BTC21

BRIDGING THE GAP

TACKLING DIFFERENTIAL ATTAINMENT IN THE MEDICAL PROFESSION- FULL REPORT

BAPIO
INSTITUTE FOR HEALTH RESEARCH

Tackling Differential Attainment in the Medical Profession

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FULL REPORT

September 2021

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

BAPIO INSTITUTE FOR HEALTH RESEARCH

BAPIO BRITISH ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN 25 YEARS SILVER JUBILEE 1996-2021

BTG21 FULL REPORT

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AdvanceHE

RCGP Royal College of General Practitioners

The Royal College of Ophthalmologists

BIPA

Doctors' Association UK

MANSAG

British International Doctors' Association

MDS Medical Defence Shield

FAIMER Foundation for Advancement of International Medical Education and Research

The University of Newcastle Australia

St George's University of London

King's College London

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Executive Summary

- This is the full fat report: the culmination of over a year of voluntary work by a large team of medical professionals, from students to senior clinicians and our academic experts. This is designed to accompany the BTG21- Short report and provides the background information gathered by our research team and detailed discussions from the Workshops.
- Our purpose was simple: review the full range of literature related to differential attainment in medical professions, using a thematic synthesis approach exploring the why and then work out how to eradicate this ailment.
- For this purpose, we engaged a wide range of professionals, academics, stakeholders and representative organisations. First, we conducted a qualitative review and research of lived experiences. Next, we published our thematic reviews as a series of manuscripts in Sushruta Journal of Health Policy & Opinion. Finally, we chose a set of questions for each of the consensus building workshops and then captured the debate and discussion. This is a result of this whole spectrum of work.
- We established that the 5 fundamental reasons for differential attainment were bias, social class, deprivation, anti-immigrant mentality and geo-political disadvantage. We understood that the root cause of DA lies in the inequalities that exist in society and all its institutions. Each of the above 5 drivers are interconnected and each individual's experience is determined by their intersectionality of drivers.
- We have consolidated the actions, recommendations and areas for further research into a 10-point plan.
    - Data, transparency
    - Benchmarking
    - Accountability
    - Celebrating the contribution of immigrants
    - Equality, diversity and inclusion
    - Redefining professionalism to include diversity of professionals, patients and including organisational responsibility
    - Reforming system of assessment from high stakes summative to multiple, low stakes assessments with feedback
    - Representative leadership
    - Role models
    - Support- mentorship, sponsorship and allyship
- As we know, reports and inquiries are dime -a-dozen and tend to decorate academic shelves in ivory towers whilst making little difference to the lives and experiences of people. We hope the BTG21 will be different and have envisaged a living repository of collaboration between the triumvarate of stakeholders, grassroots professionals and academic experts.
- Our challenge to all is to read, deliberate and consolidate the findings and conclusions in the report in one of 3 ways:
    - Act - design and implement changes which will make a difference
    - Reform - change policies and processes where current systems are failing to deliver equality and justice
    - Research - work together to find the answers where the evidence is scant
- The BTG team will work on each of the 10 point plan areas with our collaborators to design, develop and deliver on the aspiration of tackling inequalities in the full range of the medical profession, through the offices of BIHR.
- We are grateful for the enthusiasm of the team who have delivered this mammoth piece of work, donating every waking hour during the most challenging time for this country and the world. We estimate that the monetary value of this time is £150,000. We are grateful to each and every grassroots professional who has shared their (often traumatic) lived experiences with honesty and openness. We are grateful for all our collaborators and stakeholder institutions' help in this mission.
- We owe it to all in the profession to strive for equality and justice. We do not underestimate the huge challenge ahead to change the status quo: to move hearts and minds.
- The team have set a 5-year target to deliver change: BTG26 will review the progress on each of these areas. This is only the beginning.

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Chapter I
Background & History

btg21 - full report

BTG21 | HISTORY-BACKGROUND

SUMMARY

SUMMARY

Differential attainment (DA) is defined as the attainment gap between cohorts of people based not on their ability or motivation, but on factors such as race, ethnicity, gender or other protected characteristics. DA is a manifestation of inequality and bias in society and exists in every profession, every society and every stage of life.

1.1 HISTORICAL ASPECTS

1.1.1 AN UNEQUAL SOCIETY

In order to understand the causes of differential attainment (DA), one needs to explore the root causes of the inequalities which exist in our society. These inequalities emanate from prevalent beliefs which lead to behaviours that discriminate due to race, ethnicity, gender, or other protected characteristics (as described in the Equality Act, 2010). Another cause of DA is the inherent bias against people who are viewed as 'foreigners' and are seen as a threat by large sections of society. None of these phenomena are unique to the United Kingdom (UK), but are more visible there due to Britain's imperial legacy and the mixing of cultures due to intra-commonwealth migration.

Inferiority of Race

We live in an inequal society. A society which is divided along various fault lines based on race, gender, ethnicity, social class, religion, economic state, education, and geography. While it has always been recognised that health outcomes are different in people based on their demographic, socio-economic or educational status, it is now becoming clear that such social determinants of health have their origin in how people perceive and treat each other in society. Many of the advances in medical science came about from non-consensual experimentation on people. In 1903, Du Bois introduced explanations for racial inequalities in health outcomes not rooted in specious beliefs about the biological inferiority of (Black) people but in the environmental, political, and socioeconomic circumstances that lead to ill health, prefacing latter 20th-century discussions on the social determinants of health.[13] While studying the legacy of racism, scholars urge the debunking of the commonly held belief that racial differences are indicators of significant biological and physiological deficiencies, a belief which many used to explain the differential mortality in the COVID-19 pandemic.

We are encouraged to resist the 're-biologisation of race' and not to let such assumptions of the inferiority of certain racial or ethnic groups go unquestioned. We are encouraged to challenge the social structures that allow the perpetuation of health inequalities based on race or ethnicity. [13]

Inequality of Income

Income differentials are measures of social hierarchy and cause many of society's woes; sociologists and economists argue that if we want to do better for all, we need to become more equal. [14] In 'Capital in the Twenty-First Century', Thomas Piketty presented an alternative theory, suggesting that peaceful capitalist economies have a general tendency to become more unequal over time, as the returns to capital are greater than the general rate of economic growth (and thus the returns to labour).[15] Decreases in such income inequality traditionally occurred only as a consequence of significant events, most importantly the two world wars of the twentieth century.

However, we know that the COVID-19 pandemic was an exception to the rule, as this significant event has actually worsened economic inequalities.[16] There is evidence that three particular inequalities are likely to have worsened because of the crisis: income inequalities between richer and poorer households, socio-economic inequalities in education and skills, and intergenerational inequalities between older and younger people. [17]

Equality as a Fundamental Right

Broadly, the factors that contribute to inequality in society can be divided into those that are related to the individual's own merit, and those that are related to society's oppression of certain groups. In individual people, it can be difficult to tell which of these two factors has contributed to their outcome. The United Nations' 1948 universal declaration of human rights aspired to equality in dignity and rights (article-1) without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (article -2).[5].

The European Union Charter of Fundamental Rights [18] and the UK Equality Act 2010 [19] both enshrined the principles of equality and a life free from lawful discrimination. The Equality Act 2010 makes it illegal to discriminate anyone because of their age, race (which includes colour, nationality, ethnic or national origin), religion or belief, gender reassignment, marital status, being pregnant or on maternity leave, disability, gender identity or sexual orientation.

Yet, data from the National Health Service (NHS) Workforce Race Equality Standards (WRES) and gender pay-gap reports [20] demonstrate a persistent picture of discrimination within NHS organisations, particularly disadvantaging staff on the basis of race, ethnicity, religious belief, gender, disability and other protected characteristics. [21]

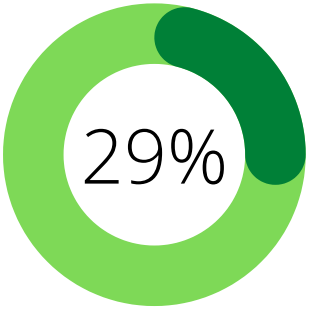
Foreigners

In the UK, as in many countries with a large migrant population, factors that attract the immigration of health professionals include higher education facilities, a lack of employment opportunities in home countries, better working environments and higher earnings compared to low or middle income countries, as well as a growing demand for trained professionals in high-income countries. Discrimination towards 'foreign professionals' is usually due to their ethnicity, race, nationality, accent or religion. In the UK and many EU countries, migrants are twice as likely and a third of their adult children (32%) are more likely to face discrimination in social interactions and in their professional life. [22]

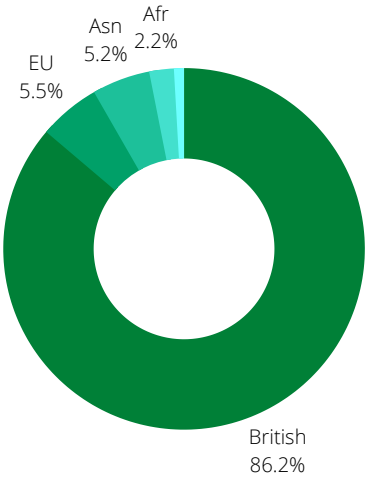
Discrimination is often difficult to observe and measure directly: people do not always realise if they have been discriminated and on which grounds, while those who discriminate against others will often not admit it, whether because discrimination can be illegal or because they discriminate unconsciously.

MOST COMMON NATIONALITIES OF NHS STAFF

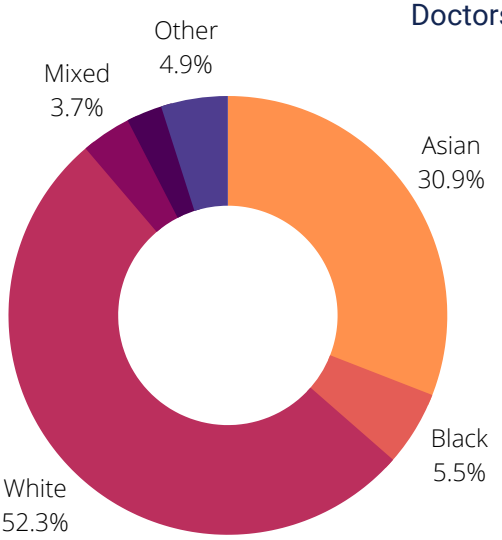
UK/British	1,062,273		Spanish	5,580
Indian	25,809		Romanian	4,731
Filipino	22,043		Pakistani	4,313
Irish	13,697		Zimbabwean	4,192
Polish	9,904		Greek	3,317
Nigerian	8,241		Ghanaian	2,863
Portuguese	7,469		Malaysian	2,491
Italian	6,528		German	2,485



Doctors from overseas

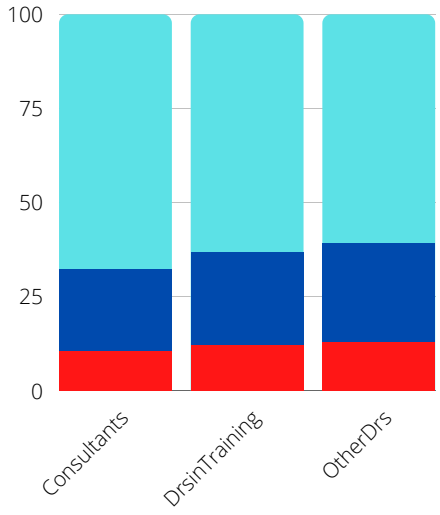


NHS Staff from overseas



Ethnicity of NHS doctors
April 2021

The UK NHS gets around 17% of its 1.3 million-strong workforce from foreign countries across the world. The proportion of medical professionals in this category is much higher: around 29%. Therefore, nationality and immigration status including being a member of a race, ethnicity or having an accent that is viewed as 'foreign' is a significant source of discrimination for healthcare professionals.[URL] [URL] [URL]



Drs experiencing discrimination
White vs BME

"DA is not a new phenomenon, nor will it be resolved in our time. As long as there is inequality between human beings this phenomenon will remain."

BTG TEAM MEMBER

1.1.2 DIFFERENTIAL OUTCOMES

Differential Attainment (DA) or outcomes has been long recognised in education. In the 1940s, the United States census started gathering data each year on the educational attainment of the population, initially measured as the number of years in education, and later the highest degree/ diploma achieved. The analysis of this data compared to other demographic and social determinants helped to paint a picture of the success of education and progress in various strata of society.[25] The story was not simply one of uninterrupted growth in educational attainment over time. Growth fluctuated at times, not all socio-demographic groups' attainments grew equally and some groups saw signs of decelerating or even reversed growth. This data is almost a century old; clearly, the gap between genders, ethnicities and socio-economic groups in education has been long recognised. [26]

In the 1960s, the causes of DA were considered to be more than differences in educational ability or intelligence. DA was considered to be the combined effect of class, educational achievement of parents/ families, poverty, lack of access to high quality learning environments and unsupportive or uninspiring networks. Further exploration of the underlying causes highlighted race and ethnicity as structural barriers which led to a lack of opportunity, exclusion and poverty.

DA is more widely understood in terms of well-known factors such as prior attainment, socioeconomic disadvantage, and systemic biases. Judgements made about potential and achievement are socially constructed, vary in different societies and therefore need to be applied holistically with due attention to cultural norms, difference, and pluralism.[27]

Ethnic differences in academic performance are widespread across different medical schools, different types of examinations, and in both undergraduate and postgraduate careers. They have persisted for years and cannot be dismissed as atypical or local problems. [28] Meta-analysis of the effects from 22 reports (n=23,742) indicated candidates of “non-white” ethnicity underperformed compared with White candidates in undergraduate assessments, postgraduate assessments, machine marked written assessments, practical clinical assessments, assessments with pass/fail outcomes, assessments with continuous outcomes, and specifically for White vs Asian candidates only. [28]

1.1.3 Immigration

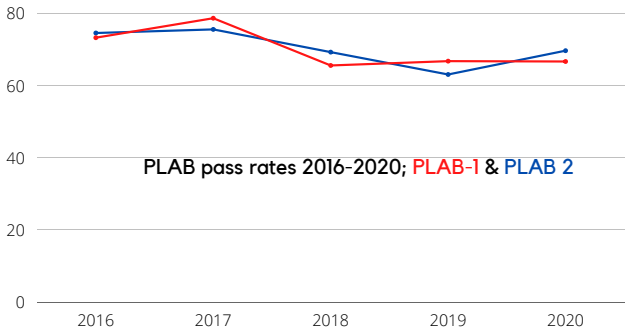
DA in the UK medical profession was originally recognised during the pre and post-war period when there was a significant influx of refugee doctors from Germany and Austria, predominantly comprised of Jewish immigrants. However, measures to control the immigration of overseas doctors were not officially initiated until 1966-1972. [29] In the post-war boom, the UK needed immigrants.

THE ROYAL COMMISSION ON POPULATION

immigrants of “good stock” would be “welcomed without reserve”

1949

Mass migration from Britain’s former colonies was a huge boon to the NHS, which by the 1960s had become the country’s biggest employer. But these thousands of much-needed medical staff faced widespread racism as they tried to build lives and careers in their new home country. [30] This was recognised and led to the provisions of the Race Relations Act in 1968.[31]



PLAB pass rates 2016-2020; PLAB-1 & PLAB 2

> Enoch Powell, health minister from 1960 to 1963 in the Macmillan government, invited Pakistani and East Pakistan (subsequently Bangladesh) doctors and nurses to come to the UK because of a staffing shortage in the NHS. Almost 18,000 are reported to have come. By 1971, 31% of all doctors in the NHS were born overseas.
>
> UK PARLIAMENTARY RECORDS

In 2019, 20% of General Practitioners gained their primary medical qualification (PMQ) outside the UK, 16% in South Asian or African countries and 4% in the EU. [10] The proportion of immigrant doctors that work in the UK NHS has broadly remained the same from 1971-2019.

Also in 2019, it was found that there was differential treatment of overseas doctors, who often found themselves in challenging situations, where they faced both unfair dependency on them and criticism. International medical graduates (IMGs) worked in under-resourced and unpopular parts of healthcare systems, in the UK and elsewhere. Their presence provided an additional dimension to Hart's inverse care law: that *'the resources are fewer where the need is greatest'*. Not only were the resources few and the need great, the practitioners dealing with the consequences were more likely to be IMGs.[32, 33]

British social policy and the elite discourse of 'race' has constructed the belief that migrants and British-born 'non-whites' are a moral threat to the country leading to inevitable discrimination. [34]

> BTG TEAM
>
> There is a danger of treating the low attainer as the 'problem' and thus focussing on improving the individual, when in fact it is the system which is failing the learner.

For IMGs, the issues are more challenging as their medical degree was recognised, but they failed to get jobs because they didn't pass the Professional Linguistics Assessment Board (PLAB) test (see figure). Many doctors have criticised this test, which assesses English language and clinical skills, for being 'inordinately difficult' that evem many British-trained doctors would fail. [35]

1.1.4 INTERSECTIONALITY

DA affects different people in different ways, although there are many common themes. Evidence suggests the existence of different groups; by race, ethnicity, gender, IMGs, and those who belong to under-represented or minority groups. [36] Intertwined within this is the issue of intersectionality, when gender, ethnicity and socio-economic deprivation may compound the attainment gap. [37]

The Critical Race Theory provides an understanding that "race" is socially constructed and that "racial difference" is therefore invented, perpetuated, and reinforced by society. [38] The demonstration of the impact of intersectionality provides proof of the influence of power, oppression, agency, or identity leading to bias and discrimination. [39] It is how people belonging to these 'out-groups' are perceived by the socio-economically privileged groups and how these mis-perceptions are shaped by the multiplicity of categories to which they belong, some marginalized, some privileged.

'Intersectionality is more than the sum of its parts - it is a transformation of unidimensional systems of inequalities; not simply a statistical phenomenon, but merges micro and macro levels of analysis; it reveals the simultaneous experience of oppression and privilege'. [40]

Consideration of the intersection of multiple aspects of identity provides a more nuanced understanding of diversity and how these intersections contribute to unique experiences of oppression and privilege. The combination of identities is not simply additive; they interact to produce a significantly distinct experience. [41]

1.1.5 DA in the UK NHS

It is clear that ethnic diversity is not proportionately represented through the NHS hierarchy.[42] This is because NHS systems and processes continue to drive differences between different ethnic groups.

As early as the 1980's, survey data revealed striking differences in career patterns between British medical graduates of native ethnic origin and those of ethnic minority origin. Graduates from ethnic minorities reported lower success rates and more difficulty in obtaining jobs. They were also more likely to have changed their original choice of career because of difficulty in obtaining suitable training posts or unfavourable career prospects.[43]

Ethnic discrimination was demonstrated in career progression and reward for work, as shown by the variation by ethnicity of consultant winners of Clinical Excellence Awards, a form of performance pay.

Racial abuse by patients or colleagues and unfair treatment by the regulator result in a higher likelihood of ethnic minority doctors receiving high impact punishments at each stage of the fitness to practice process than their native ethnic peers.[20] Examinations and assessments were similarly prone to bias.

WELLBEING & ENGAGEMENT

Experiences of actual or perceived discrimination, barriers to progression and other inequalities have a negative impact on wellbeing with a link with patients' perceptions of care. If staff felt motivated and valued, patients are more likely to be satisfied with the service they receive.

IMPACT OF DA [44]

Workforce Race Equality Standards

Action is needed to reduce DA. Indeed, some action has been taken, such as the ten-point strategic NHS Race Equality Plan developed in 2004. However, almost two decades later, there is little evidence that the plan has progressed with its aims.[44] Other efforts have also been made. In 2014, the NHS Equality and Diversity Council agreed to ensure employees from black and minority ethnic (BME) backgrounds had equal access to career opportunities and received fair treatment in the workplace. [20] In April 2015, after consulting with key stakeholders including other NHS organisations across England, the Workforce Race Equality Standards (WRES) were mandated through the NHS standard contract, starting in 2015/16. Since 2017, independent healthcare providers have been required to publish their WRES data.[45] In 2021, the Medical WRES standards were published, focusing on the specific outcomes for doctors. [46]

This consensus recommended a way forward which included tailored support, comprehensive induction, fair assessment and cultural competency for all.

FAIR TRAINING FOR ALL REPORT 2015 [48]

1.1.6 YEAR 2014-THE WATERSHED YEAR FOR DA

The British Association of Physicians of Indian Origin (BAPIO) sought to challenge by way of judicial review the lawfulness of the continuing adoption and application of the Clinical Skills Assessment (CSA) by the first defendant Royal College of General Practitioners (RCGP) as assessors and the second defendant General Medical Council (GMC) as regulators. The CSA is the test which GPs must pass in order to practice unsupervised. Doctors rarely fail the CSA but of the 133 who did between 2007 and 2012, 120 were IMGs. A smaller proportion of minority ethnic and South Asian doctors passed, compared to those who described themselves as 'White'.

The claimants argued that, in 'doing nothing' to redress this state of affairs, the respondent had failed its Public Sector Equality Duty (PSED). The respondent had begun to consider the ways in which the apparent disparity could be addressed but had not yet acted. Since 2012 no Equality Impact Assessment (EIA) or Equality Assessment (EA) had been completed. Rt Honourable Judge Mitting held that there was no breach of the PSED at the time of the claim. Were the regulators not to address the issue 'very soon' they may be in breach, but at the date of the claim, there had been no breach. The lack of an EA/ EIA was not fatal. Further, the requirement to pass the CSA had not been unlawfully racially discriminatory either directly or indirectly.[47]

Following this case, the British Medical Association (BMA) organised a conference with key stakeholders. In this conference, it was agreed that training is a social phenomenon and the learning environment contributes significantly to DA experienced by IMGs and learners from minority ethnic groups.

These issues were further revisited in 2016-17 but many of the same challenges were still recognised alongside wider hurdles including perception of bias in assessments, lack of opportunities for career progression, limited access to leadership roles and in academic or research careers or funding. [49] In addition, it was found that doctors in training lacked of autonomy about their geographical location of work, combined with isolation from families and a poor work-life balance - leaving them (especially IMGs) isolated and vulnerable to anxiety, depression and other mental health conditions.

Since 2013, the GMC had begun a programme to tackle DA working with a range of stakeholders to raise awareness by publishing data on achievement gaps in training as well as by holding organisations to account.[50] A review commissioned by the GMC found that DA in postgraduate medical education in the UK cannot be attributed to a single identifiable cause, but results from a combination of factors yet to be fully explored. [51]

01

Questionnaire respondent

I kept having criticisms, even though I was being praised by my peers, there were 'feelings' about me that I should not progress - .... Other Asian female doctors in the speciality would share that it was definitely one where people of colour were expected to be quiet and subservient

A bias arising from differences due to the perceived social construct of race, is 'racism'. Racism exists in the UK and many societies across the world.

BTG TEAM

1.2 DRIVERS FOR DA

It has been established that DA exists in the medical profession. However, the causes of DA are uncertain. In order to explore the determinants of DA, one may need to dig deep into the lived experience of those that experience DA, as well as those that may be contributing to inequalities at an individual or systemic level. This report draws on the insights from qualitative literature and richness of the lived experience of many.

1.2.1 Bias

One of the fundamental reasons for differential outcomes for medical professionals is because they are perceived as different. This includes differences in gender, race, ethnicity, religion, sexual orientation, disability, language, socio-economic status. For those who were born or who trained overseas, this is a real difference and has been shown to determine the way society and the prevailing 'system' interacts with them. This is bias. This bias leads to discrimination.

A bias is a tendency, inclination, or prejudice toward or against something or someone which can lead to altered behaviours, attitudes and actions. Whether demonstrated wilfully (explicit) or unintentionally (unconscious), these biases are attitudes that can manifest anywhere: in the home, social interactions, the justice system, the workplace, the learning environment, or in the healthcare system.

In 1993, Esmail & Everington demonstrated that there was racial discrimination in the recruitment of doctors in the UK NHS [52,53]. Several years later, the situation has hardly changed.

Many believe that 'race' is a social construct to justify imperialist or societal superiority and does not have any genetic or organic justification. However, the concept of 'race' and discrimination based on 'racial profiling' remains an important determinant for the demonstrable under-achievement in certain groups of people. [54]

The experience of bias is not the same for different ethnic or racial groups. [55] For example, Asians in the United States experience discrimination both interpersonally and across many institutional settings, including housing, healthcare and face microaggressions.[56] There is an argument for the granularity of the experience of bias in each group of people to be recorded and disaggregation of these experiences because of vital differences between ethnic minority groups in their behaviours and their experience of discrimination. [57] This disaggregation helps in understanding the specific causes of bias and finding meaningful solutions. The 'lumping together' of different ethnic minority groups into one artificial 'us' (White) vs 'them' (minority ethnic) picture is unhelpful and most likely the prime cause for little or no progress. [58]

DA in educational attainment and career progression is estabished. Even in publishing multivariate analysis has shown that compared to White authors, Black authors were 26% less likely to be published, Asian authors were 46% less likely to be published and Hispanic authors were 49% less likely to be published, while female authors were 10% less likely to be published than male authors.[59]

02

Questionniare respondent

[There is a] low level discrimination of BAME colleagues along with the expectation that they are here only for the work and are not interested in assuming other roles or responssibilities.

A study of the career achievements of Welsh surgeons (in an overwhelmingly male sample) showed that while Welsh multilingualism offered a significant career advantage (based on the Wittgenstein advantage [60]), non-EU multilingualism offered a significant negative career impact, showing clearly that the discrimination based on ethnicity/ identity was rife. [61] This study demonstrated that the even the theoretical advantage offered by multilingualism (most IMGs are fluent in 2+ languages) is counteracted by the stronger negative vector, of racism or bias.

Exclusion

There is evidence of ingroups and outgroups, often segregated along lines of ethnicity, race, language, religion or immigration status in higher education institutions as well as the workplace. Such ethnically segregated networks and the lack of opportunities for adult, academic cross-fertilisation and informal transfer of knowledge leads to impaired performance, often isolating minority groups from useful academic information. [62]

Perception of Fitting In

There is also the implicit expectation to hire teams that 'fit in' to an organisational culture, which leads to discrimination on the basis of race, gender or ethnicity. Minority professionals have to either avoid applying to such 'homogenous' or 'minority-hostile' organisations, or adapt their language, behaviour and attire to 'fit in' and progress in their careers, a process known as acculturation. [63]

In a study exploring formal assessment bias, there was evidence of examiners responding to culture-specific language clues but did not always translate to evidence of bias in how assessments were made. [64] Yet, bias in real-life assessments has been shown to be one of the key factors in determining differential outcomes for people based on their protected characteristics.

There is a lack of leaders who are willing to listen to minority voices and their stories and understand where institutional structures and practices could be modified to enable inclusion.[65] There is an aspiration that unconcious bias training may be successful, but there is little evidence to back this up. Sociological research suggests that strategies that embrace multiculturalism are more effective than colour-blindness and acculturation. [66]

1.2.2 Social Class & Deprivation

The relationship between the educational system and social class inequalities is one of the most fundamental issues in the sociology of education. Educational institutions can be both the means of achieving equality in society and the propagators of inequalities. [67] Social mobility generally requires one to be well educated. Yet, if immigrants or people from deprived classes are to succeed in the education system, they have to abandon certain features of their class/ethnic background: acculturation. Therefore, these groups struggle to access social mobility, even through education.

While fundamental differences in medical education, training, cultural norms and English language skills may be relevant, it is also very likely that this is a manifestation of the inherent biases in the system against IMGs.

[73]

The structural relationship between social class and educational attainment is fundamentally different to that of gender, race and ethnicity. Both failure to incorporate a working-class perspective and failure to decolonise the curriculum continue to perpetuate educational inequalities. [68]

Research into the social origins of DA shows that the effects are most strongly associated with parental education and then, to a lesser degree, with parental status, while little association exists with parental class and none at all with parental income. [69] Parental educational attainment is closely linked to historical opportunities which were not available to certain groups of people and therefore led to the stunted socio-economic progress of their descendants within these communities. Hence, the circle of educational socio-economic deprivation continues through generations and people from disadvantaged communities perpetually struggle to break through.

