WHY ARE WE STILL HERE?

The factors *still* affecting the progression of ethnic minority doctors in the UK

May 2022

A report produced by:

brap

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CONTENTS

EXECUTIVE SUMMARY

This research was commissioned by the British Medical Association to understand the factors that lead to doctors from ethnic minority backgrounds not progressing at the same rate as their white counterparts. The research was guided by two key questions:

- what are the factors that lead to doctors from ethnic minority backgrounds not progressing at the same rate as their white counterparts?
- are there examples of effective solutions that have been implemented at a micro, meso, and macro level to remove the barriers to progression at an individual, organisation, and system level?

Latest data from the Medical Workforce Race Equality Standard (MWRES) shows ethnic minority doctors are underrepresented in consultant, clinical director, and medical director roles. Currently, only 26% of clinical directors and 20% of medical directors are from ethnic minority backgrounds (despite ethnic minority people comprising 42% of all doctors in English trusts and CCGs). Previous research has similarly shown the existence of barriers to career progression, most recently data collected by the Royal College of Physicians (RCP) which shows that ethnic minority doctors have to apply for more posts than white colleagues before they are appointed to consultant positions. The consequences of such treatment are far-reaching impacting, not least on the pay of ethnic minority doctors: ethnic minority medical and dental staff earn on average 7% (£4,310) per year less than their white colleagues.

1. METHODOLOGY

Research was undertaken in three phases. In the first phase, 66 doctors took part in focus groups and one-to-one interviews to discuss issues affecting their career progression. In phase two, 22 doctors took part in interviews to further reflect on the issues arising in phase 1 and identify the key factors that enabled or hindered their progression in the NHS. Participants represented a range of different ethnic groups (including White British), worked in a range of settings, were at different stages of their careers, and came from all four UK nations.

Phase three consisted of 25 interviews with individuals representing a range of stakeholders including medical directors, representatives of medical bodies, and employers who have decision-making authority over the career pathways of doctors. The aim of this phase was to identify perceived institutional barriers to, and opportunities for, progress towards racial diversity in medical leadership.

2. FINDINGS

The research identified key 'moments that matter' along the career pathway for doctors (from pre-medical school through to applying for senior leadership roles). These include:

2.1 UNDERTAKING MEDICAL TRAINING

Access to medical school was felt to be influenced by class which might influence a lack of encouragement from state schools, and the absence of inside knowledge of what pre-application experience might be favourably looked upon by medical schools.

Once successful, ethnic minority doctors were more likely than their white counterparts to identify experiences at medical school as potential factors explaining why their careers had not progressed at the rate they would have liked. In particular:

- many felt they were not provided the support and encouragement their white peers were by educators
- overseas students feel isolated and lack the support networks many UK-born students have. As such, many feel they underperform

The combination of these two factors can serve to undermine doctors' confidence and lead to feelings of self-doubt which can persist long into people's careers.

2.2 POSTGRADUATE FOUNDATION AND SPECIALTY/GP TRAINING

When asked about crucial moments within their careers, a small number of ethnic minority participants referred to their experience of postgraduate foundation training. In particular, participants described how they were excluded from supportive development relationships and opportunities that were provided to their white peers. As such, they had fewer opportunities to develop as clinicians, gain credibility, and enhance their reputations. This exclusion also led some ethnic minority doctors to believe the system is not geared up to support people like them. One participant, for example, relayed that she has never applied for a post-consultant job/role that she had not been asked to apply for. 'I still can't shake off the idea I don't belong here,' she explained.

2.3 PRACTICE AS A SPECIALIST

Participants relayed several factors they faced post medical qualification they felt contributed to ethnic minority doctors not progressing at the same rate as their white counterparts.

Career guides: sponsors and mentors

Insight sessions with white doctors indicated how preparation for success in medical careers led to automatic assumptions of 'fit' in the profession. They then often found themselves fast tracked by sponsors and mentors – 'career guides' – who operated on assumptions of readiness for next career steps. In contrast, ethnic minority participants reported that they were less likely to be mentored or have a senior colleague champion them.

Evaluations of performance

Both ethnic minority and ethnic majority participants suggested double standards apply to evaluations of doctors' performance, with ethnic minority doctors being held to a stricter

standard of competence than white doctors. Especially when these happened early in their careers this could steer doctors into less prestigious specialisms, less choice of rota allocation, and, for some, becoming an SAS doctor rather than a consultant.

Exhaustion and alienation from the system
A common theme relayed by ethnic minority participants was being 'othered' or made to feel part of an 'out group' based on both 'trivial' and overtly discriminatory behaviour. Continued exposure to these behaviours was frustrating, exhausting, and has led many to disengage from the system. As such, many ethnic minority doctors have decided to focus their energies outside the NHS (on family life or voluntary work, for example) rather than seek leadership in a sector they are led to believe is not for them.

Models of leadership and 'fit'
Participants noted a variety of 'hidden' or assumed leadership qualities that are culturally specific or, at the very least, informed by culture and upbringing; these include having a facility or command of English, speaking with a 'cultured' or 'posh' accent, and being able to express ideas with (a certain type of) humour or in an engaging way. Participants also suggested there is a lack of appreciation/knowledge of models of leadership that do not accord with 'white, western' norms. Some also argued the need to de-colonise the curricula of medical schools.

Unconscious bias in recruitment processes
Both ethnic minority and white doctors suggested interviews and other assessment practices are subject to bias (both conscious and unconscious) and are not fully effective. A participant involved in appointing decisions in his trust reflected: 'there is a tension because we tend to appoint people who we know and like into our teams and that doesn't breed heterogeneity almost by definition'.

2.4   PREPARING FOR MEDICAL LEADERSHIP ROLES
Ethnic minority consultants face a range of challenges trying to exercise their authority and apply for leadership positions.

Lack of respect
Ethnic minority participants talked at length about the barriers they faced being taken seriously as leaders and potential leaders. Participants have faced a range of challenges to their authority, ranging from staff openly questioning their competence to colleagues undermining their decisions by not following through on actions. Many participants linked this doubt over their leadership credibility to internalised assumptions people have regarding who a leader is and what they look like.

Development opportunities
When asked to identify critical turning points in their careers, ethnic minority participants were more likely than white colleagues to discuss the impact of various leadership development programmes. These can be crucial in developing doctors' confidence in their leadership abilities. Access to development courses, however, can remain unequal. On the

other hand, examples were given of 'stretch' opportunities (such as significant projects, secondments, participating in quality improvement initiatives, encouragement to research and active sponsorship) that appeared to be allocated through a 'tap on the shoulder' which ethnic minority doctors appear to less likely to get.

Assumptions of competence and readiness for leadership
Recognizing the power of stereotypes and assumptions, it was common for white participants to discuss the advantages they had experienced by virtue of their ethnicity and, in some cases, their gender. For example, participants discussed how perceptions of individual doctor's skills are filtered through the prism of how the person looks, how they 'carry themselves', or (even more vaguely) their 'bearing'.

Mechanisms for identifying competence
Some ethnic minority participants attributed their relatively slower rate of progression within the sector to the informal, unstructured way competence and potential are measured. In addition, the different ways consultants gain recognition – publishing papers, taking on national roles – is not immediately obvious, particularly to those from overseas. Furthermore, the disproportional rate at which ethnic minority doctors are referred to the GMC hinders perceptions of competence (even when claims are dismissed as groundless).

Imposter syndrome
Ethnic minority doctors emphasised the cumulative impact of being marginalised and unsupported upon their self-confidence. Many consultants who have reached relatively senior positions within their organisations still experience 'imposter syndrome'.

2.5 ISSUES FACING SPECIFIC GROUPS

Women
Women doctors from ethnic minority groups are disadvantaged more than their male counterparts are. Female ethnic minority clinicians repeatedly reported being taken less seriously than their male counterparts. Given the increase in women in undergraduate medical programmes in the last decade, participants felt the system should look at the intersectional nature of the challenges faced by those who come from visible minority groups.

International medical graduates (IMGs)
IMG doctors were more likely than UK-born participants to talk about experiencing overt discrimination. These experiences has led many to disengage from the system. Participants also suggested perceptions around the 'professionalism' of IMG doctors are shaped by cultural perspectives and biases.

Staff and associate specialist grade (SAS) doctors
A number of participants discussed how SAS doctors are viewed within the hierarchical structures of the NHS. Many reflected on how 'demeaning' the term 'middle grade' doctor is,

especially for those who are senior in experience. It was felt it is harder for SAS doctors to gain recognition.

