Follow-up reply to Dr Luke Evans MP question during 3 November 2020 evidence session on Safety of maternity services in England

1. Dr Evans asked "in your experience with regard to BAME and getting complaints, how much of it is down to communication, as opposed to actual ability in terms of practice or outdated practice methods, if it is coming from abroad? Is there a discrepancy between the two if you are comparing British trainees and British-trained graduates, both white and BAME, with doctors from abroad"

2. In research commissioned by the General Medical Council, Doyin Atewologun and Roger Kline sought to understand why, in the UK, certain groups of doctors are more likely to be subjected to both formal local investigations through a local disciplinary process and to referral to the GMC Their report *Fair to refer* (2019) has been accepted by the GMC and their recommendations are being implemented

Context of race discrimination and referrals to the GMC

3. The context within which these issues were explored included the well recorded data on race discrimination within the medical professions. The treatment and experiences of BAME doctors in the UK, including their entry to medical school (Esmail and Everington, 1993), postgraduate Royal College of General Practitioners (RCGP) exams outcomes (Esmail et al., 2014), and the impact of the discretionary points award scheme for doctors (Esmail, 2003) has been a continuing source of concern over the last two decades. Most recently the Royal College of Physicians whose own October 2020 survey found that BAME doctors "are consistently disadvantaged when applying for jobs"**.**

4. A quarter of BAME GPs surveyed reported experiencing discrimination from patients at least monthly, with three quarters saying they faced racial discrimination from their patients at some point. One quarter said that they felt discriminated against by a practice they had applied to join (Mahase, *Pulse May 2018*).

5. In England, where comprehensive data exists for National Health Service (NHS) staff as a whole (all staff groups taken together), BAME staff are more likely to enter local disciplinary processes, though since the NHS Workforce Race Equality Standard (2015) highlighted this, the numbers have significantly declined as NHS Trusts started to introduce new strategies on disciplinary action more focussed on learning than blame.

6. Across all healthcare professional regulators, the rates at which registrants are referred into the Fitness to Practise processes are higher for BAME registrants than they are for white registrants. (West 2016; GMC, 2018; General Pharmaceutical Council, 2018; Nursing & Midwifery Council [NMC], 2018).

7. Specifically, employers refer to the GMC more than twice as many Black, Asian and Minority Ethnic (BAME) doctors compared to white doctors. Employers refer 2.5 times more non-UK compared to UK graduate doctors.[1] These groups are also more likely to be referred to the regulator, the General Medical Council (GMC) by their employers or healthcare providers, for subsequent formal disciplinary action.

8. Groups over-represented in the GMC fitness to practise (FtP) procedures include doctors who are neither GPs, nor specialists, and not in training (primarily SAS doctors) BAME doctors overall slightly more likely to be referred than White doctors and overseas graduates more likely to be referred than UK graduates. Other more likely to be referred include older male doctors, some non-specialist doctors, certain specialties (Occupational Health, Obstetrics and Gynaecology, Surgery, Psychiatry) and locums (GMC's *State of medical education and practice in the UK* reports, 2017, 2018).

9. Disproportionality in referrals by employers and healthcare providers into the Fitness to Practice process has a significant impact because although referrals from employers have been steadily falling in recent years and now comprise just 4.3% of referrals (GMC, 2018), referrals from employers,

healthcare providers and Persons Acting in a Public Capacity are far more likely than complaints from the public to be investigated by the GMC (84% compared with 16%) and to subsequently lead to sanction (GMC Fitness to Practise statistics, 2017).

10. The negative effects of these sanctions on doctors for patient care are also well-documented. For example, sanctioned doctors increase "hedging" behaviours, such as over-referral of patients, reluctance to handle perceived high-risk cases, and recommend more invasive procedures even when these are contrary to their professional judgement (BMJ 2015; Bourne et al., 2015). Further, when doctors' practices are investigated, whether formally or informally, there are adverse implications for their careers, reputation and wellbeing (Chamberlain, 2016).

11. Overall, the GMC's data and other studies consistently show patterns of over-representation of some groups of doctors in complaints made and concerns reported. The likelihood of a doctor being complained about, or having a concern about them raised, varies according to factors including gender, specialty, type of contract, age, ethnicity and place of Primary Medical Qualification. BME doctors have more than double the rate of being referred by an employer to the GMC compared to white doctors. 1.1% of BME doctors were complained about by employers 2012–16 compared to 0.5% of white doctors. Non-UK doctors have 2.5 times higher rate of being referred by an employer to the GMC compared to UK graduate doctors. 1.2% of non-UK graduate doctors were complained about by employers 2012–16 compared to 0.5% of UK graduate doctors

    - Men (White and BAME) are much more complained about than women (White and BAME)
    - Amongst doctors who are neither GPs, nor specialists, and not in training, BAME doctors are slightly more complained about than White doctors
    - Doctors who are international medical graduates (IMG) are more complained about than doctors who trained in the UK or the EEA

- The category of GPs most complained about are BAME doctors whose place of Primary Medical Qualification was either EEA or IMG
- Most groups of doctors are more likely to be more complained about by members of the public than their employer. However, for Speciality and Associate Specialist (SAS) doctors, the overall referral rates of complaints are lower; these doctors are more likely to be referred by employers than members of the public
- Specialist locums are as likely to be complained about as permanent specialist members of staff and twice as likely to be investigated
- The likelihood of older doctors being complained about is higher than for younger doctors and is slightly lower (15%) for older white doctors than it is for BAME older doctors (18%) across 2012-2017
- There is significant variation in complaints received by speciality with doctors working in occupational medicine, obstetrics and gynaecology, psychiatry, surgery in particular likely to be complained about.

