Doctors are no different.
- Education and training of the healthcare workforce is a lengthy and resource intense process. No nation-state can be truly self-sufficient. Hence workforce migration is a reality where various pull and push factors lead to professionals moving across countries and continents, in the service of populations.
- Society is divided along many lines and steeped with structural inequalities. Many of these are the result of thousands of years of history, legacy and societal wrongs. Healthcare services and professionals reflect similar patterns of the 'big society'.
- The phenomenon of differential attainment (DA), which is the subject of this report is simply a manifestation of such structural inequalities. DA or differential outcomes for doctors due to their age, race, gender, sexual orientation, ethnicity, disability, socio-economic deprivation or influenced by migrant status - rather than motivation, ability, effort or enterprise.
- DA is fundamentally unfair. Those affected by DA are either unaware or unable to counteract the influence on their careers. DA leads to demoralisation, disengagement and poor outcomes for professionals and their patients. It takes its toll not only on careers but on lives and livelihoods. DA leads to a huge under-utilisation of human resources- a true waste of talent and enterprise.
- This report- BTG21 focuses on DA in the medical profession exploring the career cycle through the themes of recruitment, assessments, career progression, research & academia, leadership roles, awards and professionalism.
- BTG21 is people-centred and in tackling inequalities offers solutions on career fulfillment and wellbeing- by an ideological shift of hearts and minds.

THEMATIC SYNTHESIS

- BTG21 summary report is the culmination of a thematic synthesis of evidence covering the full spectrum of medical careers. It presents lived experiences (collected through mixed method approaches) capturing patterns in peoples experiences through an online survey, and in-depth qualitative interviews with a purposive sample of professionals from across the career cycle, range of ethnic heritage, medical specialism and country of origin.
- Followed by consensus developed through workshops by a triumvirate of experts, stakeholders and grassroots professionals.
- There are 5 primary causes of DA- bias, social class & deprivation, immigration status, geographical and individual factors and impacts every stage of medical professional careers.
- *The thematic synthesis reviews are published in the [Sushruta Journal of Health Policy](#).*

RECOMMENDATIONS

- The Workshop discussions, recommendations (the 10-point plan) include policy enablers, immediate actions and research questions in the following areas;
 - Tackling bias
 - Embracing diversity & inclusion
 - Celebrating the contribution of migrants
 - Leveling the playing field
 - Inclusive leadership & accountability
 - Removing structural barriers
 - Review-Reform-Rethink assessments
 - Redefining professionalism
 - Disaggregation-intersectionality-benchmarking of data
 - Support-flexibility & Wellbeing

We encourage readers to consider the highlights presented in this summary report, and then explore the full report. We look forward to meaningful collaboration and partnerships in the implementation of the 10-point plan. The BTG21 team will revisit this in 2026 in order to evaluate demonstrable impact.

INTRODUCTION

- 1.1 Health is a fundamental human right and provision of good health for its citizens, is one of the key functions of any nation-state. Healthcare is one of the most demanding, yet noblest of professions and attracts the brightest and best talent. The competition ratios of medical schools in any country is usually a testament to this.
- 1.2 Although there is a huge infrastructural requirement in setting up and providing healthcare and its accompanying science, technology and innovation- the most crucial ingredient remains the dedicated healthcare workforce. Therefore, education, training and nurture of this vital component is key to success of any aspirations for 'Health for all'.
- 1.3 By its nature, workforce planning remains the most challenging of resources to predictably manage and requires both art and science. Ensuring that "the right people, with the right skills, in the right places, at the right time" is an art as everything can change rapidly. Hence, most healthcare systems depend on large scale movement of professionals across borders, often across continents. The migration of medical professionals is therefore a reality.
- 1.4 Many societies have inherent, structural inequalities built over generations, often several hundreds of years. These inequalities are propagated due to bias which is in turn based on differences between people. Often determined by demographics, race, ethnicity, colour, gender, sexual orientation, religious beliefs and disability (many considered protected characteristics by law). Health services are not free of such bias and inequalities.
- 1.5 DA is a manifestation of such inequalities and this report, focuses on DA as applicable to the medical profession.

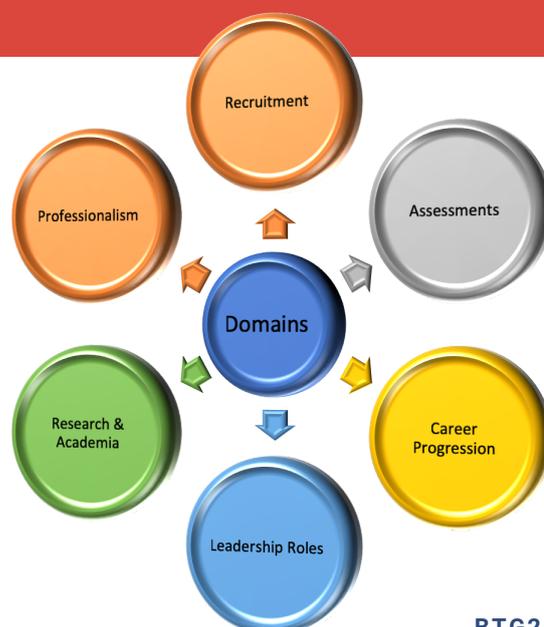
SUMMARY REPORT



- 1.6 The Bridging the Gap (BTG21) series explored the full range of drivers for DA in the career cycle of medical professionals. The mixed methods analysis adopted are summarised later and the full description of the protocol is published. [\[URL\]](#)
- 1.7 This report draws its conclusions from a thematic synthesis of existing evidence, primary qualitative data from workshops and independent in-depth interviews of DA; thus exploring its drivers, the impact on the individual as well as organisations and seeks solutions. Findings have informed the development of recommendations in 10 broad areas, capturing a mix of macro, meso and micro level actions. The outcomes are structured into a summary and a full version.
- 1.8 This is the summary report and therefore deliberately brief and focused on recommendations. Both the reports draw on the underpinning evidence syntheses and primary qualitative research which is presented in a series of published papers in Sushruta Journal of Health Policy & Opinion. The full version of the report presents a detailed summary of workshop discussions in each of the 6 domains considered covering a lifecycle perspective to medical training and careers. This is to encourage those who are interested in delving into specific domains of DA to easily access the content of each workshop and key discussion points.

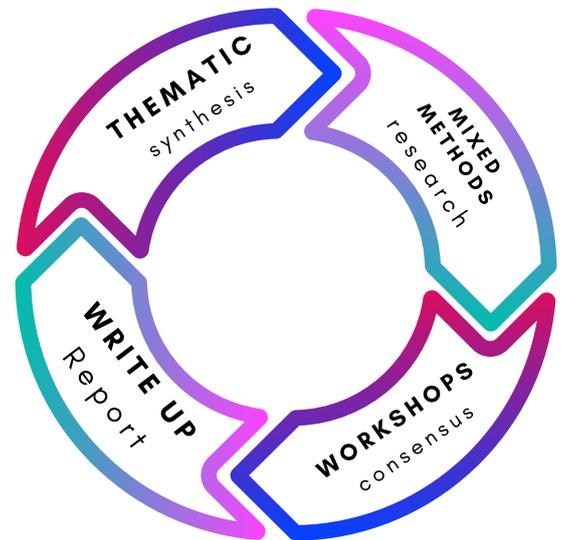
6 DOMAINS

- 1.9 There were 6 teams and 6 consensus building workshops undertaken from August 2020 to April 2021 and the construction of the report till July 2021. Between July-September 2021, the report has undergone several iterations as the team and contributors have pored over each word, sifted through volumes of notes/ transcripts and discussed-debated each recommendation till there was consensus. A summary of the findings is presented here.



NEW APPROACH TO CONSENSUS

- 1.10 What the BTG series has done for the first time is to explore the full spectrum of DA by bringing together the career-cycle of a doctor.
- 1.11 This report combines grassroots individuals/ organisations at the same table with stakeholders and experts to discuss, deliberate and develop consensus.
- 1.12 The output is deliberately taking a broad, societal-systems approach to solutions rather than specific, narrow spectrum solutions, although these are included.



BTG PROCESS MAP



WORKSHOP

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PARTICIPANTS

INTERVIEWS

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QUALITATIVE

PARTICIPANTS

- 1.13 Over 150 people representing stakeholder organisations, training providers, academics, researchers and grass roots trainees and professions have given their time towards what we hope will be a road map to address long standing disparity in training and career experiences of many cohorts of professionals.
- 1.14 Our mixed-methods research invited participants openly via social media utilising a number of channels. There were 166 respondents to the questionnaire (see figure below) and 24 professionals who were interviewed.
- 1.15 Many of the workshop participants shared personal experiences which are captured throughout this report.

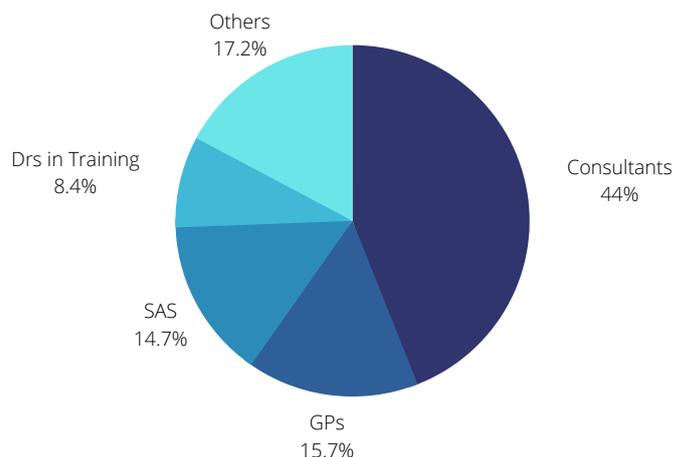
ALLIANCE FOR EQUALITY

1.16 The 'Alliance for Equality in Healthcare Professions' (AEHP) chaired by the British Association of Physicians of Indian Origin (BAPIO) was founded in 2020, in the early days of the arrival of SARS-CoV-2. Its primary task to address the differential outcomes for professionals from minority ethnic or multiple deprivation backgrounds, through its arms-length body, the BAPIO Institute for Health Research (BIHR).

1.17 BIHR's stated mission is promoting excellence in healthcare through the pillars of equality, diversity, leadership, innovation and education are long standing prime drivers in BAPIO's 25 year history in the UK.

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Questionnaire responses



REDUCE DA BY 2026

- 1.18 The evidence of DA in the medical profession is persistent and has been recognised openly (in the UK at least since 2006). In its many guises, DA was discussed and debated by various medical royal colleges, by the UK regulator - the General Medical Council (GMC) and by UK parliamentary committees. Yet, demonstrable progress in the past two decades has been disappointingly modest.
- 1.19 The BTG team and AEHP stakeholders as well as their collaborators have committed to supporting a rapid reduction in DA with sustainable impact within 5 years (BTG26) to make equity in training and career journeys a reality.

'Bridging the gap is not just a morally right thing to do but will also make organisations more effective and efficient'

WORKSHOP PARTICIPANT

YOU ARE ALL THE AGENTS OF CHANGE AND I HOPE THAT WHEN YOU GO BACK, YOU WILL INFLUENCE 10 PEOPLE, EACH OF YOU - TO MAKE THAT CHANGE

Martin Fischer, Facilitator



TERMINOLOGY

• 1.20 *Minority ethnic*

We are mindful of using the term 'minority ethnic' throughout this report. First because language is constantly evolving, individuals vary in how they prefer to reference their identity. Where feasible, we are specific in our use of descriptors of individual heritage, and for communities of professionals. Secondly, we acknowledge that people do not fit into neat boxes. There are intersectional identities that shape experiences and outcomes. We make effort to consider this where data and discussion support. Finally, the BTG team itself has chosen to use the term 'minority ethnic' to place emphasis on being a 'minority' within a larger societal context as the issue, not ethnicity in and of itself.

• 1.21 *Decolonisation*

The phrase decolonise means to 'de-centre Eurocentric knowledge and production and is an acknowledgment of alternative forms and centres of knowledge', however, originally it meant 'to undo colonial rule over subordinate countries'. Decolonising the curriculum herein means creating spaces and resources for a dialogue among all members of the community on how to imagine and envision all cultures and knowledge systems in the curriculum, and with respect to what is being taught and how it frames the world of diversity. In this report we apply it to represent an aspiration for inclusion and equality above legacy.



PRIVILEGE

- 1.22 The BTG team have considered the root causes of inequalities in society as this we believe fundamentally drives DA. Herein, we consider the prime drivers of such inequalities in - privilege, intersectionality and the influence of immigration both on the migrant and society.
- 1.23 Privilege is an advantage that only one person or group of people have, usually because of their position or because of wealth. Privilege grants unearned access to resources or power that is only readily available to some people because of structural factors, membership of social class or groups and granted to or enjoyed above and beyond the common advantage of all other groups.
- 1.24 Everyone has privilege in some situations or as a result of their unique circumstances and may be denied in others.
- 1.25 Among healthcare professionals, doctors have more privilege than many other co-professionals. Privilege is often invisible to those who have it. It is our consensus that the fundamental driver of DA is the granting or denial of privilege to certain people/groups of people based on their demographics, protected characteristics, economic, educational or immigration status.
- 1.26 The opposite of privilege is not simply being underprivileged, but oppressed. While the term underprivileged has a connotation of having a passive status, factors that actively drive inequality or prevent access to resources are oppressive. Those denied privilege are powerless to implement change in their environment or circumstances and therefore experience structural oppression.

