Insights from the GMC's 'Fair to Refer' Report

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The recent report commissioned by the GMC -*'Fair to Refer'* highlighted several issues. The report sighted inadequate induction and support from employers could be behind the high number of referrals of black, Asian and minority ethnic doctors to GMC investigations. *'Fair to Refer'* hopes to stop doctors getting caught up in unnecessary probes in the first place and focus on employers, rather than regulators or inspectors. While the report is generally welcomed by many organisations, one might think that this realisation is not new. The real problem may indeed be at Board level where Non-executive members often fail to take their corporate responsibilities seriously and hold the executive to account. In the absence of an effective mechanism for meaningful engagement with clinicians and front-line professionals, the blame culture and the unsupportive mindset may remain unchanged.

The NHS Workforce Race Equality Standard (WRES) published a report in July 2019, 'A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce. It concluded that in the management of people-related issues and conduct of workplace relationships, there needs to be greater consistency in demonstrating an inclusive, compassionate and person-centred approach, underpinned by a concern to safeguard people's health and wellbeing, whatever the circumstances. It has flagged up the need for demonstrable leadership, accountability and support interventions to continuously improve on race equality. It is a credit to the WRES team that they have provided some valuable suggestions that may help deliver the twin priorities of reducing (a) the ethnicity gap in entry into the formal disciplinary processes, and (b) the overall levels of punitive action taken on all staff.

These report acknowledges the prevailing environment where employers are known to be more likely to refer doctors who obtained their primary medical qualification outside the UK and those who are from a black and minority ethnic background to the regulator, than they are to refer UK qualified or white peers. The situation is not much different amongst other healthcare staff and in many non-health related industries. Unfortunately in amongst healthcare workers the consequences are more severe, complaints from employers are more likely to result in formal investigations and sanctions. While the individual caught up in the episode is left in an environment of fear and persecution, often without any support. It is not fair for healthcare staff who are often working in sub-optimal conditions, infrastructural deficiencies or staffing shortages to face consequences of actions which are often dependent

on circumstances rather than individual failing or malpractice. The report highlights the common fate of a BAME staff is that the matter escalates much faster to a formal internal process and thereafter, an inevitable 'referral to GMC'.

The recent highly publicised case of 'Hadiza Bawa-Garba' highlighted many aspects of poor induction, lack of supervision, unsafe staffing and systemic failures yet the nurse and junior doctor were scape-goated by the system. To be fair, this was a turning moment in the history of medical training, one that united all medical and nursing professionals; the subsequent review and recommendations has acted as a catalyst to change the very fabric of organisational responsibility and accountability.

The NHS Trust Boards have been shown in its functions to lack credible processes that provides for corporate and managerial accountability and implementation of good practices in most investigations. The cost to an individual are often too high and the loss in time and service are too precious to squander away.

The NHS faces a recognisable void, in the confidence staff often place in the management. The environment which often sustains a culture of suspicion, blame and fear has made it a poor employer, allowing unnecessary drain on what are limited resources that could be put to for improving patient care. There are some who suggest the NHS Trust Board to be made an elected body with Council of Workers to vote on the nominees. This may require a major shift of political will but also involve the legal framework for amending the public appointment system that is currently prevailing. Meanwhile, some have advocated a different approach by suggesting that the NHS Trust Boards established an 'independent committee' to be a Conflict Resolution forum with specific remit to review Pre-investigation and Pre-referral to GMC recommendations of the Managers against any employee.

The latter option may be potentially viable facilitating mechanism for setting an investigation standard. Further, possibly may open a legitimate route for the workforce to raise issues relating to systemic challenges in nature involving patient care and safety. It can lead improvement in relationships and develop a meaningful consultation processes to help identify 'heat map' of conflicts! Often such bodies can facilitate staff from all walks of life, in feeling valued, sharing ideas and be part of local solutions.

The perception that staff have recourse to someone independent who may be holding senior management to account such as a Freedom to speak up Guardian, would go a long way in re-building trust in the system. It may be a useful exercise in confidence building and reduce the need to 'whistle blow' as a last-ditch act. For the NHS Trusts an independent 'watch dog' could provide an insight in to any potential hot-spots where clinical practices and safety may be compromised.

Fair to refer: Key Findings & Recommendations [1]

- Doctors in diverse groups do not always receive effective, honest or timely feedback because some managers avoid difficult conversations, particularly where that manager is from a different ethnic group to the doctor. This means that concerns may not be addressed early and can therefore develop.
- Some doctors are provided with inadequate induction and/or ongoing support in transitioning to new social, cultural and professional environments.
- Doctors working in isolated or segregated roles or locations lack exposure to learning experiences, senior mentors, support and resources.
- Some leadership teams are remote and inaccessible, not seeking the views of less senior staff and not welcoming challenge and this can allow divisive cultures to develop.
- Some organisational cultures respond to things going wrong by trying to identify who to blame rather than focusing on learning. This creates particular risks for doctors who are 'outsiders'.
- In groups and out groups exist in medicine including relating to qualifications (including by country and within the UK by medical school) and ethnicity (including within BME populations). Members of in groups can receive favourable treatment and those in out groups are at risk of bias and stereotyping.

Recommendations

1. Providing comprehensive support for doctors new to the UK or the NHS or whose role is likely to isolate them (including SAS doctors and locums)
2. Ensuring engaged and positive leadership more consistently across the NHS
3. Creating working environments that focus on learning and accountability rather than blame
4. Developing a programme of work to deliver, measure and evaluate the delivery of these recommendations.

Reference

1. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/fair-to-refer