3. PRINCIPLES FOR CHANGE

Based on the above issues, we have identified 20 principles that NHS employers and others should promote to ensure more equal outcomes in relation to ethnic minority career progression.

1. Managers and leaders at every level need to apply themselves to understanding the root causes of racism and in particular the more subtle acts of discrimination within recruitment and career progression which constitute 'institutional racism'.

2. It is not sufficient to be a 'non-racist'. To effectively dismantle the barriers to ethnic minority doctors' career progression requires an anti-racist approach.

3. A culture of inclusion and psychological safety is not an optional extra but essential if any improvements in representation are to be sustainable and the benefits of improved representation leveraged effectively.

4. Difficulty talking about race and discussing issues with ethnic minority colleagues is a major contributor to the lack of honest discussion and organisational commitment on race equity. All those in any position of responsibility should be expected to learn how to create the conditions of trust that underpin effective conversations and learn how to undertake them.

5. Bias plays a crucial role in 'bringing alive' race discrimination. The NHS in all four countries needs to develop, share, and monitor the implementation of an evidence-based strategy which emphasises debiasing processes, inserting accountability, and developing clear goals. All this needs to be underpinned by leaders adopting an anti-racist approach towards these issues.

6. Data is a bedrock of an effective strategy. Doctors, employers, and system leaders must approach data using a problem-sensing approach, not a comfort-seeking one.

7. Support and encouragement to doctors and medical students can take many forms and is very important. However, this is not a substitute for those with authority at employer and system level (including regulators) taking action to remove or mitigate institutional and system drivers of discrimination. Those in positions of responsibility at all levels must constantly consider whether the support, encouragement, treatment and opportunities that ethnic minority doctors and students receive compares to that of their white equivalents.

8. Stretch opportunities such as 'acting up', secondments, and involvement in projects are a crucial part of career progression and access to them must be equitable.

9. When concerns exist, staff and students should feel it is safe and effective to raise them. It is crucial that those in authority at every level are proactive and preventative, intervening early and informally wherever possible. Leaders at every level should ensure that concerns are dealt with promptly and effectively (or escalated if appropriate).

10. Leaders must pay attention to the impact of wider adverse treatment on career progression.

11. Whilst some forms of diversity training and unconscious bias training can increase cognitive understanding of the causes of racism and its impact, such training needs to be underpinned by an anti-racist perspective. Research suggests that debiasing processes is likely to be more effective in mitigating bias, especially when allied to an emphasis on accountability.

12. Clear measurable goals with both accountability and support are essential.

13. Regulators need to ensure that a core driver of their scrutiny and interventions is whether medical schools and employers are fit for purpose in actively promoting respectful treatment for all staff and students and equitable career progression for under-represented groups.

14. Retention is important. Decisions to leave medical school or employment are likely to be significantly influenced by individuals' treatment and the perceived fairness of career progression. Doctors' turnover should be examined through an equity lens.

15. A very large minority of NHS doctors are international medical graduates. Their treatment from arrival onwards is marked by discriminatory practices including within career progression. Addressing those practices is a priority for employers and system leaders.

16. SAS doctors experience occupational segregation as a crucial (and large) part of the workforce of the NHS. There is too little opportunity for career progression, with much poorer terms and conditions. Addressing this is a serious challenge and must be a priority.

17. Doctors who identify as female and who are from ethnic minority backgrounds experience additional discrimination. The intersectional impact of being a female ethnic minority doctor can be especially challenging and requires urgent attention.

18. Notions of what constitutes an effective leader do not largely correspond with the evidence on what makes an effective leader. A major overhaul of how leaders are developed and appointed is essential.

19. Listening to the lived experience of ethnic minority staff at all levels and providing a serious voice to challenge and hold to account employer and system leaders is important. That requires resources. However, employers and system leaders must not transfer responsibility for leading or designing evidenced interventions to ethnic minority networks as a way of relinquishing responsibility themselves.

20. Where integrated organisations exist which include employers of doctors it is essential that their governance enables them to prioritise equity for staff and patient care, with an

understanding that addressing racial inequity in career progression and treatment is a key enabler of such work. When new integrated care structures are created it is essential that meticulous attention is given to the appointment processes to avoid reproducing the ethnicity gradient seen elsewhere in the NHS – and ensuring the voice of medicine is heard.

Many of those we interviewed (both white and ethnic minority doctors) emphasised that equitable career progression would not only benefit the workforce but would benefit care and safety for patients too.

INTRODUCTION

1.1 WHY THIS RESEARCH?

In March 2021, the Commission on Race and Ethnic Disparities published a report exploring 'important questions about the state of race relations today'.[1] The report stated that the NHS is a 'success story with significant overrepresentation of ethnic minorities in high status professional roles'. It went on to praise 'the onward march of minorities into positions of power and responsibility in…medicine'.

In response, the British Medical Association (BMA) noted an alternative narrative could be told.[2] 85% of doctors who died from COVID-19 in the UK were from ethnic minority backgrounds. Ethnic minority staff are more than twice as likely as white staff to report experiencing discrimination at work from a manager, team leader, or other colleague. And ethnic minority doctors still face barriers to progression within the NHS.

Latest data from the Medical Workforce Race Equality Standard (MWRES), for example, shows ethnic minority doctors are underrepresented in consultant, clinical director, and medical director roles.[3] Currently, only 26% of clinical directors and 20% of medical directors are from ethnic minority backgrounds (despite ethnic minority people comprising 42% of all doctors in trusts and CCGs). Data collected by the Royal College of Physicians (RCP) also shows ethnic minority doctors have to apply for more posts than white colleagues before they are appointed to consultant positions. All this has an impact on pay: ethnic minority medical and dental staff earn on average 7% (£4,310) per year less than their white colleagues.

These inequalities have dogged the sector for years. In 2020, for example, the RCP reviewed eight years of annual surveys reporting on the experience of, and outcomes for, clinicians within one year of passing their Certificate of Completion of Training (CCT).[4] It found ethnic minority doctors have been 'consistently' disadvantaged over that time when applying for jobs. Discussing the progression of doctors, the BMA has noted the pass rate gap in all medical postgraduate exams, between UK-trained white doctors (76%), UK-trained ethnic minority doctors (63%) and international medical graduate (IMG) doctors (41%).[5] Looking at awarding gaps within medical schools, Woolf et al concluded that ethnic differences in attainment were a consistent and historic feature of medical education in the UK and had persisted 'for at least the past three decades'.[6]

A number of factors have been posited to explain these disparities, including a lack of mentoring opportunities, bias in the shortlisting and appointments process, exclusion from development opportunities, and a lack of positive role models.[7] However, there has been little work to systematically identify the relevant issues and evaluate their relative importance. Understanding critical points in doctors' careers – the moments that matter – will

allow trusts and other strategic agencies to produce guidance that is targeted to where it can have most impact.

This will be important to trusts, clinical commissioning groups, and others going forward. The sector has pledged to eliminate the ethnicity pay gap by 2028 by getting more ethnic minority staff in senior positions. Continual reporting against MWRES indicators will shine a light on racial inequalities affecting progression. And the sector's operational planning guidance continues to stress the need for 'development plans' that 'improve diversity through recruitment and promotion'.[8]

But there are wider issues too. Eradicating health inequalities will require fresh and creative approaches. Research has shown that diverse leadership teams make decisions that are more evidenced, devise solutions that are more innovative and inclusive, and have discussions that are more analytical.[9] More practically, there is a growing evidence base suggesting patient care and experience improve where staff are more representative of the communities they serve.[10]

As the Black Lives Matter movement, MeToo, and the disproportional impact of Covid continue to highlight systemic inequalities, communities are asking more of the organisations they are asked to put their trust in. Promoting diversity in leadership can help win this trust by helping the sector deliver its core mission: providing compassionate care to those who need it most. It is this principle that motivated the doctors we spoke to as part of this research. It is the reason they are working for a fairer NHS.

1.2 RESEARCH AIMS AND APPROACH

A full methodology is outlined in appendix 1.

This research was guided by the following questions:
- what are the factors that lead to doctors from ethnic minority backgrounds not progressing at the same rate as their white counterparts?
- are there examples of effective solutions that have been implemented at a micro, meso, and macro level to remove the barriers to progression at an individual, organisation, and system level?

Research was undertaken in three phases.