INTERSECTIONALITY

- 1.27 The team recognised the interconnectedness of factors that drive DA and their complex relationships, which influence outcomes for individuals or groups. These various drivers of societal inequality do not operate independent of each other; they interact to create interrelated systems of oppression and domination. The concept of intersectionality refers to how these various aspects of social location “intersect” to mutually constitute individuals’ lived experiences [1] and should be considered in future DA research.



A CALL FOR ACTION



- 1.28 This summary report presents the consensus on actions, signposted to the organisations or agencies most likely to be required to take the initiative on condensing these recommendations into meaningful actions. The team has consolidated the actions/ recommendations along the lines of the 4 'I's - Ideology, Institutions, Interactive and Internalised/Individual factors.
- 1.29 For each recommendation, there are actions, recommendations and areas for further research identified. Throughout each section the team have included quotations from the lived experience of participants both from the online anonymised questionnaire and the structured interviews of grassroots individuals. These are included to illustrate the experiences presented.

THE INFLUENCE OF MIGRATION

- 1.30 The influence of migration on DA is profound. Migration may be driven by pull (demand, better pay and working conditions or aspirations for scientific innovation/professional progress) and push factors (comparative lack of opportunity, economic challenges, over-supply and lack of scientific or technological opportunities). Access to the medical profession in most countries around the world is hugely competitive and therefore open to only those with socio-economic and educational privilege.
- 1.31 International medical graduates (IMG) make great sacrifices to obtain employment in foreign countries. They must overcome financial, social, and geographical challenges plus hurdles such as certification, Licensing examination, repeated testing, application fees, interview travel costs, and obtaining a visa all add up to a great financial burden. Even after overcoming such challenges they are often relegated to the least desirable locations, unpopular specialties and given sub-standard training- yet there is an abundance of aspirants. Over 37% of the UK medical professionals are either born or trained overseas.
- 1.32 In addition to the influence of race, colour, ethnicity or command of language, there is abundant evidence of arbitrary skills discounting and a bias due to immigration status. IMGs are consistently evaluated less favourably in recruitment, assessments, career progression and when dealing with complaints or fitness to practice investigations, despite their comparable education level, work experience and personality (with exceptions when primary medical qualifications are obtained in first world countries).
- 1.33 The BTG team found that majority of literature on DA, individuals, grassroots organisations and stakeholders, all recognised immigration status and an overseas medical qualification as a driver of DA.

THEMATIC SYNTHESIS HIGHLIGHTS

- 2.1 Differential attainment is recognised and demonstrable in every part of the medical career from recruitment to retirement. The quantitative evidence is clear in medical school entry, recruitment and summative assessments but scant in research, academia, leadership and professionalism.
- 2.2 There are substantial gaps in the literature exploring the drivers for DA, which makes it difficult to systematically draw on such evidence to formulate targeted actions. However, there are clear and irrefutable signals linking DA with economic status, gender, ethnicity, and immigration (via link to a primary medical qualification (PMQ) obtained overseas).

UNDERGRADUATE

- 2.3 In medical school entry, there is DA affecting those from Black heritage, lower economic status, lower parental educational attainment, from areas with lower access to higher education and geographical backwaters.
- 2.4 There has been a noticeable increase in the proportion of women, certain minority ethnic applicants (some Asians groups) and those with declared disability.
- 2.5 Several schemes for widening participation are showing signs of improved access, but there is still insufficient overall progression, especially in applicants from areas of high deprivation and those with identifying with other protected characteristics.
- 2.6 There is DA in medical school assessments for minority ethnic students.

POSTGRADUATE

- 2.7 In recruitment to postgraduate medical posts including primary care and consultants, there is clear DA adversely affecting candidates from minority ethnic groups, women, those with disability and with a non-UK PMQ

SAS & LOCALLY EMPLOYED DOCTORS

- 2.8 However, for specialty doctors, associate specialists, locally employed doctors, less than full-time applicants and those with disabilities, the situation remains largely uncharted and unmonitored with no agency accepting leadership or accountability.
- 2.9 SAS and Locally employed doctors are facing the most systemic neglect and discrimination. They continue to be used by the system to fill gaps in rotas and areas of the health service which are unpopular or difficult to fill.
- 2.10 The vast majority do not have access to resources for formal supervision and training, there is no career progression, there is no monitoring or cognition of their views, they do not receive due recognition for their clinical ability, have very little autonomy and no reward (i.e. excellence awards).

01

Questionnaire respondent

'I did not get the specialist registrar's post.... Then I did not get the consultant post where I wanted... I do not get the clinical excellence award despite being honoured as a best teacher. Society in general does not value the work I do. If the same work is done by the natives then it is valued more.'

02

Questionnaire respondent

'Incorrect presumptions made about my commitment and ambition because I work less than full time; first author positions on papers [were] given to others when I was on maternity leave.'

03

Questionnaire respondent

'My age was a factor when I first came to this country or so I was told. Frequently I saw colleagues with less experience and ability progressing.'

04

Questionnaire respondent

'At a Registrar teaching in in 2006, the program director and head of the department at the time stated that it was time for the UK to stop training overseas graduates. This he said to all Registrars with two overseas Senior SHOs in the audience.'

INFLUENCE OF MIGRATION

- 2.11 Although there are more than a third of medical professionals in the UK who were born or trained outside the UK, at every stage of recruitment they are far less likely to be shortlisted or appointed. Many are forced to accept placements in geographical backwaters, unpopular locations or specialities, and have to endure sub-optimal support, remaining at great distances from their families or support networks and working in placements with challenging circumstances

FORMATIVE VS SUMMATIVE

- 2.12 In summative assessments, there is evidence of DA affecting those from minority ethnic backgrounds and with a non-UK PMQ. This is apparent in situational judgement tests, written machine-marked assessments and particularly in observed clinical settings.
- 2.13 There is DA in formative assessments, which remain highly variable delivered by faculty who have little dedicated time or training and therefore fail in providing meaningful or constructive feedback. Professionals from minority ethnic groups and IMGs who have not been afforded high levels of privilege in their personal career journeys are more likely to be impacted by DA due to lack of access to peer networks, adequate information on resources available and due to exclusion or othering.
- 2.14 There is a disconnect between performance in summative assessments and outcomes of annual review of career progression (ARCP) for a proportion of candidates.

ASSESSMENTS

- 2.15 The current systems of assessment of medical students and professionals are an imperfect science. The trust that is fundamental to medical practice relies not just on scientific knowledge, proficiency of skills but a host of more esoteric variables - experience, judgment, thoughtfulness, ethics, intelligence, diligence, compassion, perspective - that are mostly lost in current assessments. These difficult-to-measure traits are the critical components in patient care.
- 2.16 DA adversely affects candidates in both summative and formative assessments and there is variation observed across groups when split by a number of protected characteristics, including age, gender, ethnicity, socio-cultural and economic factors.
- 2.17 While there is demonstrable reliability and reproducibility of formal, high stakes, summative assessments undertaken at each stage of transition in the professional career, there is little evidence that these are meeting the requirements of ensuring that the system trains safe and competent doctors for the full scope of their practice. The link between poor performance in assessments and the clinical and professional competence of a doctor, are at best tenuous.

05

Questionnaire respondent

'Being an Associate Specialist has meant opportunities to apply for leadership training or posts has been very limited- told they were only for Consultants. Excluded from management meetings and service developments.'

07

Questionnaire respondent

'I feel that I am going to be treated like second grade doctor in UK. I want to highlight this difference and request BAPIO to help to stop this differential treatment of SAS doctors. We should be awarded CCT at the end our training same as trainees.'

09

Interviewee

“I had friends who struggled because they didn't have those links with getting the hospital work experience and you had to wait 6 months for them to actually reply to you. Whereas if you knew somebody that was expedited. So for me it was quite easy” Participant 4, British Pakistani Male, Age 22, 4th year trainee.

06

Questionnaire respondent

'I am a specialty doctor/SAS doctor preparing to apply for CESR. As non-trainee doctor working in UK for past 8 years, I have to prove that I attain all the competency same as a trainee doctor. At the end we are offered CESR by GMC . Whereas a trainee is offered CCT.'

08

Questionnaire respondent

'There is a general feeling when talking to medical students at my own medical school and at others, that regardless of how much effort the BAME students put into preparing for exams and observed clinical examinations, we always seem to perform worse compared to our white counterparts.'

RESEARCH & ACADEMIC CAREERS

- 2.18 In access to research and academic careers, progression and funding, there is evidence of DA adversely affecting those from minority ethnic backgrounds, women, lower economic status, and geographical areas outside the Oxford-Cambridge-London and major metropolitan areas.
- 2.19 Though equality monitoring is standard practice for many funding bodies, public reporting on application and success ratios by demographics is not always transparent.
- 2.20 In the UK, less than 10% of doctors have a career in academia, at a time when the entire world has woken up to the value of high quality research and a skilled research workforce during the current pandemic. Recent studies report a decline in the capacity of NHS staff to undertake, or even to engage with, research. This situation will likely worsen given the current pressures on the healthcare workforce in recruiting and retaining staff. There is also a decline in the number of clinical academics, who operate at the interface between academia and the NHS and lead research.
- 2.21 The entire spectrum from research career opportunities to funding and choice of research subjects has evidence of exclusivity and this perpetuates social inequalities. There is evidence that offering substantial time for research experience in undergraduate education broadens access and diversity in the future workforce. Yet not many students are able to afford the additional time or access to opportunity for research experience as undergraduates. Unlike other educational programmes, research is not a mandatory component of medical training in the UK.

DIVERSITY IN ACCESS TO RESEARCH

- 2.22 Diversity data from the Research Council 2018 shows that 84% of the academic population in the Medical Research Council (MRC) identify as White heritage, with 4% and 1% belonging to Asian and Black backgrounds, respectively. Further, 79% of the student population at MRC was from a White ethnicity despite most medical schools having a greater proportion of their cohort, made of individuals identifying with a minority ethnic group.
- 2.23 Success rates for principal investigator funding across MRC grants and awards in 2016-17, demonstrated a higher proportion of applicants identifying as White heritage (24%) compared to successful applicants from minority ethnic backgrounds (16%). The award rate has improved to 21% for minority ethnic applicants in 2018-19.
- 2.24 Data from UK Research and Innovation (UKRI) in 2019 suggest the gap may be widening with a higher success rate observed again among individuals identifying as White heritage (27%) compared to those identifying from a minority ethnic (17%).
- 2.25 Data from the Wellcome Trust on grant funding awards, identified the majority of successful applicants identified as White (87%), and there was a consistent gap in success rates over a three-year period between 2016-2019. Across this data, minority ethnic applicants were also under-represented among those who were successful at obtaining more senior awards and fellowships.

10

Questionnaire respondent

'I did a research officer job and other than the 1 project I was working on, no one would let me get involved with any other projects. It was very frustrating and I ended up changing my career options.'

11

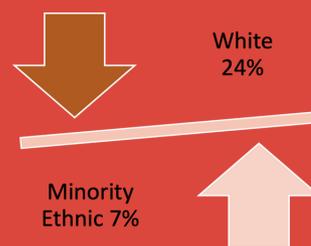
Questionnaire respondent

'I'm significantly older than colleagues at same level of seniority. I'm criticised in grant applications for not moving around the country/world for jobs.'

12

Questionnaire respondent

'I think mainly due gender. I work with the U.K. armed forces and the sexism there is particularly prevalent. People make assumptions that you cannot be smart or competent in a medical field because I'm a woman or that I won't be as good at my job because of it.'



0.68x

the Odds of non-White applicants receiving funding compared to White applicants. Wellcome Trust 2016-2019

Probability of success in research funding New investigator - MRC 2017-18

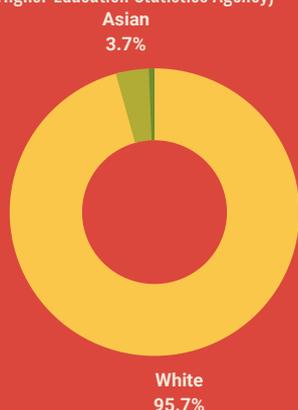
PROTECTED CHARACTERISTICS

- 2.26 Students from minority ethnic backgrounds were also less likely to progress to scientific jobs after graduating than students identifying as White heritage.
- 2.27 Reporting of outcomes from individuals with protected characteristics can be limited due to the need for protecting anonymity when group sizes are small. Individuals with visible and non-visible disabilities are under-represented in a range of work settings, and the trend is no different in the scientific workforce.
- 2.28 People with a disability have less success at grant award rate (13% versus 15%).
- 2.29 Although not strictly a protected characteristic, deprivation is associated with poorer outcomes especially among individuals with protected characteristics. Individuals from a lower socio-economic background, irrespective of ethnicity, are less likely to enter research and academia, and are also less likely to progress in their careers as well as take longer to get to professional level. Similarly, 2017 data from the Wellcome Trust, suggested inequalities in entry to doctoral studies due to socio-economic background, despite the same attainment level in graduate studies.
- 2.30 A Freedom of Information request to UKRI revealed that over the last three academic years (2016-2019) of the total 19,868 PhD funded studentships awarded by UKRI research councils collectively, 245 (1.2%) were awarded to Black or Black Mixed students.
- 2.31 There are consequences of the lack of diversity in scientific communities and the outcomes for populations they serve, where inequalities of access and unconscious bias leads to differential health outcomes. A strong association exists between researchers and the people they study. Predominantly White middle-class groups of scientists focus their research programs primarily on White, middle-class populations. This reliance on “convenience samples” does not appear to stem from purposeful neglect of other potential samples but from ignorance or invisibility of researcher - privilege.