However, in certain cohorts, such as in Chinese or South Asian families, parental educational aspirations for youth are found to be related positively, both directly through parental involvement and indirectly to the youths' perceptions of parental aspirations, thus raising the youths' own educational aspirations. Hence, in these communities, there is a counter-balance that can reduce socio-economic disadvantage. [70]

In order to address societal barriers, public policies need to go beyond equal access and address structural and societal barriers that hinder lower and middle-class minority families and their children.[71]

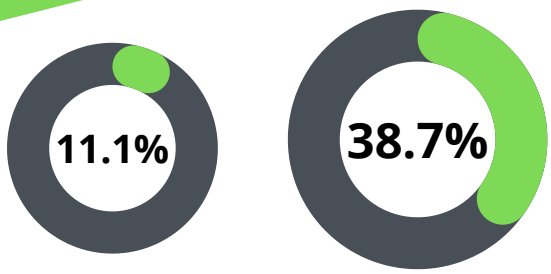
1.2.3 Anti-Immigrant Mentality

Within the UK, the pattern of simultaneous over-reliance on and denigration of IMGs has a long history. Rao & Adebowale argued that anti-immigrant mentality remains an important determinant for discrimination in post-Brexit Britain. [24] Doctors from the EU and overseas are more likely to receive complaints from patients, be reported to the regulator for breaches of professionalism, assessed for fitness to practice assessments and receive harsher sanctions when found in breach compared to their UK trained and/ or White peers. [72]

IMGs have been traditionally compelled to work in areas that are unpopular with British graduates—such as primary care in inner city areas, ex-mining communities, and specialties such as psychiatry and geriatrics. This denigration has been caused by the anecdotal perception that IMGs have suboptimal training, skills and capabilities and therefore are likely to provide poorer care, rather than any robust evidence. The tendency has been to consider IMGs, especially if they have come from non-Western countries, as less able than local graduates and by implication less likely to provide good quality care.[74] More often than not, international graduates work in areas that are low priority, insufficiently resourced, and high need. [75]

1.2.4 Protected Characteristics

According to the World Health Organization (WHO): "'sex' refers to the biological and physiological characteristics that define men and women. 'Gender' refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women." [76]



Women in less than fulltime work at 1y and 6y after qualification

In general, women were more likely to secure a medical school place, obtain a higher degree classification (except in obtaining a first class), perform better in continuous assessments [77] but have no perceptible difference in obtaining postgraduate level jobs, with some notable exceptions. This has been changing over the last decade and women now outnumber men in medical school entry as well as exmination performance, with exceptions for women of colour and other protected characteristics.

However, there are persistent differences in overall gender balance between specialities such as general practice, paediatrics, anaesthetics and obstetrics where there are more women vs surgical specialities, emergency medicine or cardiology where there are disproportionately lower numbers of women. [78] There continues to be significant differences in access to senior leadership positions, as well as obtaining research funding, academic promotions and pay.

It has been postulated that androcentrism (defining the standard person as male), ethnocentrism (defining the standard person as a White American for example in the United States), and heterosexism (defining the standard person as heterosexual) may lead individuals with intersecting identities to be regarded as non-prototypical members of their constituent identity groups and thus cause them to experience intersectional invisibility.[79]

1.2.5 Geopolitical Influence

In countries such as the USA, there are clear historical reasons for the geographical differences in the experience of discrimination for different cohorts of people. [80] On top of history, it is well recognised that climate, natural resources, fertility of land, industrialisation and population densities have a significant influence on socio-economic development, distribution of health, opportunity and bias. [81]

Within countries or groups of nation-states such as in Europe, there are similar disparities in wealth, health and socio-economic disparity between groups of people determined by geographical factors. While it is in the most remote areas that are underserved or in urban inner city areas of deprivation that health problems are more prominent, increasing the demand on health care system. Paradoxically, instead of encouraging movement of staff towards rural areas, excess numbers of health professionals in urban areas often promote external "brain drain", as professionals leave for employment opportunities abroad.[82]

How does this affect DA in medical professions?

Certainly geographical factors affect the pull and push of trained medical professions across borders driven by demand-supply for people, opportunity and economic factors. For example the need for trained staff in post-war Britain led to the induction of doctors and nurses from South Asia and the Caribbean. [83] This trend continued with 1 in 6 doctors in the Organisation for Economic Co-operation and Development (OECD) countries being born or trained overseas. [84]

On the one hand, richer, southern areas tend to have more concentration of doctors than poorer, northern areas, in the UK. On the other hand, at a local level, urban–rural differentials and the influence of the location of medical schools, do not appear to influence movement of doctors.

Use of more reliable disaggregated data produces a more nuanced picture than a number of earlier accounts. [85, 86] However, within countries there is an engineered bias in geographical re-distribution of medical professionals to areas of deprivation, reduced availability of resources, inner cities or industrial hinterlands, and where 'locally trained' professionals are reluctant to go. This phenomenon is seen in the USA, Canada, UK and Australia and perpetuates poorer outcomes for health services. [87]

Such geographical disparities are also key drivers for population movement and immigration.

1.2.6 Individual Factors

Predominantly, DA literature and subsequent interventions have focused on the individual - basing the different outcomes on a deficit model. This is based on the presumption that there is one identity, one expected standard and therefore assessments are made against this monolithic model and interventions are designed to mirror this unidimensional model of the good or an ideal doctor. Unfortunately this model is based on a White male of a certain vintage, an elevated socio-economic status as well as accomplishment, and a cultural privilege drawn if not from inherited social standing, then from a public school education.[88] Therefore everyone who does not fit this unidimensional image is different, eligible for differential outcomes and therefore to be realigned or socially engineered to this majority image.

There is a serious lack of role models demonstrating that it is normal and acceptable for doctors, leaders, academics to have diversity and be different yet equally aspirational, committed, successful and worthy of their assigned roles and positions of responsibility.

There is evidence for ingroups and outgroups based on protected characteristics leading to differential outcomes Some of the interventions therefore focus on developing diversity in support networks. These combined with improved access to mentors, sponsors and allies are proposed as a way to tackle DA.

There is a substantial literature dedicated to the enhanced support of IMGs to help acclimatise to the new country and culture. Efforts to ensure equality focus on social, psychological and cultural factors that are known to disadvantage learning or performance in minority ethnic professionals.[64]

Curriculum design

Not having a diverse curriculum can be a structural disadvantage for professionals (and their patients) thus resulting in DA, apart from teaching and assessment practices in different institutions and subjects. [89]

There are differences in motivation and confidence in speaking in English for different ethnic groups which may go some way to helping understand the gaps in attainment. In addition, male and minority ethnic students tend to overestimate their likelihood of achieving a good outcome, compared to other groups.[90]

The self-determination theory proposes that achieving one's full potential for learning, alongside experience of wellbeing, is supported by environments that help individuals to meet their needs for relatedness, competence, and autonomy. Minority ethnic students encounter many obstacles that inhibited their experience of fulfilment of their needs, which undermines their desire to achieve their full potential.[91]

Cultural Factors

There is evidence from the USA that although East Asians (Chinese) face less prejudice than South Asians, are equally motivated by work and leadership, but were lower in assertiveness, which consistently determined the leadership attainment gap. Their lower assertiveness is incongruent with western societal norms on how leaders are expected to behave and communicate. [92]

Yet, in the quest to understand differences across cultures, little attention has been given to the significant variation that exists within cultural groups. For example, lumping all Asian groups—from East, South, and Central Asia—may not only miss important subcultural differences but may also neglect the distinct barriers that different subgroups face in attaining status and power in societies at large. [93]

1.3 Has there been any reduction in DA?

The real answer is none or negligible.

In summative assessments, the statistics continue to demonstrate DA. According to the RCGP's annual report from 2017/18, the pass rate of the AKT exam for white doctors was 86.8% and 60.7% for all minority ethnic doctors. For the CSA exam, 93.8% of white graduates passed, compared with 83.4% of UK-educated minority ethnic graduates and 39% of internationally-educated minority ethnic graduates. [94]

The UK medical workforce is increasingly ethnically diverse. More than half (54%) of the doctors joining the register in 2020 identified minority ethnic. The number of IMGs joining the UK medical workforce continues to increase.

Between July 2019 and June 2020, over 10,000 IMGs joined – more than UK and European Economic Area graduates combined. Retention continues to be a challenge as 10% of doctors leave clinical practice each year. Those with a non-UK nationality are disproportionately high among those leaving after Foundation year 2 and that doctors who first qualified outside the UK are more likely to leave soon after attaining a CCT. [95]

It is true that there has been increased awareness of DA and a willingness from key stakeholders to collect data, offer a degree of transparency and an honest desire to understand the root causes. However, even the perception that DA is a manifestation of an unequal society and fringe measures that have been enthusiastically designed and trialled in many organisations including the 'unconscious bias training' and equality impact assessment of such measures are largely unsuccessful.

There is growing evidence that the government's "package" of hostile environment policies are causing serious harm to public health in the UK. [96]

Although the UK NHS is dependent on immigrant healthcare professionals - most critically with doctors and nurses, the immigration rules, the NHS surcharge and lack of support for dependent relatives leads to stress, a sense of being undervalued and attrition. The committee, which advises the government on migration issues, recommended that all doctors should be on the list for professions most in need of alleviation of workforce crises, and Royal College of Physicians (RCP) supports the creation of a welcoming environment. [97]

abc

Reduction of Bias

Analysis of the causes of failure of diversity programs from over 800 businesses in the USA, found that organisations were trying to reduce bias with outdated programs based on flawed theories from the 1960s. The blind dependence on traditional tools such as diversity training, hiring tests, performance ratings, grievance systems—tend to make things worse, not better, often decreasing the proportion of women and minorities in management. They're designed to preempt lawsuits by policing managers' decisions and actions but counter-intuitively may activate bias and encourage rebellion.[98]

Working together with the GMC and other stakeholders including the other three UK nations, Royal Colleges and clinical placement providers, HEE have recently committed to understanding the complexity and interdependencies of DA in order to inform solutions for all those pursuing a career in medicine and to provide equal opportunity for all to reach their true potential and have fulfilled careers.

There is consensus that the beneficiaries to this approach are the patients, the medical professionals, the wider healthcare workforce and taxpayers.[99]

BAPIO
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Chapter II
DA IN RECRUITMENT

btg21 - full report

DA IN RECRUITMENT

SUMMARY

- Differential attainment exists in every stage of recruitment from medical school entry to senior grades.
- At the stage of entry to medical schools, DA is most evident in the achievement gap of applicants from Black heritage and multiple deprivation backgrounds.
- There is a noticeable increase in the proportion of women, certain Asian minority applicants and those with declared disability.
- Several schemes of widening participation are showing signs of tackling DA but there is still insufficient overall progression, especially in applicants from deprived backgrounds and those with other protected characteristics. [100, 101, 102]
- In postgraduate appointments, there continues to be an achievement gap for minority ethnic candidates compared to their White peers from foundation to speciality and consultant posts.
- The situation with entry to primary care is similar but much more complex due to the variable routes of entry and inconsistent data availability.
- 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.
- Overall, those who were born or trained outside the UK, at every stage of recruitment 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, remain at great distances from their families or support networks and work in placements with challenging circumstances.
- As part of the Bridging the Gap project, the priority setting partnerships (PSP) discussed the results of the thematic review and agreed that a different perspective was necessary to understand and tackle DA in undergraduate, postgraduate, primary care, consultant, SAS and locally employed doctors.

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- Yuvaraj Venugopal GP, LNC Rep

WORKSHOP Aims

- The key questions were focussed 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.
- The PSP agreed to build consensus on interventions likely to lead to systemic change in each of the cohorts from the workshop.

CONSENUS

The workshop participants agreed that it was crucial for excellence in patient care and meeting the objectives of the NHS people plan that - staff understand and were aligned to the values of the organisations, feel valued. That their identity and diversity was celebrated, that the system was transparent, demonstrably fair and just, that their education, training and pastoral needs were met, that there were role models representing them at all levels of organisations and leaders were visibly accountable for upholding the principles of equality, diversity and inclusion as well as tackling DA.

It was considered important for stakeholders to acknowledge and be aware of the nature of DA, commit to transparency of data and be aware of its impact on the organisation, as well as the individual. The stakeholder organisations needed to appoint responsible officers to monitor and lead on EDI initiatives, embed EDI impact assessment and implement changes in every aspect of the process of recruitment.

Finally, the system should be held accountable for tackling DA and chairs of recruitment committees were to be held responsible for achieving equality. At an individual level, applicants needed support-mentorship and awareness of the skill-set required, the values of the organisation, the complexities of the appointment process, with input from role models, mentors, and given pre- as well as post assessment feedback.

Within specific groups the workshop participants agreed on the following;

Undergraduate entry

- the requirement of certain mandated subjects and minimum grade requirements were a cause of DA and needed to be reconsidered/ removed
- the process of widening participation from underrepresented groups should continue and HEIs were to be held financially accountable for progress as per agreed timelines
- role models with appropriate diversity to represent the catchment population and targeted to underrepresented groups was essential
- application and assessment process needed to be reformed to mitigate against the disadvantage for certain groups
- Situational judgement tests (SJT) needed robust assessment of their equality and diversity impact
- innovative ways of entry to medical school encouraged including the apprenticeship model

Postgraduate entry

- the impact of modified national recruitment based on application and long-listing criteria, but without interviews, needed to be analysed and it's EDI impact assessment published
- role models and encouragement for flexible training, less than full time training and gender balance in certain specialities was essential

Primary care entry

- the SJT needs to be assessed for EDI impact, especially for applicants who have trained or qualified outside the UK
- the application process for those with disabilities needed to be reformed
- the requirement for driving licence to be removed
- role models championing doctors with disabilities to be encouraged

SAS & LEDs

- new nomenclature was required; as SAS (recognising their autonomy and independent practice)
- Doctors in training ((National for HEE appointed trainees) and (Local for Locally employed doctors))
- A nationally consistent job description, guaranteed minimum requirements of supervision, education and training portfolios, study leave resources
- A nationally consistent process of recruitment with supervision from medical royal colleges was essential
- National recruitment data needed to be collated and published by Health Education England (HEE or Health Board) regions.

Consultants

- to implement a staged, multi-dimensional and multiprofessional process of assessment of the full range of knowledge, skills and behaviours as well as alignment with organisational objectives was needed to replace the archaic and ineffective interview process
- Two-stage independent panels to assess short-listing and assessments
- Robust equality, diversity and inclusion (EDI) representation and training of assessment panels combined with accountability for appointing based on equality and diversity expectations was required
- Organisational leaders to be accountable for all appointments were meeting EDI standards

2.1 BACKGROUND

The UK NHS is one of the most diverse workforce in the world with 22% of staff from minority ethnic backgrounds and a similarly large proportion being born or qualified outside the UK. This diversity is most noticeable in proportions of doctors from Asian (30% vs 10%), Black (5% vs 6%), Chinese (2.6% vs 0.6%), and mixed (3.5% vs 1.7%) ethnicities, compared to the ethnicity distribution for the 1.3 million workforce.[103] Among career grade doctors there is a higher proportion of Asian doctors in SAS grades while the proportion of Black consultants is significantly lower (2.9% vs 5.2%) compared to a higher proportion in training grades.

There is a demonstrable geographical or rural-metropolitan skewed distribution with a higher proportion of minorities represented in areas of socio-economic deprivation and inner city areas particularly in the north of the country. The reasons for such distribution are often based on governmental policy, market forces and inherent inequalities or biases that exist in the higher educational or NHS institutions. [104]

The recruitment into UK Medical Schools in 2020 demonstrated 62% female students, with incrrease in the entry from those with minority ethnic backgrounds (29%, including a 58% increase in students of Black heritage), from the lowest participation of local areas (POLAR) quintile (35%), from the lowest index of multiple deprivation (IMD) quintile (46%), from state schools (14%), from those whose parents do not have higher educational qualification (11%) and students with disabilities (33%). [105]

However, both undergraduate and postgraduate entry to NHS organisations have been shown to disproportionately favour White applicants [42] and those from socio-economic privileged backgrounds. [105] In 2018, Esmail et al demonstrated that doctors from ethnic minority backgrounds are less likely than white colleagues to be considered appointable. Across the three years, three quarters (75%) of White, but only 53% of ethnic minority applicants to training posts were deemed appointable.[106]

Doctors from ethnic minority groups have to apply for many more consultant posts than white doctors to secure a job, as reported in 2018 by a survey of applicants' experiences by the RCP London (29% of white respondents were offered a post after being shortlisted for the first time, compared with just 12% of minority applicants). [107,108]

In the case of minority ethnic doctors, those who were born/trained overseas, and those with other protected characteristics (as per the Equality Act 2010), the disparity is multiplied. There is sparse data on the recruitment or progression of those with disability or by sexual orientation. [104]

"We all should know that diversity makes for a rich tapestry, and we must understand that all the threads of the tapestry are equal in value no matter what their colour".

MAYA ANGELOU

2.2 HIGHLIGHTS FROM THEMATIC REVIEW

2.2.1 *Why is it important to tackle inequality as manifest by DA?*

The UK NHS was founded upon the principle that every person is treated fairly, equally and free from discrimination regardless of their gender, race, disability, age etc.[109]. Ultimately, this desire to offer a 'level playing field' is critical for a fair society, supporting professional excellence, sustainable and safe healthcare delivery to patients. [48]

Discrimination or bias that exists in the recruitment of the medical workforce adversely affects morale, motivation, self-worth, and impacts on the performance of teams, resulting in poor organisational outcomes. Ultimately, it hurts the workforce and therefore service users/ patients. It is vital to examine these disparities, explore the contributors and consider how they might be remedied.

The NHS equality objectives document (Equality objective 6) aspires to improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice.[24,110]

2.2.2 Drivers for DA in Recruitment

The evidence is clear that there are complex, interconnected structural barriers pre-university due to biases emanating from race, ethnicity, parental educational attainment, schooling, geographical disadvantage, socio-economic deprivation and choice of pre-requisite subjects acting as barriers to entry into medical schools. For candidates from Black and economic disadvantage there is a demonstrable lack of aspiration, inspiration, role models and also a mismatch between aspiration and academic achievement.

For those who are successful in gaining entry, there is a differential experience of academic life with ingroups and outgroups, differential access to learning resources, supervision and bias in assessments. This leads to a differential outcome in degree performance and hurdles in gaining employment in competitive specialities.

The stakes are higher and steeped against those who have migrated from overseas or have a PMQ from overseas. They continue to be relegated to the lower division and have to be content with less competitive specialties and regions where they face a double whammy of poorer supervision and stress of separation from family and friends.

The curriculum is traditionally written and caters to a colonial mindset, which fails to recognise the diversity of the population, the different presentations and aspirations of people from diverse socio-cultural and religious backgrounds. This is also reflected in assessments such as the Situational judgement tests (SJT) adding a further layer of disadvantage.

There are prevalent gender stereotypes and additional hurdles for doctors in recruitment such as in some surgical specialities, cardiology and in leadership roles. The rigidity of the 'training system' is often a deterrent to all but the most resilient of doctors and certainly pushes away those who wish to have families, or a more cohesive work-life balance.

03

Interviewee

'I've been aware of a very kind of macho environment in our department of surgery where people think they're the bee's knees that they're tough and they can keep operating for 36 hours because they're real men and so on.' -P9, Male, Surgeon, British Mixed Heritage, age 58

The circumstances associated with the recruitment of Specialty doctors, Associate Specialists (SAS) and Locally employed doctors (LED) to the health service were considered by the research team and remained a significant area of focus for the workshop. In 2020, there were approximately less than 100 thousand doctors in the UK, who were identified in this category based on records held by the GMC. Of these approximately 25,000 belong to the category of SAS and the remaining are in the LED group. It is documented that the majority of LED and SAS doctors were IMGs and there was an over-representation from minority ethnic groups.

Economic benefit to UK society

There was recognition that the cost to society of training IMGs was borne by other countries so there was a net benefit to UK society to the tune of £250,000 per IMG inducted to the UK healthcare workforce. The approximate amount of NHS resources spent annually on employing locum doctors to fill gaps in health care workforce rosters was £1.5 billion. If there was a better system of healthcare workforce planning, with managed migration of IMGs to the healthcare workforce, and educational resources invested in their training, there was likely to be benefit both to IMGs, their home countries and the UK NHS.

Experience of SAS & LE Doctors

The expertise and contributions offered by this staff group included 83% who have been practising for more than 15 years. In the first ever survey conducted by the GMC of 6,400 respondents (25%) in 2019, there were widespread reports of experiencing difficulty accessing training to maintain essential clinical skills and resources to advance their careers.

Overall, there was grossly insufficient support related to wellbeing, appraisal, and revalidation.[111] The proportion of SAS & LE doctors who reported being bullied or harassed and being treated unfairly was much higher compared to results from GMC Trainee surveys.

Flexible working

At the same time, the proportion of medical trainees choosing to enter GP specialty training has fallen in the past two years and salaried GPs (who tend to work part-time) increased by a factor of 10 between 2000 and 2010. In 2011, 43 per cent of all doctors in England were female, exceeding 100,000 for the first time with numbers increasing at a faster rate than male doctors.

Women are expected to outnumber men by 2022, accelerating demand for flexible, part-time and salaried posts raising the prospect that more doctors may be required to provide care in future years. [112]

Across all cohorts, 42 % of women and 7 % of men worked LTFT. For female doctors, having children significantly increased the likelihood of working LTFT, with greater effects observed for greater numbers of children and for female doctors in non-primary care specialties (non-GPs). While >40 % of female GPs with children worked LTFT, only 10 % of female surgeons with children did so.

Conversely, the presence of children had no effect on male working patterns. Living with a partner increased the odds of LTFT working in women doctors, but decreased the odds of LTFT working in men (independently of children). Women without children were no more likely to work LTFT than were men (with or without children). For both women and men, the highest rates of LTFT working were observed among GPs (~10 and 6 times greater than non-GPs, respectively), and among those not in training or senior positions.

04

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

2.3 WORKSHOP CONSENSUS

2.3.1 Recruitment to Undergraduate and speciality training

The intended outcome of medical education is doctors who deliver effective and compassionate healthcare to the public. In order to achieve this, medical schools need to select students who can be educated to deliver such care. This selection remains one of the major challenges for medical schools.

Over the years this belief that fundamental understanding of the intricacies of the 'science' remained the mainstay of all assessment methods for medical school entry. Yet there is little evidence to support this belief beyond performance in medical school or postgraduate summative assessments.

There is little if any correlation between scientific knowledge and academic prowess with success as a doctor. Professional quality—the "art" of medicine—is based on factors other than knowledge of chemistry. Performance in the premedical sciences may be inversely associated with many of the personal, non-cognitive qualities so central to the art of medicine.[113]

Medicine remains a popular career choice and the number of applicants for medical school places greatly exceeds the number of places available. In theory, this enables medical schools to select those students most suited to a career in medicine.

DA IN RECRUITMENT

> "No man is fit to study medicine, unless he is acquainted, and pretty thoroughly acquainted, with the fundamental facts in physical, chemical, and biological subjects…The facts of the biological, physical, and chemical sciences are the pabulum on which medicine feeds. Without these sciences, everything that goes under the name of medicine is fraud, sham, and superstition."

Victor Vaughan, 1914 [108]

Conceptually, one should be able to define the attributes and competencies necessary for the successful practice of medicine and test the applicants for possession of such attributes and aptitude. A similar approach has been used for many years by a wide variety of employers. In practice, medicine is so diverse that it is difficult to define a core set of competencies in a form that is amenable to testing. Instead, prior educational attainment has commonly been used as the main criterion for selection. [114]

However, this only explains a proportion of the variance in future performance.[115] When performance in aptitude testing is used as a screening tool for those that are chosen to be interviewed, there is a small additional predictability. [116, 117]

What has plagued most of such measures for choosing the right candidates is the non-transferability and fallibility of the surrogate outcome of *'performance in future summative examinations'*, rather than how one performs as a doctor. While ability to acquire, retain and implement knowledge can be reasonably measured by summative assessments, this is only a small proportion of the behaviours and aptitude required to be a successful doctor. Multiply this by the huge variation in skills and attributes needed in different clinical settings or roles then the system is faced with a mammoth challenge.

There is an important threshold of scientific knowledge that forms the foundation on which a medical education is built. However, once one has exceeded this cognitive threshold, additional scientific knowledge adds little to subsequent performance as a physician.[113]

Multiple Mini Interview

In response to data that balancing cognitive and non-cognitive strengths of applicants does not compromise eventual quality or competence of future doctors, some medical schools in the UK and USA have adopted, or are evaluating, alternative admission criteria, using the Multiple Mini Interview (MMI) conceived by McMaster Medical School in Canada - and used to assess psychological and personality aspects of potential students. However, it is clear that the evidence for MMIs, aptitude testing, SJTs and selection centres is "better" overall than that for traditional interviews, references and autobiographical reports.[118]

The final hitherto unknown factor in medical school selection is the impact of ethnicity, bias and deprivation which systemically disadvantage certain cohorts of the applicants and hence adversely affect their chances of success. Any society and system that wishes to address such systemic disparities while performing a wise and meaningful selection process, has to build in multiple layers to compensate for each of these challenges. Therefore workshop participants considered the 'touch points' where differential attainment happens in medical school recruitment in the UK, their causes and potential solutions to address these.

Subject prerequisites

There was a narrow spectrum of subject interests amongst medical school aspirants based on the traditional requirement of science subjects over the years. This frequently led to an unbalanced postgraduate experience, absence of a broad liberal arts education which transferred to a deficit of humanistic values - to the detriment of a profession dedicated to caring and healing. That such narrow 'science' based pre-medical requirements were of limited value in the practice of modern medicine. [119]

The participants were aware that the UK Universities and Colleges Admissions Service (UCAS) has liberalised courses so prerequisites are less rigid, however applicants still come with the same set of qualifications e.g. chemistry. Another unintended consequence of such 'science based' admissions prerequisites were recognised to be posing a systemic handicap for students from schools with weaker science departments and those from non-professional parental or lower socio-economic households.

Predicted Grades

The participants favoured a post-achieved grades system which offered a wider opportunity to candidates who were less confident of their performance, had personal challenges, hailed from less ambitious or inadequately supportive school or parental environments, as was based on their performance in externally validated assessments. It is known that only 16% of applicants achieve the A-level grade points that they were predicted to achieve by their teachers, based on their best 3 A-levels.

And the vast majority of applicants are over-predicted – i.e. their grades are predicted to be higher than they actually go on to achieve. But among the highest achieving students, those from disadvantaged backgrounds receive predicted grades that are lower than those from more advantaged backgrounds. [120] Black students are more likely to get lower predicted grades compared to their actual grades. Thus this system is known to disadvantage pupils from schools which are in areas of multiple deprivations, those with disadvantaged parental educational or financial achievement and those from ethnic minority populations.

Pandemic year admissions

There was a recognition that during the COVID-19 pandemic, medical students were admitted based on their school predicted grades. Hence, the entry cohort of 2020, would provide a test case for comparing the validity of entry using assessment by teachers who are expected to know their pupils much more thoroughly then the assessment methods that are practiced by the majority of medical schools. Bespoke algorithms used by grade awarding bodies to balance the over-prediction of grades by school teachers and offer a national consistency were heavily criticised for being fundamentally flawed, and had to be scrapped in 2020. [121]

For those who are first in their family to graduate college or apply to medical school and/or who hail from socioeconomically disadvantaged backgrounds, often referred to as first-generation and/or low-income students, this unsettling disruption to the admissions cycle may amplify already intimidating barriers to educational mobility. Aside from the obvious financial obstacles, these students' on-paper achievements are potentially limited by opportunity costs, time constraints, and poor social capital. [122]

Situational Judgement Tests

Situational judgement tests (SJTs) represent an innovative approach to the formal measurement of interpersonal skills in large groups of candidates in medical school admission processes and are becoming increasingly popular in recruitment in primary care and foundation placements as well. Interpersonal skills assessments carried out using SJTs have been shown to add value over cognitive tests for predicting interpersonal performance in curriculum, examination and on the job performance in a case-based interview. [123]

However there are systemic weaknesses. Females significantly outperform males on the SJT tests, and minority ethnic candidates or those from diverse socio-cultural backgrounds have a significant disadvantage, primarily due to the unidimensional social and cultural construct of these tests. The workshop participants agreed that, if SJTs are to be used, they will need to be assessed for their construct validity in a multicultural context. In spite of the challenges, studies indicate that a greater reliance on SJTs may improve diversity in medical school entry compared to academic scores or prior achievement. [124]

Interviews

Interviews are a fundamental assessment method employed by large proportions of medical schools in the UK and in a vast majority of recruitment processes. While there are some advantages, there are major systemic flaws. Advantages are in assessing aptitude, resilience and personality types amongst other soft skills such as communication, thinking style among others. [125] Most interviews are known to be unstructured, non-standardised between interviewers and offer poor reproducibility [126].