In the first phase, 24 focus groups were conducted with 66 doctors. Participants represented a range of ethnicities, ages, specialities, and covered England, Northern Ireland, Scotland, and Wales. Follow-up questionnaires were sent to 13 participants. The aim of this stage was to gather a wide range of themes to be further tested in the second and third stages of the study.

In the second phase, 22 follow-up interviews were conducted with participants to understand in more detail the factors and incidents that acted as barriers or enablers to their career progression.

Finally, phase three consisted of 25 one-to-one interviews with individuals representing a range of stakeholders including medical directors, representatives of medical bodies, and employers who have decision-making authority over the career pathways of doctors. The aim of this phase was to identify perceived institutional barriers to and opportunities for progress towards racial diversity in medical leadership.

Participants across all phases were assured of confidentiality. As such quotes cited in this report are not attributed to named individuals. However, a list of all the stakeholders who gave permission to be named as contributors in phase 3 is outlined in Appendix 1.

1.3 TERMS AND DEFINITIONS

In this report, 'progression' is defined as a person's capability to move towards a more senior position, gaining qualifications or experience (if they choose to). Progression can have different pathways, and can involve a person gaining more experience, education, or training. As the BMA notes, there are various pathways to progression for doctors. These include (but are not limited to):

- Foundation Year 2 doctors being accepted into the specialty training
- GPs becoming GP partners
- SAS doctors becoming consultants
- junior doctors becoming consultants
- applying for and being awarded clinical excellence awards
- increasing rates of pay and reward
- applying for and being appointed into formal medical leadership roles

GLOSSARY

BMA	British Medical Association
CCG	Clinical Commissioning Group
CCT	Certificate of Completion of Training
EPR	Electronic Patient Record
GMC	General Medical Council
GP	General Practitioner
HEE	Health Education England
IMG	International Medical Graduate
RCP	Royal College of Physicians
SAS	Specialty and Associate Specialist
MWRES	Medical Workforce Race Equality Standard

1.4 STRUCTURE OF THIS REPORT

In relaying findings, we have attempted to show how inequality affects doctors (and students) at different points along their career pathway. This 'life cycle' approach will hopefully identify critical points along the career pathway that are particularly important in explaining disproportionalities in progression rates, which should be considered when designing interventions.

Our timeline is based on medical training pathways and information provided by the British Medical Association and the NHS. For clarity, sections within this chapter roughly correspond with steps in a doctor's career in the following way:

STEPS IN A CAREER	CORRESPONDING SECTION IN THIS REPORT
Apply to medical school	Section 2: Undertaking medical training
Undergraduate medical training	
Postgraduate foundation training: a 2-year foundation programme, working as a junior doctor	Section 3: Postgraduate foundation and specialty/GP training
Specialty and general practice (GP) training	
Receive a Certificate of Completion of Training (CCT)	
Practice as a specialist	Section 4: Practice as a specialist
Apply to become a consultant	
Apply for and fulfil other leadership positions within trusts	Section 5: Preparing for medical leadership roles

Some of the significant drivers identified in career pathways are then considered. Finally, we highlight issues facing two specific cohorts: international medical graduates and SAS doctors.

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[1] Commission of Race and Ethnic Disparities (2021) *The Report of the Commission on Race and Ethnic Disparities*

[2] See, for example, BMA (2021) *A Missed Opportunity: BMA response to the Race Report* and personal correspondence from Dr Chaand Nagpaul CBE (BMA Council Chair) to Dr Tony Sewell CBE (Chair, Commission on Race and Ethnic Disparities) dated 13 April 2021 (available at: www.bma.org.uk/media/4006/bma-letter-to-dr-tony-sewell-cbe.pdf)

[3] *Medical Workforce Race Equality Standard (MWRES): WRES indicators for the medical workforce*, published July 2021

[4] Royal College of Physicians (2020) *Medical CCT Class of 2018*: Royal College of Physicians

[5] BMA (2021) op cit

[6] Woolf K, Potts H W W, McManus I C (2011) 'Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis' in *BMJ* 2011; 342:d901 doi:10.1136/bmj.d901

[7] See, for example, Sait, S., Nayar, V., Chauhan, D., Rao, S., & Menon, G. (2020) 'Differential attainment in Leadership roles in the UK NHS' in *Sushruta J Health Policy & Opin* vol 13; issue 3; epub 22.10.2020 DOI https://doi.org/10.38192/13.3.22

[8] NHS England (2021) *2021/22 Priorities and Operational Planning Guidance*
[9] NHS England (2018) *NHS Workforce Race Equality: A case for more diverse boards*
[10] NHS Employers (2015) *Diversity and Inclusion: The power of research in driving change*

UNDERTAKING MEDICAL TRAINING

2.1 APPLYING TO MEDICAL SCHOOL

Interviewees stressed how ethnicity (and class) influenced decisions to apply to medical school, the likelihood of being accepted, and the difference that creates in terms of navigating successful access. For example, the quote below from a stakeholder describes how a trust, recognizing the impact of a disadvantaged background, has actively intervened to provide opportunities and training for potential medical students from those groups:

> *What we've done in our trust is provided sixth form work experience for four children from disadvantaged backgrounds… from state schools. As you move along, get into medical school, people tend to know what they want to do. So, if you've trained here, you would know that you need to do quality improvement projects. You will know you need to get a paper, you will know there are certain things that you need to do which will help your foundation application, which will help your core training application, which will help your higher training international medical graduates. That's not open to you unless someone takes you through it.*
>
> Strategic partner 1

In the context of the above proactive support offered by some trusts, some participants described the lower expectations directed at potential medical school applicants, notably for those from state comprehensive schools compared to students from private schools:

> *If you're talking about people coming into the medical workforce, that starts from the secondary schools and what expectations you have on the students… And there have been numerous stories that you've heard from people who were told when they were in secondary school, 'this is not for you: this profession is not for you; and you should not be aiming that high'. I think personally we have a low expectation in state secondary schools of students and that becomes a self-perpetuating prophecy.*
>
> Strategic partner 1

2.2 UNDERGRADUATE MEDICAL TRAINING

Ethnic minority doctors were more likely than their white counterparts to identify experiences at medical school that likely contributed to why their careers had not progressed at the rate they would have liked. Participants tended to raise two key issues.

First, participants from overseas who had come to the UK to train talked about how isolated they felt due to a lack of support networks during their medical training. Participants experiencing this issue highlighted the emotional pressure and stress associated with completing a medical degree and noted how UK residents are better able to deal with this

stress given their proximity to their family and friends. As such, doctors coming to the UK to study often felt they underperformed.

Secondly, and more commonly, participants talked about a lack of support from lecturers and supervisors at medical school. It was common for ethnic minority participants to feel 'dismissed', 'ignored', or 'looked down on' by educators. During the interviews, participants struggled to identify the behaviours and actions that contributed to this effect, noting that implicit or unconscious bias manifests itself through ostensibly trivial actions (i.e. micro behaviours). However, it was common for participants to discuss how they were left unsupported educationally when trying to grapple with some of the complexities of their course. This was particularly the case in relation to exam results. As one participant put it:

> *Exam failure is quite common in medical education. When others failed their exams it was 'oh, that's ok: just try again'. When I failed it, I got labelled as someone who was struggling and a failure. I didn't get any help. I remember going to outside people: I went to see professors in London…someone in Bristol, got their advice about what I was studying and this is how I turned things around.*
>
> Female Black doctor

The lack of support was compounded by the sense of relative exclusion reported by some interviewees at medical school:

> *The experience of learning in an environment where you don't feel as included impacts. When you're a medical student in a small group, is the eye contact of the person teaching you going to be more focused on the eloquent white colleague – or even Asian colleague – and less on those that may appear different or speak differently? How does that impact on your ability to learn? Those are real issues that will impact on your learning, on the feedback you get – which is all part of education and achievement.*
>
> Strategic partner 2

The impact of a poor learning experience can be devastating:

> *It's pretty shaming to not get through an exam: your whole construct as a doctor is based on achievement. And to not pass an exam is a pretty great insult on your sense of being. I mean, it's pretty, pretty depressing. And I think that has a very real impact on large numbers of doctors in terms of those that don't get through these exams as a result of differential attainment.*
>
> Strategic partner 2

Substantial change will be needed to the assessment process according to one senior figure with detailed knowledge of the issue:

> *We need to examine our approach to person specifications and the scoring criteria to see whether there are changes that can be made. It determines where you will train.*

> *Because currently that's a ranked order with the highest scoring people having the first pick of where you go basically.*
>
> <div align="right">Strategic partner 3</div>

The combination of both these factors – being geographically isolated and lacking support from educators – served to undermine doctors' self-confidence. Doctors can carry this negative self-perception with them long into their careers:

> *That [experience in medical school] affected my confidence, and this is why I rely now on external validation. My experience as an IMG, training and work experience, it's like you're a second-class person, so you lack the self-confidence… Over time you start to believe the negative behaviours. I internalised a lot of what was being said: the idea that I was not as good as the others.*
>
> <div align="right">Female Black doctor</div>

'I certainly did not feel as able as some of my peers,' claimed another participant. 'When I left [medical training] I wasn't sure I would be a consultant. It was years before I thought of applying for leadership… before I saw myself as someone who could be a leader'.