GENDER & INTERSECTIONALITY

- 2.32 The Athena Swan Charter has no doubt attempted a systematic shift in gender equality in higher education, with independent reviews speaking to its impact on organisations. However, the Charter has yet to take a truly intersectional lens to ensure that those identifying with multiple characteristics equally benefit- e.g. women identifying as minority ethnic, those with a declared disability.
- 2.33 The DA observed among women despite the Athena Swan programme demonstrates other factors such as allyship, apprenticeship, sponsorship and mentoring which may be accessible to some individuals, but not others.
- 2.34 Furthermore, ethnicity appears to be a barrier to accessing this form of support, and women of White heritage appear to have more privilege in receiving this type of support.

Ethnicity of Professors in the UK
(Higher Education Statistics Agency)



3.2%

Proportion of Heads of the Institutions identified as Black and minority ethnic (HESA)

2%

UK-based applicants for Wellcome grants declared a disability at the point of application (19% of working-age adults are disabled according to the UK Government family resources survey 2016/17).

3%

of PhD studentships in the UK out of 15,560, given to Black students. Leading Routes Report, 2019

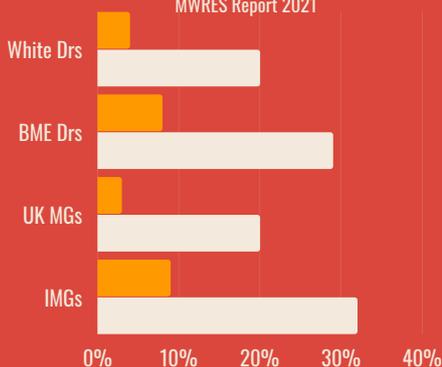
PROGRESSION & LEADERSHIP ROLES

- 2.35 In the NHS, HEIs, the medical royal colleges, HEE, NHS Improvement, the regulator and similar arms-length bodies, there is evidence of DA affecting candidates from minority ethnic backgrounds, women, and those with a non-UK PMQ
- 2.36 Women are particularly disadvantaged in having to shoulder the majority of parental or caring responsibilities. Hence they end up working flexibly, passing up opportunities to compete for leadership positions, or taking additional management responsibilities; therefore suffering the consequences of not reaching their academic or professional potential; taking much longer to move between career progression stages, having a significant pay and attainment gap, suffering stress, demotivation as well as demoralisation.
- 2.37 The majority of leadership positions in the NHS are still taken up predominantly by those who identify as male, white, and with significant underrepresentation from women, minority ethnic and those with other protected characteristics.
- 2.38 The access to leadership positions for the immigrant healthcare workforce is also severely restricted.
- 2.39 According to 2018 Workforce Race Equality Standards (WRES) data for England, only 16% of NHS medical directors were from minority ethnic groups compared to 46% of the NHS hospital medical workforce.

PROFESSIONALISM

- 2.40 The standards of medical professionalism and the legislation which provide the legal and ethical framework have not kept pace with the scale of change in science and societal values. Medical professionals rarely ever operate on their own and are now responsible for care in teams and abide by the rules set by large organisations both in the public sector (i.e. NHS) or by large private corporations.
- 2.41 Yet the professional standards are still pinned to the individual and the regulators are still only focusing on the individual when standards are breached. There is an international aspiration for organisational accountability for providing the environment for medical professionals to operate safely and optimally.
- 2.42 In matters of complaints, serious incidents, fitness to practice investigations, referrals to the regulator, the governance around how such referrals are investigated and resolved by the regulator – there is clear evidence of DA adversely affecting men and those from minority ethnic backgrounds.
- 2.43 There is evidence for DA in investigations into complaints, breaches of maintaining high professional standards (MHPS), as well as doctors fitness to practice (FtP) referrals to and by the regulator. Under-represented groups including minority ethnic doctors are more likely to face referral to the UK regulator the GMC, to have their cases formally investigated and likely to face 'harsher' sanctions (although that still remains to be established) on conclusion.
- 2.44 Complaints from employers are more likely to result in an investigation being opened, and ultimately more likely to result in a sanction being applied.

Percentage of staff referred to the GMC (in white) and percentage of staff being formally investigated by their Trust (in yellow) in 2019
MWRES Report 2021



13

Questionnaire respondent

'Leadership roles are less likely to be given to women as are promotions because they think you're going to have a baby in a few years so all the training is wasted.'

15

Questionnaire respondent

'I find it difficult as an IMG to get in to leadership positions.'

14

Questionnaire respondent

'Applied for clinical lead position and the person doing it for 8 years said that she will stand down, however due to politics she was asked to stand again by other white colleagues.'

16

Questionnaire respondent

'As a newcomer to the system I was put through a very difficult time very early on in my career by having to defend a complaint on my own, instigated by my own health board.'

BIAS & EDI

- 2.45 There is evidence doctors experiencing overt discrimination, racism, unconscious bias, bullying - undermining from patients and colleagues due to their race, religious beliefs, proficiency of English, ethnicity, gender identity, sexual orientation and immigration history.
- 2.46 There is paucity of transparent, collection-analysis-dissemination of DA data within and across organisations which hampers acknowledgment and progress
- 2.47 There is significant variability in acknowledgement and accountability from senior leadership in the NHS, HEE, HEIs, medical royal colleges and NHSE/I along with Department of Education and Health-Social Work as well as the regulator. There are no benchmarks to evaluate organisational commitment and progress in tackling DA - like the Athena Swan charter, Workforce Race Equality Standards (WRES) and Race Equality Framework (REF).
- 2.48 The definition and interpretation of medical professionalism by the UK regulator is in need of reform and does not currently acknowledge diversity, inclusion, organisational accountability.

SUPPORT & WELLBEING

- 2.49 In matters of support from induction, supervision, access to learning resources, peer networks, role models, mentorship and sponsorship, there is evidence of DA adversely affecting women and those from minority ethnic backgrounds.
- 2.50 There is a significant adverse impact on wellbeing and morale for doctors from minority ethnic backgrounds and those with non-UK PMQs, particularly due to lack of family support, distance from support networks and socio-cultural isolation.

17 Questionnaire respondent
'Stifled, marginalised, harassed, bullied, career stopped.'

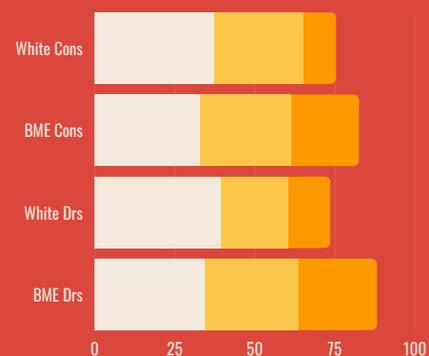
19

Interviewee

"I remember once there was a father who brought his son into the clinic and the son had this very black eye and I was asking him, what happened to your son. He said, he's come here for medication review.... I needed to make a few calls and the father was getting quite irate. I overheard him then on the phone, most likely to the mother, saying well 'I'm talking to a coloured girl with dreadlocks'. I then turned to him and said, excuse me I heard you, I'm sorry I'm your consultant, your child's doctor and not just a coloured girl with dreadlocks and I've heard you say that and I'm going to document that, and I will not tolerate that kind of language in my room." (Participant 19, Female, Black African, Consultant Paediatrician, Age 54).

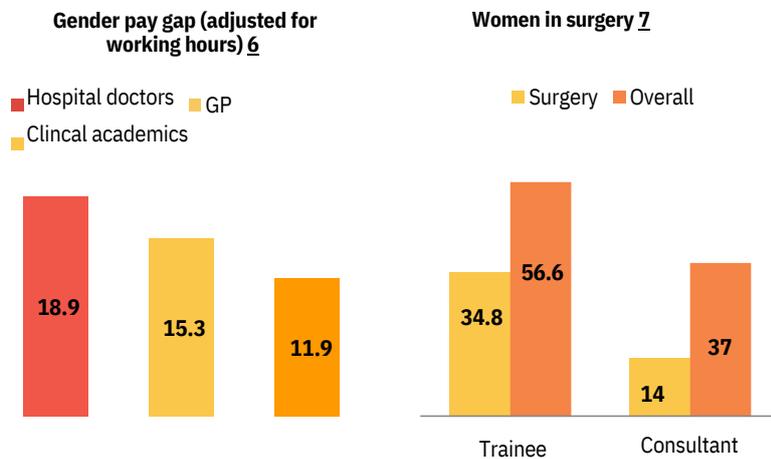
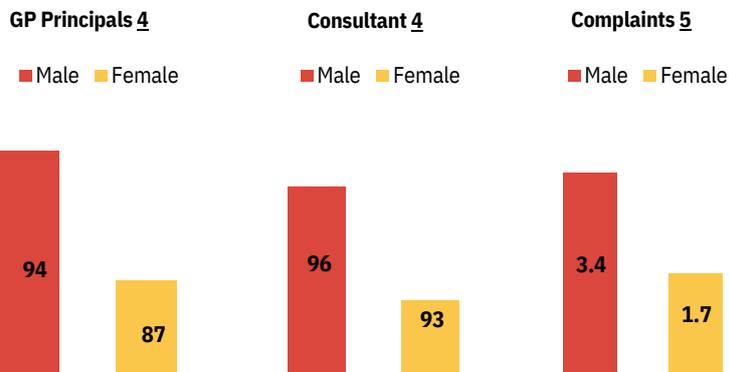
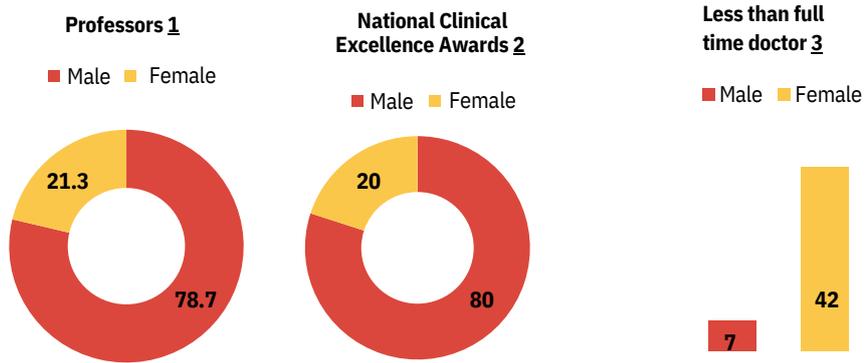
18 Questionnaire respondent
'I was treated differently because I graduated from overseas. My background of work which was mainly in Saudi Arabia was looked down upon. Small things were highlighted as big issues every single day to an extent that I lost trust in my supervisors, in training, and had to leave my career in the speciality that I loved.'

Doctors (Consultants & Drs in training) experiencing bullying and harassment from patients/ public (white), staff (light yellow) and facing discrimination at work (dark yellow). MWRES Report 2021



DA FACTSHEET

Gender & Intersectionality



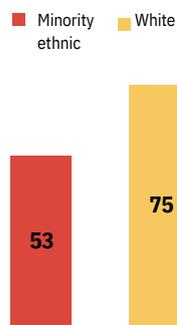
On 31 March 2021, 45.8% of Hospital and Community Health Services (HCHS) workforce identified as female; Data is displayed in %

DA FACTSHEET

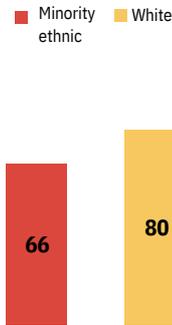
ETHNICITY

Recruitment success rate 8, 9

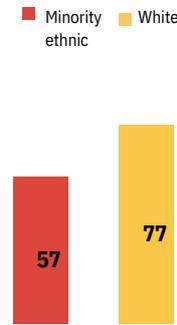
Specialist training 2016-18



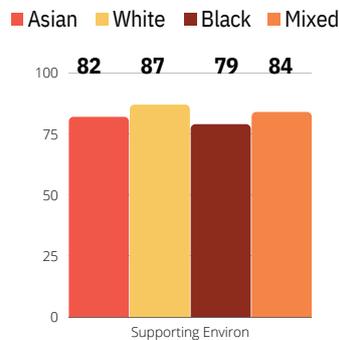
Consultant Shortlisting



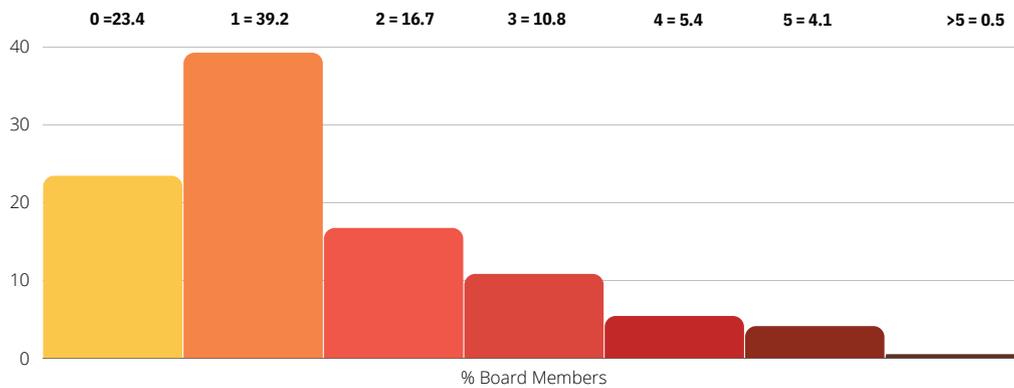
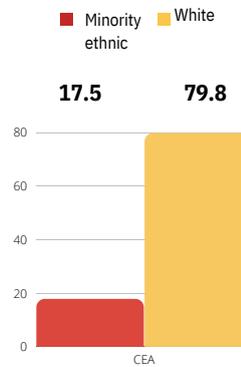
Consultant Job offers



Supporting working environment 9



Clinical Excellence Awards 2



In 2021, 43.8% of Hospital and Community Health Services (HCHS) workforce are from a Black, Asian and Minority Ethnicity background in NHS and 45.8% were female.