However, there was consensus that traditional interviews were a crude, archaic and largely ineffective modality of assessing aptitude or academic ability for predicting performance and success in medical school or in subsequent health careers. Although the ability to communicate clearly and effectively is essential for most of the patients facing facets of the doctors work, but not exclusively. Traditional Interviews offered undue advantage to candidates with certain extroverted personality types, those with ability to express themselves well and appear 'agreeable in appearance' in securing higher scores and a greater chance to enter medical school. [127]

Multiple Mini Interview

The Multiple Mini Interview (MMI) model of assessment has many advantages in offering a structured approach, balancing individual attributes of interviewers and interviewees by using a higher number of interactions, aligning the subject areas to the diverse needs of the profession and the curriculum and assessing aptitude, communication and behavioural attributes. It is demonstrably fairer, and can be transparent, free from gender, cultural and socio-economic bias, and not favour applicants with previous coaching. [128] There is less variance between interviewers and medical schools [129,130].

Traditional interviews and MMIs had inherent weaknesses based on the diversity of panels, the socio-cultural construct of the interview stations, content and for applicants from disadvantaged backgrounds.[131] There is evidence that after achieving a 'realistic threshold' for academic scores or performance, sole reliance on the MMI is likely to lead to a more representative and diverse cohort for medical entrants. [132]

Personal attributes

The participants agreed that the health service required doctors with a range of skills and attributes. It was not sensible to have a 'one size fits all' approach. The skills and thinking styles required for those that may pursue a future career in research and academia would be distinctly different to those who may follow a career in primary care or public health. Therefore the range of medical schools should be focussed on recruiting and training a wide range of students, not only from a diverse population, but also diversity in the range of skills, strengths and attributes.

Therefore the methods of recruitment should encompass the full range of skills required for the future healthcare medical workforce. The current centralised system of assessment (UCAT/ BMAT)[133, 134] and range of interviews needed to be assessed for the effectiveness of their ability in detecting and valuing the skills required.

Core personal competencies considered valuable for doctors include; ethical responsibility to self and others; reliability and dependability; service orientation; social skills; capacity for improvement; resilience and adaptability; cultural competence; oral communication; and teamwork. [135, 136] At present none of these are explicitly assessed in MMIs or admission processes. Compared to admissions based on prior academic achievement, those that include assessment of non-cognitive or personality attributes tend to be more representative of the expectation of future medical professionals, [137] and thus a constructively aligned selection procedure that includes these personal attributes is likely to be better in selection of future doctors. [138]

Diversity

Distribution of demographic characteristics of medical school entrants demonstrates certain trends where this is skewed compared to the applicants as well as when compared to the catchment population they represent. There was a particular preponderance of women, those from Asian heritage and low numbers of applicants from Black heritage, lower socio-economic status.

Bias

Implicit bias exists among faculty members and interview panellists which have an adverse outcome for those that belong to traditionally underrepresented groups, which can be altered when panellists are made aware of their bias. [139] Although there are many procedures designed to exclude unconscious bias, such as 'diversity training' there are no robust and effective methods currently in practice for admissions to medical school.[140]

Models of implementation and delivery of diversity training are varied, but the fundamental principles are based on established social psychological theory that guides the coherent development of diversity initiatives. [141]

Many training programs to tackle bias focus on individual attitudes and fail to increase awareness or appreciate differences, and do not offer effective behavioural solutions. [142] When training comprehensively addresses organisational systems, and sets employer performance goals, their effectiveness can be enhanced. [143] There was consensus that generic EDI training was not appropriate, specific aspects relevant to the task at hand (context) were more effective and were further enhanced when the training is delivered (temporally) close to the task being undertaken. Even if those deemed biased are motivated to change behaviour, structural constraints can militate against pro-diversity actions. [144]

Therefore the participants considered evidence-based strategies such as 'blinding the panel to appearance', finding areas of shared narrative or familiarity between panellists and candidates and offering an insight to candidates' personal journeys, as ways to mitigate unconscious bias. [145]

Work experience & Self-selection

The participants agreed that asking healthcare organisations (i.e. Teaching hospitals) to facilitate work experience, would provide an insight and an understanding of what happens in a career in medicine. During the COVID19 pandemic in 2020-21, some medical schools undertook virtual visits and video interviews, which were effective but appeared to be unpopular among applicants, who missed the physical orientation to the campus and workspaces as well as the people's interactions. [146]

There are suggestions that, rather than using non-cognitive admission criteria, admission officers should assist prospective applicants to make informed decisions based on a reflective self-appraisal whether or not to apply to medical school or clinical posts. To this end, medical schools and appointment bodies should disseminate easily accessible information on the strains of medical training and practice, the frequency of medical errors and the most common causes of dissatisfaction and burn-out among practicing physicians.[147]

Widening participation

Data reporting is generally poor although there is some evidence of effectiveness of pre-entry activities. Data is lacking in terms of support for successful applicants and the career pathways of students from widening participation from lower socio-economic backgrounds.[118]

Medical apprenticeship model

The workshop participants were in support of the value of the newly proposed medical apprenticeship model of undergraduate education which is likely to improve diversity and provide access to a much wider cohort of candidates. This should also be extended to IMGs.

2.3.2 SPECIALTY TRAINING

MMC & MTAS

Recruitment to specialist training in the UK changed with the controversial introduction of medical training application service (MTAS) and modernising medical careers (MMC) initiative. [148] The selection system was unpiloted, flawed, and the principles of revising training for doctors became lost in the inflexibility of the system, which was imposed with the tightest of time scales and shifting aims.[149, 150]

The impact on IMGs who make up around ⅓ of the NHS medical professionals was also unprecedented, leading to many aspirants being out of employment, with little or no prospect of following their chosen specialities and relegated to the back waters. [151]

Many doctors were concerned with the lack of availability of family-friendly/part-time work, and concerned about attitudes to gender and work-life balance. [152] A large proportion (36%) of candidates who had been on a Senior House Officer training schemes were left without a training post and reported psychological trauma with the proces. There was recognition that the system favoured UK/EEA applicants. [153]

05 **Questionnaire respondent**

Whilst applying for jobs, it was very evident that there was preferential treatment towards local graduates

DA IN RECRUITMENT

Postgraduate recruitment
The process of recruiting medical graduates into specialty training in the UK starts after a 2 year foundation and 2-3 year core level training with minimum examination requirements (i.e. MRCP/ MRCS) which assess that candidates achieve a predetermined threshold proficiency in clinical knowledge as well as clinical skills including communication and patient ethics. There are run-through specialties where there is no requirement to complete a staging examination prior to entry but this is still required to progress from core to higher specialist training. There are exit examinations in primary care and in many specialities.

Define skills and attributes needed
The participants agreed that fundamental aspect of recruitment was to clearly define standards for the job, the values and attitudes as well as desirable attributes (including alignment to values of the organisation). This should be clearly communicated to potential candidates and adhered to in every step of the recruitment process.

Structural bias in longlisting
Application process uses an online portal (ORIEL) where candidates are scored according to predetermined criteria including demonstration of prior experience, competencies, research or publications, commitment to specialty and personal attributes such as leadership and team working There are structural disadvantages for candidates from deprived backgrounds, those with limited access to research/ publications and additional qualifications. IMGs are predominantly unable to secure high enough scores and have stringent visa related restrictions on access to training- often relegated to round 2 applications which are reserved for hard to fill, unpopular or remote placements.

Following longlisting interviews are conducted natiionally where a small cohort of consultants select candidates. The interviews are structured and graded to achieve uniformity in assessment, but often resemble an exam-like setting using a standard multiple mini interview set composed of three 10-min stations, testing clinical knowledge, clinical governance, acquaintances with ethics and similar dilemmas.

Higher scores at shortlisitng and obtained at interview predict successful career progression (satisfactory ARCP outcomes), after controlling for the influence of postgraduate exam failure. [154] However, there is significant bias demonstrable in the likelihood of success for candidates from minority ethnic background even in MMI interview process of recruitment. [106, 155] Additionally, the short duration of the MMI and limited number of stations decrease their reliability. [156, 157]

Giving feedback to the unsuccessful candidates - The participants felt that providing detailed and meaningful feedback to unsuccessful candidates was a fundamental step in a fair process and offered constructive suggestions for improvement

Quality assurance
There was room for improvement by making the recruitment process a multi-stage, multi-dimensional assessment of skills, aptitude and value driven behaviours. One of the suggestions for quality assurance of the interview process was to record the interviews and have a proportion assessed by an independent panel to check for consistency and bias. Some agencies applied quality assurance with external observers and lay representatives but these were often insufficient.
Excessive weightage is given to interview performance at specialty recruitment which is influenced by age, sex, previous experience and economic disparity of the country of PMQ especially for IMGs. [158] Recruitment processes are vulnerable to bias and in a system where success in recruitment determines where in the country one can get a job, UK minority ethnic, disadvantaged candidates and IMGs are more likely to face separation from family and support outside of work, and report more stress, anxiety or burnout that hinders further their learning and performance.[36]

06

Workshop participant

Interviews are an oddity, far from reality, a staged event with unfair advantage to some and disadvantage to some based on personality and communication styles.

Bias
Participants agreed that it was vitally important to ensure that everyone involved with the process of long listing, shortlisting for interview/ assessment had complied with a bespoke, action orientated diversity and unconscious bias training almost immediately before participating in the recruitment process. It was also important that the recruitment team reflected the diversity of the workforce and the values of equality and inclusion. That the diversity of the leadership was clearly demonstrated robustly at every level.

Role of allyship, mentors and sponsors
There are significant advantages offered by teams which offer allies in the system, mentors who are tasked to support and look beyond the inherent disadvantages of gender, race, ethnicity and sponsors who will open doors.

Leadership and organisational culture
The participants agreed that diversity and compassionate leadership was a key ingredient and had a fundamental role in minimising negative practices, mitigating against biased processes and in tackling perceptions of inequality with robust interventions.

Affirmative actions
There was agreement that the inherent disparities and challenges facing candidates based on gender, age, ethnicity, sexual orientation, disability, multiple deprivation and IMGs needed to be balanced with appropriate interventions prior to the process of recruitment - to level the playing field.

07

Questionnaire respondent

Hierarchy within NHS medical staff meaning anyone who is not a Consultant gets limited respect and opportunities. This is particularly the case by Consultants who continue to call SAS 'middle grade' or 'dead-end jobs' rather than allow personal and professional development within role.

2.3.3 SAS & LEDs

Nearly a quarter of all job advertisements in any period were for non-training, non-consultant grade doctors. These tend to include specialty doctors, associate specialists in some areas but the majority are junior clinical fellows or Trust grade doctors. and are advertised to fill gaps in rota and for 'service provision'. Some of these roles often fall outside the scrutiny of the European Working Time Directive which restricts the number of hours of work and provides safeguards, and offer little to no option for enhancement of education and training. [159]
These are filled by doctors from outside the UK and EEA, with little apparent organisational responsibility for their duty hours, career progression, external quality monitoring or training value. [160] Till recently the requirements for specialty examinations were only deemed to be met in positions recognised for specialty training, therefore inadvertently excluding LEDs. [161]

Nomenclature
The participants were keen to recognise that SAS and LE doctors were one of the most diverse groups of doctors employed in the NHS. However, SAS in the early days were very different groups with very different needs. Many locally employed doctors have trainee-like characteristics, whereas many experienced SAS doctors are more consultants like and work autonomously and independently. Whilst there was agreement that there were too many terms used for SAS and in particular, Locally employed doctors (LED), they should need to be standardised to reflect scope of work, experience and level of responsibility, autonomy or independent practice, primarily for the benefit of patients.

Nationally standardised job descriptions
There was agreement that there should be national terms, and suggested that all doctors in the UK NHS system should have a set of 'universal terms and conditions of employment', regardless of which silo said doctor sits in.

Minimum terms
These terms should include as a minimum expectation for support and induction, access to a supervisor or relevant tutor training and lifelong learning time and resources for appraisal and portfolio, a budget that can be accessed less than full time work policy, and that there should be a differential attainment lead involved in the process both nationally and locally.

08

Questionnaire respondent

[We need] a more equal way of applying for training posts, the overall structure of non-training jobs should be revised, and focus should be on learning rather than just service provision

Uniform recruitment processes
There should be national terms and standards, but it was considered acceptable to continue with a local appointment committee, provided that there was diversity and a differential attainment lead so that the process is monitored and data published transparently for external scrutiny.

Clinical Development Fellowships
There were good examples of Trusts which have developed bespoke training programmes incorporating a range of clinical, communication and leadership components for doctors in locally employed positions.[162] Others have offered access to training that is on offer to 'doctors in formal training roles'.

Often IMGs come from medical education systems which are science/ knowledge based and lack psychosocial aspects, working in multi-professional teams and nuances of local dialect and linguistic challenges, as well as understanding patient-centred communications, which need to be addressed in such fellowships. [163, 164] The success of such support training schemes depend heavily on the awareness of faculty or supervisors on the specific challenges faced by IMGs and doctors in non-formal training roles. [165, 166]

Adoption by Colleges, HEE and GMC
There was consensus on the current infrastructure of educational and training support by HEE, review and monitoring of job descriptions and recruitment processes by Medical Royal Colleges and quality assurance by the GMC.

2.3.4 Primary Care

International GP recruitment
In the quest for expansion of numbers of doctors in primary care and creating a multi-professional workforce, there are schemes for recruitment of international GPs to help alleviate the current shortage. European Economic Area (EEA) doctors can join the UK's GP register under European law but non-EEA doctors must obtain a Certificate of Eligibility for General Practice Registration (CEGPR), demonstrating equivalence to UK-trained doctors. [167]

Yet recruitment and retention of GPs remains complicated. [168] Selection into GP speciality training is based on results of a multi-method job analysis of six competency domains assessed through a national selection process, including empathy, communication, integrity, clinical expertise, problem-solving, and resilience. Each applicant is assessed using clinical problem-solving and situational judgement machine marked tests, followed by high fidelity exercises at regional selection centres. These show good internal reliability and predictive validity, with high correlations with subsequent job performance and outcomes in the MRCGP examinations. When comparing selection methods, candidates perceive high fidelity assessments (for example, a consultation exercise with a simulated patient) as the most relevant and fair. But there is significant DA in GP recruitment as well as the MRCGP examination

09

Questionnaire respondent

I had to take GP- CSA - consultation skills exam 3 times to pass. Each time it cost me £2000. I got 84% in medical knowledge theory test first time.

Weaknesses in SJTs

- Cultural - Participants agreed that SJT can inflict bias as in the case of how questions are framed and thus disadvantage those who have different socio-cultural backgrounds or are IMGs.
- Process - The requirement of SJT questions responses to be arranged in order instead of best pick creates additional difficulties for IMGs, who may be unfamiliar with such systems.
- Ageism - It was recognised that doctors who are younger do better than experienced /older GPs.This might be due to the fact that younger doctors might have done this assessment while gaining entry into foundation school

Typically in GP recruitment, 10–20% of applicants are rejected at short-listing, with a further 20–30% at the final-stage selection centre. Initial evidence of the predictive validity of the selection system has been demonstrated 3 months into training. [169]

Data

Participants discussed the lack of published recruitment data on ethnicity and protected characteristics in entry to primary care training programmes and for GP recruitment following completion of training. The variable entry routes to GP training and for entry to the GP register provide an additional challenge.

GP Training

The training of GPs currently involves a three-year programme in which trainees undertake a combination of hospital- and general practice-based posts. Before the end of training they sit the membership examination of the Royal College of General Practitioners (MRCGP), which has two parts, the Applied Knowledge Test (AKT) and the Clinical Skills Assessment (CSA). If these are passed, and in-training Work-place Based Assessments (WPBAs) have been satisfactory, the doctor can apply for entry onto the General Medical Council's (GMC) GP Register (i.e. obtain GP Registration), which allows independent practice as a GP.

10

Workshop particpant

The requirement to complete the MRCGP examination parts continued to be a major factor fuelling DA for entry to the GP register.

DA in GP Selection

Concerns remain about differential performance between UK and IMGs.[170] Exploration of the ways to improve recruitment by changing the selection process alone suggested only a small impact on the number of GP registrations; while reducing/removing cut-off scores would have a much larger impact. However, experts estimate that this would also increase the number of trainees requiring extensions and being released from training which would have adverse consequences for the profession.[171]

Challenges for IMGs

There are known challenges for IMGs in completing GP training and qualifying as GPs which requires not only satisfactory completion of workplace based assessments but also success in the MRCGP examinations.

Four areas are commonly identified as particularly challenging for IMGs.

- Theoretical versus real-life clinical experience': participants report difficulties recalling information and responding to questions from theoretical learning compared with clinical exposure;
- rote learning helped some IMGs recall rare disease patterns.
- Recency, frequency, opportunity and relevance: participants report greater difficulty answering questions not recently studied, less frequently encountered or perceived as less relevant.
- Competence versus insight: some participants were over optimistic about their performance despite answering incorrectly.

11

Workshop participant

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

Weaknesses in SJTs

- Cultural - Participants agreed that SJT can inflict bias as in the case of how questions are framed and thus disadvantage those who have different socio-cultural backgrounds or are IMGs.
- Process - The requirement of SJT questions responses to be arranged in order instead of best pick creates additional difficulties for IMGs, who may be unfamiliar with such systems.
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12 **Questionnaire respondent**

Fixed interviews; lack of inclusivity; unprofessional leaders in hospital management; institutional racism; institutional bullying; club culture

Data

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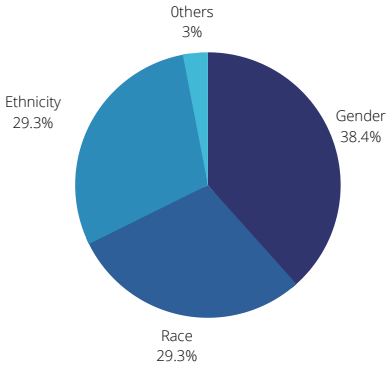
- rote learning helped some IMGs recall rare disease patterns.
- Recency, frequency, opportunity and relevance: participants report greater difficulty answering questions not recently studied, less frequently encountered or perceived as less relevant.
- Competence versus insight: some participants were over optimistic about their performance despite answering incorrectly.
- Cultural barriers: for IMGs included differences in undergraduate experience, lack of familiarity with UK guidelines and language barriers which overlapped with the other themes.[172]

Bias
There was recognition of the recognised flaws in the system of recruitment based on gender, ethnicity and disability due to the constitution of the panels, the design and content of scenarios and the lack of diversity of assessors. The participants recognised the use of video assessment of candidate-recorded scenarios which were implemented during the pandemic.

Disability
The participants agreed that there was a lack of data on the impact of disability in recruitment. This was partly due to perception of stigma and therefore reluctance to disclose disability related to neurodiversity and mental health issues. It is well-known that there is a lack of support and often there was no one responsible for (or dedicated and trained in) supporting those with disabilities.

- Role models - participants agreed that there were very few, if any role models of GPs with visible or invisible disability in leadership roles. There was no clear system of encouraging disclosure and supporting those who choose to disclose in a sensitive and empathic manner.
- Driving - The requirement of some schemes to have a valid driving licence was considered to be particularly discriminatory for those unable to drive or with certain disabilities excluding them from driving.
- Lack of accountability from the system.
- Paucity of infrastructure supporting disability access both at entry and during training. Often the placements are declared or allocated at short notice or sometimes do not offer suitable facilities. There is a lack of information on availability of facilities for those with disabilities.
- Participants discussed the recognition of the impact of 'hidden' disabilities such as undiagnosed borderline attention deficit hyperactivity disorder (ADHD), dyslexia which may might have a contributory role in people failing to score high marks in MSRA recruitment.
- Geographical bias - There was a consideration of bias in Stage 3 assessment due to people travelling to different regions for interviews both as assessor and as potential recruits. Candidates from the devolved nations and certain regions may have a different local culture and systems which may offer a potential opportunity for bias.



Causes of DA from Questionnaire respondents n=166

Ranking - In common with many other recruitment schemes the participants considered the issue that high ranked candidates have better selection of placements and as such get better supported ones, thus paradoxically lower ranked trainees ending up in isolated jobs with sub-optimal support. Hence there was a higher probability of these lower ranked candidates failing their ARCPs and examinations.

Role of intersectionality of various factors such as disability and ethnic-minority might also be looked into while discussing DA in recruitment. Currently in COVID pandemic, the stages of GP recruitment have changed so that stage 3 has been removed and performance in Stage 2 i.e. MSRA forms the basis for selection and ranking of GP trainee recruits. Stage 2 MSRA is further divided into clinical assessment and SJT scenarios. Hence, DA is expected to be compounded against minority ethnic and IMGs.

2.3.5 Consultant Recruitment

Consultant recruitment presents a mixed picture. The NHS is heavily reliant on junior doctors, but concerns around quality of care and calls to move towards the provision of consultant cover seven days a week have prompted a review of this model of care. Growing numbers of doctors-in-training are expected to increase demand for a finite number of positions at consultant level, while changes to pension arrangements may prompt doctors to work beyond retirement age, reducing the number of available consultant posts.[112] There has been a rise in the number of consultants from 87,000 in 2004 to over 125,000 in February 2021 – a 44% increase. [173]

DA IN RECRUITMENT

It was clear from the review of the literature that there was recognised DA in consultant recruitment which disadvantaged applicants from ethnic minority groups, IMGs and those with disability or based on sexual orientation. The impact of a candidate's gender was complex, as there were a proportionately larger number of women in the medical workforce, many choosing to work flexibly and therefore not unexpectedly there were a lower proportion of women in most consultant posts with the exception of specialities such as paediatrics and obstetrics. When interviewed for consultant posts, women had a slightly higher probability of being offered a post compared to men, however this was not true for women from minority ethnic backgrounds.

Process of recruitment

There was broad based agreement that the traditional process of consultant appointment through interviews was not fit for purpose. There were several weaknesses identified leading to nepotism, discrimination against certain cohorts of people and poor fit for the role required.

- Pre-interview - Panel which shortlists should be independent of the panel which conducts the interview or assessment. There should be a thorough assessment of skills and attributes to consider suitability for the role. There was agreement that panels should seek to have a team not only with the right skills for the role, values that match the organisational ideals but also a willingness to represent and serve the local population. This process should be robustly blinded. There should be a pre-interview visit/ consultation process with applicants, opportunity to interact with the full range of team members, chance to interact and receive multi-dimensional feedback provided in time for the applicant to prepare.
- Panel constitution - To make the assessment process robust and reflective of the workforce and population served, requires careful consideration of the skill-mix of the panellists. To have an accountable panel which takes ownership of the requirements of the organisation, the skill mix needed, adherence to the values and culture of the organisation.
- Interview process - There was agreement that the current interview process was unscientific, not intelligent enough, and most of the 'thinking' happens outside the interview process, so the interviews are just used as a legal tick-box exercise and the participants felt it should be completely abolished.
- To be replaced by a variety of stakeholder events with different formats of introducing various stakeholders, assessing different skill-sets including communication and team-working. To include an EDI champion or an inclusivity champion who will monitor and be empowered to actively consider the EDI aspects of each appointment. There should be awareness and accountability to meet the organisational objectives for EDI.
- Feedback - There was agreement that the feedback process in the majority of interviews was not robust enough. The panel must have accountability for providing meaningful advice, guidance and offer solutions to unsuccessful candidates.
- Feedback from people who are being interviewed - irrespective of the grade, successful or not successful. If all candidates can give feedback in a confidential way, in a way of accountability, and also how they felt they were treated as additional metrics, and reflection of the whole process. It would be most useful for consultant interviews because potential colleagues spend hours in assessing various aspects of departments, teams and organisations - the strengths and weaknesses would be akin to a peer review.

Organisational and leadership readiness for change - important to acknowledge that the process is wrong, and therefore willingness to change and leaders being held accountable for quality assurance and fairness of the process.

13

Workshop participant

When I was an aspiring surgeon and my registrar said, '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.'

DA IN RECRUITMENT
RECOMMENDATIONS

2.1 WIDENING PARTICIPATION

- In reaching into schools, parents & communities with role models, career advisors with preparatory workshops raising awareness of application and assessment processes
- Offer funded foundation courses
- Affirmative action including - adjusted weightage or contextual grading in assessment scoring based on multiple deprivation by recognising the distance travelled and the challenges faced in the journey of those stepping up from underrepresented communities.

2.2 COACHING, MENTORING & ROLE MODELS

- Targeted coaching & mentoring should be offered to all potential candidates from under-represented groups including IMGs. Coaches or mentors should be offered diversity training
- Peer role models - from a diverse background more effective in attracting and inspiring

2.3 WORK EXPERIENCE & OBSERVERSHIP

- Work experience/ Clinical Observerships should be offered in a systematic way to all potential applicants at UG level led by HEIs and NHS Provider organisations.
- Taster sessions and clinical observerships should be essential before considering application/ appointment for all
- Observerships should be essential for all IMGs before they are allocated to be responsible for patients

2.4 APPLICATION PROCESS

- Application Process – creating a balanced application process that does not disadvantage applicants from deprived or minority ethnic backgrounds. This should be co-designed and created by current students and mentors with appropriate EDI training.
- There should be an agreed formula for applying a weighting grid to different components of the process- Knowledge/Behaviours/ Aptitude based on the values required for a good doctor and not based on prior achievement

2.5 SITUATIONAL JUDGEMENT

- Provide a comprehensive instriduction and acclimatisation for SJTs for all IMGs
- Assess all SJTs for equality and diversity impact
- Montor and review the performance of candidates based on IMG/ protected characterisitcs and remove items which create disparities

BTG21
RECOMMENDATIONS

2.6 INTERVIEWS

- Process innovation - MMIs should be reviewed to check content, number, depth of exploration of KBA and consistency
- Focus on specific 'values' and not prior achievement
- Consider recording interviews for quality assurance
- Interview content must be assessed from EDI perspective
- Feedback - Everyone not shortlisted or unsuccessful needs personalised and constructive feedback.
- Feedback loops are important - Candidates should give confidential feedback

2.7 DIVERSITY TRAINING & MONITORING

- EDI training is essential immediately before assessing interviews and applications
- Increase awareness of DA for all candidates and professionals involved in recruitment
- Understand and value the diversity of the individual rather than looking for a fit to the system
- Ensure diversity of panel composition
- Empower people who are involved in the recruitment process, so they are able to speak up when the process isn't working

2.8 DATA & DISAGGREGATION

- Data on demographics, protected characteristics and multiple deprivation indices should be published openly for all recruitment processes including competition ratios
- Data on ethnicity should be disaggregated by individual characteristics
- Monitoring for the impact of intersectionality should be routine practice

2.9 ACCOUNTABILITY

- Accountability - Each trust should have a DA lead during each recruitment.
- Leaders to educate why we need diversity in organisation
- Accountability - Where does responsibility lie for Lead employer doctors as HEE/GMC doesn't want to have their responsibility. We need to fix accountability – Both internal and external

BTG21
RECOMMENDATIONS

2.10 SAS & LOCALLY EMPLOYED DOCTORS

- Nomenclature should be standardised and based on autonomy and responsibility
  - Specialty & Associate Specialist doctor- a doctor working in an autonomous role within a department/ firm
  - National Trainee Doctor (Doctor in a National Training Program)
  - Local Trainee Doctor (in a Local Training Progam including all Trust fellows at every level)
- Nationally agreed terms and conditions – as per SAS /LED charter
- Recruitment would be to nationally agreed standards and must mirror the MMI apprach for training doctors
- Educational tariff - should include provision for supervision, study leave funding, enhanced induction and support for career progression including CCT. Funding equivalent to that allocated to doctors in training should be available for all doctors, monitored, disbursed and accountable to HEE/ Equivalent training board

2.11 INTERNATIONAL MEDICAL GRADUATES

- Enhanced induction should be mandatory and must include all the requirements essential for working in the NHS, cultural norms, life in the UK accllimatisation and linguistic refresher on dialects
- Introduction to existing educational, social and cultural networks
- Peer support along with coaching, mentoring and role-models
- Health and wellbeing support
- Support for medical defence, insurance, accommodation, schools, health and financial planning including pensions

2.12 DISABILITY

- Increase awareness of disability both visible and invisible
- Encourage visibiity of role models and disability champions
- All organisations should provide support and guidance to educational supervisors and TPDs. Develop support algorithms for doctors developing disability.
- Ensure that recruitment and assessment facilities and expectations meet disability standards and do not disadvantage doctors with disability
- Develop a national consensus on standards for training and assessment for doctors with disabilities by Academy of Royal colleges
- Develop an earmarked funding to support doctors with disability for infrastructure, resources, and training of supervisors

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Chapter III
DA IN ASSESSMENTS

btg21 - full report

3.1 SUMMARY

Apprenticeship vs standardisation of medical education

In the eighteenth century medical education was steeped in the apprenticeship model, where the pupil acquired knowledge, behaviours, attitudes and professionalism from the single master or tutor, inevitably leading to variation. The assessment also based on the views of the master or tutor. The big shift in the nineteenth century was to hospital based medical schools and subsequently to universities which attempted to standardise knowledge required, embedded generic values and behaviours considered essential for professional excellence. A concept of a professional identity as well as community of practice was formed.[174] Hand-in-hand with this went the need for, and development of modalities of assessment to demonstrate that such prescribed 'professional competency and standards' had been achieved by the trainee professional.