A smaller number of participants also discussed other issues they experienced as students. In particular, participants who had arrived from overseas to study noted how important an understanding of 'social' or 'cultural' context is to developing a relationship with examiners, educators, and peers. Again, participants found it difficult to articulate precisely what this looked like with regards to their student experience but were clear it went beyond mere language proficiency and instead related to accent, customs, and having shared experiences to discuss. One participant framed her experience of interacting with examiners in the following way:

> *With written exams, I scored quite high, but with interactive exams I failed one three or four times. I contacted examiners saying 'I'm struggling, can I have some advice?' It really showed me the importance of networking. After doing this – I will never forget this – for the final exam attempt, the examiner came and shook my hand after. And it was all to do with the advice I had taken from the relevant people I found externally.*
>
> <div align="right">Female Black doctor</div>

Similarly, when pressed on how they had navigated the early stages of their career pathways, some white doctors highlighted aspects of their upbringing and background that enabled them to 'fit in':

> *I got work experience though someone's dad at a hospital in London. It's that connectivity that enables you – someone to read your UCAS form for you. I did lots of mock interviews. And had friends of friends, a whole network that's very driven... I remember being sent to one of these pre-med school conferences ... full of Westminster children... There is definitely a leg up there without even having to try hard. And if you come from a deprived background, you're not going to have those connections.*
>
> <div align="right">Female white doctor</div>

The consequences of such treatment surfaced when career paths were shut down as a result of the adverse impact on exam results of a poorer learning environment:

> *When I was a medical student, I set foot in a GP practice and thought, 'Wow, this is what I want to do!' But that's not actually the story of many others and I don't know what it must feel like if you live the rest of your career with that sense of not doing what you really wanted to do.*
>
> Strategic partner 2

POSTGRADUATE FOUNDATION AND SPECIALTY/GP TRAINING

Perhaps predictably, ethnic minority participants raised similar issues in relation to their postgraduate training as those identified during their undergraduate medical experiences. Many reported feeling excluded from supportive development relationships and opportunities that were provided to their white peers:

> *What is unconscious bias? It's so subtle. For example, a supervisor would walk into the room with me and another registrar: they're from the UK. A completely different background. And the supervisor would always talk to them. I never get offered any experiences. I had to work with what's left. 'This is an interesting case, would you like to review it? Why don't you look into that? Come with me and see this'. I never got any of that. I was never invited to those. I had to work hard to find opportunities.*
>
> Female Black doctor

The importance of these development opportunities was twofold. First, they enabled those who had access to them to develop as clinicians, gain credibility, and enhance their reputations. This invariably led to encouragement to apply for leadership roles. Secondly, the exclusion experienced by many ethnic minority doctors led them to believe the system was not geared up to support people like them. For example, the participant relaying the above quote went on to say that she has never applied for a post-consultant job/role that she had not been asked to apply for. 'I still can't shake off the idea I don't belong here,' she explained.

When asked about crucial moments within their careers, a small number of ethnic minority participants referred to their experience of postgraduate foundation training. Some (older) participants suggested their difficulty finding placements (coupled with their experiences at medical school) left them on the verge of leaving the profession:

> *White people don't know they have white privilege… Out of 160 students in my year, I was one of only four people unemployed at the end of house jobs. Despite having numerous interviews, despite being House Man of the Year in one of my jobs, why couldn't I get a medical job at that stage is a real, real question. And one of my mates, when he still talks about it, he said, this absolutely stinks. This is just not right.*
>
> Strategic partner 17

More commonly, other participants discussed how their difficulty finding placements narrowed their options and therefore led them to choose specialities they had little experience or interest in:

> *I was new to the UK, I was looking for a job, and spoke to the postgraduate dean and he wrote to all the departments, said I was a doctor from [country redacted] and looking for a clinical attachment. That was when my supervisor contacted him and said she was happy to have me. This practically chose my speciality for me.*
>
> Female Black doctor

One system leader suggested disadvantage in respect of access to learning medical procedures was an issue:

> *I spoke to some junior doctors who came from the Caribbean… they came here as IMGs. And they were telling me how when it came to learning how to do certain medical procedures that are required as part of your training, they often found they were the last in the rota.*
>
> Strategic partner 2

One senior clinician recalled the dissonance between work experience and exams for GP trainees:

> *Let me talk about the CSA exam. I was a trainer in [a particular area]. Most of my trainees were ethnic minority trainees. We had a very high pass rate, but that was because we worked the system. That was because, we've always said, those of us who work in the inner cities with immigrant populations, that your exam doesn't reflect real life general practice in the United Kingdom. It's taken the pandemic for them to really work at changing that system that you can now present consultations which reflect where you are.*
>
> Strategic partner 4

These types of experiences tended to be relayed by doctors qualifying before or just after the turn of the century, perhaps suggesting the quality of support has improved in the preceding years. More recently qualified doctors tended instead to raise concerns regarding the stressful nature of speciality and GP training. One ethnic minority participant commented on his experience:

> *The working environment included one junior doctor, which is me, plus or minus one advanced nurse practitioner. The registrars are at home, the consultants are at home – I have to take care of six wards by myself. It has a bed occupancy of 96 patients, which are usually overfull. So, on average, we take care of 100 patients.*
>
> Male Arab doctor

While this is an extreme example, other, more recently qualified doctors relayed similarly stressful placements. The difference in white and ethnic minority doctors' experiences lie in the support mechanisms in place to deal with these pressures. white participants tended to reference the emotional support available from friends or family (some of whom were doctors themselves and therefore understood the issues involved). Those ethnic minority participants from abroad relayed feeling more isolated. Some spoke of feeling 'trapped' in a profession they now had little enthusiasm for. For example, the doctor

quoted above relayed how British doctors have more options for dealing with the stresses of specialty/GP placements:

> *Let's say I'm British and I'm stressed out. What can I do? I'll go less than full time. I can go 40%, 50%: it's up to me. I want to take a year off. I can – I'm British. An immigrant cannot do that. An immigrant, by law, the lowest they can go is 80%. Now, for me, for my health, I need 60%. But I cannot do 60%; I'm not allowed. I'm an immigrant again: I cannot access certain support channels, because I'm an immigrant. This makes living in the UK difficult. Makes it stressful. Makes me feel like no one cares about me. Makes me feel a lack of safety. Because, again, I might be deported, deported if I don't perform adequately, because I'm not getting enough support.*
>
> <div align="right">Male Arab doctor</div>

Participants suggested the lack of support during placements can cause doctors to underperform, leading to an under-development of their talent and a chronic lack of self-confidence. As the example above shows, doctors can also end up feeling distanced from their profession. This experience is exacerbated by a perceived lack of concern for their emotional wellbeing. For example, echoing a concern raised by other ethnic minority doctors, the participant above also queried whether immigrant doctors are treated with the same compassion as their non-ethnic minority peers:

> *My dad got sick within the beginning of my rotation. So I told them, 'I need to go be with my dad. If you don't allow me to, I'll quit right now on the spot'. They said, 'don't quit. We'll allow you to be with your father. We'll just move your on-calls'. Which I found weird because in my previous rotation, whenever someone couldn't make an on-call, they would just find cover. They would never move on-calls. Anyway, after I came back, all of my on-calls were stacked together. So all of my nights, all of my weekends, all my long days, were back to back to back.*
>
> <div align="right">Male Arab doctor</div>

This perceived lack of empathy has led some to believe the NHS views immigrant doctors as 'workhorses'. 'We get treated like donkeys,' claimed one participant, 'they clearly only see you as a resource; not a human being'. Participants suggested it is not just a lack of concern from their immediate managers that contributes to this feeling: a legacy of not tackling inequality within the NHS has led many to feel the system is indifferent to the inequality they experience. 'There is still an attainment gap in under- and post-graduate medical education,' said one participant, 'we can't deny this. But the NHS does not value its black and brown staff'.