Pay - In consultant posts, BAME staff earns 2.3-3.3% less than their white peers 10

Diversity of Trust Boards - In 2020, only 22 NHS Trusts in England had 4+ minority ethnic board members

DA FACTSHEET

Professionalism & Fitness to practice

GMC referral 5

Minority ethnic doctors likelihood of being referred to GMC is 1.1 vs 0.5% White peers



Erased or suspended 11

Minority ethnic doctors likelihood of being erased or suspended from the register is 50 vs 23% for White peers

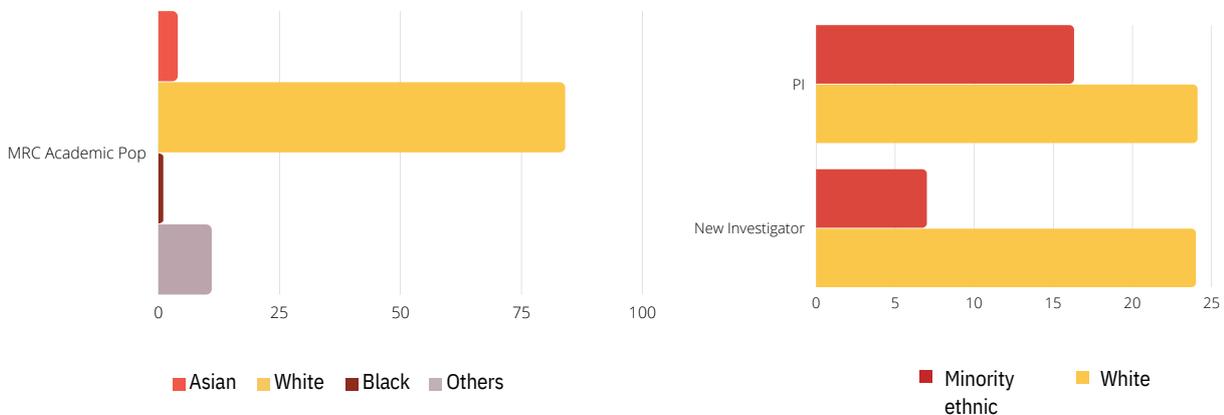


Employer referral 9

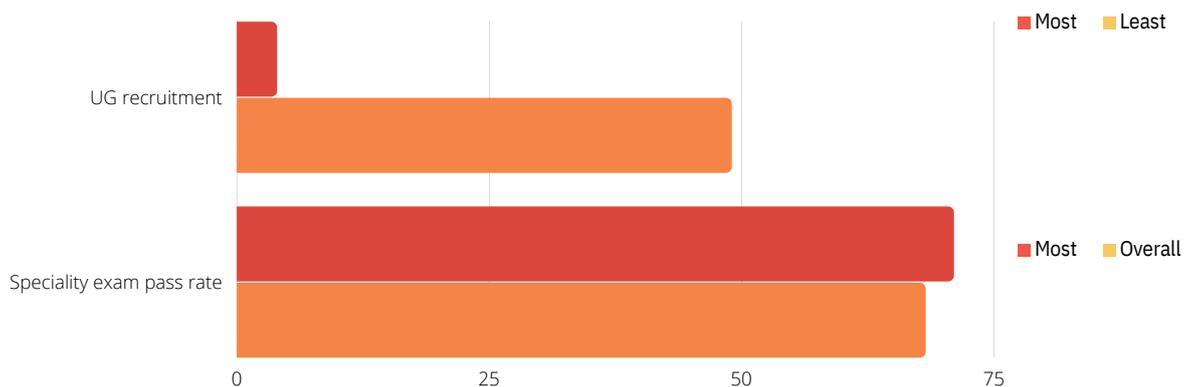
Minority ethnic doctors likelihood of being referred for formal disciplinary investigation and to the regulator is 8.9 vs 4.3%



MRC academic population & funding success rate 12



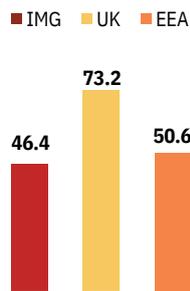
Undergraduate recruitment 13 & Speciality exam pass rate 14 Least vs most deprived



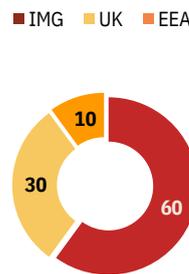
DA FACTSHEET

International Medical Graduates & European Economic Area candidates

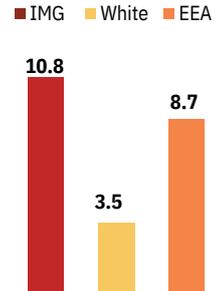
Speciality exam pass rate 15



Non-training posts 16



Employer referral 9



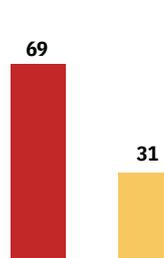
GMC referral 5



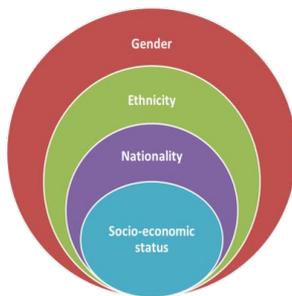
GMC Investigations 5



Erased or suspended 11

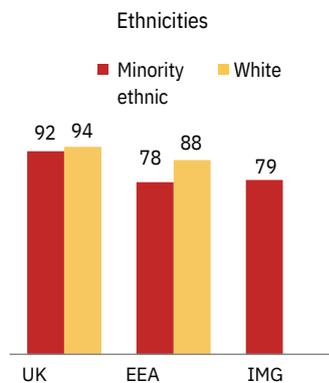


Intersectionality:

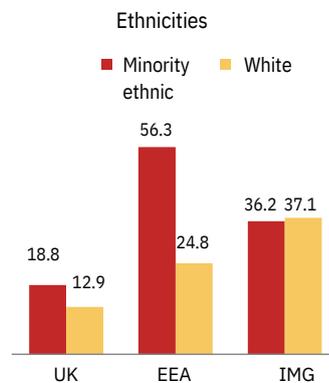


Primary Medical Qualification and ethnicity in

Foundation program-Y2 recruitment 17



Unsatisfactory ARCP outcomes 9



Gender and ethnicity interplay in academia suggested only 20 black female professor in UK and less than 2% are BAME Female professor (HESA data)18



20

Interviewee

'It is white men who traditionally have the opportunities to 'hit the ground running'

21

Interviewee

'I wasn't aware of that (referring to DA) before. I thought that the gaps and things would probably decrease by the time you get to medical school, for example, everyone would be on a level playing ground' P7, Female, British Bangladeshi, Medical Student, aged 18 years

22

Interviewee

'I did not even think about differential attainment as a trainee. I thought that if I endured the discrimination, when I became a consultant the playing field would become even and that I would be recognized and respected for my competence and contribution.'

23

Interviewee

'However the predominantly white management and executive were strongly biased towards White British Consultants and Clinical Managers. The latter felt empowered by this support and bullied and harassed me regularly and did everything possible to stop and impede any patient safety initiatives I attempted to initiate.'

24

Interviewee

'When I raised concerns for the safety of patients I was belittled and rubbished and finally I resigned. I was ok to fight the discrimination towards me, but when this started making it impossible for me to deliver safe care, I could not continue.'

THEMES FROM MIXED-METHODS RESEARCH

- The qualitative interviews were conducted and analysed by an independent team from the University of Hertfordshire, School of Life and Medical Sciences. The interviews aimed to explore the lived experience and perceptions of DA with a range of grassroots professionals from trainees to doctors at varying stages of their career journeys.
- The full details of the primary interview based research and the findings are published separately.
- The following themes reflect the overlap of findings from the mixed-methods employed (evidence syntheses, questionnaires, interviews, and workshops).

DA BLINDNESS

- 3.1 We observed that for the majority of early career professionals, the existence of DA came as a surprise. Many were unaware of the impact of DA on them and the link with equality, diversity and inclusion. This observation was less so for those who were born abroad.
- 3.2 Whereas, doctors in the more advanced stages of their career were aware of DA, but not the drivers, except when they had personal experience or were aware of someone close to them who had experienced DA. Many doctors in this stage of 'late realisation' of DA were demoralised by the revelation.
- 3.3 Some early career doctors had learned to internalise the awareness of DA and accept this as the 'norm' in society for people like them- a feeling of learned helplessness but focusing on survival and doing more to progress through 'glass ceilings' but on a 'sticky floor' of DA.

MERITOCRACY

- 3.4 There was a commonly held perception (by doctors who held positions of power or influence in the profession), that those who experienced DA were 'either not good enough', needing 'enhanced mentoring/ coaching', or that DA was justified because of the need to maintain 'meritocracy and excellence of healthcare'.
- 3.5 This perception of being less meritorious (and hence less deserving) was particularly applied to doctors from widening participation schemes, IMGs, and those from underprivileged -oppressed groups.

PRIVILEGE

- 3.6 The term privilege derives from the Latin privus ('one's own') and lex ('law'). Privilege in its original sense refers therefore to 'exempt[ing] oneself from laws applied to others.' There was a perception of the intellectual superiority of certain groups of doctors yet not recognising the privilege accorded to them by the system, based on their gender, Whiteness, economic status, prior educational attainment, and access to parental or other sponsorship and exclusive networks (in-groups).

TOKENISM

- 3.7 Many of the interviewees in particular believed that diversity was being achieved as a 'tick box' exercise by many organisations with 'token' representation from under-represented groups (i.e. women, minority ethnic and LGBTQ+ individuals) based on their alignment, fitness to the team and acculturation. Therefore failing to recognise the true strength of diversity in viewpoints, lived experiences, culture and international healthcare training.
- 3.8 In the same light, there was a perception that workplace policies and procedures often acted as tokenistic gestures without properly building confidence in instigating them. Such 'token' representatives were therefore considered to be part of the problem rather than the solution.

MICROAGGRESSIONS

- 3.9 It was common for doctors who were in the 'out-groups' from diverse backgrounds, under-represented cohorts to face and rationalise everyday acts of microaggressions within their workplace and social interactions.
- 3.10 The most common of these microaggressions was the challenge of pronouncing non-anglicised names. The mute acceptance of wild variations of 'apparently harmless' disfigurement of non-anglicised names which was prevalent in every stage of doctors careers, was deep down an unconscious acquiescence of the inferiority of position in the healthcare system of such doctors.
- 3.11 There was also the realisation that doctors in positions of power or influence, who were accepting this disfigurement were making it harder for others who were in less privileged positions to be accepted as equal.



25

Interviewee

'So there was a position of fellowships and they said that they were going to give priority to BAME candidates and based on that they opened the position and obviously they had this influx of applicants. And someone was saying, this is great but actually the applicants that we're getting are not necessarily the people that would have struggled if we didn't give them the job. They are well spoken and well educated, so if they didn't get this job, eventually, they would have done, and you know they might have struggled a little bit from being from a BAME background, but eventually would have got there. But we're not getting the layer under, who didn't even think of applying because they didn't think they'll get the job anyway, because those you know privileged BAME people are getting the jobs.' –

P13, Female, 38, Clinical Academic, Black heritage, IMG

26

Interviewee

'because they [senior doctors] can't pronounce my name, if it's a situation where they want it to be interactive and students to talk, because they can't pronounce my name they wouldn't pick me, they would go around with everyone, but then they wouldn't pick me because I'm guessing they can't pronounce my name and other people, like my friends would be like oh I bet they didn't pick you because that she can't pronounce your name it's like it's a really obvious situation'

P23, 3rd year trainee, female, IMG, age 21'

THEMES FROM MIXED-METHODS RESEARCH-2

INFERIORITY OF INTERNATIONAL TRAINING

- 3.12 Similar perceptions of the apparent 'inferiority of international healthcare training and experience' were rampant in all organisations and stages of the medical career. Hence, propagating substandard treatment in interactions, undervaluing international experience, and acceptance by the privileged majority that DA was inevitable and therefore not a reflection of bias, but just due to inferiority.
- 3.13 Doctors linked such perceptions as the inherited legacy of the 'Empire and colonialism'. Thus recognising that this perception resulted in them being denied fundamental 'respect' and the value of 'diversity of a multicultural and international experience'. Counter-intuitively, those from mixed ethnicity/ heritage felt that they were the most deprived as they felt not being able to belong to any easily identifiable cultural or ethnic group.

STIGMA OF IDENTIFYING AS MINORITY ETHNIC

- 3.14 Some doctors expressed that they were not comfortable to be identified with any minority characteristics as they feared being 'othered', facing renewed discrimination and disadvantage in their careers. This was also applicable to those professionals who were differently able or with non-binary gender and diverse sexual orientation.
- 3.15 In contrast, others had a strong sense of their identity being reflected in disaggregated, iatrogenic, arbitrary and non-logical characterisations such as 'BAME' - Black and minority ethnic groups or 'disabled' irrespective of the underlying disability. There was fear of being 'stereotyped' and 'victimised.'