The trust that is fundamental to medical practice relies not just on scientific knowledge, proficiency or skills but a host of esoteric variables - i.e. experience, judgment, thoughtfulness, ethics, intelligence, diligence, compassion and perspective - that appear to have been lost in currently prevalent quality measures. These difficult-to-measure traits generally turn out to be the critical components in patient care.[175]

Why do we assess doctors?

Regular assessment of knowledge, behaviour and skills are important for demonstration of acqusition as well as maintaining professional competency, thus ensuring confidence of the public in the profession and safe practice. Meaningful assessments of the full range of practice are therefore a fundamental pillar for every stage of the profession. Based on Miller's pyramid, there is a distinction between established assessment technology for assessing 'knows', 'knowing how' and 'showing how' and more recent developments in the assessment of (clinical) performance at the 'does' level, where real life performance is assessed. [176]

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Workshop participant

The link between performance in summative assessments and clinical performance as a doctor, is at best tenuous.

It is believed that a more reliable indicator of professional behaviour is the incorporation of the values and attitudes of the profession into the identity of the aspiring physician - thus a fifth level reflecting the presence of a professional identity 'is'. [177] The organisations that are entrusted with assessing the achievement of pre-defined professional standards need to ensure that the assessment systems are able to provide the confidence that society needs. In addition, the organisations providing education and training for medical professionals must also ensure that the training meets the requirements of the profession, and is aligned to the assessments undertaken.

The regulator has a legal duty to ensure (to the profession and to the wider public), that education and training is of optimum quality, and that systems for assessment are fit for purpose. All organisations have a legal duty to ensure that the entire process meets the moral and ethical requirements of the Equality Act, 2010.

There is consensus that the current systems of assessment of medical students and professionals are an imperfect science. That 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.

3.2 DA in Assessments

In addition, the current systems are consistently delivering differential outcomes for groups of medical students and doctors based not on their academic ability, knowledge-behaviour-skills-attitudes (KBSA), but on their demographics, protected characteristics and other socio-cultural-economic factors. This differential attainment (DA) is demonstrated across the world and in every healthcare education and training system. 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, social class or measures of multiple deprivation.

Although demonstrable in machine marked written assessments, DA is most prominent in face-to-face, clinical assessments and in high stakes summative examinations. DA in summative examinations offer a lens to the differential experiences and outcomes that occur throughout the educational journey and such systemic issues should not be discounted or ignored, whilst focussing on high-stakes examinations. DA affects predominantly candidates from minority ethnic groups, those with multiple deprivation backgrounds and those who trained and obtained their primary medical qualification from abroad.

3.3 Drivers of DA

Bias

Although the causes may be complex and inter-related, there is a recognisable link with discrimination and bias, both overt and covert that exists in a systemic way. Even after several years of academic research and several interventions, there has been little progress towards equality and justice.

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Worshop participant

Structural racism exists in organisational processes of assessment and in summative examinations. Some of it overt, some covert and impacts on liberty. One would be complicit if one were to accept this.

There was acknowledgement that structural racism existed in organisational processes of assessment and in the examination process. Some of it overt, some, covert and impacted on liberty, and that one would be complicit if one were to accept this. If the current system is consistently producing the same results and the weakest link is constantly occurring at the same point, then the system has to be held to account.

There was recognition of the medical workforce challenges and a need for the system to reform such that medical training is delivering value for public money, as well as safe and competent doctors.

Mechanics of Assessments

Differential outcomes are at least partially a result of the kind of assessments that have been designed. There are a variety of assessment methods including high stakes, summative knowledge tests (using multiple choice, short answer and essay type questions), interpretation of investigation results and clinical decision-making, situational judgement tests, standardized clinical patient scenarios, history taking, consultation and communication assessments. In addition there are standardised learning events recording educational interactions and real-life assessment by a range of clinical supervisors.

For procedures, there are log books recording the range of pre-set minimum numbers and directly observed procedural assessments completed by suitably designated assessors. All this evidence is collated and presented to a panel of independent assessors who are then entrusted to make a judgement on an individual's suitability for career progression (i.e Annual Review of Clinical Progression- the ARCP).

Weaknesses of Assessments

While there are a plethora of assessments designed at least theoretically to assess a wide range of skills of the professional in standardised and real-life scenarios [178], the reality is somewhat different.

There are many challenges and weaknesses in this system which requires assessment processes that are more continuous and frequent, criterion-based, developmental, work-based where possible, use assessment methods and tools that meet minimum requirements for quality, use both quantitative and qualitative measures and methods, and involve the wisdom of group process in making judgments about trainee progress.[179]

In the UK and in many countries, satisfactory completion of a range of high stakes summative assessments were considered fundamental to entry into medical careers and progression through the key stages. A proportion of candidates therefore had their entry into medical school, qualification as a doctor and further into as well as exit from specialty training - thwarted or delayed because of their performance in such assessments. There was particular concern for candidates where there appeared to be a mismatch - who were judged by the various other work-based assessments to be demonstrating all the requirements of the competency based curriculum but were unsuccessful in reaching satisfactory thresholds in summative assessments. There are additional challenges for IMGs who are largely unfamiliar with expectations of UK healthcare systems on which assessments are based.

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Worshop participant

Lack of appreciation [by IMGs] of difference in skills required in MRCP [UK examinations]

There was agreement that the current summative assessments (exams) needed to be retained, as the 'system' was reliant on this heavily for professional progression, until innovative systems were tried and tested in parallel. There was an acknowledgement of the potential danger of sweeping away a system that was working (for the majority) before a fairer and more comprehensive system was established. It was understood that it is likely that the whole system will need to go through cycles of evolution relatively quickly.

Participants felt that finding solutions and reforming the current system was an evolutionary process but there was a risk that if the problem was perceived to be too complex, then one may be tempted to retreat into inaction. They agreed to start thinking of potential solutions that would remove the barriers, although these may not achieve absolute equity, but can narrow the attainment gaps. This can be achieved by exploring the issues in granular detail and finding tangible reforms through task and finish groups.

Collaborative system leadership

Participants recognised the vital role of academic system leaders in tackling DA. It was apparent that not all organisations (including medical schools and royal colleges) entrusted with the function of designing and delivering assessments were aware of, or proactive in addressing the recognised DA in their assessment systems. Unfortunately in some cases, the burden of raising awareness had fallen on those that were disadvantaged and mostly under-represented (i.e. IMGs and minority ethnic doctors) and that needed to change. It was important that all stakeholders needed to recognise and take responsibility for addressing DA and be accountable.

There was recognition of the established partnership between HEE, NHS E/I, GMC and the colleges and the increasing consensus for support around tackling DA.

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Questionnaire respondent

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.

There was agreement to establish a fair, transparent and robust pathway for an individual that is coming into training, through stages of progression, assessment, Continuous Professional Development (CPD) and right the way to retirement.

Accountability

There was a desire to set up processes to be accountable and outcomes that are measurable. There was a resolve to take decisive action at any point where this was found to be failing. But to do this in a way that the final outcome is free of bias and prejudice. Developing an equitable assessment process that is not only fair to all, but is also vital in demonstrating a safe and competent doctor that ensures professional excellence and retains public confidence in the system.

Recommendations

In order to tackle DA in assessments there was agreement that;

- *Root and branch reform* - of all assessments must be undertaken to understand the specific factors that leads to DA in outcomes in order to demonstrate the equality impact assessment of all steps in the assessment process and to undertake appropriate, evidence based interventions to remove DA
- Individualised support - the education and training system needs to identify the candidates likely to experience 'differential outcomes', objectively, systematically based on wealth of observational evidence, and early so they can be given appropriate and bespoke support to offer a just and balanced playing field.

- Tackling Bias- there needs to be open acknowledgement of the existence of DA and demonstrable commitment at the highest level of organisations to take the necessary actions which must include investment in developing awareness as well as essential training for all in supervisory or assessment roles (Diversity/ Bias training)
- Data monitoring and benchmarking - the organisations responsible for maintaining oversight of education and training i.e Medical Schools Council, Health Education England, Health Education and Improvement Wales and Health Boards in devolved nations and General Medical Council must commit to monitoring of DA data for all assessments within their areas of influence and this must be published openly.
- There must be independent benchmarking of assessments/ organisations based on agreed robust criteria to be developed collaboratively
- Accountability -it is imperative on all organisations responsible for designing assessments, creating content, setting standards and administering the assessments to demonstrate robust diversity in membership of all responsible committees and (This recommendation applies to all Medical Schools, GMC PLAB committee and Medical Royal Colleges)

3.4 HIGHLIGHTS FROM THEMATIC SYNTHESIS

Who is affected by DA?

In the UK students and doctors from minority ethnic groups, and IMGs have, consistently, poorer outcomes in assessments when compared to white students/doctors and UK medical school graduates. The quantum of this difference varies across examinations and cohorts, but equates to about a 10-15% gap between UK minority ethnic and UK White doctors and about 30-50% gap between IMGs and UK graduates. Clearly, these are group differences with many individual outliers that defy the norm.

18 **Questionnaire respondent**

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.

What is the impact of DA?

- Retention & Recruitment - Bias whether explicit or implicit and discrimination in any form, leads to a perception of the organisation being non-compassionate, and leads to turnover of highly trained staff as well as challenges in recruitment. Such behaviour or culture breaches the fundamental principles of 'Our People Plan' and rights that are enshrined in the 'NHS Constitution'.
- Psychological impact - It leads to a loss of psychological safety, adverse impact on wellbeing, psychological or physical weathering, moral injury and demoralisation. Such unsupportive culture deters individuals to speak up when there are safety challenges with dire consequences for patient safety
- Financial impact - There is additional cost for recruiting, retaining and extending the training of staff. It is estimated that in 2019, it costs £88,000 for an additional year of training for general practitioners. Moreover, it also limits the number of new trainees that can be trained, creating further pressures on workforce capacity. Demoralisation in the workforce leads to a loss of productivity and poorer patient outcomes.
- Individual cost - There are too many Individual stories of personal and professional tragedy, which in many cases may be associated with significant morbidity, and sadly in some with untimely mortality.

3.5 THEMES FROM WORKSHOP & ROUNDTABLE DISCUSSION

3.5.1 Aggregation & Disaggregation

DA, when described, should be clarified as being differences in the average attainment of two or more groups. For instance in a discussion about DA, this may be applicable to IMGs versus UK graduates or differences between a minority ethnic group versus White group, among UK graduates. There is also DA based on specific ethnicity among IMGs, which should be described as such. The participants were keen to ensure that there was a wider understanding that such disaggregation of arbitrary categories was important when exploring causal factors and seeking solutions. It was also important to recognise the diversity within minority ethnic and IMG categories and to be careful not to aggregate diverse groups into one.

The participants discussed that the term 'BAME' was unpopular as it was considered to be just too 'all-encompassing' and did not recognise the significant diversity and different characteristics within the group. It was agreed that it was better to describe the groups where possible by specific ethnicity rather than consider an arbitrary, aggregated category such as BAME. Some of the UK census categories such as mixed white and black Caribbean, for example, could be quite a small group. Under the census data, there are clearly defined categories. In this report, the authors have agreed to use 'minority ethnic'.

3.5.2 Recognising Intersectionality

Causal factors are often connected to each other in complex ways. These could be related to living, working in a different country to the one that one has qualified in, those that relate to being of a different ethnic group to the white majority. Sometimes candidates can be affected by more than one factor. It is critical to remember the inter-relatedness and interconnectedness of causal factors.

3.5.3 Removing nuances of victimisation

The participants discussed that 'differential attainment' wasn't the preferred term to use anymore as it implied that the problem was as a result of an individual deficiency. Since it was well recognised that the issue was due to a systemic discrimination or disadvantage, it would be better described as 'differential award' which demonstrated that it's actually the system that's creating the difference rather than the attainment by the individual.

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Workshop participant

A human story –
I wish to describe the story of a talented, ambitious, hardworking 42-year-old doctor who failed the Clinical Skills Assessment (CSA) exit exam for the Royal College of General Practitioners (RCGP) and therefore was no longer able to be registered or work as a General Practitioner. This disappointment proved to be too much, as the doctor sadly ended his own life in tragic circumstances. This anecdote was described as an extreme, but not an isolated example of the stress and mental health impact of assessments for doctors.

3.5.4 Recognising the impact of discrimination

The weathering effects of any kind of discrimination, racism or sexism, were the same, and those had an adverse impact on physical and psychological health of medical professionals. And this manifests as problems for the workforce, whether it's in terms of sickness absence, physical and moral injury and a non-compassionate culture. That can only result in worse patient outcomes and demoralized staff. And that, this was completely contrary to what was agreed in the NHS People Plan.

3.5.5 Leadership and Organisational culture

If the workforce felt their leaders and the system was unfair, this would have a direct impact on their performance and outcomes for the organisation. There were key moments where employees were engaging with the values of an institution, such as assessments and examinations where a perception of being discriminated against or not valued would have a direct consequence on their engagement and motivation towards their work. A workforce which felt that the institution did not treat or assess them fairly would also not have the psychological safety to raise concerns which may impact on clinical standards and patient safety.

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Workshop participant

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

3.5.6 A systemic issue

There was recognition from multifactorial analysis that it was bias due to ethnicity that was driving the attainment gap in many examinations. However, it was unclear if it was simply the design, the structure, or implicit bias within an examination that was causing the differential. Participants believed that it was a systemic issue, and causative relationships of various factors were complex.

That is both at a systemic level (in terms of the processes around content of assessments, selection and training of assessors, standardisation of processes), and other factors at individual level - such as relationships with educational supervisors, the quality and accuracy of feedback that's given.

Although the examinations provided a lens on the problem of DA, the participants felt that the exams were not the problem in themselves. The idea that testing using low and no stakes assessments, taken frequently through a period of learning can enhance retention is not new.[181] Currently summative assessments are designed to evaluate acquisition of knowledge, behaviour and skills essential to perform the duties of a good doctor. [182] While high stakes summative assessments are prone to bias, stress for the candidates and unlikely to address inherent unfairness, there is a solution in using low stakes assessments in a real-world setting.

3.5.7 Impact of Assessments on Wellbeing

Examinations are a number one cause of stress among candidates. Failure affects all candidates, leads to a lack of professional fulfilment and consequent disengagement, often affecting patient outcomes, stunting progression, can lead to poor mental health. This is related to low expectations, fear or experience of discrimination, poor learning environment or opportunities and suboptimal support for minority ethnic and IMG candidates.

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Workshop participant

‘I know of one particular person who would go to the GP surgery, park his car there and worry all day and go back home and pretend he had been at work. And this came out in a meeting at the final appeal. With appropriate support, the trainee returned to training and became a very successful GP’

The roundtable and the workshop focussed on the role and validity of assessments in demonstrating the qualities of a good doctor. There are two types of assessment: summative and formative; often referred to as assessment *of* learning and assessment *for* learning, respectively.

3.5.8 Summative assessment (SA)

SA sums up what a learner has achieved at the end of a period of time, relative to the learning aims and the relevant standards. In healthcare there are well defined points for progression when such assessment is mandated, usually at annual intervals both in undergraduate and postgraduate stages. A summative assessment is in the form of written tests, observations conducted in a part-simulated or part-real clinical settings and communication exercises in either receiving or conveying relevant information - thus demonstrating proficiency in communications. It may be recorded through writing, observed in person by a range of assessors or by interpretation of visual media. Whichever medium is used, the assessment shows what has been achieved. It summarises attainment at a particular point in time and may provide individual and cohort data that is useful for tracking progress and for informing stakeholders. There is a well-defined standardisation and quality assurance process applied to ensure reliability and validity. Often differential item performance may influence the performance for certain cohorts of candidates based on demographics and other protected characteristics, but is unlikely a major effect. [183]

The crux of the discussion in the workshop was in comparing summative assessments that are reliable, consistent and reproducible, but do not offer the same degree of content validity (demonstrating the qualities of a good doctor) and are also inherently shown to be unfair to certain groups of candidates. Therefore, continuing with a summative assessment system that is consistently unfair to a proportion of candidates is no longer acceptable. However, they can be undertaken in a simulated and standardised manner. It was clear that individual doctors’ proficiency was mapped to the generic professional capabilities framework present in the mandated curricula, the required information from a range of diverse scales and domains, were not all suitable to be assessed in an artificial examination setting simulating the real life healthcare scenarios.

3.5.9 Formative assessment (FA)

Formative assessment takes place on a day-to-day basis, begins with a diagnostic assessment, indicating what is already known and what gaps may exist in skills or knowledge. If an assessor and learner understand what has been achieved to date, it is easier to plan the next steps. As the learning continues, further formative assessments indicate whether teaching plans need to be amended to reinforce or extend learning. Formative assessments are often fraught with inconsistencies, dependent on individual relationships, motivation and training of assessors, and most certainly are not standardized across organisations, specialities and geographical locations. There was consensus that formative assessments needed to be improved, with a new framework, before being considered for adoption in overall progression judgements.

3.5.10 Assessment of Progression - Triangulation

The annual review of career progression (ARCP) is a process where an independent panel of educational assessors review the evidence demonstrating the full scope of practice of an individual and provide a decision/ outcome on progress to the next stage. In addition there is a mandated requirement for successful completion of summative assessments conducted by the medical royal colleges. There is a proportion of learners who have achieved all required competencies barring the summative assessments. In some cases, candidates are unable to progress and are dropped from formal training due to multiple failures.

Differential outcomes in summative assessments has a negative impact on career progression, leading to stress as well as financial penalties for doctors. Minority ethnic doctors and IMGs who experience DA, are over-represented in the ARCP unsuccessful outcomes and appeal panels, for cessation of training.

There was agreement that 'good doctors' need a diverse range of skills, and that these cannot be assessed in a 'snapshot' and artificial or simulated exam settings. Progression based on summative assessments alone was not an appropriate metric to assess doctors. Assessments should be based on real world performance, which can rightly inform judgments, about the capability and readiness to progress.

Thus the 'workplace' is the best setting to assess skills and capabilities of a doctor. Theoretically, it is possible for a summative assessment to be complemented with formative assessments, but there is widely accepted or established mechanism yet, for such integration.

3.5.11 Supervision & Information exchange

A system that is designed to utilise a broad range of feedback, information and observations can inform judgments about progression in a way that may increase the confidence in making judgements on progression. Yet, there was no robust, systemic connectivity and information sharing regarding doctors between different training programs or organisations. Hence opportunities were lost for providing a holistic oversight and constructive feedback. The participants agreed that investment was needed in developing the infrastructure and faculty to support doctors, especially those who need additional support in order to get through exams. Supervisors are often not aware of personal or health challenges that each trainee/ candidate may be facing, with an adverse impact on their performance i.e unrecognised dyslexia or dyspraxia - which can be successfully resolved with appropriate coaching, and adjustments. This was especially relevant for IMGs or minority ethnic trainees who culturally are less inclined to seek help.

3.5.12 Governance

The participants recognised that although prescribed guidance (i.e. Gold Guide[184]) at one level, the educational governance structures, on paper look good, but then they are rarely followed, and many doctors in training do not receive timely and appropriate feedback or are not given opportunities to improve.

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Workshop participant

'One particular case I was involved in at an ARCP appeals panel where a trainee had been deemed not to have completed her training. She was of course an ethnic minority doctor. What stunned me when I went in as a trade union representative, was there was really very little accountability about the process. It was almost as though the decision had been made that they didn't want her. And they were then going to construct it in such a way to dismiss her. And for me, it was quite indicative and sitting around the panel with me, were senior professors, senior members of the deanery. I won the case for her. But it was just striking how very little regarded being given to the process.'

DA IN ASSESSMENT
RECOMMENDATIONS

3.1 INTEGRATE FORMATIVE AND SUMMATIVE ASSESSMENTS

- Integrate and link with agreed weghtage, information from holistic, multiple assessment points conducted by a range of assessors over a period of time, (available in Portfolios) allows for multi-dimensional assessment and can neutralise bias from a single point assessment.
- Use multi-dimensional components available in formal summative examinations/ assessments (e.g. clinical/communication/procedural skills) and not an arbitrary pass or fail system
- Empower independent, properly constituted, representative ARCP panel to be the final arbiter of progression outcome

3.2 REVIEW & ADDRESS EQUALITY IMPACT OF SUMMATIVE ASSESSMENTS

- Diversity of Assessment Panels - Ensure that assessment panels should be representative of the workforce, demonstrate the diversity of expertise, lived experience and have a patient voice
- Content validity - Assessments should be aligned to the curriculum and be mapped to the needs of the profession, the health service and attributes of a good doctor
- Context validity - Assessment should resemble the real-life scenarios and be representative of the multi-professional work environment
- Reliability - the standards must be set to reflect the expectations for competency and optimal delivery of safe and effective healthcare. The results must be reproducible between different groups of assessors and assesses both in geography and temporally
- Tackling Bias - measures to ensure timely, contextual training of assessors in learning effective strategies for avoiding / eliminating bias must be ensured
- Leadership & Accountability - the organisations responsible for designing, delivering and quality assuring assessments must ensure that differential outcomes are eliminated by applying appropriate affirmative interventions to those who are adversely affected
- Feedback - Ensure detailed, comprehensive and meaningful feedback is provided to all candidates
- Supervision - Supervisors must take responsibility for assessing preparedness for assessments, ensure that any personal challenges, health handicaps are duly assessed and corrective action taken
- Data & System accountability - Organisations must publish transparently data on DA in all assessments and their action plans to address such inequalities.

3.3 REFORM – MULTIPLE LOW STAKES SUMMATIVE ASSESSMENTS

- Develop and pilot - Multiple, low stakes summative assessments combined with appropriate weightage to provide a holistic picture which matches or is undertaken in real-world settings
- Undertaking regular low stakes assessments allow the targeting areas for improvement and differential learning styles
- Deliverability and standardisation of content and context can be ensured and require less resources

3.4 RETHINK - MULTIPLE MULTI-DIMENSIONAL FORMATIVE ASSESSMENTS

- Continuous feedback - MMLFA provides meaningful and constructive feedback against a pre-set benchmark and sets out clearly what learning outcomes are expected.
- Benchmarking for the pogramme - to demonstrate that the system is effective in providing the learning environment and outcomes for all
- Multiple independent assessors - undertaking multiple interactions increase the confidence in the context, content validity as well as tackling assessor bias.
- Standardisation - is essential for setting learning goals and optimum thresholds to be reached which is aligned to the requirements of the health system

3.5 PORTFOLIO OF EVIDENCE

- Judgement by portfolio of evidence - is recognised in other regulated healthcare professions (such as in the NHS, clinical psychology, physician associates and advanced practitioners), being judged on a portfolio of multiple pieces of evidence including assingments and assessments
- Technical skills are assessed using directly observed procedures anad using simulators with haptics and quantitative scores

3.6 TRAINING FOR FACULTY

- Develop and pilot - Multiple, low stakes summative assessments combined with appropraite weightage to provide a holistic picture which matches or is undertaken in real-world settings
- Undertaking regular low stakes assessments allow the targetting areas for improvement and differential learning styles
- Ensure deliverability and standadrisation of content and context can be ensured and require less reources
- Ensure diversity and cultural awareness training for all supervisors

3.7 LEARNING AGREEMENT, PDPS & ACCOUNTABILITY

- Ensure a formal Learning agreement is signed and set up for all supervisor-supervisee relationship wit clear outcomes and Personalised development plans
- The supervisor must be equally accountable for delivery of the personalised development plan
- Ensure that all candidates have a good understanding of the curriculum, expectations, mechanics of assessments and marking systems

3.8 INTERNATIONAL MEDICAL GRADUATES

- Ensure that IMGs are provided appropriate training and understanding of the cultural norms and expectations in the clinical context before any assessments are undertaken

3.9 FURTHER RESEARCH

- There is a need for more structured and methodologically sound programmes of research into
  - supervision in practice settings so that detailed models of effective supervision can be developed
  - how to do formative assessment well and provide effective feedback which drives leaning
  - on integrating multiple summative assessments to inform progression decisions

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Chapter IV
DA IN CAREER PROGRESSION

btg21 - full report

DA IN CAREER PROGRESSION

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DA IN CAREER PROGRESSION

4.1 RECOMMENDATIONS

- Establish a minimum dataset on career progression linked with their registration, published and benchmarked at organisational level, every 5 years of the revalidation cycle.
- The distinctions between trainee and non-trainee are defunct and need to be abolished.
- There should be flexible training champions in all organisations
- SAS Doctors - Career progression should be monitored as per agreed contract thresholds
- For consultants and GPs there should be an annual census which would monitor EDI data
- Organisational should be benchmarking on performance in eradicating DA committing to an agreed timeline for improvement.
- Every organisation must commit to and establish an Equality, diversity and inclusion network / committee which will be representative of the workforce, have patient and stakeholder representation, hold the CEO to account for compliance and offer dispute resolution
- Every organisation must ensure that there are mentors with resources and training to guide, inspire and support all doctors.
- International medical graduates should be given enhanced holistic induction, an appropriately timed period of adjustment to the new society and organisational norms, given support for understanding career choices, required qualifications and attributes and additional resources to make up any differences in comparison to their peers.

4.1 SUMMARY

The focus of the doman was on seeking solutions to tackle DA in career progression for doctors. The research and workshop activity was concentrated in three key cohorts of people affected.

- 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.
- Minority ethnic doctors were found to be facing discrimination at every stage of their careers from entry into medical school, to securing positions on training programmes, in competitive geographical locations or specialities and in securing consultant or GP posts. 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.
- IMGs - 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.
- 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 - there is both an ethnicity, success gap in Clinical Excellence Awards, and a gender gap. Only 22% of awards were received by women. And when you look at 2018 BME staff made up 22% of applications but 16% of awards received and that's lower than in 2014.

DA IN CAREER PROGRESSION

4.2 HIGHLIGHTS FROM THEMATIC SYNTHESIS

Medical careers extend several years from qualification through a myriad of placements, periods of research, additional qualifications and self-selected or out-of-programme experiences to culminate in a certificate of completion of training where one may reach the point of joining the medical register as a General Practitioner or as a Specialist. In the UK, the career pathways are usually differentiated into specialist, primary care or the academic ones. In addition, there is a large proportion of doctors who do not follow the traditional 'formal training trajectories' and often occupy posts as Speciality Doctors or Locally employed doctors, many on short to medium term contracts.

Almost 40% of doctors registered to practice in the UK obtain their primary medical qualifications outside the UK and 37% are from minority ethnic backgrounds. Yet, the systems to induct, integrate and train professionals from 'abroad' are biased and severely deficient. The subsequent treatment of such migrant doctors in the NHS is inexplicable and certainly unfair. There is little general recognition of therichness of culturalexperience and clinical diversity that migrant doctors (and other healthcare professionals) bring with them.

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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.

According to Eckhert [185], IMGs are forced to leave their own countries due to lack of postgraduate training programmes. Taylor and Esmail [186] noted that the migration of physicians from the South Asian countries of Bangladesh, India, Pakistan and Sri Lanka to the UK in the 1960s and 1970s was [187] primarily demand-led due to workforce shortages in destination countries triggering active recruitment strategies.

International recruitment is attractive to employer organizations because it offers a relatively quick fix, giving scope for rapid increases in staff numbers without the training lag period needed to increase home-grown health professionals entering the workforce. Conversely, the migration of physicians from developing countries represents a lost investment of significant training costs to these countries [188]. Furthermore the countries from which such graduates come, have scarce resources to support healthcare.

Research from several developed countries suggests that IMGs experience obstacles to accessing postgraduate training opportunities in their destination countries, contributing to slower and stalled career progression in comparison to their locally-trained colleagues. In the UK, Young et al. noted that non-EU doctors did not make as many successful applications for specialist registrar posts and were more likely to be working in non-accredited training posts or to have been appointed to staff and associate specialist group posts, which precluded progression to consultant posts.

It is estimated that almost 70 % of doctors taking up these posts are IMGs, with most being unsuccessful in gaining a place on a structured training programme. Thus, IMG mainly fill posts to provide clinical services and often used to free up time to training posts.

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Hostile environment policy

From 2006, new immigration regulations resulted in the UK NHS only being able to recruit internationally when they could not fill a training post with a UK or EEA graduate, or a refugee doctor. This ruling creating a deliberately unfavourable employment environment for IMGs combined with, an increase in UK medical school output and the influx of doctors from the new EEA accession states, made it extremely challenging for IMGs to receive any training; even if their intention following training was to return to practice in their home country. Among consultant physicians and GPs in England, there were 4-6% from Europe and 16-18% who had trained overseas.