Additional evidence of informal social structures protecting doctors in the 'in' or 'dominant' group was provided by white participants. A white GP, for example, emphasised the importance of training practice and trainer relationship and the support that is needed to ensure that both trainee doctor and patients stay safe. The participant experienced difficulties due to understaffing and this resulted in the death of one of her patients. In

discussing her experience, she outlined how the system protected her from the professional (although not necessarily the emotional) ramifications of the incident:

> *I was a junior doctor with a consultant who was always doing private work. and I had a trainee who was on back-to-back annual leave and study leave who's one above me. And the registrar had already quit the job to become a consultant somewhere else. I was 24 years old, and nine months out of med school. Anyway, there was a patient that was really sick. And I'd ask people for help. I didn't know what to do with her. Long story short, she died… After much complaining and trying to get support, I was basically told 'if you don't shut up, you'll never work again'… I was lucky: I had a supportive family and I had supportive friends. And I was local. I guess if you trained abroad, someone maybe could have thrown in a racial slur... I can imagine it would just be a gazillion times worse than it already was for me.*
>
> <div align="right">Female white doctor</div>

Interviews revealed several examples where 'insider status' appeared to protect someone from the consequences of mistakes. This is in line with previous research commissioned by the GMC[11] suggesting that part of the explanation of the over-representation of ethnic minority doctors in the fitness to practise process may be attributed partly to white doctors' errors being 'managed' and developmental feedback provided before issues get escalated to the GMC.

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[11] Atewologun D and Kline R (2019) *Fair to Refer: Reducing disproportionality in fitness to practise concerns reported to the GMC:* GMC

PRACTICE AS A SPECIALIST

Participants relayed several factors they faced post medical qualification that contribute to ethnic minority doctors not progressing at the same rate as their white counterparts. They discussed at length their lived experience of the NHS and how this impacted on their careers.

4.1 CAREER GUIDES: SPONSORS AND MENTORS

Many participants described their restricted access to everyday resources that help other doctors navigate the medical career system successfully. The quote below captures succinctly how those who belong to 'out groups' lose out from acquiring techniques to learning the system (or the 'hidden curriculum'), which helps navigate the profession. Knowledge such as familiarity with the application system, including how to write CVs, is gleaned through networks and contacts: the absence of these networks is a significant barrier to progression:

> *So for those who might not be from privileged backgrounds or those who might have English as a second language ... international medical graduates, they don't necessarily know the system, they don't have the networks and contacts that other people have. They don't necessarily know the application system or what's expected to put on your CV to get that particular job.*
>
> Female Multiple heritage doctor

In some participants' accounts was a systematic and systemic experience of inclusion often coming through the role of 'career guides' (rather than career gatekeepers) as sponsors and mentors. Indeed, sponsorship and mentoring appear to be the most important factors identified by those who felt they have progressed: they were crucial in accessing development opportunities, providing reflection on career development and personal growth, and promoting participants' skills and qualities:

> *Life turned around when I met my white, Cambridge-educated husband… It's the influence he's had on me when I've had to apply for things. And over time, he's helped shape the way I present myself… Because of the exposure I've had to some key people through the BMA at an earlier stage of my career, and people like my husband who have helped shape it. Otherwise, an interview question might be responded with, "I'm good for the job, because I've done X", you know, rather than "this is what I bring, this is what my skill set means"*
>
> Female South Asian doctor

> *I must say it is a white Caucasian male that has been most helpful in my career progression. So, I have a mentor, who's a surgical professor and he also has a huge leadership background. He is somebody that ... I felt truly understood and had my best interest at heart. ... he was very good in encouraging me, supporting me, but*

then challenging me as well. ... He knew the system, the barriers, the difficulties as a trainee, as a surgeon, somebody who's trying to sort of develop a leadership portfolio.... He is the one person that has helped me see things differently and helped provide some clarity and perspective on my career on my five, ten-year plan

Female Multiple heritage doctor

I definitely benefited from being perceived as somebody who's slightly more European, slightly less ethnic or less stereotyped into that category. So, when I was the senior trainee, and I was applying for consultant jobs, the relationships I'd made in my training with people of this demography certainly helped me in terms of identifying the opportunities. Maybe a nice word here, recommendation and things like that

Male South Asian doctor

As the above quote indicates, sponsorship is often reserved for those with whom senior leaders easily connect and have affinity.

In parallel, a lack of both informal and formal mentorship and sponsorship was identified, by many ethnic minority doctors, as having a negative impact on career progression:

I'm not saying preferential treatment is good but at the same time if everyone had the same opportunity to be mentored, then potentially I would have had a different experience if I had identified a mentor from the same cultural background

Female East Asian doctor

So the biggest thing for me is [a] mentor. Particularly for ethnic minority women, because we know that it's even harder to get into leadership as a woman anyway

Female Multiple heritage doctor

Mentoring a big deal especially for ethnic minority women. A lot of what I do is about confidence especially for those not from a privileged background and SAS doctors

Female Multiple heritage doctor

Overall, insight sessions with white doctors indicated how preparation for success in medical careers led to automatic assumptions of fit in the profession. They then often found themselves fast tracked by sponsors and mentors – 'career guides' – who operated on assumptions of readiness for next career steps. This process, while not individually articulated by each participant, overall was recognised by ethnic minority individuals who reflected on their white colleagues' experiences. Indeed, many ethnic minority participants highlighted the importance of factors that ethnic minority doctors are excluded from, including the suggestion that ethnic minority consultants need to understand that 'decisions aren't made in the interview room… so we need to be doing more networking'. There was an urge to understand that one has 'to play the game' particularly for ethnic minority women and a need to navigate the 'politics 'at an individual, unit, and system level. There was also a requirement for doctors to familiarise themselves with the formal and informal power

dynamics of cultures in which the patriarchy still flourishes and which, if not managed, becomes another impediment to career progression.

4.2 EVALUATIONS OF PERFORMANCE

Many ethnic minority participants relayed a sense that double standards applied for majority- and minority-group doctors. For example, some participants suggested ethnic minority applicants were held to stricter standards of competence than white applicants:

> *With BAME colleagues, I think the fact that there are higher number of complaints throughout from patients to healthcare organisations... GMC-related sanctions across the board … they go after the BAME doctors who screw up, but they don't go after the white doctors*

> Female South Asian doctor

> *There have been less experienced white doctors who have got less scrutiny, but it's very difficult to prove*

> Male South Asian doctor

A white doctor also alluded to such experiences:

> *I can think of someone in my organisation who is always getting complaints. I have set up a forum for discussing such issues and I think the threshold for raising the issue is different for some staff. I am really uncomfortable about this but there are some complaints where if it were a white surgeon no one would bat an eyelid. Saying it makes people really uncomfortable, but I have got people thinking about the issue at least.*

> Female white doctor

Additionally, some participants questioned how objective annual assessments and grading processes are, highlighting these are subjective with the potential for bias in the evaluations. There was a view that appraisals are 'paperwork', with nothing significant arising from them.

4.3 QUALITY OF OPPORTUNITY

There was a clear sense from many participants that doctors' differential progression is exacerbated by leadership roles not being easily accessible. Some suggested that when ethnic minority individuals do step into leadership, it is often into roles that others do not want:

> *I think there is something to be said about the norm, which is white men. No matter what experience they have or don't have, they are waltzed into Partnership. They literally get offered it … waltzed into management roles. They get tapped on the shoulder and asked to take on these jobs and roles and this is the norm. … I've also*

seen those opportunities for some white women. But where I have seen ethnic minority individuals get into positions of power or partnerships... management, they've usually had to fight really hard for it. Or it's because nobody else wanted it … you tend to get the leftovers.

Female South Asian doctor

I've just stepped up to take on a more senior leadership role... Sometimes you get left to do these jobs where either you fight tooth and nail for it or no one wants to do it because it's so hard to do. And I think I found myself in a place where no one else was stepping up to the plate because it was too hard to do.

Female South Asian doctor

Conversely an experienced and senior surgeon recalled being 'replaced' by white colleagues in a clinical leadership role because another newer recruit 'fitted' better:

On another occasion, having been clinical lead of my speciality for two years, with no complaints raised about my leadership nor to be honest any feedback at all, I was invited to re-apply for the post. A new doctor had been appointed; it was clear that the medical director wanted this doctor in my position.