COLLECTIVE VS INDIVIDUAL AUTONOMY

- 3.16 Many doctors believed that there was an ideological challenge in the autonomy of the profession being misinterpreted (by some doctors) as individual autonomy. Unlike, the regulated and standardised care afforded through the UK NHS and expected adherence to the guidelines from organisations such as National Institute of Clinical Excellence (NICE), or the prescribed norms of behaviour as outlined in the Good Medical Practice guidelines (from the GMC), the lack of such prescriptive standards (of regulation) in many countries around the world was a factor in some IMGs finding themselves at higher risk of receiving complaints or being investigated for breaches to maintaining high professional standards.
- 3.17 There was a perception that this aspiration for individual autonomy may be driving some doctors to primary care, where it was perceived to be preserved. Such misperception could be leading to doctors facing a higher risk of censure in fitness to practice investigations and an apparent refusal to accept when breaches occur as a 'lack of insight'.

SOCIAL EXPECTATIONS

- 3.18 Expectations from Family/Friends - the 'social expectation' to respond to the healthcare needs of family and friends in times of crisis is also an area of concern, where doctors from less regulated environs may find themselves in breach of expected GMP professional standards.

INSURMOUNTABLE STRUCTURAL BIAS IN RECRUITMENT

- 3.19 Doctors were aware of the predetermined, traditional essential and desirable qualifications and attributes in recruitment, which offered an insurmountable barrier for doctors from underrepresented groups, those who had lower economic status or trained abroad. Examples were the extra credit given for 'an intercalated or higher degree', previous research experience, first author publications in research, academic fellow or consultant appointments.
- 3.20 These factors made it impossible for those without these experiences from getting into such roles for career progression. There was an argument that these had little to do with the required skills and attributes of the job and therefore a call for a complete overhaul of the recruitment process and removing such structural biases.

DRIVERS OF DA

BIAS

- 4.1 One of the fundamental reasons for the differential outcomes across the spectrum is related to being perceived by the system to be different; being different by gender identity, race, ethnicity, religion, sexual orientation, disability, language, socio-economic status. This is bias, which leads to discrimination.

Disaggregation

- 4.2 Although there is a growing school of thought to move away from such aggregation of the oppressed in society within categories as Black and minority ethnic (BAME), there are others who are keen to recognise the strength in an approach which identifies the common experience of the denial of privilege that provides cohesion and a critical mass to have their opinion heard. They argue that disaggregation of data will turn the clock back on decades of progress in aspiring for justice.
- 4.3 The BTG Team believe in the argument for granularity of the experience in each group of people (disaggregation) as there are vital differences between groups in areas of socio-demographics, motivation, aspiration, behaviours and experience of discrimination.

INTERSECTIONALITY

- 4.4 There has been a realisation in academic circles in the last 2 decades, that each of these factors that determine bias are interconnected and interactive in complex ways – thus the intersectionality may vastly modify the impact of each of these determinants on an individual's outcome. Hence, any benchmark or data analysis will need to identify and take these interactions into account.

SOCIAL CLASS & DEPRIVATION

- 4.5 The structural relationship between social class or economic deprivation and educational attainment is fundamentally different to that of gender, race and ethnicity. Social class has deep roots in early civilisation when the divisions and outcomes were determined by the working/ rural vs land owners or ruling class divisions. Privilege and oppressions are still determined by such fundamental structures albeit now incorporating the corporate rulers into the upper class cohorts.
- 4.6 The professional class to which doctors belong is a phenomenon of the Victorian era and followed advances in science and engineering. The professional class inherits many of the attributes of the working classes such as the virtues of hard work and enterprise, enjoy a degree of value and autonomy granted by a grateful society, but are also able to enjoy some of the fruits of their labour and aspire to the joys of spare wealth.
- 4.7 The abstract laws of human society propose that each class aspires to the dream of upward movement and thus a journey from oppression to privilege. Failure to recognise and incorporate a working-class perspective or to decolonise the curriculum continues to perpetuate inequalities manifested as DA.

27

Questionnaire respondent

'Racism is still the most prevalent cause for this. Lack of understanding of the NHS functioning also contributes to this.'

28

Questionnaire respondent

'Racism, institutional structural disadvantages e.g. for women returning from maternity leave - the who medical career progression is designed for men in the 1950's and is not flexible - it's incredibly difficult to become a leader in the current system as a woman working in a part time role and it is considered culturally that you are less valid if you are not working full time.'

29

Interviewee

'Cultural differences in expectations and modes of expression.'

30

Interviewee

'Poor basic training combined with bigotry and failure to understand nuanced cultural differences.'

31

Interviewee

'Suppression as a BAME - can't become a consultant in SW England as told population will not accept my colour in early 2000's.'

32

Interviewee

'Was bluntly told that I should not aspire for posts in tertiary care or specialty training.'

33

Interviewee

'IMG candidates being considered inferior, once an IMG has been considered fit to work, they should be able to apply with the same parity as home grown doctors, I feel.'

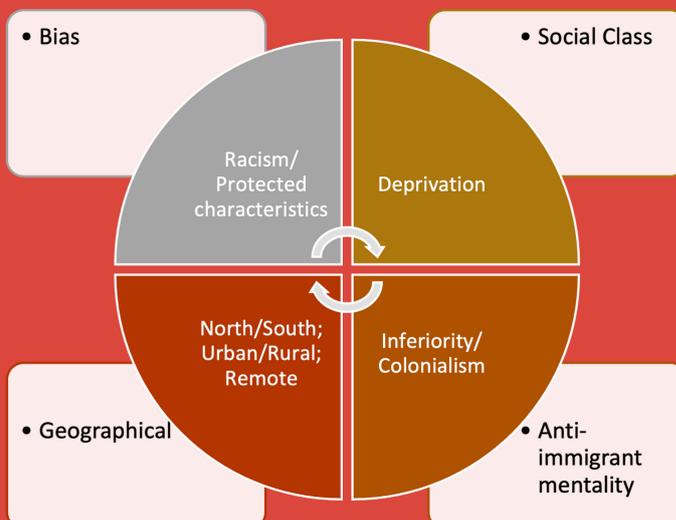
DRIVERS OF DA

ANTI-IMMIGRANT MENTALITY

- 4.8 Migration is a basic human behaviour, determined by the need for survival, for propagation and betterment. Drivers for migration are dynamic and often categorised as pull or push factors. The mass trade in humans as part of the slave trade or migration due to war or persecution are distinct entities.
- 4.9 However, there is a fundamental truth in the recognition that immigrants are treated differently by native societies. Migrants from dominant and powerful nation-states may enjoy additional privileges due to the power gradient with native societies.
- 4.10 The UK has a peculiar relationship with migrants determined by whether they were brought in for filling gaps in skilled or unskilled workforce and by the power divide between the UK and their countries of origin. An immigrant from Australia, New Zealand, Canada, the USA and EU certainly experiences a different treatment to Jewish, Irish, Asian, African or Afro-Caribbean origin.
- 4.11 This discrimination resulting from ones immigrant status is applicable equally to doctors who were born or trained overseas and to the descendants of immigrants.

INDIVIDUAL FACTORS

4.12 Factors driving DA at individual level are poor induction for IMGs, lack of supervision-mentorship-sponsorship, absence of role models in leadership, research or academic positions, absence of allies in high places, the phenomenon of othering from peer networks, facing daily microaggressions, lacking a voice, inability to raise concerns, not receiving timely- constructive feedback, and being dealt with punitively when errors occur.



34

Interviewee

'Despite a good IELTS score, clearing the PLAB in my first attempt and a post graduate degree in internal medicine, like many others I am sure, I struggled to even get an interview for my first job. Fortunately before my visa ran out (as there were no skype interviews at that time) I got a break as a PRHO (foundation doctor equivalent) at a hospital in a town on the end of a railway line, by the seaside!'

35

Interviewee

'Low opinion of overseas trained professionals. [We are] not one of the inner circle members.'

36

Interviewee

'Gas lighted. Incivility. Abused. Harassed. Victimised. Assaulted.'

37

Interviewee

'Consultants attitude to help only trainees. Deferred recognition and delayed grants, delay in publication.'

38

Interviewee

'Institutional bias and subtle racism. Lack of UK experience, Visa status.'

39

Interviewee

'There may be issues with structure of exams and interviews i.e. the white male version of performance in these settings is seen as the gold standard and everything has to match to this. When viewed through this narrow lens, there is little appetite for alternative approaches to the same issue.'

40

Interviewee

'I have been overlooked for leadership and management roles due to my ethnic origin.'

41

Interviewee

'We don't fit in naturally, have different lingo and colour.'

HIGHLIGHTS FROM THE WORKSHOPS

- 5.1 The purpose of the workshops were to work with the triumvirate of experts, grassroot professionals and stakeholders in building consensus for system change to eradicate DA. The process of bridging the gap includes the fundamental principles of equality, diversity and inclusion for achieving a level playing field for all. In this section, we report the summary of discussions both in common across the domains and individually from each workshop.

EQUALITY, DIVERSITY & INCLUSION

- 5.2 Crucial for excellence in patient care and for meeting the objectives of the NHS Peoples Plan were;
 - staff who were aligned to the values of organisations,
 - felt that they belonged (inclusion), that their identity and diversity was respected,
 - that the system was fair, just and transparent,
 - that their education, training and pastoral needs were met,
 - that there were role models representing them at all levels of organisations and
 - that their leaders were visibly accountable for upholding the principles of EDI, as well as genuinely committed to tackling DA.
- 5.3 The workshops recommended that organisations such as the NHS, medical royal colleges, Health Education England and other healthcare organisations in the UK, should proactively engage and participate in the initiatives and interventions that celebrate diversity as proposed by government, non-governmental agencies and communities. Such initiatives include Black Lives Matter, Melanin Medics, South Asian or African Heritage month, etc.
- 5.4 Respect, fairness and inclusion are integral to the culture and values for the entire health care sector and every organisation and member of the profession must therefore strive to make it relevant in everything they do. Commitment to equality therefore goes beyond legal compliance – and is crucial to core healthcare business.
- 5.5 Within their cohorts and catchment areas, healthcare and higher education institutions should regularly invite ideas and innovations from their workforce, membership and their populations, co-design and co-develop initiatives which are then resourced to engage, empower and embed equality, diversity and inclusion in all its offerings.

43

Workshop Participant

'We have to build partnerships and not enemies. Collaborating to organise systemic change.'



44

Workshop Participant

'The truth [about DA] should and does sit uncomfortably with all in the health sector and certainly with leaders, who do have the power and influence to lead change.'

EDI NETWORK/ COMMITTEE & DATA

- 5.6 Every organisation should establish a well-resourced, empowered and representative workforce network/ committee which has the remit to uphold and monitor the organisation's performance on EDI.
- 5.7 This committee should provide the oversight to develop a metrics to collect, analyse and publish transparent data on EDI performance.
- 5.8 The committee should be empowered to challenge, investigate and encourage system leaders to take necessary action to meet the organisation's declared EDI objectives.

ACCOUNTABILITY & ACKNOWLEDGEMENT

- 5.9 All organisations have a duty to be aware of and acknowledge DA, commit to transparency of data and be aware of its impact on the organisation, as well as the individual.
- 5.10 Finally, the leaders of organisations should hold themselves accountable for tackling DA and commit to achieving equality.

DATA & BENCHMARKING

- 5.11 Data is power. Throughout our work, the team have explored the length, breadth and depth of data that is available to decide that DA exists, its impact on people and organisations and how the data may inform the effectiveness of interventions.
- 5.12 Data also has several limitations particularly in how it is collected, missing pieces and how the groups are integrated. Therefore, defining meaningful data and creating a robust framework for collecting, reporting and interpreting data is essential for any programme.
- 5.13 There is consensus on the need for disaggregated data that advances an understanding of how different groups are differently situated and the interconnectedness- interrelationship of different causative/ contributory factors for DA.
- 5.14 Data should be disaggregated with sufficient detail to understand varying groups' circumstances. Often the data we have available for use do not go far enough. "Black" is an umbrella term that encompasses the differently situated experiences of African Americans, Afro-Caribbeans and African immigrants.
- 5.15 BAME -includes people from over 52 countries as applied in the UK, of different ethnicity, religion, cultures, habits and languages. Beyond racial/ethnic disaggregation, analysis is likely to benefit from the ability to break out race/ethnicity by gender and age, for example.
- 5.16 It is important to work with whatever data is available – acknowledging its shortcomings – while one aspires to data that can enable future analysis and actions to become more fine-tuned. Equally, intersectionality of various attributes compounds the disadvantage experience, for example female gender and black ethnicity combined.
- 5.17 There was agreement that any data on careers should be collected longitudinally and linked to PMQ or Registration and collated over career transition points. There is currently no infrastructure or framework for such data collection.
- 5.18 Without structural data, individuals or groups of individuals often get blamed for the inequitable outcomes they experience, and the structural drivers get overlooked as the focus for change.

45

Workshop Participant

'So, my experience of visiting a famous London teaching hospital. Approximately 50% of the population served was BAME, but when you looked at the senior staff in that organisation, the more senior you got, the less the BAME representation. And that was true of the consultant body as well.'