Filling gaps

Other research has shown that IMGs are more likely to 'fill gaps' in specialities that have shortages or those that are hard to fill, such as geriatric medicine in the UK in the 1980s; psychiatry also relied on IMGs to fill junior and senior posts. Studies in the United States have shown that IMGs tend to practice in areas with doctor shortages, characterised by below average physician-to-population ratios and residency programmes with unfilled positions. Canada has historically relied on internationally-educated health professionals to address shortages in rural and remote locations and hard-to-fill positions. IMGs reported the difficulties they experienced in obtaining these positions and securing their future work as doctors in Canada as "a harsh and unexpected reality" and that the major obstacle in the process of becoming fully licensed to practice medicine related to difficulties in obtaining postgraduate training. In Australia, the majority of IMGs take up positions as general practitioners in outer metropolitan or rural and remote areas, or work in hospitals as junior medical officers and registrars. Often, the scope of work is not well informed and majority only learn the reality of non-training grade pathways after arriving to UK following PLAB exam. In fact there is lack of career counselling or advice by the regulator or royal colleges to make the informed decision to migrate.

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Workshop participant

It took me 13 years to become a consultant in this country in spite of having come here fully trained from India.
IMG candidates are 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

Scarcity of data for Non-training grade doctors

This review has also highlighted that there is scarcely any published data, monitoring of career progression or responsibility for the plight of thousands of SAS and non-training grade / Locally employed doctors who arein the under-represented minority at government or regulatory level. Health Education England since its existence has been focussed on the improvement of the learning environment, working with the medical royal colleges has developed and delivered curricula, but until recently has shown little interest or provided any support to the 'non-training grade' doctors.
The regulator (GMC) has only started exploring the feedback from non-training doctors, attempting to understand the plight of SAS doctors and recognised that DA in medical professions is an unacceptable manifestation of systemic bias.

The governmental agencies have often worked against each other (Home Office regulations vs Department of Healthand Social Services) adding to the predicament of healthcare professionals who have answered calls for recruitment 'to keep the NHS from collapsing'. Doctors unions and support organisations such as the British Medical Association have previously made little contribution to the improvement of standards of education, training and employmentand addressing the bias that has existed for the disadvantaged minority.

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Workshop participant

The truth [about the treatment of SAS & LEDs) 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.

DA IN CAREER PROGRESSION

SAS Grades

SAS grades embody the complex picture of structural disadvantage and systemic discrimination. Also referred to as Non-Consultant Career Grades (NCCG), the grades encompass associate specialists, staff grade doctors, clinical assistants, hospital practitioners, community health doctors and a number of other local non-standard trust grades. Associate specialists are senior post holders while the staff grade is a permanent career grade that doctors can enter from the Senior House Officer (SHO) grade, i.e. instead of moving to a higher specialist training.

The distribution of minority ethnic doctors throughout the SAS grades is disproportionately high. Of the ethnic minority doctors, those who qualified overseas (approximately 70%) are over-represented in the SAS grades and nearly all of them have been unsuccessful in obtaining structured training leading to a consultant post in the UK [189].

Some studies have investigated the reasons for entry into the staff grade doctors. The SAS grades were created in the 1980s to retain doctors in the hospital service who had, for various reasons, no prospects of promotion to the consultant grade. The inability to obtain a senior registrar or consultant post, the desire for a permanent post and family situations were identified as the reasons why doctors enter the grade. According to these surveys, between a third and half of the doctors still hoped to become consultants in spite of the formidable obstacles in their path. Around 20 per cent said that they wished to remain as staff grade doctors while nearly 70 percent realistically thought that this was their likely career position in the long term, with progression to associate specialist as the best that they could achieve.

The majority of IMGs who take up SAS jobs do so as a matter of necessity because they face barriers to their career aspirations (e.g. limited training opportunities) and often experience a considerable delay in securing employment even after passing the PLAB exam despite having spent several thousand pounds on the PLAB fee, international travel and local subsistence in the UK [189].

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Questionnaire respondent

Multiple factors, being overseas graduate, of different race, not able to have closer personal relations due to different culture and different interests.

SAS doctors lack professional development, educational opportunities and certainty of career progression [190]. Many of them do clinical work that is comparable to that of consultants and have an operational responsibility for their work but the majority of them feel frustrated about their lack of career progression and feel that their contribution to the NHS is not recognised. Analysis of IMG SAS doctors demonstrates a complex comparative picture with overseas-qualified doctors earning more, working for longer hours, having less autonomy and a lower morale than their UK-qualified comparators. Thus pointing to the SAS career structures to structurally and systematically disadvantage groups. [190]

Locally employed doctors

However, there is yet another cohort of doctors who are not successful in getting equivalent training or accreditation, or choose to work as Locally employed doctors (LED). There is often interchange of training tracks between formal versus Non-formal training -NfT, depending on personal circumstances and choice. There are 29% women and 67% of IMGs who train in NfT posts. Drawing on intersectional insights shows that women IMGs are the most disadvantaged despite the apparent protection of human capital by law.

CCST/ CCGPT - Completion of training leads to a Certificate of Completion of Training (CCT/CCGPT) with entry to the Specialist Register for many doctors. However, some doctors may not manage to secure a training post and therefore pursue an alternative pathway (NfT), which can take longer and pose many logistical challenges to secure the evidence required to satisfy the requirements for getting a certificate of completion.

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Intersectionality -
The doctors who identified with some or many of the above characteristics were likely to face discrimination and bias which had an additive or multiplicative impact. So an ethnic minority woman in a SAS or LED position would be much less likely to achieve her aspirations or find due recognition of her talents and efforts.

Disability -
Although much less in terms of numbers, the workshop also recognised the impact of visible and invisible disability as well as sexual orientation amongst doctors which led to a negative impact on securing training positions, jobs in competitive specialities and particularly in primary care with archaic requirements for driving licences and a lack of physical infrastructure and supportive culture.

Gender & Less than full time (LTFT)
There were 38% of consultants and 54.4% of GPs who identified as female in the workforce, among consultant physicians as reported in the 2019 RCP census [191, 192]. Overall 23% of all physicians were in LTFT posts, yet only 3% were in a job share. LTFT training is more prevalent in NfT, primary care and in certain specialities such as obstetrics and paediatrics. Intersectionality studies which have investigated gender differences in the work experiences of UK doctors indicate that male and female doctors both express dissatisfaction with the balance between their career and family life. However, female doctors seem more likely to be disadvantaged than their male counterparts regarding issues of employment, are less likely to get promoted, advance more slowly in their careers, have fewer leadership positions and are more likely to be discriminated against in the receipt of awards and discretionary points. Women are marginalised in the medical hierarchy, experienced more bullying and harassment on the basis of gender and race-ethnicity, and thought that the values and conditions in the workplace mainly benefit men.

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Interviewee

'We have two consultants who are Asian females, and they are the only female consultants in the unit. And I've noticed that the way that they are treated by the other consultants is clearly different - the way that they will be basically told what to do because they are junior. But there are other junior consultants who are white males, but they're more likely to be told in a kind and respectful way, rather than, I'm telling you this is how it's done' -P9, Male, British mixed heritage, Surgeon, age, 58

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Workshop participant

Belief that coloured Doctor may go back to their country of origin so wasted time for Professors or other senior person's time. An old surgical professor admitted that my being a woman of non white origin contributed to it

DA IN CAREER PROGRESSION

Geographical distribution

In the UK, overall there were 1 consultant physician to 4345 population, however there was wide variability in distribution with East Midlands having the highest at 1: 5771 and London South the best at 1: 2608. There was a direct correlation with density and likelihood to have unfilled positions at interview and cost of locum appointments. Only 21% of specialist trainees reported applying for permanent positions outside their training regions, hence highlighting the importance of appropriate distribution of training numbers by regions as per population and needs of the health service.

1:1526 average GP per population in England with the lowest ratio in the Midlands 1:1689 GP to population ratio and 1:1326 in NHS South West. However the ratio of GPs who had qualified overseas was distributed from 7.5% in some rural areas to over 40% in others. [172]

The issue of discrimination in the health services is all the more complex firstly because the health services rely on migrant workers to deliver their services and secondly because workers who qualified outside the UK may face different conditions. Doctors from India, Pakistan, Bangladesh or Sri Lanka and British-born and qualified doctors of the same ethnic origin are the largest identifiable group among non-white doctors that is affected by racial prejudice and discrimination. [193]

Doctors from ethnic minority groups trained within or outside the UK who succeed in getting senior appointments are substantially more likely to end up in unpopular parts of the country, less prestigious institutions, less popular and competitive specialities, as an associate specialist and in staff grade or locum posts rather than as substantive consultants.

Nearly 20 years ago, the Commission for Racial Equality (CRE) compared career developments of white and minority ethnic doctors with similar qualifications and concluded that: (1) overseas doctors waited longer for promotion to higher grades and had to make more applications for posts than their white British colleagues, (2) overseas doctors were concentrated in lower grades and unpopular specialties (for doctors belonging to white ethnicity) and (3) 33 percent of the overseas doctors who had made more than one application for a higher post at the time of the survey had to make more than ten applications for any particular post. [194]

Among Consultant physicians, there were 2% Black, 23% Asian and 68% of White ethnicity. There is a recognised pay gap of 4.9% for minority ethnic consultants. [195] Minority ethnic doctors often practise in deprived areas with large patient lists; are substantially more likely to end up in unpopular parts of the country, in less prestigious institutions and less popular positions; face racial prejudice and discrimination in the selection of applicants for British medical schools; and are far less likely than white doctors to be given consultant jobs or other senior positions in the NHS. [23,190,193]

Patronage vs Competency

Jackson et al.'s [195] survey found that half of the overseas doctors in training agreed that there is too much patronage in the way that people are selected for posts at the SHO level as opposed to 26 per cent of UK doctors in training. They also found that overseas doctors have less access to the largely informal support networks that are currently the main sources of career advice and guidance. Trewby et al [196, 197] also noted that patronage plays a part in doctors securing clinical attachments in which case doctors who are lucky enough to obtain clinical attachments are often favoured in their own hospital.

According to a BMA policy paper, the consultant appointment process is effectively governed by a patronage system, as opposed to one based on competency, and thereby works to the disadvantage of ethnic minority doctors and those who had qualified outside the UK. It has also been argued that the medical profession in the NHS runs 'a white man's register' with 'jobs for the boys' with enormous power being concentrated in the hands of consultants from upper middle-class families who have authority to decide who is shortlisted for jobs, the make-up of interview panels, the evaluation of the performance of junior doctors and the provision of both formal and informal guidance on career progression.

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Questionnaire respondent

I am a specialty doctor/SAS doctor preparing to apply for CESR. As a non-trainee doctor working in the UK for the past 8 years, I have to prove that I attained all the competencies the same as a trainee doctor. I feel that I am going to be treated like a second grade doctor in the UK.

4.3 Workshop Discussion

4.3.2 Monitoring & transparency of data

What data do we need to analyse the impact of interventions?

The participants agreed that there was a dearth of data on career progression because of the variability of career pathways, a limited understanding of the exercise of choice or aspiration for individuals, impact of geographical migration both from overseas and within the UK and the stages of recruitment (which are mutually exclusive). There is no mapping of the long term trajectory of doctors moving through healthcare except perhaps within formal training pathways, to allow for a straightforward monitoring system.

The data exchange between medical schools, employing organisations, Royal Colleges and Health Education regions is severely limited. The GMC and HEE are perhaps in the best position to coordinate the career progression metrics, map them against factors including socio-economic status of protected characteristics and publish in a transparent way.

The Medical Register
Participants considered the potential for mapping and retrospective monitoring of career progression data starting at the point of registration with the regulator. Although this may highlight individual or group characteristics which may either lead to privilege or reveal systemic bias, this data would be too high level to allow for any meaningful interpretation of the causes or identify 'pinch-points' in careers, where bias may have crept in. The participants considered the learning from research in Gender Pay Gap in Medicine [21], recommending a similar longitudinal panel approach on a cohort of doctors, seeing where they are at each 5 year revalidation point, allowing the ability to disaggregate the major factors that impact on career attainment and differences between groups, such as intersectionality of characteristics like gender and ethnicity.
The comparison of careers between formal route of training leading to (CCST/CCGPT) compared to alternative pathways to specialist/ GP registration via Article 14 (CESR-CCT) was also considered to offer the ability to identify and highlight where discrimination or bias exists.

Flexible training – Disability
The workshop considered the availability of flexibility in training pathways as a particular factor for bias against those who wished to have families or had variable caring responsibilities. There were examples of medical or surgical specialties where lack of flexibility was a prime cause of glaring disproportion based on gender or disability. There were many structural and infrastructural challenges for those with aspiration to train flexibly.

The data set demonstrating the resulting gender pay gap was a manifestation of such lack of flexibility in the training system. There was a need for a real time, annual monitoring and benchmarking of the gender based career progression and subsequently a plan for achieving equality.

Doctors with disability or on the basis of gender- were not able to take on additional/ leadership roles, so tend to be left behind by their peers in career progression. The type of disability would be useful to monitor so appropriate solutions can be found

Consultant/ GPs
There were 34500 GPs in England in the 2015 census. There was little or no data on career progression of consultants and even less for General Practitioners. A new system of metrics for consultant / GP career progression should be aligned to the 5 year licensing cycle for revalidation and appraisal. There was a need for a national standard for appraisals and revalidation agreed for all Trusts and monitored/ benchmarked by NHSE. The participants proposed an annual national survey (similar to one conducted by the Royal College of Physicians Consultant Census) which would be linked to previous answers from the same individual, if a change of organisation/ geographical location had occurred, thus demonstrating longitudinal data linked to known factors affecting DA. Similar datasets would be needed for GPs from RCGP/ CCGS.

Accountability
The participants agreed that there was a need to build trust in the leadership, and acknowledging and confronting inherent bias was indeed uncomfortable and the courage, determination and motivation needed to make a difference and be the lead role model for change was challenging.

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The consensus was around leaders to challenge themselves to take on a wider brief of equality, inclusion and justice for their workforce and to the patients they are here to serve. And this sits firmly with chief executives, Trust Chairs and the most senior people in the organisation who should and must be personally accountable for what happens to their people. The workshop participants agreed that accountability for addressing the differential attainment should lie with the top leadership of all responsible organisations including the GMC, HEE and NHS Employers.

National voluntary organisations working on EDI (such as BAPIO) and umbrella organisations representing the Medical Schools and Royal Colleges (such as MSC or AoMRC) can undertake the collection of data, consider the interpretation of data, set benchmarks and develop a charter (like the Athena Swann Charter). Further research, pilots for benchmarking and assessing accountability should be core business for all organisations.

Open forums & Allyship

The participants agreed that there should be safe and open forums for people to talk about their lived experience, which was powerful in influencing change.There should be opportunities for these stories to be shared and repeated so they can alter hearts and minds.

There was agreement that there was a lot to be gained by seeking out allies, usually people who are by definition different from the disadvantaged groups but are keen to make and sponsor change. Change can come at individuals, amongst colleagues or small teams or in large organisational arenas.

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Workshop participant

I'm going to go back and see whether we can try and incorporate that into how we do things. But I would also call for all of us to think what's the one thing that I as an individual, can do to make a small difference today, that will make a big difference in the future.

Non-Training Non-Consultant/ SAS doctors

These are appointed by the NHS Trust at local level, therefore there is very little neither national or regional harmonisation nor data on EDI. Participants acknowledged that Specialty and Trust doctors (Non-training, Non-Consultant NTNC) grade doctors do not have a collective voice or representation. Having local or regional data available from each region in a national database would be important for monitoring career progression and benchmarking.

Challenges of those working in this grade included lack of career progression in this grade with the Associate Specialist grade being closed, changing hours to work on-call, minimal job satisfaction, lack of respect and autonomy. The participants agreed that the process of obtaining entry to the specialist register via Article 14 regulations was laborious, challenging, fraught with long delays, inconsistent between specialities and viewed as unfair by applicants. There was consensus that specific interventions- reform was needed by the regulator to improve the process, transparency and efficiency. Some organisations offered a guided pathway for obtaining the necessary accreditation such as using 'CESR fellowship schemes' - this should be the norm.

Limitations of data on progression

The participants considered the challenges in acquiring the data and limitations. Primary amongst the limitations was the lack of recording of a doctors 'intention to progress'? A surrogate measure was the attempts that a doctor may make in securing new posts and data reflecting their probability of success mapped against EDI characteristics. There were challenges in accessing information held by NHS Digital via the Employee Service Record (ESR) portal due to confidentiality, consent and quality of the data stored. The Trainee Information System (TIS) used by HEE was still hugely variable on a regional basis and often outdated or inaccurate. There was no data on Socio-economic status (SES) or deprivation index available as a link to ESR datasets.

DA IN CAREER PROGRESSION

Qualitative data
The workshop participants agreed that in addition to quantitative data and aggregate of trends from the NHS Digital ESR database, there was a need to expand the career progression themes with an annual qualitative survey of career intentions, challenges and attempts to progress.

Data from appraisals
The participants agreed that the system of appraisals were conducted with inadequate training and lack of dedicated time to appraisers; and appraisers, were often considered without alignment to national guidance and lacked objectivity. If conducted appropriately, the data from appraisals would be a very useful source of data on career progression and if mapped to EDI characteristics offer a mechanism for benchmarking. The current system of NHSE/I monitoring the proportion of appraisals undertaken by Trusts was considered inadequate.

Challenges of data on ethnicity
The workshop recognised the challenge offered by incomplete data sets on ethnicity data in most surveys, as this field has been considered optional and many from minority ethnic backgrounds have felt that such identification may lead to bias. The participants agreed that there should be consensus and consistency in the granularity of ethnicity data that was collected across all surveys and databases. The datasets from NHS WRES standard data 2019, the medical WRES and proposed GP WRES data were considered important for benchmarking.

International medical graduates
There was agreement that the WHO globally-applicable regulatory framework for recruitment [198] guaranteeing the fair treatment of migrant health personnel should be adopted by the NHS. It emphasises the importance of equal treatment for migrant health workers and the domestically trained health workforce including education, training and to reduce the need to perpetually recruit migrant health personnel.

Equal rights for SAS & Locally employed doctors
The participants agreed that there was widespread variability in how the healthcare system treated doctors who were in Associate Specialist, Speciality Doctor or Locally employed doctor grades, often leading to exploitation due to unfair, unstandardised and discriminatory processes. There was concern that there was little or no scrutiny at a regional or national level and very little recourse for their voices to be heard. Although many Royal Colleges, HEE regions and trade unions such as the British Medical Association offered some representation to SAS doctors, there was none for LEDs and often no system to capture their feedback.

The participants recommended a major overhaul of the non-training grade career system with a nationally agreed job description, approval and monitoring of working conditions by a national representative council, allocation of the same standards of clinical or educational supervision as any doctor in a formal training post, allocation of time and resources for professional development and regular appraisal against agreed development plans. There should be an annual feedback mechanism similar to the HEE and GMC's National Training Survey with organisations benchmarked against their peers, with action plans that organisations were held accountable for. Doctors working on short term contracts or for locum agencies should also be included in these standards and organisations held accountable.

Tailored induction for IMGs
The participants felt that the commonest reasons for IMGs finding themselves in difficulty in managing to secure posts offering prospects for promotion and progression were often related to being placed in unmatched clinical placements, given inappropriate level of responsibility, being unfamiliarity with the healthcare system or the prevalent cultural norms in patient or colleague interactions, and poor supervision.
The participants recommended a tailored, enhanced induction and supernumerary or directly supervised roles in the first weeks-months of being appointed. This should be combined with mentorship, coaching and ongoing well-resourced support system.

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Early leadership opportunities

The participants agreed that certain groups of doctors never applied for substantive consultant posts or leadership positions despite having the necessary attributes. The causes included lack of role models, inadequate sponsorship and encouragement from their immediate line managers, inadequate appraisals or development plans and a hostile perception of the organisational leadership culture. There was consensus that the data on diversity of each leadership rung would provide a surrogate measure of organisational environment as would the feedback from WRES reports. Therefore the Trust board should have sight of and accountability for this data.

The Trust board should be responsible for agreeing a trajectory for balancing the diversity of leadership and setting internal benchmarks for encouraging sponsorship and reverse mentoring for all current leaders. Thus every board working through the organisational leadership would be responsible for engagement with the diverse workforce and for encouraging aspiration and ambition for approaching leadership positions.

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Workshop participant

I became more aware of differential achievement during my Consultant job. During my training, I was not aware of this issue. Currently when I consider my progression and leadership roles, I find that the system is built to prevent people like me from progressing.

The workshop discussed the potential barriers for tackling DA in organisations including members of the top leadership not acknowledging the issues of inequality, not taking personal responsibility, not being held accountable by the board or external agencies and not being engaged with the diversity of the workforce. A leadership team that was non-representative of the workforce or a Trust board which did not reflect the spectrum of the population they were serving should be avoided. There is an adherence to the 'status quo' and inertia in adopting change. There was an inherent culture of blame, bullying and structural racism.

The participants recognised the lack of protection for whistleblowing and ineffectiveness of the guardians to speak up is often a recognised barrier to raise concerns.

Incentives

The workshop agreed on the importance of financial incentives to be offered to organisations encouraging and accelerating the change to unfair practices, to achieve parity in WRES benchmarks and NHSE/I ambition for proportional representation in leadership teams.

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Workshop participant

Even when someone did the job for eight years. I went for that interview and they forced that person to stand again for the same job, just so that I won't get it. Now, you have no idea how that feels and like someone said before, people will only understand the rest of them what colour they are, they will only understand when they put themselves in my shoes. Believe me, I almost moved to Australia because of all this, and it is against me you know it's painful it's hurtful. So, there is no argument for saying that people are not volunteering for these jobs.

Recognising excellence

Participants recognised the inherent bias in some organisations supporting recognition of their workforce for extraordinary contribution in the form of clinical excellence awards. While some organisations adopted democratic processes for the panels judging applications, avoidance of identifiable information on applications, discouragement of cronyism, others have allocated proportions to represent the breadth of the diversity of the workforce.

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Workshop participant

I may not be the same colour as everybody else in the room but I do need to be thinking alongside colleagues and fighting that way through this ensures that the right voices are heard.

DA IN CAREER PROGRESSION

4.1 DATA MONITORING & BENCHMARKING

- 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 jointly by Health Education England, HEIW and NHS Employers 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.

4.2 TRAINING PATHWAYS FOR ALL DOCTORS

- The arbitrary distinctions between trainee and non-trainee are defunct and need to be abolished. To be replaced by a doctor as a national appointment for training (NTN) or Local appointment for training (LAT).

4.3 FLEXIBLE TRAINING

- Flexible training champions in all organisations with responsibility to monitor, power to facilitate and resources to ensure the necessary structural changes are implemented to encourage and support doctors to work and train flexibly
- Data on flexible training should be published annually for each organisation and specialty

4.4 SAS &LOCALLY EMPLOYED DOCTORS

- SAS Doctors - Career progression will be monitored as per agreed contract thresholds [200,201] and presented in the form of a portfolio with relevant documentation attached and included in
- Stage one - undertaken CPD activity as per Medical Royal College guidance, a 360 degree multiprofessional feedback and annual appraisal
- Stage two - criteria that allow the doctor to demonstrate a higher level of skills, experience and responsibility;
  - autonomy in making clinical decisions and carry responsibility without direct supervision
  - involvement in management roles or team leadership
  - involvement in service development and modernisation
  - involvement in providing teaching and training
  - involvement in research and publications
  - committee/ representative work
  - innovation within area of specialisation/ expertise
  - involvement in regular audits, quality improvement and patient safety

DA IN CAREER PROGRESSION

4.5 MONITORING FOR CONSULTANTS & GPS

- An annual census run by the relevant medical royal colleges and collated by NHS Digital which would monitor data in the following areas based on demographics and other characteristics;
  - Census data and PMQ, at organisation level (as published by NHS Digital for CCGs and NHS Trusts)
  - Probability of success in appointments to leadership, managerial or additional appointments, per 5 year revalidation cycle
  - Pay,
  - Proportional distribution to incentives such as excellence awards or equivalent system
- Adherence to a nationally agreed appraisal standards

4.6 ACCOUNTABILITY

- CEO and Chairs of organisations (NHS Trusts, CCGs, Private sector healthcare providers) should be responsible to NHSE/I and CQC (Well Led standard), for publishing organisation level data on DA, achieving parity in terms of the provisions of the Equality Act, committing to an agreed timeline for improvement. This benchmark should hold agreed financial incentives.

4.7 EQUALITY, DIVERSITY & INCLUSION CHAMPIONS

- Every organisation must establish Equality, diversity and inclusion network / committee which will be representative of the workforce, have patient and stakeholder representation, will be chaired by a Non-Executive member of the Organisation Board and hold the CEO to account for compliance with the provisions of the Equality Act and tackling differential attainment. This EDI committee will offer an opportunity to listen to grievances and offer arbitration in matters of dispute resolution.

4.8 CAREER SUPPORT & MENTORSHIP

- Every organisation must ensure that there are mentors allocated formally to guide, inspire and support all doctors. The mentors should receive training, time and resources to provide a high quality experience for both. Mentors should be encouraged to seek out career progression opportunities for their mentees and agree personal development plans.

4.9 INTERNATIONAL MEDICAL GRADUATES

- International medical graduates should be given enhanced holistic induction, an appropriately timed period of adjustment to the new society and organisational norms, given support for understanding career choices, required qualifications and attributes and additional resources to make up any differences in comparison to their peers.

4.10 ORGANISATIONAL CULTURE

- Every organisation should publicly acknowledged a commitment to celebrate and nurture the values of equality, diversity and inclusion from all levels of senior leadership management in all mainstream activities of the organisation.

BAPIO
INSTITUTE FOR HEALTH RESEARCH

Chapter V
DA IN LEADERSHIP ROLES

btg21 - full report

DA IN LEADERSHIP ROLES

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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.

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SUMMARY

The diversity of the UK society and its health service workforce is not represented in the senior leadership. Despite significant attempts in recent years to increase equality, diversity and inclusion, progress has been exceedingly slow. There is evidence that like the wider society, the UK NHS is failing to fully engage its members (workforce) and that there is a significant mismatch between the intention to promote equality through the services it provides' [108] and the lived experience of people from minority backgrounds. [202] This is manifest in how the NHS treats its under-represented minorities.

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, ethnic minorities and those with other protected characteristics, as per the provisions of the Equality Act 2010. The access to leadership positions for the immigrant healthcare workforce is also severely restricted. 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. [202]

The overarching cause of a lack of leadership progression for staff from minority ethnic backgrounds is of systemic bias based on multiple protected characteristics; and for IMGs - an unconscious anti-immigrant feeling and/ or projection of inferiority; also for most - a culture of privilege, exclusivism, allyship and cronyism for the white, male; a widespread lack of career support, mentorship or sponsorship; and a historic legacy of deprivation.

DA is manifest in many ways which may include a shortage of role models, lack of encouragement or apprenticeship to higher leadership positions, glass-ceilings and sticky floors as well as structural barriers to recruitment and promotion, unequal appraisal and disciplinary processes, microaggressions, bullying and harrassment.

As seen in DA literature, these do not arise from limitations in the expertise or abilities of the affected individuals, but from a complex range of social, cultural, political, economic and historical factors that give rise to, and sustain, discrimination, marginalisation and exclusion in the workplace. Due to the intersectionality of these myriad of factors there is a need to tackle the multiple systemic factors underpinning inequality, simultaneously as any focussed, unidimensional approach is unlikely to be successful.

The quality and performance of the NHS has been under increasing scrutiny in the last decade. The Rose Review [203], Dalton Report [204] and Francis Inquiry [205] all have highlighted the importance of leadership in mobilising, implementing and sustaining transformation. The NHS Long Term Plan [206] and the Five Year Forward View [207] have recognised the value of supporting and empowering leadership at all levels.

There is strong evidence that equality and diversity in leadership has a positive impact on organisational culture, staff engagement, wellbeing, service improvement and innovation. Inclusive leadership plays a critical role in ensuring that health and care systems operate most effectively for patients and the public. The UK NHS has set a national goal that NHS leadership should be as diverse as the rest of the workforce and in particular, should ensure that gender and minority ethnic representation at senior management matches that across the rest of the NHS workforce. Whilst the legal and business case for change is now widely accepted, real engagement with issues of social justice is largely absent in mainstream approaches. Interventions enacted till now including setting soft targets for attaining equality and schemes to provide targeted support to individuals from marginalised groups has been largely unsuccessful.

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In spite of the establishment of the NHS Leadership Academy and the value that CQC as well as NHSE/I have attached to organisations being well-led and providing a safe environment for staff to flourish, this has been mostly an ad hoc, reactive approach for organisations falling far below the minimum expectations. There is little national standardisation, benchmarking or a coherent, strategic vision for implementation of EDI across the vast organisational landscape.