Male Black doctor

4.4 EXHAUSTION AND ALIENATION FROM THE SYSTEM

A common theme relayed by ethnic minority participants was being 'othered' or made to feel part of an 'out group' based on both 'trivial' and overtly discriminatory behaviour. Continued exposure to these behaviours is frustrating, exhausting, and has led many to disengage from the system. As such, many ethnic minority doctors have decided to focus their energies outside the NHS (on family life or voluntary work, for example) rather than seek leadership in a sector they are led to believe is not for them.

Examples of this cultural and social exclusion are provided throughout this report. Other examples, such as not being immersed in dominant cultural practices (such as watching certain TV programmes or not engaging in dominant leisure activities such as consuming alcohol) can reinforce exclusion at both formal and informal levels:

Whether you're able to participate in the back office to chat about culturally relevant events happening in the background in the society. ...the ability to have a conversation in the coffee room about some, I don't know, some sitcom, or some TV programme happening, which might be quite relevant to majority white community, but probably an Asian or African family probably doesn't feel interested in watching ... can isolate you from the team because you're not able to participate.

Male South Asian doctor

Socialising after work ...and doctors who don't take alcohol. A lot of socialisation happens after work in pubs and stuff, and I've seen people say, "Okay I don't drink so I don't want to come," and then that kind of generates subgroups

Male South Asian doctor

The reinforcement of ingroup/outgroup dynamics occurs from patients as well as colleagues. Indeed, discrimination from patients can be much more direct:

I had one person who did not want me to anaesthetise them and that happened to me once. It happens to you all the time

Male Multiple heritage doctor

People make an immediate judgement the minute I walk in a room. …If you are at the front line, being introduced as a 'nurse' after introducing myself as a consultant

Male Multiple heritage doctor

I pretty much had it everyday with patients. There would be some kind of comment about my ethnicity. I often got asked, "Where are you from?" I'm from England. "No, no, no, … Where were you born?" I was born in London. But that's not where you're from. And I know they're asking me what my ethnicity is. I then realised that the problem was that I was saying I was English. There's an unwritten rule: if you're brown, you're not allowed to call yourself English, you have to say British. Only white people can call themselves English. I didn't know the rules"

Female Multiple heritage doctor

The impact of these everyday experiences of othering and regular 'knock backs' is often a reduced sense of confidence and diminished resilience:

Often it's because of the structural racism. It is really hard to break those barriers and your confidence is knocked so frequently. ... It's really hard to put yourself forward again and again for an opportunity when you know 99% of the time you won't get it. I'm persistent, so I just keep going but a lot of people aren't and I think that some people take those knocks really hard

Female Multiple heritage doctor

4.5 MODELS OF LEADERSHIP AND 'FIT'

Participants identified a range of traits and attributes they felt are valued in consultants. Clinical expertise did not feature heavily. Rather, participants suggested appointing managers value a range of interpersonal attributes that align with their cultural assumptions regarding what 'competence', 'leadership', and 'authority' in medicine look and sound like.

For example, the notion of 'availability' was raised. This was partly about hard work, but also about 'being present' (e.g. being able to attend meetings early and late in the day). While white men tended to say this was something leaders valued in them (and made it easy for

them to be on leaders' radars), women suggested it was difficult for them to replicate given they still shoulder the greater number of caring and unpaid roles and childcare responsibilities.

> *In some ways, my experience was I think I progressed too quickly because actually ... I didn't have any impediment to me being there early in the morning and staying late at night. I had a set of behaviours which were regarded as... affable, "he's available and he's kind of okay at what he does"*
>
> Male white doctor

Participants noted a variety of 'hidden' or assumed leadership qualities that are culturally specific or, at the very least, informed by culture and upbringing; these include having a facility or command of English, speaking with a 'cultured' or 'posh' accent, and being able to express ideas with (a certain type of) humour or in an engaging way. One participant expressed frustration with how her contributions to meetings were often undermined because of these factors:

> *I'm aware of senior leadership teams within a senior stakeholder-type organisation picking people up on their language. English is not my first language, and I'm sorry, but if you get my point, if I use a different word, and it doesn't fit in with your vocabulary, there's no problem with that... I think good ideas are good ideas, despite how you communicate them and what words you use.*
>
> Female South Asian doctor

Participants also suggested having English as a second language can have an impact on the perceived quality of written applications:

> *[The] system should have some allowances for grammatical errors*
>
> Male South Asian doctor

Similarly, some white participants relayed how ethnic minority colleagues had comments made about their communication skills – usually expressed as 'concerns' around communication with patients, despite patients not raising concerns. A doctor of East Asian background recounted her experience of colleagues speaking to her about her accent, despite her having lived in the UK since her teenage years:

> *I'm a British trainee. Although I wasn't born here, I hardly have a very strong accent but another member of the subconsultant body, due to clinical reasons, claimed to have difficulty understanding me leading to a clinical event which escalated.*
>
> Female East Asian doctor

Thus, biases against accents often played out as communication issues which were then escalated into problems relating to career progression. Additionally, participants reported barriers, stereotypes, and assumptions due to having a non-English sounding name. One female participant, for example, talked about the pressure she has experienced to take on her partner's name (which is more 'English'):

> *I'm very conscious that I've got a Muslim name... an Arabic-sounding name. But when people speak to me on the phone, they might think they're speaking to either an English or an American doctor... I've been told many times to take my husband's surname... It's ridiculous... I've been told that my active choice to not take a surname could be the reason why I might have more complaints. So, I'm conscious that my level of complaints will vary depending on what the patient has taken away*
>
> Female South Asian doctor

Further to accents and names, certain communication styles were highlighted as perceived as problematic for doctors' experiences and career progression. Some participants observed that while a lot has been done to increase the representation of doctors from ethnic minority communities at management level, unconscious bias still plays out in a way that many individuals from this group are treated. For example, a South Asian doctor's quiet demeanour was construed as a training issue:

> *I had a colleague who was a very good doctor. She actually qualified in South India and came over much later in her career to London. She had quite a significant accent and was not very confident in social situations.... quiet and recedes to the background. But clinically very, very competent, absolutely no doubt about it. But just because of the way she was projecting herself and remaining quiet and not contributing to the conversation and how she was putting her point across in handovers and meetings, I don't know what happened. Through a series of meetings amongst the consultants, it quickly became clear that she was identified as a training difficulty. And… I'm thinking, "guys, are you seeing the same thing?" I'm saying this is not a training difficulty. She is very good and not a dangerous doctor. She's an absolutely fantastic doctor. It's just that she's not able to speak as well ... and is not very confident. She was a South Indian, female graduate, who's got different strengths.… I had observed a pattern, where a lot of trainees of this particular demography [were] being identified as trainee difficulty training doctors*
>
> Male South Asian doctor

This Eurocentric bias or advantage was not just recognised by the ethnic minority doctors interviewed, but by their white colleagues too. For example,

> *I've worked with some really good obstetricians ... proudly Nigerian ... and gosh those guys were passionate about what they did! How that passion came across sometimes would be perceived as aggressive or intimidating when actually what they were wanting to do is… get their point across. And I saw that matters would go down routes of maintaining high professional standards or complaints. There was a sense of... these guys can't progress because they are difficult when actually what you were seeing was essentially what I perceived as being a cultural norm [of communicating]*
>
> Male white doctor

As a result of these constant knock-backs, many ethnic minority respondents have responded by stepping back from any NHS leadership role:

> *I know now that I have no chance of playing a game in the white management, so I don't even apply for that. I know that I will have a chance in the European meritorious academic community, in the American meritorious academic community. So I'm a member of the European [committee name redacted] and the American [committee name redacted] because that is merit based, that is knowledge based, that is academic based, that's got nothing to do with colour.*
>
> Strategic partner 18

Particularly striking was how even senior leaders 'covered'[12] part of their identity when going to work:

> *So there's a part of me that is left at home because there is a norm that I'm trying to be part of that is very unhealthy, even for someone who is relatively liberated. When I say liberated, I have enough authority to speak very freely because of my position now in the hierarchy of the health system. But yet it's not all of me that comes into work because of that. And it was a teaching moment for them because they don't even think about it. You're British, you're brought up here. You understand the jokes, you eat the food. You don't have to think about bringing all of you into work, but someone like me has to think about it.*
>
> Strategic partner 19

One senior leader highlighted the opportunity to encourage more diverse and innovative leadership models, the impetus for which took root during the height of the Covid pandemic. Inviting ideas and experimentation drawing on inclusive leadership practices they offer new ways of working and leading. Patients and users are the lead beneficiaries:

> *There is a real opportunity to develop leadership models which ensure pure headspace and an ability to try a concept with a non-conformational outcome seen as a positive rather than failure.*
>
> Strategic partner 26

Finally, some participants noted the absence of any requirement for a profound level of understanding of inclusion and diversity as a leadership quality (despite evidence suggesting this is a real benefit):

> *I don't know what happens when people are appointed as clinicians, but I doubt very much that there is a core set of questions that are being addressed. 'Is this person driven by inclusive leadership?' is a question I doubt is asked. 'How quickly will you be able to get our recovery waiting list down?' probably will be. But this in fact feeds into a negative experience and race discrimination because that sort of target-driven approach will drive discriminatory behaviour.*
>
> Strategic partner 2

4.6 UNCONSCIOUS BIAS IN INTERVIEW PROCESSES

There was a general feeling that interviews and other assessment practices are subject to bias (both conscious and unconscious) and are not fully effective. Diverse interview panels are still perceived as a tick box exercise and tokenistic.