47

Workshop participant

'And you know, it was when I was an aspiring surgeon at the time. And my registrar at the time said to me 'you've got no chance'. I asked why, and he said the first option would go to a white local graduate. The second option would go to a white foreign graduate. The third option would go to a brown or black UK graduate and then you will be fourth in line. Give up your dream.'

48

Workshop participant

'Even after passing my registration exams, nobody would give me a job. I was working at a service station, as a petrol pump attendant for a long time when I came in for only 50 pounds a week. Then they got married very quickly, in total within a year of getting married. All happened very quickly. After coming in. Nobody understood all of that.'

46

Interviewee

"I value my life and my lifestyle, which is why I've got into general practice" P7, female, British Indian, GP trainee, age 27"

RECRUITMENT

- 5.19 The participants agreed that a career and stage specific perspective was necessary to understand and tackle DA in undergraduate, postgraduate, primary care, consultant, SAS and locally employed doctors.
- 5.20 The key questions were focused on the application, the assessment / interview process and the feedback stages of recruitment. Lessons from the modified assessments undertaken during the COVID-19 pandemic were also considered.
- 5.21 The traditional systems for recruitment either using a form of shortlisting or assessment (written or interview) were flawed in structurally disadvantaging those with protected characteristics, women with families or caring responsibilities, those with multiple causes of deprivation and immigrant doctors. Therefore these systems were in need of urgent reform and rethink.
- 5.22 There was a need for aligning the knowledge, skills and attributes for each job role with the qualities demonstrated by the individual in an open, multi-faceted, assessment system, that specifically attached more weightage to skills and potential rather than previous educational achievement/ experience (denied to many due to economic deprivation or immigration status).
- 5.23 There was support for affirmative action in specific areas where there is a significant attainment gap- those from Black heritage or economic deprivation in widening participation to medical schools, for minority ethnic candidates in all careers in research or academic tracks; women in surgery or cardiology and disciplines with known gender based differentials;
- 5.24 There was support for adopting a nationally accepted nomenclature, job description, contracts - employment conditions and transparent, robust and enforceable recruitment policies for SAS and LEDs overseen by NHSE/I.

INDIVIDUAL SUPPORT

- 5.25 At an individual level, doctors need support: mentorship and awareness of the skill-set required, the values of the organisation, the complexities of the appointment processes, the expectations, with input from role models, mentors, and given pre- as well as post assessment feedback.
- 5.26 The DA observed for women despite the Athena Swan programme demonstrates factors such as allyship, apprenticeship, sponsorship and mentoring which may be accessible to some individuals, but not others.
- 5.27 Furthermore, ethnicity appears to be a barrier to accessing this form of support, and minority ethnic women appear to be less likely to receive this type of support.

49

Workshop participant

'To medical professionals, success is often paramount, and failure is often an utterly unacceptable outcome. Often interpreted as being unable to cope or that one is not considered good enough.'

50

Workshop Participant

'what we're trying to do is to build increasingly complex processes to mitigate against intrinsically unfair systems'

ASSESSMENTS

- 5.28 There was consensus that the candidates with protected characteristics primarily minority ethnic background and IMGs were most disadvantaged and this condition was well-researched, recognised but no intervention has made any difference.
- 5.29 The participants agreed that the focus for intervention should shift from 'victim support' to reforming the system that consistently produced the DA.
- 5.30 That the financial, psychological, social and career limiting impact of DA on disadvantaged doctors was significant and under-recognised.
- 5.31 While there was agreement that a form of assessment was essential for ensuring that doctors had indeed acquired the necessary knowledge, behaviour and aptitude (KBA) required for their professional roles – the evidence that high stakes summative examinations were able to demonstrate the full spectrum of the skills and attributes of a good doctor were tenuous.
- 5.32 There was support for a shift from high stakes summative assessments to a multiple-low stakes system of frequent assessment with meaningful feedback provided to doctors so that progress could be achieved.
- 5.33 There was recognition that there was variable support and feedback offered to many candidates due primarily to lack of resources and time in job plans and infrequently - lack of adequate training for faculty or supervisors.
- 5.34 In order for formative assessments of learning to be meaningful and effective, there needs to be improved faculty training, implementing the recommended job plan allocations (0.25 PA per supervisee per week) for all doctors and harmonisation of standards of formative assessments.
- 5.35 That robust EDI impact assessment is undertaken of the curriculum, content of assessments, process of assessments and improvement in the immediacy as well as effectiveness of bias training for all.
- 5.36 There was a call for transparency of data on the impact of EDI on assessments to be published and commitment from all organisations to achieve parity within 3-5 years. This accountability should be monitored and assessed by the regulator or the Parliamentary Ombudsman.

51

Interviewee

“And I find that quite a lot of the time, I can't say that people are not understanding. Because everyone is very, very honest. And I think we come from the same professional ethic. But sometimes we don't give due regard to individual differences, or learning styles, of approaches and so on. We too, are reckless in judging, if they don't do something as expected from the majority, therefore assume that they can't be good enough.”

52

Workshop participant

‘There is no formal mechanism or mentorship if you are in a non-training post. One has to be self-driven which takes longer and often finds oneself in uncharted waters. First step is to recognise the gap which exists which often is not the case when you come from abroad may it be language regional cultural barriers to name. If you are lucky to be in the right place at the right time with the right people then things can go alright but there is no standardised approach to absorb doctors from abroad here. Requirements and needs are different for every individual which makes tasks more complicated

53

Interviewee

‘And it's a lot harder to find the representation in Asian females in the medical profession than it is to look at sort of most of the people who are higher up in kind of any medical field are white males still.’ – P12, British Indian, Female, GP Trainee, age 27

CAREER PROGRESSION

- 5.37 Women doctors were found to be particularly disadvantaged in having to shoulder the vast majority of parental or caring responsibilities. Hence ended up working flexibly, passing up opportunities to compete for leadership positions, or taking additional management responsibilities and therefore suffering the consequences of not reaching their academic or professional potential; taking much longer to move between career progression stages, having a significant pay gap and suffering stress, demotivation and demoralisation.
- 5.38 Minority ethnic doctors were found to be facing discrimination at every stage of their careers. The differential outcome continued in later careers with much less chances of success in securing leadership and management positions or in getting recognition for their work via reward or excellence awards.
- 5.39 Doctors with primary medical qualifications from outside the UK were systematically discriminated against in securing positions in training programmes, in their chosen specialities and in more competitive locations and for consultant or GP jobs. At every stage of their careers, they faced bias and were less likely to be awarded leadership, management positions or be given recognition for their efforts via rewards or excellence awards.
- 5.40 SAS and locally employed doctors were the group facing the most systemic neglect and discrimination. They were used by the system to fill gaps in rotas and areas of the health service which were unpopular or difficult to fill. The vast majority did not have access to any formal supervision and training opportunities, there was no career progression pathway, there was no monitoring or cognition of their views, they did not receive due recognition for their clinical ability, had very little autonomy and no reward or excellence awards.

Clinical Excellence Awards

- 5.41 Gender and ethnicity were independent factors resulting in a success gap in Clinical Excellence Awards (CEA).
- 5.42 The gender disparity exists as women tend to make less applications. The reasons for less applications were discussed as lack of opportunities, access to leadership roles and family/ caring commitments. The culture of having to work above and beyond to demonstrate 'excellence' is often at conflict with caring responsibilities, hence the gap was even bigger for higher award levels.
- 5.43 However, when female consultants do apply, their success rate is almost comparable to their male colleagues (-3.5%), and has improved since 2013.
- 5.44 In 2018 minority ethnic consultants made 22% of applications, received only 16% of awards, which was lower than in 2014 and worse at higher levels.
- 5.45 Their chance of success was 26.7% lower than their White peers.
- 5.46 CEA does not collect data on intersectionality (e.g. the success for minority ethnic women is likely to be much lower) and other protected characteristics.

ACCEA2018

26.7% less

CHANCE OF SUCCESS FOR MINORITY ETHNIC CONSULTANTS
COMPARED TO WHITE PEERS

LEADERSHIP ROLES

The consensus view of the workshop was that;

- 5.47 Every organisation must collect, monitor and publish its EDI performance data at every level of the organisation hierarchy based on demographics and protected characteristics (aligned to a national benchmark and framework) and its action plan.
- 5.48 Qualitative and quantitative analysis of pinch points, from hiring to promotion and exits for each cohort of staff within the organisations will provide the data needed to implement action plans.
- 5.49 Every organisation must ensure that the most disadvantaged and marginalised cohort of staff (usually an intersection of women, minority ethnic and those with disability) receive appropriate levels of support and developmental opportunities.
- 5.50 Every healthcare organisation must ensure that all staff (including medical professionals) have access to personal leadership development resources, appropriate and bespoke to their needs.
- 5.51 Every staff member (including medical professionals) must have access to formal mentorship arrangement and career guidance, in addition to a robust supervision and appraisal system
- 5.52 Every staff member (including medical professionals) with leadership and managerial responsibility must be empowered to take on developmental responsibility for a suitable cohort of staff members in an apprenticeship role.

54

Workshop participant

'We are not looking at inequality, equality, or equity - we want to look at 'justice'. We want to look at the system change that we need to bring in. Interventions that will help in developing the future diverse, executive leader, nourishing leadership amongst the underrepresented staff, demonstrate organisational engagement and benchmarking to improve diversity and creating a culture of diverse leadership. Professor Geeta Menon, Theme Lead

55

Workshop participant

'So they're going to be taking a long time to have a genuinely representative senior leadership team, if we don't change something.

RESEARCH & ACADEMIA

- 5.53 The success of a nation or society is closely linked with its natural resources (i.e. people and materials), its cohesion, innovation and resilience against challenges. Research and development is critical to success. It is also clear that diversity of thoughts, culture, and people leads to a wide spectrum of innovation and stronger resilience of any such nation-state.
- 5.54 The UK has a mature and established scientific infrastructure and reputation for innovation and new knowledge generation through its higher education and research institutes. Due to colonial past and faith in the Commonwealth of Nations, the UK has an enviable position of access to a much wider and diverse pool of talent from across the world, than many of its peers amongst developed nations.
- 5.55 In science and technology as well as in medicine, there is a huge pull of high quality, educated and motivated talent from several nations. The medical workforce has around $\frac{1}{5}$ to $\frac{1}{3}$ migrants from across the world, that brings new ideas and support the science and technology infrastructure. Often this advantage has been gained with little grassroots investment and the fruits of such endeavour are denied to many developing nation-states that have contributed.
- 5.56 Yet, there is recognition that due to inherent bias and racism in the larger society (not exclusive to the UK) there is DA in research and academia, where individuals with protected characteristics, those who have migrated to the UK and those who have been naturalised, still face barriers to progression at different stages from selection in training or career pathways through to obtaining funding and getting research published.
- 5.57 Without more research into the lived experiences of individuals from non-traditional backgrounds at the micro-level, as well as data across the research and academic career pathways over time at the macro-level, the problem of DA is unlikely to improve.
- 5.58 The lack of transparency around such data at an organisational level, may exacerbate the sense of injustice within research and academia among individuals with protected characteristics, especially given that the perceived sense of DA is very real for them.
- 5.59 Universality of Access - the participants aspired to a universal access to opportunities based on merit regardless of background and characteristics. Where one is and feels equal and not have to face either privilege or barriers based on who you are, rather than one's potential, talent or motivation.
- 5.60 However there was cognition of people with structural disadvantage who will need affirmative action to level the playing field.

56

Interviewee

'It's about educating people in the benefits of equality and diversity and this isn't just a morally right thing to do, but it also brings huge benefits to the organisation as well.'

NURTURING TALENT

- 5.61 **Mentorship** - participants discussed the need to develop systems that seek the best brains in the country and give them the opportunity of starting early in childhood. Where there are opportunities for mentorship and access to networks for support (for women, minority ethnic and IMGs). And mentors who are educated and supported to be good mentors and sponsors.
- 5.62 **Metrics & Benchmarking** - where the metrics combine not only data but human stories and benchmark the effectiveness of affirmative actions and interventions.
- 5.63 **Diversity** - where representation on committees and roles represents the population that it is designed to serve. Ensuring a diverse representation for clinical research and practice, there was a need to look not just at training but also at clinical services, which are not always diverse. Participants proposed measures to improve awareness that diverse teams make better decisions and are more effective.
- 5.64 **Role Models** -where there are highly visible role models so aspirants across the diverse population can see people around that they can identify with. There was agreement of the influence of inspiring role models that demonstrated diversity, thus having the appropriate representation of people as role models
- 5.65 **Flexibility** - creating flexibility in career paths - rather than getting workforce to fit the system, create a system that works for a diverse workforce. Where the system should be aware and amicable to all the problems IMGs are facing
- 5.66 Medical training is tough, lengthy, and challenging in physical, mental and academic domains. It attracts the very best minds, those with high self-motivation, a combined drive for excellence and passion for caring, and demands resilience. It is not a preserve for those with any human frailty and takes no prisoners. However, there are consequences of this predominant culture of demanding endurance, rigidity of goals and highly stress-inducing environment. The human cost of such sustained high levels of stress, work-life imbalance, lack of flexibility or support for periods of natural variation in health can be devastating.
- 5.67 This is particularly challenging for medical professionals who have migrated to new countries, work in unfamiliar professional settings, face a new or hostile socio-cultural milieu or are separated from traditional support networks of family or friends.