The NHS invests significant amounts of time and money in leadership and organisation development, yet evidence of impact is variable. Commonly implemented approaches often take a leader-centric approach with deployment of the NHSE/I Improvement team, that fails to address embedded disparities, legacy power gaps, fractured relationships and mistrust for underrepresented minorities and perpetuates the status quo.

A proactive, holistic, transformative approach which goes beyond a narrow focus on the skills and competencies of 'leaders' or isolated disadvantaged minority groups is needed. There is need for creating a compassionate organisational culture, that builds on collective leadership capacity, develops networks, values the power of relationships and facilitates collaboration across traditional boundaries.

An organisation which is openly aware of and challenges systemic bias; which recognises and is willing to embed in its core - the value of a pluralistic identity, the narrative of a lived experience and diversity; proactively engages and encourages participation across the workforce spectrum; which is willing to listen and empower a variety of divergent individual views, reflection and critical thinking- is likely to be resilient and strong.

The consensus view was that;

- The NHS, Medical Royal Colleges, Health Education England and other healthcare organisations in the UK, should proactively engage in the interventions that celebrate diversity. Such initiatives include Black Lives Matter, Melanin Medics, South Asian or African Heritage month, etc
- Within their cohorts and catchment areas, healthcare and HEIs should invite ideas and innovations from their workforce, membership and their populations, to co-design and co-develop initiatives which are then resourced to engage, empower and embed equality, diversity and inclusion in all its offerings.
- Every organisation must establish a well-resourced, empowered and well-represented workforce network/ committee which has the remit to uphold and monitor the organisation's performance on EDI. This committee should provide the oversight to develop a matrix to collect, analyse and publish transparent data on EDI performance. The committee will be empowered to challenge, investigate and encourage system leaders to take necessary action to meet the organisation's declared EDI objectives.
- Every healthcare organisation must codesign an EDI strategy with clear aims and objectives that commits the organisation to a road map and timeline for achieving compliance with the national equality, diversity, inclusion and justice agenda.
- 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. 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.

- 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.
- Every healthcare organisation must ensure that all staff (including medical professionals) have access to personal leadership development resources, appropriate and bespoke to their needs.
- 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
- 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.

5.2 HIGHLIGHTS FROM THEMATIC REVIEW

Over the past century, the definition of leadership has evolved from

"the ability to impress the will of the leader on those led and induce obedience, respect, loyalty, and cooperation" [208] to

"the enhancement of behaviours (actions), cognitions (thoughts and beliefs), and motivations (reasons for actions and thoughts) to achieve goals that benefit individuals and groups".

Effective leadership has shifted emphasis from "who" the leader is to "what" the leader does. Who the leader is remains important and is relevant but the focus is now on relationships, influence, and outcomes thus allowing for individual differences and characteristics provided there is awareness of how to accomplish effective leadership. Effective leaders are both aspirational and inspirational.[209]

A disproportionate majority of leadership positions in the NHS are taken up by white employees, but there are similar disparities in respect of gender, sex, race and other protected characteristics. Only 42% of NHS Trust board members are female and 209 Trust boards do not have gender equality in their strategic aims.

Analyses of recruitment trends show that the current systems tend to favour white, male applicants and that ethnic minority doctors are less likely to be shortlisted and appointed to leadership positions. Women and ethnic minority doctors earn less than their white colleagues.

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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

Gender stereotypes of women as warm, nurturing, and caring and the corresponding stereotypes of men as cold, competitive, and authoritarian may have contributed to the misperception that women may be less effective than men in leadership positions. [210] The attributes and behaviours of leaders from under-represented groups are shaped by their multiple identities hence able to provide innovative leadership styles.[211, 212] Role models are an important part of the development of social identities, and the scarcity of female role models in leadership positions plays a major part in the persistence of the gender stereotypical construction of leadership. [213]

In order to be successful, leaders especially women and both men and women from minority ethnic groups must negotiate the complex interconnected pathways, combine assertive agency with the qualities of kindness, niceness, and helpfulness, in order to create social capital from interacting with colleagues and establishing positive relationships. [212]

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Questionnaire respondent

Some people sit on the post for donkeys years and not allowing other people to attain leadership posts. People at higher post look at your skin colour rather then your ability while recruiting.

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While White females, who share the same skin colour as most male leaders, can more easily focus exclusively on gender discrimination and may overlook the influence of race and ethnicity on perceptions of leadership, the same is not true for women from minority ethnic groups, whose barriers are multifold. [213]

Inclusion is universally understood to mean the simultaneous but distinct feeling of individual uniqueness (i.e. a person feels distinct from others) and group belongingness (i.e. similarity to others), [214]

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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.

Drivers for DA in Leadership

Differential attainment can be driven by staff not being encouraged to, or being discouraged from applying for leadership roles; a lack of information or awareness of the NHS governance systems or how the role works; the lack of support, mentorship or sponsorship; derogation of self-confidence due to persistent microaggressions, discrimination, bullying or harassment.

At institutional level there is a vicious cycle of lack of support, mentorship, sponsorship, restricted access to support networks, a legacy of under-representation, driving insecurity and a much lower proportion of minority staff believe that the NHS provides equal opportunity for career progression compared to their white colleagues.

At societal level, the NHS broadly mirrors the wider society in the composition of the workforce as the largest employer. Structural racism is embedded in UK society, within the DNA of many institutions and encouraged by a legacy of multiple deprivation, including the anti-immigrant feeling which has been significantly enhanced post-Brexit. [214, 215].

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Workshop participant

It is known that the 4 key principles of equal opportunities, diversity and inclusion for an engaged workforce are trust, targets, voice and choice.

SOLUTIONS

Building Trust

- Belongingness, uniqueness and inclusion - being valued as a unique member of the team and to be included in the team ethos.
- Leadership behaviours - incuding (i) empowerment (ii) humility in learning from criticism and different points of view. Acknowledging and seeking contributions of others (iii) courage in acting on convictions and principles even when it requires personal risk taking; and (iv) accountability.

Empowerment & Voice

- Develop a system through employee networks (diversity) of organisation-wide learning through lived experience – hearing and acting upon the stories of those people who have the most to gain from inclusion

Building choice & accessible resources

- Pedagogy/Andragogy - creating more inclusive approaches for learning across demographics, protected characteristics and collaboratively.
- Highly skilled facilitation – ensuring that those who facilitate leadership development are highly skilled on equality and inclusion;
- Offer a national and regional resource for leadership talent development, which breaks away from local individual influences or cronyism and offers a wider access to under-represented groups;
- Leadership development – developing best practice inclusive content, tools and approaches that are available to all organisations

Setting Targets

- Leadership practice working with system leaders in everyday practices that create and sustain progress towards inclusion
- Accountability to develop a matrix for monitoring and reporting of data on EDI in relation to leadership roles, agree to a national benchmark-framework and embed a culture of continuous improvement towards a just system

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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?

5.3 WORKSHOP DISCUSSION

What does success look like?
The workshop acknowledged that there was a prevalent, unidimensional narrative of leadership prototype mostly aligned to the white, privileged male in the NHS, which needed to change. That the current status quo of exclusive leadership in the NHS was depriving it of the talents of a wide-spectrum of individuals. That the talents of women, minority ethnic doctors, those born and trained overseas, those with disabilities or other protected characteristics and SAS or Locally employed doctors were underutilised. That such bias in leadership was leading to poor patient outcomes, mistrust, disenfranchisement, reduced productivity, lack of innovation, employee turnover, and mental health consequences. Those organisations with an embedded, insular, unsupportive culture that tolerates cronyism, bullying, harassment and did not offer an inclusive, compassionate or collaborative leadership were likely to experience higher risk of poor patient outcomes and consequent cost.

There was clear understanding that a strategy to tackle DA should include a collaborative style of leadership and culture of equality, that celebrated diversity had 4 guiding principles; [217]

- Data, Targets & Accountability - there needed to be a clear, strategic undertaking from the organisational top leadership that was committed to a roadmap for eradicating inequality by increased representation of women, ethnic minority staff, including those with protected characteristics and SAS/LEDs in including in leadership positions; such a strategy should include transparency of data, accountability and alignment with a national benchmarking

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Workshop participant

'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.' Dame Dido Harding

- Building Trust - there should be a demonstration through action from all in leadership positions of the commitment of an organisation to a culture of respect, compassion and empathy for all staff; its willingness to embrace cultural transformation, and tackle inequality of access to leadership roles, eradicate bullying, harassment and abuse; reduction the proportion of ethnic minority staff that are referred to formal disciplinary processes; provide responsive, effective and empathic supervision, coaching and mentoring; particularly for underrepresented, ethnic minorities and IMGs
- Empowering Voice - organisations should sponsor employee networks that provide a voice to the entire spectrum of diversity, an open platform to be themselves, display their identity and a forum for listening to the lived experiences,
- Fostering Choice - there needs to be an increase in the percentage of minority staff accessing non-mandatory training and continuous professional development, like leadership development and a degree of autonomy and choice in pursuing areas of career interest, as well as personal development

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Workshop participant

Some organisations have shown that change is possible, and these changes at senior leadership have given a sense of 'hope' for people who might feel that it's always the same faces at the top, it's always male, it's always a white male and the Trust is so diverse. Our leaders must represent the diversity of the population they cater to.

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Rt Hon Matt Hancock MP [219]

'I think we also need to have an honest and frank conversation about how we need to get much better at learning from our successes and from our failures. Because, despite our best efforts, error is unavoidable, and what matters is how we respond to it, and how we learn from it. And only a culture that, not just welcomes, but requires open learning can deliver that. So that's the first thing I want to talk about: the NHS needs a leadership culture change.'

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Workshop participant

'Experience of looking around the room of an august body, whether it's a Royal College, or an Oxbridge college and seeing no portraits on the walls that looked like you or me. And it reminded me why I hadn't really felt like I fit in when I was there.
And, and that as I say, speaking as someone with such a privileged background so the fact that so many of our colleagues just don't see anyone like them, it's just white faces and often just white male faces.

The workshop was divided into four breakout groups, each of which explored the following themes:

- Developing the diverse future executive leader
- Nourishing leadership development among under-represented staff
- Organisational engagement and benchmarking to improve diversity
- Creating a culture of diverse leadership

Developing the future leader

- Talent development

The participants discussed the need for a potential framework, which helps to identify people with aspiration, ambition and talent for leadership, calibrate the personal behaviour, skills and attributes which are known to be predictive of success, and allow individuals to choose to pursue career opportunities that are designed to develop and consolidate such skills at a much earlier stage, and provide skilled support right from the onset. Access to such leadership development should be fair and equitable, providing affirmative support to those from marginalised backgrounds.
Effective leaders recognise that all members of the organisation/team play leadership roles at various times in their work. Although every member of staff should have the opportunity to develop their own leadership skills and be empowered to lead within their own workplace environment, it was not necessary that all individuals had to pursue managerial or senior leadership career pathways.

Diversity of experience - The participants highlighted the value of identifying early how international experience or diversity of socio-cultural experience can enhance the effectiveness and innovativeness to an organisation. There was agreement that the traditional homogenisation or acculturation was not the best way forward, but maintaining one's identity and the strength of cultural diversity was of greater value to the organisation.

- Role models - The participants agreed that there was a scarcity of role models at the very senior manager level and there continued to be a major problem in the way leadership is portrayed and perceived in the NHS which is a complex organisation.

- Reverse/ Reciprocal Mentoring - Reciprocal mentoring provides opportunities for individuals from under-represented groups (such as BAME, LGBTQ+, disability) to work as equal 'partners in progress' with senior executive leaders in a relationship where knowledge and understanding of both sides of lived experiences creates awareness, insights and action that directly contributes towards the creation of a more equitable and inclusive organisation where the factors that generate inequity are positively and proactively addressed. [219]

Similarly, being mentored by a junior staff member lends to reverse mentoring. There is no hierarchy in these types of mentoring. Starting with listening, keeping an open mind and caring is key to the success of this approach. Being open to suggestions, feedback on performance and a 360 assessment is also helpful. [220] For such leaders, placing themselves 'in other's shoes' can help understand what life is really like in their organisation, department or team. [221] The mentors also gain confidence, understand what motivates and drives leaders and are empowered to speak truth to power.

- Apprenticeship opportunities to learn from leaders and develop individual skills and attributes. They provide opportunity for organisations to develop, nurture and grow a more qualified workforce aligned to their future strategy. Using a combination of best practice, theory and on-site application, leadership and management capabilities within your business can be improved, so that your people will lead in new and improved ways. Additionally, they also provide an effective way to ensure the future leaders and managers of the organisation develop the right skills to contribute to the growth and improvement of the organisation. As apprentices may come from a range of diverse backgrounds, from aspiring managers to those with more experience under their belt, new innovative ideas and approaches are often brought to the business which help drive it forward. Individuals are encouraged to develop creative thinking skills and strategies, enabling them to think outside of the box. Investing in the development of employees can have a positive impact on the morale, eagerness and motivation and loyalty to the organisation.[222]

- An Effective Leadership Fellowship - Access to bespoke leadership pedagogy at every level and expansion of local leadership positions - fellowships and a flexible portfolio of training. There are advantages of a Leadership fellowship model for locally led leadership, and for it to be on real projects that really made a difference so that people who could commit to it could see the benefit. It needs to be needs-based.

- Developing a bespoke programme co-designed with local staff is more likely to provide the right set of attributes required for the leadership team.

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Workshop participant

'It's ensuring that people get a buzz out of what they do day in, day out; have an open culture, say it as it is, and people may not like it, but at least you've got the opportunity if you listen, to change things for the better and that's what management is there for. It's all about trying to make life better for people who come into work and want to do a fantastic job for the NHS, day in and day out.'

- Leaders are responsible for the environment they create, they are the role models of the behaviours they want in their teams.
- Autonomy to develop through co-design and co-development of projects collaboratively with a wide network of colleagues from across the spectrum is a key to ensuring a shared vision and engagement.

Nourishing leadership development

- Creating Diversity & Support Networks – There are many exclusive clubs and cliques within the NHS, despite the diversity and the size of the workforce. Therefore navigating oneself and creating a culture, which somehow breaks down those kinds of exclusive, elite networks is a difficult task. There is a role for courses for colleagues that are under-represented, but they need not to always be in a separate room those courses should be in addition, but they actually need to be in the same room, because they're not then getting the same opportunities of others and one of those opportunities is that things like leadership programs, quickly become networks of people that support each other and encourage each other. And if those programs don't include the underrepresented, then they continue to use their network to support those that were in the program.
- Individual level - Leadership development through training appraisals, PDPs and the benefits of a 360 feedback on leadership roles. Every organization should be delivering leadership courses that are flexible and interprofessional.

- Mentorship & Coaching - Participants discussed and agreed on the value of embedding resources for the confidential support of an external mentor.
- Mentorship & Support for IMGs - To take on a leadership role requires a lot of confidence and understanding of the system for individuals. So, sometimes for IMGs who may know less about the NHS, they may not wish to take on a leadership position, because they become very visible and vulnerable.
- Inductions- getting better inductions allows one to get a better feel of the culture. There are regular overseas doctors development programs, enrolment into well-resourced coaching and mentoring relationships, and keep an open door for anyone to ask any questions and come for any advice and guidance, anytime. So that's what the coaching and mentoring does to help those individuals who are feeling fragile, feeling suppressed or oppressed, or indeed judged harshly by the system.
- Sponsorship - Mentorship alone isn't enough, that there needs to be active sponsorship and support to improve confidence to apply and reach for senior positions. There is a need for allyships with leaders who are actually the influencers, who will then help us get these people to the right places.
- Caring & Nurturing - Often the politics within complex organisations, the power struggles can lead to harm. So, if there is transparency, openness and encouragement from the top leadership then more people are encouraged to apply and there are some good examples of that around the country. Hence culture is how we live, how we work, how we talk to each other, how we think of an organisation and its values. And ultimately, we should care because we are a caring organization, and yet a lot of employers don't care, or don't care enough about individuals. The NHS offers everybody some fantastic potential to develop their own individual skills, and yet many NHS organisations don't harness that. A lot of people work below their skill level.

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Workshop participant

‘So I get these phone calls. But as we look, would you mind speaking out? And they said no, no, please don't use our name. Because this will prevent either promotion or a job they want and then I get a bad reference.’

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Workshop participant

Where there are organizations in difficulty, at the heart of it is that the leadership is not listening. If one looks at most of the organizations that are in special measures, staff are frustrated, so they use freedom to speak up or whistle blow. It's because leaders don't listen, they don't act responsibly around in responding to some very difficult and tricky situations

Organisational engagement and benchmarking

- The participants agreed that organisations should be challenged to take ownership for system change and address the differential attainment gap in leadership and demonstrate their commitment to EDI and be accountable. There was awareness that the paradigm of leadership was shifting from the leader as a hero (Heroic Leadership) towards looking at collaborative styles, resilient systems, and the creation of the whole system transformation rather than an individual top-down style of intervention. To get that right, organisations have to think about the systems and it's not just the team and the organization or the individual. Organisations have to embrace a genuine willingness to change and invest in diversity, inclusion, and compassion as key ingredients of their culture. Leaders need to emulate all of these.
- Everyone has a voice - As a leader it's really important that they set the tone of the organisation, so everyone has a voice and that right should be respected at all times. No matter what role someone has in the organization, leaders should listen to everyone. Making sure every staff member is heard as there's a real correlation between staff satisfaction, and quality. But it's more than that it's a business imperative. There's evidence to show organisations which do not embrace and adopt inclusivity, foster equality tend not to make good business decisions. A robust, trusted freedom to speak up guardian who is empowered to hold the senior leadership accountability is key to building back trust.

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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.

- Fostering support Networks – In addition to the networks that one belongs to, organisational leadership should create new networks linking with others offering a diverse range of skills. It also helps to become familiar with the people in power and therefore have a stake in the shared purpose.
- Accountability - Organisations should be accountable for compliance with the public sector duty of equality and for workforce wellbeing as well as career progression outcomes. Although empowerment and incentives are more effective, sometimes for organisations that persistently don't care, a sanction may be the only way to make change happen and make them care.
- Equal Opportunities – By definition all leadership opportunities are technically open to all, including the underrepresented groups, but in real life there is a demonstrable lack of accessibility and invisible barriers to access both overt and covert (glass ceilings). [223] Leadership development opportunities need to be easily accessible, flexible, multiprofessional and open to 'non-career grade doctors'.
- Hidden curriculum - That tells you that you're not eligible to apply for leadership opportunities. There was a concern that certain leadership resources/ courses are often by nomination (or approval), and that those that nominate in their own image, and therefore, it continues to perpetuate the limited access, and that courses and programs should be on merit and capability, not on whether one's face fits.
- Gender & intersectionality - minority ethnic doctors, women and IMGs depending on what dimensions are being considered tend to fare the worst in terms of disadvantage in hierarchy. So one considers pay, the hierarchy places White men at the top, followed by black and ethnic minority men, and then leaves Black and minority women absolutely at the bottom. The Athena SWAN charter has definitely improved gender diversity in academia, but it's only done it for middle class, white women, it has not done it for minority ethnic women. [224]
- Non-consultant staff – tend to have very limited opportunities for roles. And as IMGs and BME staff are over represented in those groups, that compounds the challenges for them.
- Monitoring & Benchmarking - The participants discussed the value for regular monitoring organisational performance data on open databases and benchmarks, such as on the WRES framework and to keep it high on the organisational board agenda. There should be a commitment to a culture of continuous improvement in EDI. Thus availability of granular workforce distribution data is key to successful transformation. Such information should be available openly on the makeup of the workforce at each level in clinical, education, leadership and research.
- To improve diversity - Evidence such as obtained from WRES data can be powerful for organisations. But more important is the actions that are taken as a result of this information. This is important for benchmarking and comparing an organisation against its peers.

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Workshop participant

'There are small things like how people are encouraged to understand each other. Even the business of trying to encourage everyone to learn how to pronounce people's names. And so, the little things as well as the big things, we need to pay attention to all of that. How to move from EDI being a fashionable subject, to the norm? That's a big journey of cultural change that we really haven't had time to think through.'

The workshop participants discussed the cultural dimension of leadership and barriers that prevent doctors from being promoted to leadership positions or roles in the NHS. They agreed on an overall narrative of the system change that is needed by shifting the focus from a deficit model related to individual characteristics to one of organizations themselves that need to do more to remove the differential gap.

- Gender, Identity & Stigmatisation

There was a recognition that inherent systemic bias as a result of one's gender, ethnicity or protected characteristics and being born or trained overseas created a clash of identity and stigmatisation of being different, 'foreign' or an 'immigrant' and therefore inferior. The stigma and its impact are well known in many sectors of society. [89, 225]

Gender is an individual difference characteristic that is relevant to how people think about themselves, are thought about by others, and act in various situations and crucial to leadership roles and effectiveness. [208] Gender also includes the manner in which individuals interact with each other and the social roles they are expected to fulfil in a society and influences identity. So it is important for organisations to take steps to stop stigmatization, and doing it in an environment where it's clear that whatever steps we take are perceived as supportive and nurturing. Organizations should recognize and be sensitive to multiple identities and manage them through awareness of intersectionality and systemic barriers, initiate culture change within the larger organisation workforce and co-design appropriately nuanced leadership training. Consideration of the intersection of multiple aspects of identity provides a richer and more nuanced understanding of diverse leaders. Thus an intersectional approach does not treat race, class, gender, and sexuality as autonomous categories but seeks to examine their interaction in understanding leadership identity, behaviour, and effectiveness.

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Workshop participant

Somebody with a different accent.- Instead of seeing them as, 'Oh, they've got an accent'; If you perceive them as having multilingual skills that can be really beneficial to our organisation or community. If they've not trained in the UK but they've trained in an under-resourced country, they can bring really efficient solutions to us. Let's really respect that type of diversity.

It is difficult to create a system in the NHS which does not reflect the common will or sentiments of the people, as the majority of the workforce is recruited from the population it serves. Much of Brexit voting was driven by an anti-immigrant sentiment and hence it is unrealistic to expect that this will not affect the attitude of NHS staff towards colleagues from abroad. This is an example of a systemic bias.

- Organisational culture - The culture when discussing leadership roles is set from the top rung of leadership of any organization. And there are some organizations which are friendly and nurturing. So these organisations would actively encourage people to apply, encourage people to take on leadership positions. And there are other organizations which have a different culture where there are glass ceilings.
- Inclusivity - One of the barriers is the time taken when doctors move from one hospital to another. There is a significant lag before one is accepted, feels included, gets to know the important players (the movers and the shakers) and then feels confident to take on leadership roles. If one is not in the 'inner circle' or the privileged few in the organisation, sometimes there are roles which change hands without much fanfare. A form of cronyism.
- Diversity issues -IMGs and doctors from ethnic minorities have culture and practices that may differ from the culture of the majority of members of the organisation or team. Where there is a diversity of cultures, recruitment as well as retention tends to favour the ones who are viewed as conformist. This may also affect ability to interact socially, have informal supportive conversations or be signposted to potential opportunities. Many times, when appointments are made an important consideration is who looks like me, talks like me and who may 'fit well' with the team or organisation.
- Economic status - Often the barriers may be due to economic background such as people from deprived communities rather than ethnicity. Such barriers are unlikely to be resolved by tokenism in gender or ethnicity representation on boards. The solutions will have to come from deeper and wider socio-economic affirmative solutions.

- Cultural rigidity - Cultural issues can be considered from both within the established Anglo-Saxon or White Eurocentric system that doesn't have an open mind or acceptance for a different way of doing things, different setups. Therefore, subconsciously or otherwise, discriminate even before the applicant sets foot through the door. While it is worth more to invest in colleagues who do acknowledge their own cultural values, they tend to envisage what clashes down there may be between their values and what the white British population may find interesting, or less interesting. It's not to suggest modifying or sacrificing one's own culture, or thinking and awareness to be able to intelligently interpret the disparity between what the culture expects, and what culture you congregate.
- Cultural awareness - By proactive reflection, people take time to enlighten and encourage or educate colleagues about their values, and how valid those values are, and the mutual respect that they have for other people's values. And therefore make it easy for them to be accepted, there's got to be two ways, there's got to be a change in the kind of local established culture to be receptive to values or perspectives that are different. And yet preserving and nurturing one's own culture.
- Microaggressions - Undertake racial equality education to change mindsets with a collection of approved education materials for example about how to deal with accents and microaggression for all doctors and starting at undergraduate level.
- Power of narrative on lived experiences – involves first acknowledging the data, having open and honest discussions about the challenges and listening to staff. And no matter how useful hard evidence might be, it is really powerful to hear and share narratives and the stories, and that's what changes hearts and minds.
- Systemic approach - inclusive talent management, inclusive recruitment and the importance of induction, learning, learning and development and training. A well run supervision and appraisal system. Support for sponsorship of staff. Opening support and interaction amongst staff groups by fostering inclusive networks. However, despite those cultural differences one can be seen as a leader, if the organisation ensures that the cultural differences are not just respected but regarded as something that enriches the diversity, rather than seen as something that's alien or different or not so good.

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Workshop participant

'That racism is a determinant of health.' If our most trusted leaders, who talk about health inequalities, and do not acknowledge racism, and what it does to health in society. Then we're in a bit of trouble so how do you create, if you're talking about creating a culture of equality of understanding of racism and issues across all of leadership.'

DA IN LEADERSHIP ROLES
RECOMMENDATIONS

5.1 RECRUITMENT TO LEADERSHIP ROLES

Career paths for executive leadership roles should be managed by an '**Executive Recruitment Framework**'.

- This framework will be co-designed by diverse and representative multi-stakeholder committees and
- Panels will undergo equality impact assessments to ensure it is fair, applicable, and accessible for all.
- The framework will outline career progression, job descriptions, desired experiences/skillsets and a transparent recruitment strategy, including where and how vacancies can be advertised.
- The framework will serve as an adaptable template for Providers to recruit transparently into their executive roles thus providing uniformity across the NHS with regional flexibility
- An independent, expert recruitment agency should undertake and monitor appointments to senior leadership positions
- The impact of EDI specific 'projects' and 'initiatives' need to be measured and shared. Experience and impact related to EDI should be credited on a CV/job application in a similar manner as academic achievements.
- SAS doctors should have access to and be mentored for leadership positions

5.2 ACCOUNTABILITY FOR DIVERSITY IN LEADERSHIP

Trust/Provider Boards to be held accountable and rewarded for promoting diversity in senior leadership roles.

- 'NHS Employers Diversity in Leadership' award – organisations could be accredited for their diversity-related indicators and measures.
- A scoring matrix should be compiled by a multi-stakeholder Task & Finish group, including NHS Employers, NHS Trust executive leaders and NHSE Workforce Race Equality Standard. High scores on this matrix can lead to recognition awards for the provider. This is a similar structure to the Independent Investors in People (IIP) Award where organisations are accredited for investing in their workforce, applicable to the NHS and public sector.
- Every organisation should identify a Senior Responsible Owner (SRO) for equality and diversity and bear the duty of presenting diversity data to the Trust Board and holding them to account internally.
  - This could take the form of a new role or be a specific part of the role of the Chief People Officer / Head of Human Resources in the organisation. These individuals could also be a part of the Integrated Care Systems (ICSs) within the People Board.

5.3 APPRENTICESHIP- ASSOCIATE EXEC & NON-EXEC ROLES

To support the pipeline of diverse clinical leaders an apprenticeship model for leadership training is proposed to fostering leadership skillsets and the benefit of mentorship

- Associate Executive and Non-Executive Director roles should be created, advertised and diversely recruited

5.4 SHARING BEST PRACTICE

An organisational 'Buddy System' would team up a 'good' organisation with one that was struggling with their efforts in improving diversity, managed by the NHSEI regional teams and the support of Trust leaders to agree to 'buddying'.
The 'buddy system' would follow the vanguard model with a memorandum of understanding and report on effectiveness anually

DA IN LEADERSHIP ROLES
RECOMMENDATIONS

5.5 CHANGING DIVERSITY TO POSITIVE EXPERIENCES

- Implementation a framework that celebrates diversity and values the positive infuence of differences especially with international medical graduates and minority ethnic backgrounds
- Encourages staff to be able to bring their whole identity to the workplace and challenge discrimination without fear of negative repercussions
- Encourages conversation and changes in perception, rather than negative unconscious bias.
- Develop a national campaign with NHS Employers / NHS Charities (eg. 2022 – The Year of the International Healthcare Staff).