I know that at an interview, I have characteristics that would work against me and my ethnicity. ... The fact that I am a mother, all of these things will work against me whether somebody says it outright or whether they think it is still there.

Female Multiple heritage doctor

My feeling very much is that we've now moved ... away from a position where they would carry out interviews and panels which are all men or all white. They've now started to introduce tokenism. … I feel that many panels are purely tokenistic and many interview processes are purely tokenistic. I still feel that they are a tick box by saying, "Oh yes, we interviewed X number of ethnic categories and women." …I think a lot of people like me will be sharing similar thoughts, I'm sure there are people who've gone along to interview them and felt that they were just purely getting through a tick box exercise type ... thing.

Female South Asian doctor

How a particular doctor comes across in the interview process, simple eye contact and body language, and how people judge somebody's confidence or competence.... So, credibility based on one's body language, the interview structures and the recruitment structures that organisation have in place while not deliberate, there might be an intrinsic bias. The structures might favour - without intending to - people coming from a majority background than from a minority background. So, yeah, I mean, I've seen all of this affect the possibilities and opportunities that the doctors have"

Male South Asian doctor

One white medical director reflected on how bias influences decision making at this level:

Something which needs to be tackled certainly in my organization is the way we appoint people to consultant jobs. There is a tension because we tend to appoint people who we know and like into our teams and that doesn't breed heterogeneity almost by definition.

Strategic partner 5

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[12] 'Covering' refers to members of underrepresented groups, whose identity is not recognised, allowing their identity to become invisible, not only to others but for themselves. They may thus improve their own careers or life chances, but at the potential cost of their wellbeing. For further discussion, see Schmitt, Michael & Branscombe, Nyla & Postmes, Tom & Garcia, Amber (2014) 'The Consequences of Perceived Discrimination for Psychological Well-Being: A Meta-Analytic Review' in *Psychological bulletin*. 140. 10.1037/a0035754.

PREPARING FOR MEDICAL LEADERSHIP ROLES

This section will look at some of the challenges ethnic minority consultants face trying to exercise their authority and apply for leadership positions.

5.1 LACK OF RESPECT

Ethnic minority participants talked at length about the barriers they faced being taken seriously as leaders and potential leaders. Participants have faced a range of challenges to their authority, ranging from staff openly questioning their competence to colleagues undermining their decisions by not following through on actions. Many participants linked this doubt over their leadership credibility to internalised assumptions people have regarding who a leader is and what they look like (see section 4.5 above for a breakdown of 'model' leadership qualities). In this respect, it was common for both women and ethnic minority participants to discuss feeling undermined, with ethnic minority women in particular arguing they are doubly disadvantaged:

> *I know that some of the challenges I have had from a white and Black staff are to do with their perception of my racialised identity. You can be in a meeting and be ignored. But also how you are questioned about your opinion. You face more disbelief. Even when you are in a position of responsibility, nurses will double check your requests with other white leaders. It's open doubt of your authority.*
>
> Female Mixed heritage doctor

5.2 SIGNIFICANCE OF DEVELOPMENT COURSES

When asked to identify critical turning points in their careers, ethnic minority participants were more likely than white colleagues to discuss the impact of various leadership development programmes, including those run by the NHS, Kings Fund, and Health Foundation. The Leadership Academy's Ready Now programme (and, to a lesser extent, Stepping Up) was most frequently mentioned as providing participants with the confidence to apply for, and fulfil, leadership positions by outlining alternative models of leadership, encouraging participants to reflect on their skills and accomplishments, and increasing awareness of key management concepts and tools:

> *The Ready Now programme from the Leadership Academy was very useful, as it gave me the right vocabulary. I became an Associate Dean, took responsibility for equality and inclusion. Before I didn't understand the vocabulary, the concepts: this is what the Ready Now programme did for me. I have to attend every five years – it's always energising.*
>
> Female Black doctor

However, participants also raised a number of concerns regarding access to such programmes. Many suggested they had been prompted to apply by a mentor or supportive manager, and raised concerns for ethnic minority colleagues who are without such encouraging career guides (see also section 4.1). One ethnic minority doctor reported having to self-fund her participation on the Ready Now programme as her trust were indifferent to her career development. Based on conversations with other participants, she suggested this was not an uncommon position for ethnic minority doctors to find themselves in. Early exposure to informal and formal leadership development initiatives were identified as critical to build the capabilities and confidence of potential leaders and many spoke of the need to address issues of equity of access:

> *Many of the initiatives require someone to signpost you to an opportunity or – even more limiting – for someone to sponsor you onto a course. This is difficult for two reasons. One, the proposer may not see the potential due to inherent bias. Two, the individual may not 'feel' that they should take up the offer because they fear being incompetent or failing to deliver and undermining the support of the sponsor.*
>
> Strategic partner 26

5.3 ASSUMPTIONS OF READINESS FOR NEXT CAREER STEP

Everyday experiences of belonging and inclusion meant more opportunities for being noticed for cultural fit and perceptions of potential. The most significant impact was the recognition of the phenomenon of being 'tapped on the shoulder' and encouraged to apply or take part in different forms of development opportunity.

> *They [white colleagues] get tapped on the shoulder. They don't sit there thinking, "Can I do the job, they just get told, here you go, you're the best person for the job"*
>
> Female South Asian doctor

> *I tended to take on opportunities because people sort of tapped me on the shoulder and said we think you might be quite good for this. You want to give it a go? And usually I would panic and think, "Why not?"*
>
> Male white doctor

> *I never set out my career to be anything other than a consultant. ... I started off wanting to be a GP, got persuaded down another route. ... I definitely hadn't planned at all....It was about being encouraged and being ... tapped on the shoulder*
>
> Male white doctor

> *There is something about a set of behaviours that has been historically ingrained in the NHS, where people have a tap on the shoulder because there's a set of appearances, there's a set of circumstances that enables them to move forward into positions. ... Sometimes it's a combination of motivation and abilities. But sometimes it's a set of accepted of accepted behaviours, accepted appearances, accepted norms that ... had fitted with the generation before*
>
> Male white doctor

The cumulative impact of this encouragement can be stark. Here, a white consultant describes his path to becoming Medical Director:

> *I did have some ambition, because my passage through my career was frictionless. There were no impediments: no hurdles to stop my progress. I found myself in a position... being Medical Director of a huge organisation for district general hospitals, community hospitals, primary care, public health, mental health. And I actually really didn't have the experience or knowledge to transact that role.... It was a series of requests of why don't you apply for this?*
>
> Strategic partner 16

In contrast to the above, a female ethnic minority consultant described her experience of progressing in the sector in this way:

> *My personal journey was somewhat slower in surgery .... it was more difficult because I don't feel like I was given the same advice or pushed as much as some of my male Caucasian counterparts. But then it's not necessarily just the race, I think it is largely gender as well in surgery. Say for example, at a stage where I was considering research, I was given the advice not to necessarily worry about doing a research degree. Whereas I found most of my male counterparts, which were largely Caucasian, were advised to do research. This later became a problem because as part of the requirements for completion of set surgical training, you need to have research evidence and you need to have publications, which then became a bit of a struggle, because publications out of research is a bit more difficult to get than if you had done your research*
>
> Female Mixed heritage doctor

In recognition of some of the 'headwinds' facing them, some ethnic minority doctors reflected on the skills needed to navigate their careers, including the ability to assimilate, having perseverance and resilience, and the ability to adapt to open up career development opportunities.