PROFESSIONALISM

- 5.68 For any profession, keen on maintaining public trust, self-governance, autonomy and responsibility, it is imperative that it sets for itself the highest expectation for the acquisition of optimum professional knowledge, skills as well as the demonstration of compassion, empathy, standards of behaviour, honesty and transparency worthy of this responsibility. Such standards are defined and enshrined in treatises such as the 'Good Medical Practice'.
- 5.69 However, there is continuous progression in scientific knowledge, technological innovation, therapies and consequent expectations from members of society. Therefore any such defined professional standards are only valid for the scientific and societal conditions that the profession exists in and are subject to challenge as well as change. The standards of medical professionalism that guide and set expectations for the profession, the legislation which provide the legal and ethical framework have not kept pace with the scale of change in science and societal values.
- 5.70 There is now a wider recognition of social injustice, embedded discrimination and resulting health inequalities. The participants recognised the impact of advancement in genomics, biological therapies and a focus on primary prevention as well as health promotion. The progress in the power of interconnectedness through smart phones, the rise of social media, the potential of large scale data analysis, massive digitalisation of health records, and democratisation of medical knowledge has opened up immense possibilities for collaboration across the world but also concerns regarding confidentiality, misuse of data and exploitation of the vulnerable by multinational corporations which are often more powerful than nation-states.
- 5.71 Medical professionals rarely ever operate on their own and are now responsible for care in teams and abide by the rules set by large organisations both in the public sector (i.e. NHS) or by massive private corporations. Yet the professional standards are still pinned to the individual and the regulators are still only focusing on the individual professional when standards are breached. This needs to change and organisations must be accountable to the same high standards and demonstrate that due support and training has been provided to all professionals to help them maintain the expected standards.
- 5.72 There needs to be an acknowledgement that a narrow, colour or culturally blind, homogenised definition of 'expected standards of behaviour' that are set by a small proportion of powerful individuals in society and one that ignores as well as excludes the lived experiences or diversity of the professional workforce and the public it serves, is no longer viable. The participants highlighted that the societal issues of racism, bias and discrimination were also applicable to doctors, amongst many other professions.
- 5.73 That there was a need to broaden the definition of medical professionalism to reflect the diversity of the public and the professional workforce; to include the shared accountability of organisations as well as the individuals
- 5.74 There is a need to recognise the stresses and the variable access to support in the workplace environment which leads to compromise of personal health and wellbeing; and
- 5.75 The discrimination in the governance processes around dealing complaints, with breaches of professionalism thus leading to disengagement and demoralisation for certain groups of individuals.

57

Workshop participant

"So if you are single, if you are a Muslim girl, who's a single mother with children, who can never go to a pub, or because she wouldn't drink, therefore may miss out on such opportunities."

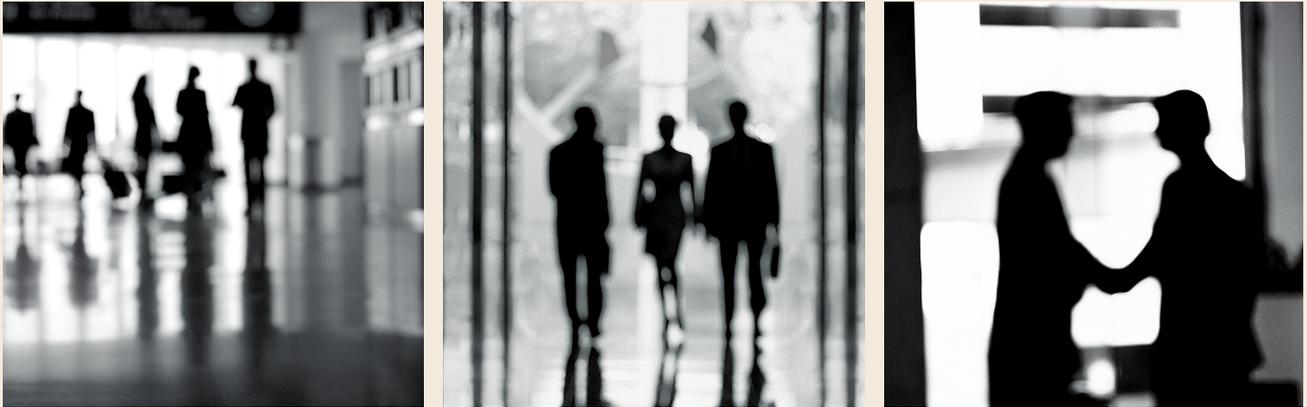
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Workshop participant

"So, I wouldn't put myself up for awards, I wouldn't expect anything of myself. I was just there to scrape by. I'm just here, but looking back it's definitely because I internalized a lot of what was going on. I didn't know what it was, but I wasn't quite accepted there for myself, so I became less confident and felt I was probably not bright enough."

PROFESSIONALISM 2

- 5.76 The workshop participants discussed the unacceptable risk of stress, new mental impact of being subjected to formal investigations by the regulator and the risk of self-harm or suicide. The fact that 70% of people in the with identified mental health or substance abuse problems who committed suicide during an FTP investigation either had no known suicide risk or no risk assessment completed was disconcerting. Specific case histories were discussed and there was consensus for avoiding isolation, offering adequate support to the individuals under investigation and an optimum timeframe for completion of investigations.
- 5.77 Where instances of self-harm or suicide do occur, participants were keen that an independent investigation (by the Coroner) be undertaken and the organisations responsible for acts of omission / commission are held accountable.
- 5.78 There was agreement that differential outcome data for referrals, investigations and where sanctions are given; are published and monitored for impact of protected characteristics as well as for IMG status.
- 5.79 Participants recognised that some organisations based on their WRES data were in the upper quartile for equality and justice. There should be a formal arrangement (by NHSE/I or CQC) to set up partnerships for organisations in the lower quartile so good practice can be shared and lessons learnt.
- 5.80 In matters of formal investigations undertaken by Trusts for doctors, there was a recognition of the impact of discrimination for minority ethnic doctors. There were examples of Trusts who have set up a diverse committee to support the transparency and equality elements of the decision-making process for the Responsible Officer or Medical Directors. The participants agreed that this should be the norm and must be monitored by CQC and NHSEI.



RECOMMENDATIONS - THE 10 POINT PLAN

'My plea to you is to be brave and be radical. And let's help each other, to make a difference, because I really do think we can transform the world to be how you want it to be. So I would like to encourage you to be radical and to be angry. We should not accept this. We should be angry but we need to change but I'd also be trying to be optimistic because I do think change is possible.'

Baroness Dido Harding

10-POINT PLAN

The BTG21 team worked with our collaborators to critically review the data on DA, to understand with grassroots professionals and organisations of the drivers and considered potential solutions from a societal perspective. This work was done while the fabric of the world we live in underwent tumultuous change. The events of 2019-2020 from #Blacklivesmatter movement to the #COVID-19 pandemic exposed the cracks in civilisation, and changed the mindset of a critical mass of people around the world.

It is our conviction that it is no longer acceptable to continue to watch passively, or perhaps by masterly inaction propagate inequalities and injustice for different people. The world needs and demands change.

Although it may be coincidental that the Alliance for Equality in Healthcare Profession was conceived in 2019 and implemented in 2020, the mission is the same- to tackle injustice and restore equality to all in the medical profession.

In the realm of medical professionals, societal injustice is manifest in differential outcomes for cohorts of people based on all the factors described here. Therefore, one of the ideological battles to tackle differential outcomes is to encourage disruptive thinking and engender a real change in the big society.

Here is a summary of the 10-Point Action Plan that captures the fundamental tenets of the Bridging the Gap thematic workshop series. The details leading to the recommendations are presented in the full report which will be published in October 2021 - for reference.



59

Workshop participant

'Sadly, this is data that we all know and many of you would have seen year in, and year out. So, I would like to start by framing the question: how do we move on from describing the problem to together, taking risks and taking radical action to drive real change?

60

Workshop participant

"I think the reality is we are an organization that is unequal and inherently biased in our way in which we work. So I think we have to be completely open and transparent about that, and speak about it openly and say this is a problem in our organization, what are we together going to do to change it.'

61

Workshop participant

"It just felt like there's just this weird class difference, I didn't know what it was, I almost felt like there was a certain way that we're expected to be expected. So just the way that patients or even colleagues would interact with me was very different to how they would interact with the white medical students. And it's, it's so difficult to put into words. It was as if people were not used to seeing people like me (Black) as doctors.'

10-POINT PLAN

1

TACKLING BIAS

In order to tackle bias, it is important that the following actions are taken by all organisations;

- 1.1 Acknowledgement of the existence of systemic inequalities, conscious and unconscious bias which leads to a favourable as well as an unfavourable outcome for groups of individuals;
- 1.2 Declaration of the highest, public commitment and timeline from senior leaders to eliminate bias and achieve justice for all
- 1.3 Training in the elimination of bias should be mandatory, meaningful - aligned to the activity being undertaken and delivered immediately before each activity, where it is likely to be most effective.
 - The current system of a 3-yearly renewal of unconscious bias training is ineffective and seen as a 'tokenism'.
 - Effectiveness of bias training must be reviewed periodically and matched with relevant data from each activity, which is made available transparently
- 1.4 Composition of every assessment/ recruitment/ investigation panel must be balanced to represent the full diversity of the profession/ workplace/ organisation
 - Safeguards must be built into systems for raising concerns and having voices heard and appropriate action taken.

2

EMBRACING EDI

The actions are to;

- 2.1 Measure and publish data on equality and diversity at every stage of the medical career and in every process of recruitment/ reward
- 2.2 Develop a diversity benchmark for EDI for all organisations integrated with Workforce Race Equality Standards for NHS organisations and Race Equality Framework for higher educational institutions and for all research funding bodies as well as academic publishers.
- 2.3 Ensure that every assessment/ recruitment/ investigation panel has a diversity champion with empowerment.
 - Importantly, the burden should not fall on those who are minorities to fulfill this role, but there should be shared ownership.
- 2.4 Establish a diversity and inclusion council for all organisations which is truly representative, empowered to monitor and act as necessary and tasked to achieve EDI objectives
- 2.5 Ensure EDI impact assessment of all examinations/ assessment/ recruitment processes and curricula and these are transparent and published.
- 2.6 Set targets for achieving EDI goals, monitor effectiveness of interventions/initiatives and publish compliance assessments by an independent body.
- 2.7 The organisations must co-design (working with EDI networks and cultural champions) and implement a living charter of culture as well as behavioural norms for patients and professionals, which embeds the values and behaviours embracing equality, diversity and inclusion for all.
 - Ensure that posts related to EDI-work properly recognise the necessary skills-set to be a leader of change.

62

Workshop participant

'Diversity isn't a choice in our NHS, it's just a fact. But inclusion is a choice. And, unfortunately, the statistics shows that we are nowhere near as inclusive as we would want to be'

10-POINT PLAN

3

CELEBRATING THE CONTRIBUTION OF MIGRANTS

In order to tackle DA faced by IMGs, immigrants and their progeny, the following actions are needed for all healthcare organisations;

- 3.1 Recognise the contribution of immigrant professionals with an international health worker week (e.g. April 5-9)
- 3.2 Develop reciprocal arrangements for mutual benefit of the people of countries from where majority of IMGs migrate- recognising the economic contribution of these countries in training healthcare professionals
- 3.3 Implement and adequately resource a comprehensive evidence-based, effective induction and support package for all IMGs (and for other professionals)
- 3.4 Decolonise the medical curriculum- de-bias assessments (i.e. SJTs) or processes so that diversity is recognised and minorities are not structurally disadvantaged.

4

A LEVEL PLAYING FIELD

The medical profession has been the preserve of the privileged for centuries. Those who are disadvantaged educationally are also disadvantaged economically and socially; the equity and justice agenda dictates that all should have the opportunity to succeed. Participation must be widened not simply increased. Widening participation involves increasing access to learning and providing opportunities for success and progression to a much wider cross-section of the population. All those who are not fulfilling their potential or who have underachieved in the past must be drawn into successful learning.

- 4.1 Widening participation in medical careers initiatives should be provided in every higher education institution, in-reaching into schools and communities which are traditionally under-represented.
- 4.2 Affirmative actions should include
 - removing subject prerequisites which perpetuate the DA at entry, but also subsequent applications such as research funding/ career choice;
 - provide access to foundation courses for those without previous attainment in traditional STEM subjects,
 - provide a proportionate balance of access to applicants from state or public schools and IMGs as per published criteria
- 4.3 Breaking geographical disparities in access by targeting areas with multiple deprivation or low participation in higher education or research funding
- 4.4 Balancing economic disadvantage by providing bursaries in school and through higher education, access to apprenticeship medical courses and removing the advantage for intercalated diplomas/ degrees as essential criteria as well as providing resources to pursue early career academic/research opportunities for talented individuals
- 4.5 Removing the structural disadvantage for IMGs in summative assessments by - decolonising curricula, rationalising the requirement for high levels of English proficiency, supporting with preparatory courses in clinical communication, consultation skills and guided understanding of prevailing legal, cultural and ethical norms



63

Workshop participant

“So we know there's an ethnic penalty in higher education. For example, those who are non - White will do relatively well at school, and in fact, (which is rarely reported) but actually that trend is reversed when they come into higher education. So that penalty should be owned fully by higher education, but it's still being explained away in lots of other ways. So I think there's something about really forcing universities to own their data, to share their data, to be transparent with their data and then to recognize which parts of that data they actually are able to do something about, and not allow them to simply explain it away.”