5.6 TALENT MANAGEMENT

- Developing Talent panels to help create a database including all SAS and Locally Employed Doctors
- Enlist sponsors for employees from under-represented groups based on Talent database and consider how to best pair senior sponsors and proteges'.
- Trainers, recruiters, and leaders to be trained in the principles and skills of talent management, with a focus on ensuring and encouraging diversity. This training should be embedded within existing courses, such as 'Train the Trainers' or Leadership Induction programmes.
- All doctors should have equitable access to leadership development and training, including leadership courses either remotely or in-person.
    - A locally developed physician leadership program can be effective at both improving physicians' leadership skills and increasing understanding of the strategic goals and direction of the organization.
    - A leadership development program that includes the components of careful curriculum design, program monitoring, and opportunities to apply new skills in practice.[227]
    - This should be communicated to demographic groups, particularly those who may be less privileged or aware of wider leadership training, including IMGs, minority ethnic grous and SAS-LEDs

5.7 MENTORSHIP

- Every organisational executive team should adopt a reciprocal mentoring programme, providing regular mentoring to executive leaders. Reciprocal mentoring offers a developmental bridge that narrows the divide and eases an organization's progression through change.
- A formal buddying/mentoring scheme should be established for aspiring clinical leaders to be mentored by senior clinical leaders. This should be open and positively target under-represented groups

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Chapter VI
DA IN RESEARCH & ACADEMIA

btg21 - full report

DA IN RESEARCH & ACADEMIA

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Workshop participant

‘I think good is not good enough, because if you were providing care to patients in a trust, you would have to call for excellent or outstanding, and outstanding is what you would look for and good would be a compromise. So we say it's not good enough.’

WORKSHOP CONTRIBUTORS

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- Andy Lewington, Kidney Research UK
- Angharad Davies, Royal College of Pathologists
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DA IN RESEARCH & ACADEMIA

SUMMARY

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. From antiquity, most nation-states or peoples have progressed in conjunction with expansion (territorial or cultural), interaction with (and exploitation of) other people or their resources. The strength of such progressive or developed societies has been closely interlinked with their inventiveness. This is most apparent in the progression of science (including medicine) and technology in the nineteenth century with the Victorian engineering and since the advent of the twentieth century. Science and technology is an essential driver and nurturing scientific talent is the key to ensuring such progress.

- The United Kingdom 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. 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 ⅕ to ⅓ from migrants 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.

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Workshop participant

'And therefore, when you have a dominant discourse about what a good application looks like, using that framing of good, that's being judged by people who have a particular way of thinking...e.g. a panel dominated by men, they don't get it [social sciences], and therefore they're going to be judging it in a much more harsh way than they would look at an application based on pure science.'

Yet, there is recognition that due to inherent bias and racism in the larger UK society (not exclusive to the UK) there is differential attainment (DA) in research and academia, where individuals with protected characteristics, those who have migrated to the UK and those who have been naturalized, still face barriers to progression at different stages from selection in training or career pathways through to obtaining funding and getting research published.

This DA has a negative impact on individuals, families, large groups of people and a significant loss of talent, productivity and efficiency for organisations and the national economy. Our thematic scoping review explored DA through the EDI lens, specific to healthcare professionals in medicine, in the UK. There was a paucity of published data, benchmarking and investigation of the causes of DA and access in this area. There has been mixed success in the area of gender equality with the Athena Swan benchmarking; however differences in outcomes exist within gender when other protected characteristics, such as ethnicity. 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.

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Workshop participant

'So we know there's an ethnic penalty in higher education 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.'

Furthermore, ethnicity appears to be a barrier to accessing this form of support, and non-Black and minority ethnic women appear to be more privileged to receiving this type of support.

Without more research into the lived experiences of individuals from non-traditional backgrounds at the micro-level, as well as data across the career progression pathway overtime at the macro-level, the problem of DA is unlikely to improve. If anything, lack of openness and 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.

The purpose of this report is to start the conversation with stakeholders within research and academia, about DA and commence the process of reducing the gap using equality, diversity and inclusion as fundamental concepts for achieving a level playing field for all. This type of accountability is essential for developing trust and in the system. Such open conversations need to happen across every organisation that is a stakeholder of research and academia in the UK.

What does good look like?

Universality of Access - where there is universal access to opportunities based on merit. People should have the opportunity to access careers in research and academia 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.
Nurturing participation- Mentorship - 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, minorities and international graduates). And mentors who are educated and supported to be good mentors and sponsors.

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Workshop participant

'When I worked at an institution, we managed to get to the point where every single academic school right down to module levels data was available on a publicly shared dashboard that publicly for the universities anybody could go in and look at anybody else's data. And it was disaggregated by gender, disability and ethnicity.'

Metrics & Benchmarking - where the metrics combine not only data but human stories and bench mark inspiring role models.
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 - need to look not just at training but also at clinical services, which aren't always diverse. Need to see diversity in practice, not just in the classroom. Improved awareness that diverse teams make better decisions and diverse teams are more effective.
Role Models -where there are highly visible role models so aspirants across the diverse population can see people around that they can identify with. Thus having the right people as role models.

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 international graduates are facing

Equality -it is important to consider protected characteristics and intersectionality. Where conscious and unconscious bias is removed.

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Workshop participant

'We shouldn't hide behind not having data, I don't think you'll ever have enough data. And that shouldn't be a reason for not to put solutions in and actually start looking at putting things right.'

Recommendations

- A global set of standards (Framework-Benchmarking) is expected from members of royal society's / research funding associations and councils
- There is a need for more data on the proportion of members from distinct protected characteristics and the multiplicity of theimpact of intersectionality of various characteristics
- Improving quantitative, qualitative and longitudinal data collection on career progression for meaningful analyses.
- Improving diversity in representation on council or committees
- Tackling racism & discrimination by changing organisational culture and perceptions
- Encouraging organisations to develop policies to achieve equality and justice; to embrace change that is bold and radical as well as accountability for EDI at every level and process.
- Develop outreach, widening participation, incentives, internships and apprenticeships for those under-represented cohorts to help them counter the negative impact of multiple deprivation/ bias and compete on a level playing field.

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Workshop participant

I say it now because I now understand the value of that privilege, or the extra value that I had as a leg up, due to that. But most people wouldn't identify that but I think we should look back at it certainly for people who need it. 'But there is something about opening a door..'

6.2 HIGHLIGHTS FROM THEMATIC REVIEW

6.2.1 Background

The UK's life sciences environment has an enviable competitive advantage because of an outstanding research base in world-class universities and dedicated research institutes; thriving pharmaceutical and medical technology industries; significant capabilities in clinical and translational research in the NHS; and considerable support provided by the medical research charities. Initiatives such as the formation of the National Institute for Health Research (NIHR), investment in integrated academic training (IAT) pathways, and the development of Academic Health Science Centres and Networks (AHSCN), have transformed the UK's clinical research capacity. In 2018/19, every single NHS Trust in England took part in research, with over 1 million clinical research participants. [227] A strong science and research base is crucial to help secure sustainable economic growth, helping to rebalance and strengthen the economy for the future, which is why despite tough spending decisions many forward thinking governments protect research funding.[228]

Research as core business

It is widely accepted that research needs to be part of the core business of the NHS. The UK government believes that commissioners, providers and higher-education institutions (HEIs) should promote and use research to inform their planning and provision. [228] The UK Clinical Research Collaboration (UKCRC), a partnership of the main stakeholders that influence clinical research across the business, public and charitable sectors in the UK has a declared aim to keep the UK a world leader in clinical research. The UKCRC Health Research Analysis Forum (HRAF), a subgroup of twelve large public and charity funders of health research, plus the association of medical research charities (AMRC), responsible for analysing the health research landscape found in 2014, that £8.5bn was spent in research.[229] In the 2020 Spending review, the UK Government pledged to increase public research and development (R&D) funding to £22 billion by 2024/25 in order to achieve a target of 2.4% of gross domestic product (GDP) spent on R&D by 2027 from the 0.7% in 2021. [230]

DA IN RESEARCH & ACADEMIA

Inequality in resources

However, there is significant variation in allocation of resources being more favourable to certain HEIs and to some geographical areas of concentrated research activity (eg. London and Oxford). There exists persistent inequality throughout the health services research cycle – from agenda setting and the design of research programmes, through to the planning, delivery and evaluation of individual research projects and the implementation of the knowledge produced. [231]

Translation to patient benefit

There is a consistent failure to translate research into practice and policy. As a result of such evidence-practice and policy gaps, patients fail to benefit optimally from advances in healthcare and are exposed to unnecessary risks of iatrogenic harms, and healthcare systems are exposed to unnecessary expenditure resulting in significant opportunity costs. [232, 233] It is therefore important that every trainingand practising doctorshould become familiarwith research processesand conduct, andwhere possible have the opportunity to engage with research or pursue an academic career aspart of theirprofessional choices. [234]

Clinical Academic Careers

However, 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, a situation likely to worsen given the current pressures on the healthcare workforce, that is facing difficulties in recruiting and retaining staff, which in turn cause significant challenges to service delivery. There is also a decline in the number of clinical academics, who operate at the interface between academia and the NHS and lead research.

A diverse academic workforce has been associated with greater scientific impact and growth. Diversity across clinical academics reduces as one progresses through career milestones due to a range of factors, (e.g. gender, race, disability) which appear to contribute to limited progress in research and academia.

Diversity and Inclusion

The entire spectrum from research career opportunities to funding and choice of research subjects has evidence of exclusivity and this drives health 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. [235] Diversity is fundamental to expansion of scientific curiosity. It involves choices about what problems to study, what populations to study, and what procedures and measures should be used. In making these choices, diverse perspectives and values are important. [236]

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.[237] A strong correlation exists between researchers and the people they study. Predominantly White middle-class group of scientists focuses their research programs primarily on White, middle-class populations. This reliance on “convenience samples” has disadvantageous consequences, as results based on this narrow slice of humankind may not, generalize to other populations. [238, 239]

Impact of Covid-19 Pandemic

Some thinkers warn against the risk of ‘Covidisation’ of research [240] at the peril of losing the impetus in non-COVID areas of interest-healthcare priorities, focussing inadequately skilled or motivated workforce exclusively in areas of infection and public health, due to the pressure of funding and for need for generating evidence.

Existing Benchmarks

In recognition of these barriers to progression, the Research Excellence Framework (REF) – (a system for assessing the quality of research in the UK), places greater emphasis on organisations to demonstrate their commitment to reducing inequality and increasing inclusivity.The Athena Swan Charter was specifically developed to minimise the impact of gender on career progression. There is a statutory duty to reduce inequality.

6.2.2 Equality, Diversity & Inclusion (EDI)

Research across multiple sectors and work settings has demonstrated the value of diversity within teams, for increased productivity. Problem solving is better with a diversity of 'problem solvers' as compared to teams with 'high-ability' problem solvers.

Differential career trajectories

In the UK, a clinical academic career involves a complicated training programme, with competitive multiple entry points across Foundation, Core and Specialist training, some of which, but not all, maybe integrated within clinical training programmes. However, across all these entry points, there are marked differences in success, for individuals who identify with a protected characteristic - starting with selection into programmes and success in obtaining funding awards. These differences continue beyond training, and extend to career progression as well as development opportunities, or achievement of senior academic posts.

The factors that contribute to disadvantage are wide ranging and are commonly considered to interact with each other.

- **Gender**

As a sector, higher education is relatively diverse, with almost equal representation from men and women. However, the trend is different when looking at contract type (fixed term vs. permanent) and appointment into senior positions such as Readership and Professorships. These senior positions in STEM were, and still appear to be male dominated (79% male Professors). Although >50% of early career researchers are women in clinical medicine and biosciences, the proportion drops dramatically at more senior levels. The Athena Swan Charter [224, 241] was a system-wide programme to address the structural inequalities facing women progressing with their careers in science, technology, engineering and maths (STEM).

The 2011 announcement by NIHR to only shortlist clinical academic departments with a 'silver' Athena Swan award for (certain) research grants, resulted in an increase in the number of (White) female clinical academics in senior positions but not for minority ethnic women and men.

Often, more than one protected characteristics could play a role in attainment; for example there are less than 20 Black Professors in the UK.

Ethnicity

- Individuals from minority ethnic backgrounds make up less than 17% of doctors in academia and much lower in senior postions. Diversity data from 2018 shows that 84% of the academic population in the Medical Research Council (MRC) identify as White, with 4% and 1% belonging to Asian and Black backgrounds, respectively.
- Success rates for principal investigator funding across MRC grants and awards in 2016-17, demonstrated a higher proportion of applicants identifying as White (24%) compared to successful applicants from minority ethnic backgrounds (16%).
- 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 (27%) compared to those identifying as minority ethnic (17%).
- 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. Furthermore, the odds of non-White applicants receiving funding were 0.68 times those of White applicants.
- The Higher Education Statistics Agency (HESA) suggested that 91% of Professors identified as White compared with 3.5% who identified as Asian and 0.6% who identified as Black. Only 3.2 % of Heads of the Institutions identified as Black and minority ethnic.
- In September 2019, Leading Routes report revealed that of a total of 15,560 full time UK domiciled PhD students in their first year of study, just 3% were Black. A Freedom of Information request to UKRI revealed that over the last three academic years (2016/2017–2018/2019) of a total 19,868 funded PhD studentships awarded collectively, 245 (1.2%) were awarded to Black or Black Mixed students, with just 30 of those being from Black Caribbean backgrounds. [242]

Other protected characteristics
Only 2% of 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). There is some data to suggest that people with a disability have less success at grant award rate (13% versus 15%).

Deprivation
Individuals from a lower 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 professorial 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.

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Workshop participant

And so having sat on professorial conferment committees over the years I have observed how there has been a change to become more gender diverse but it certainly wasn't racially diverse.'

WORKSHOP DISCUSSION

Why Equality, Diversity & Inclusion?
...for better utilization of the diversity of talents for the benefit of society and the nation.

Who are we trying to influence?
The system. The stakeholders and the grassroots professionals.

What does good look like?

- The participants agreed that the idea of good and the normative assumption of what good looks like, should be culturally appropriate and constructed not merely from a White, middle class, hetero-sexual, middle-aged male narrative.[244]
- Representation on research and academic teams should really reflect and represent the population they serve for research to give meaningful outcomes. So, there are disparities in distributing research funding if the people leading the studies are not representative. Eventually, this will influence the diversity of populations recruited to studies.
- There was agreement that change was needed and that change needed to be radical. So, the ultimate goal should be to shatter all barriers, including financial.

Incentives to foster change
There was consensus on the need to offer incentives to organisations to implement change, within their processes. The system will reach the aspired stage of excellence when justice has been achieved and that in order to do that we would really need to start tackling the broader societal issues before we start asking academia to follow suit.

Starting early
Earlier on in medical careers, there is a lack of development of scientific curiosity, or encouragement for the people with the right skills and attributes to go into research and academia. So this disparity starts from a very early age, in school where independent learning, self-motivation, self-direction and the confidence as well as freedom to pursue an idea is fostered only in a few settings of privilege.

Role models & misperceptions

- Role models serve can influence goals and motivation: acting as behavioural models, representing the possible, and being inspirational. [244] In early stages, individuals pay attention to role models to create a viable self-concept; in middle stages, they seek to refine their self-concept, and in late stages, they seek to enhance and affirm their self-concept. [245]
- There is evidence that gender and ethnicity matched role models help to inspire potential early career aspirants to follow their ambition. [246] and provide career counsellin, rather than their own achievements. [247, 248]
- The interactions with role models must be undertaken in an environment that emphasizes a spirit of enquiry, is supportive and understanding of needs and aspirations, and is characterised by civility and sensitivity to cultural, ethnic, and gender issues.
- There is evidence that longitudinal exposure that facilitates active engagement [249, 250] and sharing lived experience can inspire younger aspirants. [251]
- Discrimination in allocation of dedicated time for clinical research or a poor life work balance presents negative model.
- Misperceptions are damaging if people think this is not my career because they don't see anybody like themselves in it, or if they think they are not going to do well because there's bias, and thus, many won't even try.
- Some successful academics from underrepresented groups do not wish to be identified by their gender or ethnicity because of a perception that their achievements may be discounted or devalued. This misperception tends to do more harm to others who are trying to emulate their success and look up to them as role models. Being comfortable and owning one's identity is important for creating the new norm which is diverse and thus encourages aspirants. [252]
- Organisations often shy away from the commercial or reputational 'risk' of appointing someone who may not 'fit the narrow norm', or are awaiting a first leadership or senior role.

Culture, Academic Leadership & Governance

- Many academic organisations have a perception of a **narrow prototype of a strong academic leadership** model for improving performance, based on the premise that leadership behaviour/culture drives employee engagement/satisfaction, leading to improved organizational performance. [253] There are some personality types predicated by the current system, where more value is attached to attracting grants then supporting and promoting diverse talents.
- **Models of governance** span a wide spectrum between autocracies to democracies. [254] Despite the fact that more participatory governance models are the norm in practice settings outside of academia, many academic physicians seem to take an autocratic model more or less for granted. Therefore, often success in research careers is mistakenly associated with being autocratic, an alpha male, white, mature person, but not one who is inclusive and embraces diversity.
- **Cross-cultural leadership** is a valuable asset in academic leadership. Values such as openness, diligence, teamwork, and transparency provide evidence that all traditions of leadership are culturally bound and when applied in cross-cultural or multi-cultural contexts, the traditions become either a catalyst or obstacle to effective leadership.[255] Cultural norms determine the level of formality or informality as well as styles of communication and decision-making. So good should be appropriately culturally defined.
- **Culturally diverse teams -** Working with an integrated and culturally diverse team provides an opportunity for academic teams and leaders to learn other cultures through team and social interactions and enriches their cultural and professional perspective when making decisions.[255, 256]
- There is a need for a representative governance structures so that those who are making judgements on benchmarks (of what is good) are not the committees which have traditionally or historically lacked diversity and are representative of the population they are here to serve/ represent.

Transparency and diversity of conferment/ progression committees

Transparency encourages openness, and sits alongside accountability, efficiency, and effectiveness.[257] Academic committees often 'make judgments against arbitrary (non-diverse, non-inclusive) criteria that are diffuse, open to ambiguity or nuances and mostly born from a set of embedded, unconscious biases, then they are more likely to favour people with privilege above diversity.' There is a critical need to implement greater transparency throughout the risk assessment process of academic recruitment or conferment and thus provide essential information on how a particular conclusion or decision was made, thereby increasing confidence. [258] Independent or trained observers can counterbalance the level of bias. The workshop participants proposed the benefits of 'radical transparency', where every single decision, every action (that wasn't confidential or did not include commercially sensitive), is made visible to everyone in the organisation and the public.

Challenges of disclosure of ethnicity/ protected characteristics

- The mere presence of diversity and equality policies does not necessarily demonstrate that gender and ethnic inequalities are being addressed. Such policies may simply result in a 'tick box' exercise unless embedded within culture and practice. Additionally, there is a need to consider intersectional identities supported by transparent data collection. [259]
- Often in surveys people are mostly reluctant to disclose their disability, ethnicity, race or sexual orientations/ preference. This is usually a reflection of mistrust in systems, confidentiality or fear of breaching data protection. Many organisations implicitly demand fitting in, and the inability to fit in and merge by academics from under-represented diverse, minority ethnic backgrounds hampers their careers.[260]
- In matters of geography, socio-economic status, deprivation index or previous attainment is more difficult to measure or record with a degree of accuracy.

Alternative Pathways

- There are multiple different career paths to academia and success often is not recognised in the context of the career journey of an individual. If the system were able to recognise and value how people have progressed, what challenges and barriers they might have met along the way, it would allow for a much fairer system of recognition. So, it would not lower the bar in terms of quality, but would widen the definition of how quality and success is described, recognised and rewarded. It is likely to lead to a fairer society and balance the differential attainment.
- If the academic institutions and funding bodies have a diversity policy, a diversity council or officer can get recruitment search committees to consider a wider range of candidates, beyond those recommended by like-minded colleagues from similar backgrounds.
- Often this is a challenging ask, as the number of suitably qualified candidates from under-represented backgrounds is scarce due to the traditional processes which have excluded then at early stages of careers. [261]

Career workshops/ internship/ Apprenticeships

- Early or mid-career internship and apprenticeships are effective ways to support and nurture talented individuals from under-represented backgrounds to develop, consolidate their skills and take up appropriate positions in academic and research leadership roles. These need to be combined with an affirmative process of allocation according to equality, diversity and justice policies. Many universities have launched a new gateway year to support accessing medicine course. Such policies set an expectation of success for organisations, encourage aspirants, and provide them with resources that build their interest and confidence.

Support & Mentorship

- Mentoring programs can support by connecting with senior academics who can advocate for them and show them the ropes. Developing a diverse network of role models in academia and the public and private sectors is the goal.

Opportunities

Some aspirants face additional challenges because of coming from different countries, educational backgrounds, systems and not knowing the prevalent systems, expectations or not being able to access appropriate advice, guidance or mentorship. The system should foster opportunities for academics to be able to encourage sabbaticals, visiting lectureships etc to go to different places either internationally or within the country.

Inclusive Work Culture

Academic institutions that foster a work culture that embraces diversity with a goal of learning and integration is more effective at reaping the benefits of multiculturalism than one that tries to be “colour-blind.” Engaging and training senior academics as ‘diversity champions’, who act as mentors internally and as ambassadors externally, at community diversity events which can encourage inclusion behaviours, such as activating, respecting, leveraging, and enabling differences—learning how to recognize and take advantage of the rich diversity in our workforce.

Trust in the System

For an aspirant in an early career stage, it is vital that there is trust in the fairness and robustness of the governance processes of organizations, that they are being judged according to the merit of their application, rather than anything else. Often that new funding usually follows previous funding so making it tougher for new applicants. But underpinning it all is the fact that there are unconscious biases in organizations which need to be tackled.

Narratives influencing policy

Often it is not enough to just demonstrate data trends but to include human stories. For example, the challenges faced by international medical graduates in academia are best illustrated by narratives of their personal journey.

6.4.2 Value of data

- Among stakeholders, there was no good data available to go on. There was no framework or a set of standards that could be implemented. And therefore it becomes impossible to chart progress in meeting organisational intentions or plans such as 'fairer representation of minorities in higher positions within those organizations such as councils.'
- The group believes that Universities and research organisations, and funding charities do collect and have the data on characteristics of applicants or staff in recruitment areas but may choose not to share the data. Due to strict data protection regulations, comparing data-sets across organisations is challenging.
- There is an additional challenge that organisations feel unable to force people to reveal information about their protected characteristics (i.e ethnicity) so response rates are quite low. And that is likely to increase the risk of being able to identify in smaller cohorts the identity of people, who have completed such surveys.

Regulatory Influence

- The requirement for transparency in publishing datasets and longitudinal trends can be helped by clear guidance/ requirements set by regulators and national bodies such as 'Office of Students'. Many organisations tend to explain away their responsibility for many of the recognised disparities by claiming that these are due to factors beyond or before their involvement. But there are other things that they're much less willing to own
- **Moving the narrative from statistics to experiences** - Recognition that there were lots of different paths to reach a particular endpoint, and those paths would allow for each individual's different experiences. Everyone would be allowed to be their authentic self and that their different traits should be celebrated, so that there isn't just one kind of mythical personality type that is considered to be conducive to success.
- Personal stories help to understand background and hurdles.

Sustainable Interventions

- Positive discrimination / affirmative actions

Organisations have battled for a long time on the balance between affirmative actions to counter the historical. There is a pull for making sure that people are appointed on merit, and that they aren't a token appointment. And, there is a worry that if targets are set arbitrarily, this may compromise the academic standards. There is a need for transparency and robustness of processes.

- Additional/ Targeted Support

One of the ways to keep the recruitment or quality bar uncompromised but to provide equity in approach would involve support that may provide compensation for the years of disadvantage. An example is the widening participation scheme for medical school entry (such as gateway year for medical courses).

- Disaggregated Data on Progress

There are clear advantages for organisations to annually monitor their processes of recruitment, progression, funding distribution against disaggregated data on individual and group characteristics. Although in smaller cohorts or organisations there is a risk that disaggregated datasets may expose individuals but a culture of trust and transparency should counteract this risk of discrimination. And so therefore trust is important, and trust that this data will be used appropriately. And that people will take it in the way that it should be taken.

There was consensus that significant achievements were possible when narrative data, lived experiences are combined with quantitative data. In addition to taking into account the subtleties of personal experience and identity, the incentive scheme must consider intersectionality and the complex, interconnected clusters of risk factors or characteristics that increase the challenges.

- Incentives

Incentives such as widening participation, diversity of academic faculty (Athena Swan accreditation) and targeted funding allocations (NIHR Fellows/ Research Professorships) are important to kick start the process and achieve balance.

- Coaching and mentoring

So therefore it's important that networking, mentoring and contacts is available, not just at an undergraduate level but moving up the ladder to postgraduate level and beyond.

Longitudinal data

- It is well recognised that longitudinal data collection can be difficult because it's difficult to compare to historic data, as the questions, framework and definitions may have changed several times.
- Data on progression can identify some of the bigger trends, for example, and the sort of lower success rate of grant applications within the minority ethnic groups. Hence a consensus framework is needed for more common characteristics over time.
- It is also important to track people's career pathways and progression to review the reasons for success or why some people may choose to leave.
- There is a need for a public conversation for ethics of individual versus common good which can determine how much data will be available or should be collected in a transparent way. Quantitative data, is important but doesn't provide the whole picture,so there's a need to focus on collecting more qualitative data to explain why there may be differential attainment.
- As longitudinal data sources, the group considered empowering and connecting with medical school alumni associations to communicate with ex-students, and then link using existing frameworks where possible, and trying to look at what's the best in class currently in terms of data collection.
- Creating an anonymised database of medical students in the UK, that collects data from a level, through to medical school and later career points. Data are routinely collected, granular, refers to individual/ group characteristics and is universally available.
- Encouraging regular reporting continuous entry into existing databases for truly longitudinal data capture is also important. Circulating and cascading surveys to everyone, including all parts of the UK would help understand regional variations. Importantly, capturing data on people who have left academia, who do not pursue a career in academia or research will identify further areas to focus. Through exploration using qualitative methodology, understand why they left the workforce.

DA IN RESEARCH & ACADEMIA
RECOMMENDATIONS

6.1 DATA

- Disaggregated cross-sectional, quantitative data on recruitment, progression, funding allocations (for funding bodies) must be collected and published annually for all characteristics included in the Equality Act of 2010 and sources of multiple deprivation index.
- Ensure that data is collected in confidence and there are robust measures to prevent misuse and discrimination to gain complete trust and confidence of the workforce.
- Ensure interconnected, intersectionality of multiple characteristics is fully acknowledged and accounted for.

6.2 TRANSPARENCY

- Longitudinal data on academic career progression and narrative of lived experiences should be collected on a 3 or 5-year cycle, linked to professional registration (where relevant) or higher education institutions and published

6.3 BENCHMARKING

- Assessment on a nationally agreed benchmarking framework for achieving equality, diversity and inclusion to meet both the spirit and the letter of the Equality Act 2010 in each 3 or 5-year cycle.
- This should be linked with current existing framework such as Athena Swan, Research Excellence Framework and Workforce Race Equality Standards;

6.4 ACCOUNTABILITY

- Accountability in meeting the spirit and letter of the Equality Act 2010 provisions must be held by the Chief Executive, Vice-Chancellor or Chair of organisations and funding bodies, with transparent, published action plans and commitment.
- Embed the expectation of delivery of diversity outcomes at all leadership levels and measured against performance objectives

6.5 EDI CHAMPIONS

- Establish diversity or equality/Inclusion champions with a clear remit, resources, empowerment, and access to take appropriate action at every level to help achieve the organisational EDI duty. This should include the entire spectrum of the recruitment, progression and funding allocation process

6.6 AFFIRMATIVE ACTIONS

- Composition of Awarding Committees - ensure that grant awarding bodies and academic promotion committees reflect the diversity of the system.
- That the diversity and equality in those committees are truly representative of the population as well as the academic/ researcher population

DA IN RESEARCH & ACADEMIA
RECOMMENDATIONS

6.7 AFFIRMATIVE ACTIONS

- Widening participation for entry into medical schools (Gateway year) uses a model of affirmative actions for counteracting the inherent disadvantage of some groups to allow them a fairer position when being assessed with their peers.
- A similar model of affirmative action should be used for aspirants from disadvantaged backgrounds to prepare for grant applications or research / academic positions.

6.8 MENTORSHIP & ROLE MODELS

- Appoint, encourage, resource and empower academics from early, middle and senior career levels to become visible role models, prepared to share their experiences and provide coaching, mentoring and career support to aspirants.
- The composition of such academic role models cohorts must reflect positive selection to ensure that there is due emphasis on targeted, under-represented groups/ backgrounds and aim to build a critical mass.