(Data from *The state of medical education and practice in the UK,* GMC, 2017, 2018 and *What our data tells us about locum doctors.* GMC Working Paper April 2018).

Reasons for disproportionate referrals

12. Atewologun and Kline's found that the factors likely to account for disproportionate representation of certain groups of doctors in FtP referrals are multiple and intricately linked. These factors are evident on the one hand as 'risk factors' for certain groups of doctors and on the other hand as 'protective factors' for others. These factors layer upon each other to create a cumulative positive impact for some doctors, and a cumulative negative impact for others.

13. The likelihood of experiencing risk factors is associated with, and underpinned by, a pervasive theme we observed relating to insider/outsider dynamics. If protective factors are present for everyone (i.e. not just accessible to those doctors who happen to be insiders), then these protective factors neutralise the likelihood of experiencing risk factors facing some doctors (see page 35).

14. A doctor's pathway into UK medical practice may pre-determine their outsider status and the level of support they receive from the outset, starting with induction. A doctor who fails to have a supportive start to UK medical practice, can then continue to experience further disadvantage as an outsider.

15. We found that evading conversations regarding concerns relating to a doctor's practice (in particular regarding conduct) was a primary factor. The lack of timely, direct and honest feedback, that is sensitive to difference, can have a huge impact on a doctor's opportunity to demonstrate learning from mistakes and improvements to their practice. Further exclusion from ongoing socialisation support, often referred to as learning the informal rules of the NHS, is an additional factor.

16. We also found that working patterns and contractual arrangements in the medical profession are an additional contributory factor because BAME doctors can often experience isolated or segregated working in certain roles or locations.

17. The prevailing organisational culture also plays a part in explaining disproportionate FtP referrals, with certain cultures looking to find an individual to blame when something goes wrong, rather than trying to learn from the mistake so it doesn't happen again whilst appropriately considering accountability.

18. Their research concluded that addressing the risk of bias in the referral process is beyond the scope of doctors from the over-represented group, and rather lies with the leadership within each organisation to provide frequent, direct and honest feedback across difference, design ongoing socialisation support, integrate certain roles and teams, role model senior leadership cohesion, adopt a learning focused culture in response to mistakes and implement strategies for inclusion that counter insider/outsider differences.

19. Atewologun and Kline found a key factor contributing to disproportional reporting is exclusion from ongoing socialisation support, often referred to as learning the informal rules of the NHS. One BAME doctor in training referred to this as learning "*not the clinical stuff, but the art of medicine…the hidden curriculum*". This learning included taken for granted knowledge regarding navigating the new local context/physical environment (e.g. moving to a new town and country) but also navigating the new social, cultural and professional environment.

20. They found that in addition to practical support, socio-cultural induction is important. Doctors new to the system were described as needing and valuing induction and ongoing support in relation to the culturally specific aspects of practising medicine in the UK. This included understanding the role of the GMC and nuanced expectations in relation to professional ethics including consent, confidentiality and working in partnership with patients as well soft skills required for UK practice such as familiarity with expressions, how to communicate bad news, the relationships between different healthcare professionals, how to work with other professionals and expectations about demonstrating insight if something goes wrong. References to *Good Medical Practice* and *Welcome to UK Practice* were considered positive and necessary, but as yet insufficient and cannot remove the need for comprehensive workplace induction and ongoing support. As one clinical director put it

> *There is only so much you can do with PowerPoint presentations and discussion groups. You have to work alongside existing staff to pick up on the subtle but different ways in which patients are listened to, clinics are run, how consent is applied here, how a ward round is best done, how a MDT in a theatre or community setting works.*

21. In particular, they found that IMG doctors were often not perceived to 'know the rules' and were offered few formal learning opportunities to understand the "*hidden curriculum*" for practising "*the art of medicine*" within the UK. One older BAME GP explained that *There is no doubt that the generation of*

overseas doctors who came to the UK at the invitation of the UK government, full of optimism and ambition... there was little support to underpin challenges round arriving in a different culture, speaking English but not necessarily with an understanding of local idiom or accent, and facing significant amount of racism not just from patients but from others in the system.

22. Atewologun and Kline found that the nuances of language, accent, hierarchy and "slang" can be very subtle and capable of causing real problems. There was a strong sense that this was under-appreciated by colleagues. For IMG and EEA doctors in particular there were rich examples of how they have lost various forms of knowledge and support to which they had access in their home country, and which the NHS could focus on replenishing as soon as they arrive. Further, clinical skills might be entirely competent but the scale and pace of work might be very different, necessitating time for new norms to be acquired.

23. Overall, successful employers invested substantially in immersive support to which they attributed their relatively low cases of fitness to practise concerns.

24. They concluded that "our research indicates significant concerns regarding the inadequate induction provided by the NHS and individual employers to doctors whose Primary medical Qualification was gained overseas. In particular, participants perceived that induction and socialisation practices failed to fill the gap between differences in past and current clinical practice and context. However, we found a number of organisations that appeared to have developed effective approaches to address this need."

    Dr Jenny Vaughan, Dr Roger Kline and Dr Doyin Atewologun