10-POINT PLAN

5

INCLUSIVE LEADERSHIP & ACCOUNTABILITY

Due to the nature of the privilege that determines inequitable access to the profession, doctors are neither representative nor aligned to the population they are trained to serve. The greater the power, economic and privilege gradient, the higher is the likelihood of a discordant relationship. The NHS is often held as one of the most multicultural employers in the world, yet the lack of diversity in its formal leadership structures is a barrier to the service achieving its full potential. The leadership of the NHS, the GMC, the higher educational institutions, the research funding bodies, and majority of the arms-length bodies; neither reflect nor represent the diversity of its patient population or its workforce, and is often criticised for being elitist and formed from the monoculture. Hence we recommend that;

- 5.1 The leadership at all organisations in healthcare (NHS, healthcare delivery, higher educational, regulatory and arms-length institutions) demonstrate equal access to talented and motivated individuals and is representative of the workforce/ population they serve
- 5.2 That leaders of all institutions (CEO, Chair of NHS Trust Boards, arm's length bodies, regulator, Vice Chancellors of HEIs and research funding/ academic publishing houses) are accountable for ensuring a fair and transparent system, commitment to a benchmark for inclusive leadership based on an agreed national framework
- 5.3 That all public and regulatory institutions will be accountable for their compliance of the principles of EDI to the people via the parliamentary or judicial system (i.e. UK Parliamentary Ombudsman) with recourse to appeal and sanctions if standards are breached.
 - We encourage private healthcare organisations to achieve equal standards as the system is intricately interconnected.

6

REMOVE STRUCTURAL BARRIERS

There was consensus that much of the reasons for lack of adequate progress in DA initiatives are due to a failure to recognise the integral nature of structural barriers - the complexities of the absence of diversity, of exclusion; intersectionality, the exclusiveness of the curriculum, bias in assessment/ recruitment processes, and the follies of acculturation/ normalization, compensation and deficit approaches. Any solution must therefore tackle the established systemic barriers. We recommend that NHS Employers, HEE and health boards should;

- 6.1 Work to remove differences between career doctor (with a national training number) and non-career doctor (Trust doctor or locally employed doctor) which is a 2-tier training and employment system and thus unify nomenclature as postgraduate doctor in national or local training scheme.
- 6.2 Agree a national job description, recruitment process and support for all doctors including national employment and supervision for Locally employed doctors (LED) and SAS doctors.
- 6.3 Remove barriers and widen participation at various entry points -
 - certain required traditional criteria and interview questions used to rank an applicant may not have any bearing to being a good doctor or researcher, and may be a reflection of lack of opportunities, access to resources and not ability or talent.
 - Identify people with talent and foster/ nurture them into aspiring roles
- 6.4 Remove the structural disadvantage for IMGs in summative assessments by -
 - decolonising curricula,
 - rationalising the requirement for high levels of English proficiency,
 - supporting with preparatory courses in clinical communication, consultation skills and
 - providing guidance to help understand prevailing legal, cultural and ethical norms

10-POINT PLAN

7

REVIEW-REFORM-RETHINK ASSESSMENTS

In professional education and training, there is more emphasis on formal, summative assessments to demonstrate that certain predetermined standards of knowledge, behaviour and skills have been achieved. In addition, there is good evidence that some of the variability measured by a summative process is dependent on non-academic factors such as gender, ethnicity, linguistics and socio-cultural background.

Formative assessments and multiple, low stakes summative assessments are intuitively more meaningful but are prone to the same issues of bias, lack of training and of a variable standard so unreliable and regarded as a 'pointless, tick-box' exercise. In practice, meaningful feedback requires time, training and resources for both the assessor and the assessed considered onerous in current health services. Disruptive change in the way assessments and exams are conducted is recommended, reflecting on what is assessed and implementation of affirmative actions to overcome inherent disadvantages posed by the system;

We recommend that the Medical Royal Colleges and HEIs including the GMC should

- 7.1 Review, measure and report equality and diversity impact of all assessment processes
- 7.2 Undertake root and branch reform of established content, curricula and assessment processes to take into account EDI with a diverse, representative panel
- 7.2 Rethink processes which consistently fail to achieve equality and diversity
 - Multiple, multi-dimensional, low-stakes summative assessments undertaken in real-life workplaces, supported by adequate training, resources and time to train for assessors
 - Use formative assessment and structured, meaningful feedback
 - Make holistic progression decisions based on 360 degree assessment of knowledge, behaviour and skills collated and triangulated from multiple sources at ARCPs
 - Share responsibility and accountability with supervisors, training program directors and learners to ensure that appropriately defined standards for success/ progression are met



10-POINT PLAN

8

REFORM PROFESSIONALISM, FTP & MHPS PROCESSES

As most care is delivered by multi-professional teams in hierarchical organisations with a requirement to adhere to well-described, policies and standard operating procedures- the renegotiate of the contract with society must share accountability with organisations.

Therefore we recommend that;

- 8.1 A new multidimensional definition of medical professionalism should be developed by consensus, which must recognise and embrace the concept of diversity and inclusion both for the diverse professional and the population served
- 8.2 The new definition of professionalism must incorporate organisational accountability to the same regulatory standards as expected of the individual (to develop a new Good Medical Practice for Healthcare Organisations-monitored by the CQC and the GMC). The definition must reflect the truly multi-professional nature of shared responsibility that healthcare is delivered under.
- 8.3 The Professional Standards Authority must ensure that the regulator(s) complies with the full scope of their responsibilities, ensures wellbeing and a supportive environment, focuses on regulating in the context of the organisational responsibilities, EDI as well as promotes social justice.
- 8.4 All healthcare employing organisations and HEIs must ensure that when complaints and concerns are raised against professionals (or students) that they are dealt with (informally or formally, and investigated as appropriate) in a collaborative, open, unbiased and inclusive way that is focused on reflection, insight, learning and remediation.
- 8.5 In order that trust can be restored, doctors must, wherever possible, be informed early on about any disciplinary matters related to their practice, and this should be done in a sensitive and timely manner by the most appropriate person in the decision tree.
- 8.6 The organisation must ensure that publicly available data and benchmarks from surveys (i.e. WRES, friends and family test, GMC NTS) on culture, environment and support result in smart actions which are co-designed and delivered. The board must be held accountable by the regulator.
- 8.7 The system for providing a safe space for professionals to raise concerns and their protection from persecution must be robust, independent of the organisation and assured by the regulator or the Parliamentary Ombudsman
- 8.8 The organisation and the regulator must demonstrate duty of candour, acknowledge, learn from their errors and reform their systems.
- 8.9 The Parliamentary (health and social care) Ombudsman should be designated to provide oversight for the regulator and offer an opportunity for aggrieved professionals to seek such reassurance, when necessary. Medical professionals must have recourse to appeal the decisions made by the regulator or organisations with the Parliamentary ombudsman.

10-POINT PLAN

9

DATA & BENCHMARKING

Transparency and meaningful longitudinal data on career progression at pinch points is essential to measure the effectiveness of interventions in tackling DA and ensuring progress. We recommend that all organisations (HEIs, HEE, Health Boards, NHS Employers, Medical Royal Colleges and Regulator commit to;

- 9.1 Generating meaningful, disaggregated and longitudinal data including all the protected characteristics as well as language, country of origin, primary medical qualification, multiple deprivation indices and geographical factors
 - There should be a minimum dataset on career progression of all doctors in a postgraduate category, linked with their registration numbers with the regulator.
 - This data should be collected and published on an open national database.
 - There should be categorical data describing the proportion of doctors progressing through the different pre-defined career progression points.
 - This data must be mapped to demographics, PMQs and all protected characteristics including pay.
- 9.2 Develop a framework for collecting, analysing and reporting for the purpose of benchmarking in EDI and DA
- 9.3 Collect and report longitudinal data on careers linked to registration databases, including data on recruitment/progression/clinical excellence awards/ leadership roles/ research funding/ publication and complaints or fitness to practice referrals.
- 9.4 Set up framework for assessing the impact of intersectionality
- 9.5 Agree a roadmap for achieving success against national benchmark

10

SUPPORT & WELL-BEING

Support and well-being of professionals and workforce should remain in the middle of every action in the healthservice as is the patient served. We recommend that all organisations undertake to -

- 10.1 Develop a personalised training passport for all, which documents and ensures equity of access to support systems and
- 10.2 Provide resources to complement formal clinical/ research training with development of generic skills in leadership, communication, team-working, cultural awareness and promote collaborative-inclusive behaviours for all doctors
- 10.3 Provide coaching and career counselling specifically taking into account certain skills/ historically resource - challenged cohorts of doctors prone to DA
- 10.4 Provide universal access to mentoring, sponsorship, allyships and peer support networks to avoid isolationism and exclusion
- 10.5 Provide open forums/ platforms for role models to inspire and share stories of success and challenges.
- 10.6 Support for doctors returning to practice, IMGs and LEDs should include;
 - Comprehensive, tailored and effective induction co-developed with IMGs/ representative organisations
 - Provide personalised training, supervision and observerships
 - Promote cultural acclimatisation and leadership training
 - Provide support for health, families, parental or caring responsibilities including overseas
- 10.7 Encourage flexibility in training pathways and job plans including awareness of specific challenges for IMGs with limited family support
- 10.8 Provide targeted resources for wellbeing and appoint Wellbeing champions in all organisations



next steps

The 10 point plan will be delivered in 3 ways:

- immediate actions implemented by task and finish groups,
- influencing policy and
- research into effective solutions

In order to implement next steps, the BTG team is engaged in developing collaboration with stakeholders, experts and grassroots professionals as well as their organisations. The goals would be FAST (Frequently discussed, Ambitious, Specific and Transparent) to all involved.

1.1 Working with organisations with a track record of developing quality metrics on developing, piloting and implementing an action oriented framework to tackle race inequalities and in particular to address DA in the health service workforce. This will respect the autonomy of and recognise differing contexts of health service providers. It will draw on the AdvanceHE REC (Race Equality Charter) which is underpinned by robust data and used in higher education and which demonstrates independently evaluated positive outcomes in addressing DA.

1.2. Working with AoMRC and its member organisations, GMC and HEE and equivalent organisations in the 4 nations - on implementing reform in summative assessment including

- review of the requirement of the proportion of high-stakes summative,
- incorporating multiple low-stakes summative assessments,
- Actively working to decolonisation of the curriculum and
- ensuring fairness and equity for all cohorts irrespective of protected characteristics and IMG status.

1.3. Working with HEIs and UK Research funding bodies in affirmative action in sponsoring academics from disadvantaged background; and in implementing a minimum proportionate access to funded research/academic career paths, academic progression. A minimum target of 50% women and 30% academics from BAME background in PhD funded roles and each stage of academic careers.

1.4 Working with HEIs and Medical Schools Council members to ensure that medical school entry is reflective and proportionate to the population, by taking affirmative action in favour of students from Black heritage, economically deprived backgrounds and from geographical areas with reduced access to higher education.

1.5 Working with HEE, Health boards in other parts of the 4 nations, and NHS Trusts in providing training and resources to faculty in providing timely feedback, undertaking formative assessments and providing a holistic annual review of competency progression. EDI data in relation to ARCP outcomes should be published for all training categories.



BTG21

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Alliance for Equality in Health Professions

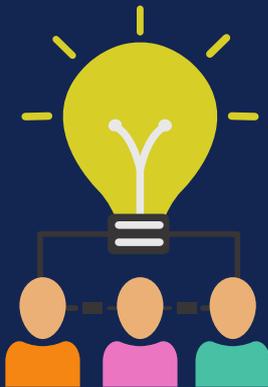




next steps - III

1.6 Working with BMA, NHS Trusts and AoMRC members in implementing a comprehensive, national charter for recruitment, terms of service, training, supervision, access to career progression as well as leadership and academic opportunities for doctors in Specialty, Associate Specialist and Locally employed categories.

1.7 Working with the UK regulator and regulation authority in rightfully interpreting the spirit and the letter of the definition of professionalism and redefining it to incorporate transparency, corporate-organisational accountability, principles of EDI in governance, reform processes of investigation and sanctions/restrictions, providing support to professionals under investigation and be accountable to the Parliamentary Ombudsman.



1.8 Working with NHS Employers and NHS E/I in ensuring that very senior leadership positions in all organisations are reflective of the diversity in the workforce and of the population served. A minimum target of 50% women and 30% from BAME backgrounds should be achieved by all by 2026. The discretionary recognition of contributions (Clinical Excellence Awards and equivalent) should be reflective of the workforce proportions.

1.9 All HEIs, NHS Trusts, CCGs, Regulator and arms-length bodies to have statutory equality committees with direct reporting responsibility to the Trust/Organisational boards for monitoring and ensuring equality of access to populations and workforce. These equality committees would be chaired by a Non-executive director or equivalent entity.

1.10 Working with NHS Trusts, HEE and Health boards, HEIs and Primary care in reforming governance and processes in relation to recruitment, collect and publish EDI data, agree targets for achieving parity and proportional representation in all job roles irrespective of privilege, protected characteristics and IMG status.

1.11 Working with NHS E/I, Race and Health Observatory in benchmarking the regulator, NHS Trusts, NHS arms-length bodies, HEIs and Research funders to demonstrate parity in removing bias due to privilege (based on protected characteristics) and holding CEOs and Chairs accountable.

1.12 Encouraging rigorously designed programmes of collaborative research into DA and associated interventions to take forward the themes emerging in this report. (e.g. U Herts PhD programme in tackling DA)