6.9 INTERNSHIPS & FELLOWSHIPS

- Provide resources for formative internships, apprenticeships, bursaries/ fellowships for early and middle career academic aspirants to develop, consolidate and prepare for competitive allocations/ progressions.

6.10 SUPPORTIVE NETWORKS & TACKLE BIAS

- Develop, support, resource and empower networks of early, middle and senior career academics or aspirants to foster sharing of ideas, learning and support each other representing the full diversity of the workforce
- Provide meaningful workshops for building awareness of lived experiences, understanding inherent inequalities and bias.

6.11 FLEXIBLE CAREER PATHWAYS & PROTECTED TIME

- Develop a flexible, wellbeing orientated, career system that is focused on career goals/ expectations and people but not locked into set, predetermined patterns of time and temporality.
- Clinical Academics - provide protected time that allows aspiring clinical researchers/ academics, who do not always have the same infrastructure support (as full time academics do) to develop and consolidate skills and prepare competitive applications.

6.12 EDI

- Develop, coordinated strategies, policies or processes (for example, on national funding, recruitment)
- Develop a specific Diversity and Inclusion Strategy as part of a refreshed and updated Talent Action Plan, which is clearly communicated.

BAPIO INSTITUTE FOR HEALTH RESEARCH

Chapter VII
DA IN PROFESSIONALISM

btg21 - full report

DA IN PROFESSIONALISM

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Workshop participant

Professionalism should not be considered in isolation. DA has scarred many professionals in several aspects of their professional and personal lives.

DA IN PROFESSIONALISM

SUMMARY

Professionalism is the basis of medicine's contract with society

- For any profession, keen on maintaining public trust, self-governance, autonomy and responsibility for providing a fundamental human right such as enjoyment of health, it is imperative that it sets for itself the highest expectation of the acquisition of excellence in professional knowledge, skills and the demonstration of compassion, empathy, standards of behaviour, honesty and transparency worthy of this responsibility.
- Such professional standards as expected by the profession and society, are defined and enshrined in treatises such as the 'Good Medical Practice' [262] and similar documents.
- However, there is a 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 world which is in a constant cycle of change and progression has changed yet again since the 2020 pandemic, with the almost universal recognition of social injustice, embedded discrimination and resulting health inequalities. Even before the COVID-19 pandemic, there were seismic changes with the advancement in genomics, biological therapies and a renewed 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.
- 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.
- 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 focussing on the individual professional when standards are breached.
- This needs to change and organisations must be answerable to the same exacting standards and demonstrate that due support or training has been provided to all professionals to help them maintain the expected standards.
- In addition to the organisational accountability for providing the environment for medical professionals to operate safely and optimally, 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.

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Interviewee

"Mine was just something which normally shouldn't even have been investigated, you know you just start those investigations to - well that's the feeling I got, just to cripple the person and just prevent the person from getting it, the consultant job. So mine had nothing to do with the GMC, had nothing even to do with the hospital as a whole, it was just my unit at that hospital investigating it, then they came to no conclusion. I told them look at this investigation quickly so that if the job is still available, I can still get it, but they were just wasting time and then it was gone." P10, male, Black African, Registrar, Surgery, IMG age 47.

The workshop explored the drivers of DA and considered solutions eventually building a consensus 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;
- the 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
- the discrimination in the governance processes around dealing with breaches of professionalism thus leading to differential outcomes for certain groups of individuals, thus perpetuating social injustice.

There were 4 key recommendations;

- The definition of medical professionalism should be broadened to embrace the diversity of the public and the professional workforce, so it meets the letter and spirit of the current legislation ensuring equality, diversity and inclusion (EDI),
- Employing organisations are accountable to the same professional standards that apply to doctors and demonstrate their commitment to providing the knowledge, skills and the optimal workplace environment to allow individuals to meet their professional obligations
- The professional standards (i.e. the UK General Medical Council's treatise on Good Medical Practice) are reviewed and updated by wider consultation, to reflect the changing nature of the social, scientific, medical and healthcare landscape which drives the societal expectations from the profession
- The process of handling complaints or breaches of professional standards (i.e. Maintaining Highest Professional Standards - MHPS code) or fitness to practice referrals are reformed, made supportive, fair, just and transparent to rebuild trust of the diverse professional workforce. This should include the formation of diversity or justice committees or councils within organisations, for the regulator and finally answerable to the public through the Parliamentary Ombudsman.

7.2 HIGHLIGHTS FROM THEMATIC REVIEW

What is professionalism?

- The fundamental tenets of a profession are:
  - autonomy in action and self-regulation,
  - an ethical code developed and pledged by the profession;
  - a distinct status within but at the same time being exclusive of general society; and
  - a corpus of knowledge, developed and maintained from within the profession, which serves as the basis for practice. [264]
- A systematic review in 2009 did not find any discernible, universally agreed, overarching concept or context of medical professionalism. Thus concluding that the dynamic nature of the organisational and social milieu in which medicine operates, creates a fluidity where no single and static definition (of professionalism) could be considered definitive.[265]
- Yet for a profession that is steeped in science attempts at objective measurement of professionalism have been largely unsuccessful. [266] There is a perpetual discourse on whether professionalism should be viewed as 'a set of attributes' or as an overarching 'ethos' providing a framework for medical practice. The challenge of using abstract concepts such as altruism, excellence, duty, honour, integrity, and respect to describe professionalism, makes them difficult to translate into practice.[264]
- Therefore a much more grounded triad includes the primacy of patient welfare, patient and professional autonomy, and that of social justice. This imparts the additional responsibility of a fair distribution of health care resources, and universality.[267]

DA IN PROFESSIONALISM

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Interviewee

"Mine was just something which normally shouldn't even have been investigated, you know you just start those investigations to - well that's the feeling I got, just to cripple the person and just prevent the person from getting it, the consultant job. So mine had nothing to do with the GMC, had nothing even to do with the hospital as a whole, it was just my unit at that hospital investigating it, then they came to no conclusion. I told them look at this investigation quickly so that if the job is still available, I can still get it, but they were just wasting time and then it was gone." P10, male, Black African, Registrar, Surgery, IMG age 47.

What factors Influence medical professionalism?

- **Shared responsibility**

Medicine in the modern world is no longer practiced in isolation or by individual experts acting alone. The prevalent model incorporates professionals employed by, and working within organisations, which determine the environment, set expectations, creates a professional framework and the multi-professional workforce that is jointly responsible for care. In this context, the antiquated expectation that each professional is held individually responsible in isolation, is fundamentally flawed. The challenge of resolving one's individual responsibility to uphold the 'high ideals' or standards of professionalism, while having little power or influence in the organisational decisions, is where most of the dilemma is rooted for doctors (and other professionals).

- **Patient Expectations**

In the UK, the definition of medical professionalism for a modern society was explored in 2005 by a Royal College of Physicians Working Party. [268] Although a direct causal association between 'robust professionalism' and better health outcomes was considered tenuous; there was agreement that patients and the public certainly recognise poor professional behaviours and associate it with poor medical care. Thus the values that doctors embrace, set a standard for what patients expect from their medical professionals.

- **Behaviours or Personal Attributes**

There are many stakeholders in the definition and the evolution of the modern day doctor, not just the employers and patients but also the regulators, particularly the General Medical Council and the Care Quality Commission, the trade union (British Medical Association), the Medical Royal Colleges, and the Government. What is interesting is that there are competing priorities amongst them on what a good doctor should look like. For instance, almost 80% of patients in a survey felt that the doctor should be well prepared prior to examining them, whereas only 35% of doctors felt that this was a prerequisite of making them a good professional. [264] The majority of complaints to the GMC are not about the skills of doctors, rather they refer to their behaviour or personal conduct, which is a bone of contention to the medical profession particularly those from a minority ethnic background as they seem to be disproportionately represented in these complaints.

- **Working environment**

There is relativity in the conditions where doctors work, where a competent doctor in a poorly managed or supported system may lead to poor outcomes. [269] Medical professionalism, therefore, is not just within the gift of the doctor concerned.

- **Impact of COVID-19 pandemic**

This paradigm was most effectively demonstrated as the global healthcare profession faced the COVID-19 pandemic. At many pinch points in the pandemic, professionals found themselves in moral, legal and ethical dilemma facing choices where the care of the individual patient had to be considered not primarily 'in their best interest', but in the context of the availability of appropriate facilities, experimental or rushed protocols of new treatments versus their personal risk (or near ones) often depending on varying standards of protective equipment or rationing, beyond their control or influence. This has led to a high degree of mortality and morbidity amongst healthcare staff, as well as moral injury and psychological impact on those who survived. [270] This gives rise to a need for new professionalism standards that includes health care provider organisations, which can set standards or guidance for decision making in a fiscally difficult, dynamic, and ethically challenging environment.

- **Organisational impact**

An evolution in the definition of medical professionalism was presented in the 'Physician Charter' in 2002, subsequently adopted both in the United States of America and in Europe.[267] However, the impact of professional standards on the quality of healthcare and patient experience was recognised as being influenced by external factors (such as organisational challenges, priorities (local and regional), by governmental policies, and the changing nature of societal expectations).

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Interviewee

"Mine was just something which normally shouldn't even have been investigated, you know you just start those investigations to - well that's the feeling I got, just to cripple the person and just prevent the person from getting it, the consultant job. So mine had nothing to do with the GMC, had nothing even to do with the hospital as a whole, it was just my unit at that hospital investigating it, then they came to no conclusion. I told them look at this investigation quickly so that if the job is still available, I can still get it, but they were just wasting time and then it was gone." P10, male, Black African, Registrar, Surgery, IMG age 47.

As such, health care organisations largely determine (positively and negatively) and influence the behaviour of their employees, including regulated professionals. Although the profession and organisations are set up 'to do the right thing' by and large, there are however, many unfortunate instances where health care providers have engaged in activities or taken decisions, that are not in concordance with the principles of medical professionalism. [205] Hence the proposed 'Charter on Professionalism for Health Care Organisations' in the USA, aimed to stimulate health care leaders, professionals, policy stakeholders, and society to evaluate their ways of operating and ensure adherence to best practices. [271]

- **Relationships with patients and organisations**

Ideally, professionalism should encompass not only the physician's responsibility to patients, but also the reciprocity of the patient–physician relationship and the responsibility of the institutional leaders to its physicians. [272] The International Charter for Human Values in Healthcare enshrines core values for all health care interactions as a guide to professional behaviour, [273] providing principles applicable to all relationships within health care; and all stakeholders share responsibility in upholding these values including attention to the prevalent cultural sensitivity. Other members of the healthcare system, clinical colleagues from nursing, midwifery and other regulated professions, as well as executive leaders (notably managers) and political masters have a reciprocal duty to help create an organisational infrastructure to support doctors in the exercise of their professional responsibilities.

Just as the patient-doctor partnership is a pivotal therapeutic relationship in medicine, the interaction between doctor and system is central to the delivery of professional care.

High-quality care depends on both effective health teams and efficient health organisations. Professionalism therefore implies multiple commitments; to the patient, to fellow professionals, and to the institution or system within which healthcare is provided, to the extent that the system supports patients collectively.

- Overall, when physicians find it increasingly difficult to meet their responsibilities to patients and society. A focus on individual characteristics and behaviours alone is insufficient as a basis on which to build further understanding of professionalism and represents an unstable foundation for the development of educational programmes and framework for its assessment. [274]
- Therefore policies to promote an institutional culture committed to professionalism and to enlarge physicians' role in institutional leadership, may help to provide stability and sustainability. [275]

Differential outcomes and impact of racism

- Racism and systemic bias exists in medicine, in every aspect including relationships between professionals and patients, colleagues, in employment, education, training and the access to services and support. There are differences between cohorts of professionals, in the likelihood of experiencing bullying and harassment in the workplace, [45] leading to loss of productivity and a high turnover of staff. This has a disproportionate impact on experience of staff from ethnic minorities and those that trained and were recruited from overseas, costing the NHS, not just in the quality of care, but also in economic terms.[276, 277] The call for a workforce race observatory to address the need for data to help to guide priorities and interventions, was answered in the creation of the NHS Race & Health Observatory. [278]

DA IN PROFESSIONALISM

DA in sanctions & handling of complaints

- 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. [279, 280] Under-represented groups including ethnic minority doctors are more likely to face referral to the UK regulator the General Medical Council (GMC), to have their cases formally investigated and likely to face 'harsher' sanctions (although that still remains to be established) on conclusion. Employers and health care providers are more likely to refer doctors who obtained their primary medical qualification outside the UK (approximately 38%), and from ethnic minority backgrounds (approximately 40%), to the regulator. Complaints from employers are more likely to result in an investigation being opened, and ultimately more likely to result in a sanction being applied.

DRIVERS

- As in all such matters of inequality and discrimination, there are multiple causes and contributors to the phenomenon of differential attainment and thus incredibly challenging to draw out simplistically. Almost all studies stress that more transparent data on ethnicities that are disproportionately affected is needed. Studies highlight that misconduct can have individual as well as social and environmental (workplace) dimensions including: stressful and unsupported work environments and a culture of blame rather than learning. Often Fitness to practise (FtP) processes or decisions are not clear or transparent thus creating a high degree of psychological distress, which for some might lead to suicide. [281]

Exploration of the evidence suggests six factors which might explain the high rates of minority ethnic doctors being referred to the UK regulator, specifically from NHS employers;

- 1. Doctors in diverse groups do not always receive effective, honest or timely feedback, or have an opportunity for remediation, particularly where they are from a different ethnic group to the managers,

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Workshop participant

I've looked after more than 300 doctors from Black & minority ethnic backgrounds who have gone through the GMC processes. It's a problem from start to finish.

- 2. Inadequate induction, or lack of ongoing support and help in transitioning to unfamiliar social, cultural and professional environments, especially if they have trained outside the UK and come from diverse cultural and social backgrounds,
- 3. Working in isolated, segregated roles or locations with a lack of supported learning, mentorship, supervision and resources,
- 4. Some organisational leaders are remote, inaccessible and do not welcome challenge or scrutiny of their processes,
- 5. Allowing divisive processes to develop and responding to errors by seeking to identify 'blame' rather than focusing on remediation, particularly affecting doctors who are seen as outsiders,
- 6. The lack of inclusion manifested by the existence of in-groups and out-groups based on qualifications, country of origin and within the UK, medical school and ethnic background. [279]

Gender & insight

There is a preponderance of men, above the age of 50 years and from minority ethnic groups in referrals to the regulator. This proportion may be due to recognisable gender differences in emotional intelligence, a perceived reluctance to accept responsibility (when breaches of professionalism have occurred) and bias from complainants or the organisation. When comparing leadership and personality styles, women tend to demonstrate higher empathy, willingness to accept personal responsibility,[282] social and emotional intelligence, thus putting men at a comparative disadvantage.

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Questionnaire respondent

Gas lighted. Incivility. Abused. Harassment. Victimisation. Abused. Assaulted.

Discrimination, Racism and Bias

In 2020, the resurgence of the 'Black Lives Matter' movement [283] and the 'COVID-19 pandemic' [284] led to the widespread awareness that inherent, systemic discrimination, bias and racism in society was leading to health disparities and was an underlying cause for the excess mortality in ethnic minority professional as well as communities.[285]

The continuing prevalence of inequalities and discrimination relating to a range of protected characteristics was recognised to be a fundamental risk for whole societies compromising social justice and heaping devastating consequences for under-represented people, medical professionals (from ethnic minorities and international medical graduates) being among the frontrunnersin such 'wronged' groups.

In FtP matters, the regulator is perceived by such professionals as remote, inconsistent in their processes, untrustworthy, punitive and unsupportive, resulting in defensive practice or reluctant engagement in reflection and remediation. [279] The consultation by the UK government from 2017-19, appears to have failed to do justice to the assessment of the impact of the Equality Act on the review of professional standards. [286]

Equality, Diversity and Inclusion

As the Equality Act and EDI applies to both patients and professionals, potential solutions include connecting medical professionals to the under-represented or deprived communities, empowering minority patients with knowledge, and diversifying the medical workforce. [283]
The same should be applied to broadening the definition and interpretation of medical professionalism to incorporate the diversity of the workforce, incorporate EDI at every step into a new model of diverse physician leadership, organizational professionalism underpinned by sustainable governance policies and procedures that address workplace climate, harassment, explicit and implicit biases, cultural sensitivity, organizational well-being, and workforce equity (including gender equity). [287]

WORKSHOP DISCUSSION

Using an EDI lens, the workshop explored how the system (organisations, the regulator and the Government) can be responsible for the highest professional standards jointly with the regulated professionals in its workforce; engage the full diversity of professionals in system leadership; and provide a nurturing, supportive and just environment as essential ingredients in the pursuit of safe and efficient quality of care standards; in full awareness of the dynamic landscape of medicine and the society it serves.
The participants considered the hypothesis that a balanced, representative, diverse health care workforce would improve patient care, safety and enhance trust in doctor-patient relationships.[275]

7.3.2 Redefining medical professionalism

Social context of professionalism

- The workshop focussed firstly on expanding the understanding and contextualization of medical professionalism and its definition, exploring that words often used to define the profession may be the root cause of the angst and challenge faced by the modern professional.
- There was consensus that the current definition of professionalism based on individual mastery, autonomy, and self-regulation was antiquated and obsolete.
- There are many evolving factors that exerted considerable influence in professional practice such as shared responsibility within multi-professional teams, devolved clinical leadership, digital communication within a interconnected world, expert patients, impact of social networks, new ethics of genomics, technological competence in using artificial intelligence, robotics and 3D-reconstruction, and communication over digital channels, in addition to integrity, caring and compassion.

Additionally, based on social production of disease in the postmodern theory of public health, differences in disease prevalence among social or ethnic groups are due to systemic causes, such as bias and oppression.[287, 288, 289]

Good Medical Practice & EDI

In the UK, the principles of medical professionalism, originally published in 2006, were refined in 2013 and expressed in the form of the Good Medical Practice guidance [263, 290], forming the basis of the compact between the profession and the public. However, the consultation in 2011 (4000 patients and 2000 doctors), demonstrated no reference to the principles of EDI.

The UK government's consultation on the regulation framework (circa 2017-19, with 900 responses), also did not receive adequate engagement to the question of 'the potential impact of the Equality Act' and therefore did not adequately explore the issues of equality and diversity. This reflects challenge in engagement and adequate representation of wider society in such exercise. The UK government did accept the need for modern and efficient fitness to practise processes, provide better support for professionals and create a more responsive and accountable regulation. [286]

In further consultation by the UK Professional Standards Authority, there was concern that the proposed efficiency by consensual disposal of cases (by the regulators) may lead to reduced confidence in the system and potential for unconscious bias. The overwhelming majority of participants felt that independent oversight should be retained and there was a clear need for 'checks and balances' within the system. [291]

The workshop participants felt that a further reform was essential due to the seismic shift of the social and medical landscape following the events of 2020 and recognition of inherent structural inequalities in public life.

There was overwhelming consensus on the first 2 principles of making the patient their first concern, keeping competency, knowledge and skills up to date and ensuring patient safety.

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Workshop participant

'I don't know whether it's the words that are limiting or our interpretation of the words that are limiting.'

The workshop considered the cultural dimension of how the healthcare system treats patients from diverse backgrounds, recognise the systemic discrimination that exists and leads to differential health outcomes for patients from minority ethnic or under-represented groups. The participants were keen to incorporate the dimension of EDI in the definition to encompass the renewed understanding of how the unidimensional nature of the word 'patient' did not account for the structural discrimination and social injustice that existed in the health service. Thus a broadened definition incorporating EDI was explicitly required to ensure that all professionals and organisations had a mandated duty to tackle this.

Collaboration & Partnerships

The participants were keen to contribute to reforming the principles of 'working in partnership with colleagues', 'establishing trustworthy relationships', 'being open, honest and acting with integrity' as these were more open to misinterpretation especially in the context of doctors from ethnic minority backgrounds. They felt that the scope of GMP [290] should include not just compassion, caring and communication, but also fairness and respect for all. It must be universally applicable to all regardless of ethnicity, gender or any other protected characteristics. There must be a degree of flexibility of interpretation based on contextual, societal and environmental factors or constraints. Any such interpretation must be based on meaningful engagement with the full diversity of the profession and the public it is designed to serve (including the under-represented cohorts or communities).

63

Workshop participant

'I have fallen down on that many, many, many times because I have seen microaggressions often where actually a colleague has not been treated unfairly by somebody else and I have done nothing. And I had done that, time and time and time again. And I'm sure I'm not alone.

When this is not explicitly defined, it tends to default to that of the 'white, Anglo-Saxon male'. The values of modern Britain have changed significantly with the shift in population compositions and therefore the definition needs to reflect modern 'big' society.

The participants agreed that although the concept of 'trust' is universal, yet in practice evidence suggests that the interpretation of 'trustworthiness' is too variable. The GMP has a narrow view on responsibility of 'others to others'. Trust in social terms is built on the foundation of competence, benevolent (caring for the welfare of, acting in the best interest of) and demonstrating integrity. There is a recognition that 'White male privilege' defaults to the assumption that they will be treated fairly, yet it is true that ethnic minority doctors (and professionals) do not automatically expect equality as a given, and perceive that they have to work twice as hard and make half as many mistakes, to be equally regarded to their White peers. Hence there was a need for rebuilding the trust in large sections of the workforce as well as a substantial proportion of the deprived population which would lead to better outcomes for all. [292]

The workshop agreed that the focus has to start with the system, rather than the individual. The system (as defined in the context of UK healthcare) would include the views of the public (it serves) at every level providing input through parliamentary oversight, legislation, governmental policies and determining locally driven strategic targets and vision. Hence, the definition of medical professionalism should include the context of the public, and set the same high standards on all healthcare organisations including the governmental departments holding them accountable.[293] The delegation of this accountability should then pass to the organisational leadership eg. Chief Medical Officer, NHS Chief Executives, Chairs of Clinical Commissioning Groups (CCG) in primary care, Medical Directors in NHS and independent sector healthcare providers, as well as voluntary healthcare organisations.

Better workforce engagement leads to lower mortality and improved outcomes. [294] Leaders are therefore responsible as an equal partner with their professional workforce in maintaining the high standards of care expected. Addressing harmful bias and discrimination is the professional responsibility of every provider and essential to effective and equitable care. [295] There was acknowledgment that if NHS has to honour its commitment to have ethnic diversity representation at every level of the workforce by 2025, reform will need to start in earnest.[296] Organisations must embrace diversity and establish strict non-discrimination policies, which should apply both to professionals and to the patients. There should be non-discriminatory hiring practices, along with policies protecting the privacy, human rights of professionals and patients with appropriate training to understand and respect the diverse cultural backgrounds and manage the cultural conflict that often arises from maldistribution of power and legitimacy.[297]
The workshop participants were concerned that the regulator was unable to demonstrate robust evidence that their processes were free of discrimination, contrary to their claim. Thus data will need to be provided openly to restore confidence of the diverse workforce. The regulator does not currently have the powers within the statute to hold non-medical professionals and organisations to account when breaches occur in GMP.

Non-adversarial
Doctors must be included in the discussions that affect them. Often there is a policy of secrecy and exclusion whenever there are any concerns raised about a doctor. It appears to be an adversarial process such as 'being investigated for a crime', rather than an inclusive and supportive process that fosters learning.

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Workshop participant

'You should see everybody and treat everybody, as you would like to be treated yourself. If you're a patient, how would you like to be seen, exactly the same way you see somebody else.'

Respect
Doctors must be accorded the respect due a professional, irrespective of their personal characteristics and especially in situations of complaints and concerns. Doctors often describe their experiences with patient bias, prejudice, and discrimination as painful and degrading. Women and minorities are more likely to be targets of patient bias, this may worsen existing disparities, cause distress or burnout and may also affect patient outcomes. [295]

Year on year, the WRES [45] data benchmarks UK NHS Trusts on several domains of feedback and some organisations which continue to demonstrate poor performance are not held to account.Organisations must be required to produce smart action plans and boards held accountable for their delivery, for WRES benchmarks, as is expected in clinical outcomes. Persistence of underperformance should require intervention by regulatory agencies.

Locum agencies
The workshop participants were concerned about the manipulation and lack of rights of doctors employed by locum agencies and often the induction, training, support and mentorship is non-existent. IMGs are most likely to face such discrimination with little prior understanding or familiarity with the UK healthcare sector. Often IMGs live in fear and are not able to stand up for themselves against these organisations for fear of being prosecuted.

Induction and supervision
There was concern that many newly arrived IMGs are appointed at inappropriate levels of responsibility, given poor inductions and frequently 'thrown in the deep end' especially with on-calls and out-of-hours work where supervision is inadequate and staffing numbers are sub-optimal, exposing them to enhanced personal risk. While working in such isolated shifts, these new doctors are easy to blame when something does go wrong. The participants recommended that the regulator and the employers had a statutory duty to provide comprehensive induction and support to IMGs and all doctors returning after a break in work.

Inclusion
Roger Kline's paper [42] demonstrated the existence of in and out-groups, with the existence of clubs within hospitals. His paper suggested that overseas doctors do not belong to a club unless "you're lucky enough to find yourself in a club". This makes IMGs automatically excluded from working collaboratively and with colleagues.

The workshop participants felt the NHS whistleblowing policy and its implementation was sub-optimal. The protection offered to the whistle-blower was inadequate. The function of the 'Guardians' for raising concerns was ineffective. The regulator and the NHS organisations must provide oversight of the protection offered to those who raise concerns and protection from malicious persecution.

Safe space
There needs to be a 'safe space' for professionals when they make mistakes. The incident reporting systems should not be 'weaponized' as it is now at times. Once reported there should be a robust, transparent process for investigation of concerns and support provided to professionals to reflect and make amends. If the process is more supportive, doctors would feel more safe in expressing remorse or regret.

DA IN PROFESSIONALISM
RECOMMENDATIONS

7.1 REFLECTION OF SOCIETY

- The broad-based concept of society (manifest in equality, diversity, inclusion and justice) must be integral to the definition, applicable to patients (in relationships and expectations) and professionals including their relationships with their leaders and managers.

7.2 RESPECT FOR IDENTITY

- Medical Professionalism must ensure the right of everyone to give respect to all and to be treated respectfully in their own right, and the ability to fully express their identity.

7.3 NEW DEFINITION

- The new definition of medical professionalism must explicitly acknowledge the diversity of patients and professionals, assess the impact of EDI on every service and process, demonstrate congruence with their variable needs and respect their autonomy.
- The term 'doctors' should be replaced by 'doctors from diverse backgrounds, persuasions and orientation' to recognise the diversity within the profession
- The scope of partnerships should be broadened to include partnerships with the full range of multi-professional colleagues. This should also embed the ethos of fairness and inclusive teams.

7.4 ORGANISATIONAL RESPONSIBILITY

- The definition of medical professionalism must explicitly include the responsibility (for upholding the principles of GMP) of the organisation within which the individual acts.
- In the current reform of the regulator's roles undertaken by the government, there should be 'organisational responsibility' added to the GMP and broadening of the scope of the regulator. This accountability must be held collectively by CEOs, Chairs, MDs and regulators.

7.5 ACCOUNTABILITY

- The Executive Board and employers must hold accountability for ensuring that the organisational culture and processes are transparent, supportive and meet the letter as well as the spirit of the principles of EDI and social justice
- Organisational leaders, (both clinical and managers), must accept and adopt practices and lead by example in demonstrating that they value their diverse workforce, show social responsibility and require that it be an integral part of the culture.

7.6 REGULATOR

- The regulator must demonstrate duty of candour, acknowledge, learn from their errors and reform their systems. Medical professionals must have recourse to appeal the decisions made by the regulator or organisations with the Parliamentary ombudsman.

DA IN PROFESSIONALISM
RECOMMENDATIONS

7.7 REFLECTION OF SOCIETY

- The Professional Standards Authority must ensure that the regulator(s) complies with the full scope of their responsibilities, ensures a supportive environment, focusses on regulating in the context of the organisational responsibilities, EDI and social justice.
- 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.

7.8 COMPLAINTS

- The organisation must ensure that when complaints and concerns are raised against professionals that they are dealt with (informally or formally, and investigated as appropriate) in a collaborative, open, unbiased and inclusive way that is focussed on reflection, insight, learning and remediation.
- 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.

7.9 ORGANISATIONAL BENCHMARKING

- 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.
- The regulator and NHS England must ensure that all medical professionals, (especially those new to the system, returning to practice or employed by locum agencies) are provided with quality assured, effective induction, appropriate supervision, and measures to foster integration within teams and protected from being manipulated, discriminated or exposed to risk.

7.10 SAFE SPACE

- 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.

7.11 EDI

- 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.

THEMATIC REVIEWS

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BTG21- FULL REPORT

2021

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