> *I think being open, being adaptable, and not having pre-fixed opinions of people and systems. And I think also willing to, you need a bit of perseverance. There will be a lot of headwinds, but I think there needs to be… resilience. I guess it is a significant quality that I think society is lacking in general, but if you come from a minority background, I think it becomes even more important that you show some resilience. You're more open, you're more flexible.*
>
> Male South Asian doctor

There was also recognition that such tactics could have an impact on one's sense of authenticity and identity. Nevertheless, some participants urged openness to the wide cultural diversity in the NHS.

> *There is a big fear of losing identity or trying to form groups within your own identity. ...Work outside that comfort zone and try and be open to the local culture. If you work*

in NHS, it's not necessarily a local culture, there is a big Greek culture, Italian culture, that is you work with doctors from Turkey, Germany, and they tend to kind of pocket around certain departments and teams. So being open to assimilate in whatever thing that comes, also offers certain productive, and influence against some of those inbuilt discriminatory systems that affect us. So, I think the doctors coming from ethnic minority needs to develop resilience, become curious about other foreign cultures, adapt, be more flexible... both at workplaces and in social groups

Male South Asian doctor

The effect of stereotypes and assumptions can be very powerful. It was common for white participants to discuss the advantages they had experienced by virtue of their ethnicity, suggesting knowledge of their impact in the sector is growing:

There's a huge reservoir of unconscious bias. I don't really like that word, but I don't know how else to describe it in me, which I have to be able to deal with my own behaviors. I talked about job descriptions and expectations when we interview: I'm really guilty of that, of thinking that if people don't look like what I think a medical director needs to look like – I don't really mean in physical appearance – but in the way in which they behave, then they probably won't be very good at the job. And that's just not true. And yet that's my base state. And I'm having to challenge myself hard. And I think probably what's true for me is true for many people.

Strategic partner 5

Participants talked at length about how perceptions of individual doctor's skills are filtered through the prism of how the person looks, how they 'carry themselves', or (even more vaguely) their 'bearing'. One participant discussed this in relation to the appointment of medical directors in a trust:

When you appoint a medical director, there's certain core skills they need to have or core abilities: the ability to run clinical governance and maintain safety in a hospital… hold people to account, that sort of thing. And I've been brought up to think that in order to fulfil those functions safely you need to have a certain way of talking and a certain way of bearing yourself. Neither of which are actually true. When it comes down to it, it doesn't really matter. These things are all peripheral to the ability to recognize what's safe and what's good quality and how to maintain standards. And yet I've attached some of those behaviors to some of the necessary skills in an inappropriate way, simply because I'm used to seeing white people behave like.

Strategic partner 5

Ethnic minority participants articulated the impact these assumptions can have on their career paths:

I ended up becoming the surgical lead in our department, which is predominantly led by all white management. Prior to this, I never had the view that I was a non-white leader; I didn't have those perceptions. But that perception was created from the day I accepted the leadership role. And, you know, at every step, every conversation used to end up reminding me that, oh, you need to have more discussions with your

colleagues because they perceive you as someone who's an outsider. I never got the confidence that I needed to progress in my role. Unfortunately, after a couple of years things got so bad that I was asked to step down, to take the heat off me. You can imagine for someone who had taken up a leadership role and wanted to progress it was very emotionally distressing for me. In the end I thought that perhaps management is not my forte. And that's why I moved away from managerial roles towards academia and education.

Strategic partner 22

5.4 MECHANISMS FOR IDENTIFYING COMPETENCE

Some ethnic minority participants attributed their relatively slower rate of progression within the sector to the informal, unstructured way competence and potential are measured. Some, especially international medical graduates, outlined a cultural aspect to this, suggesting more vocal colleagues were better placed to gain recognition. Other stakeholders discussed how the means by which doctors can gain recognition and 'make a name' for themselves can be alien to IMGs:

Research in particular is weighted heavily towards clinical excellence or making a name for yourself so people know what they need to do in order to make a name for themselves. So, it's either they publish a lot of papers, or look for national roles, regional system roles. And for ethnic minority doctors, they come from a culture where what you do is that you just put your head down and get on with your work rather than look at what are these other things which you can use to develop yourself professionally and personally. You just need to sort of get on with your work.

And I think that's why international medical graduates are disadvantaged in exams as well, because we're coming from a culture where what you do is study, study, study, and then the exam will get you there.

Female Black doctor

A postgraduate dean made a similar point, claiming expectations of ethnic minority doctors are lower and that they are not therefore encouraged to push themselves:

I spoke to someone from the Association of Black Psychiatrists recently, and she was telling me about the experience of a higher trainee who is a very hard worker, someone in my culture. You would classify them as somebody that does the donkey work. So they do a lot of hard work, but they're not achieving the milestones that they're supposed to achieve. But because they're doing a lot of hard work, their clinical supervisors are okay with that – which is not right. Rather than sort of saying, 'these are the things that you're supposed to achieve, these are the opportunities that you're supposed to take', it's a case of, well, they're getting the discharge summaries done.

Strategic partner 6

Another strategic stakeholder made a similar point regarding SAS doctors:

> *I don't think they are good at recognising the people who do much of the work and carry the organisation. It is not just teaching the mechanics of being a leader. For example, to be a matron you have to have been through three or four courses, held a budget, had some IR training… but with doctors the first time they move up from being a consultant to take on these responsibilities is when they become a clinical director and we expect them to perform miracles. For too long we have left them to not have difficult conversations and instead tell people 'don't do that old chap' and these conversations are harder with people who don't look like you.*
>
> *We need to ensure they understand that such conversations and resultant actions are affected by unconscious bias – we have to do that – and give them the skills they need. They need to be able to stop and think – a good white ally will ask a colleague "is there something else going on here I need to think about. – is it making me uncomfortable for reasons I am not clear about – should it be" since I am sitting here as a very senior person with a white background who needs this sense check?*
>
> Strategic partner 7

In addition to not having their value adequately acknowledged, ethnic minority doctors also suggested they were more likely to be accused of making mistakes and have these mistakes formally investigated. The stigma of being investigated – either through an internal disciplinary process or by referral to the GMC – can hinder perceptions of a consultant's competence, even when claims are dismissed as groundless. One white medical director outlined their experience:

> *I can say with some confidence, I think it's more difficult to avoid a disciplinary, a formal process, if you're not white than if you are white. It's that sort of quiet chat stuff, which is more difficult if you come from a different culture and as most of our leaders are white and middle class by background and often male, but not invariably. I think we find ourselves with doctors who have never been able to hook into that informal system of helping them and keeping them on the straight and narrow, and they end up in big trouble. And by the time they get into big trouble, it's too late. It's those corrective influences which haven't been able to operate or haven't succeeded in operating early on in their development.*
>
> Strategic partner 8

The challenges can easily signpost ethnic minority doctors away from leadership positions:

> *I think it's about confidence. People don't put themselves up for jobs because they don't think they're going to get them and they don't think they're going to get them because nobody who's like them has ever gotten them before. So it's a chicken and egg in there. But you need to have the role models, I think. Some of it is about taking people and helping them to develop those skills.*
>
> Strategic partner 5

> *I have noticed behavioural aspects during Covid that I should have noticed before –*
> *especially the tendency of some groups of doctors to keep their heads down, be a*
> *safe pair of hands – and I don't think that is entirely to their individual advantage*
> *when it comes to their career path*

<div align="right">Strategic partner 9</div>

5.5 IMPOSTER SYNDROME

Connected with the preceding section, ethnic minority doctors also talked at length about the cumulative impact of being marginalised and unsupported upon their self-confidence. The extent to which this occurs earlier in doctors' careers is discussed in sections 2.2 and 4.4. It is clear, however, that many consultants who have reached relatively senior positions within their organisations still experience 'imposter syndrome'[13]. Many suggested that while this is a widespread phenomenon, its impact on women is amplified. For those who identify as coming from visible ethnic minority backgrounds its impact is 'trebled' as in addition to self-doubt these doctors also have to overcome barriers caused by their race and ethnicity and the patriarchy:

> *In different ethnic minority communities, there are different cultures. So how you*
> *respond to hierarchy or put yourself forward for things is very different. In particular,*
> *there's also a gender bias in this in that if you're a ethnic minority female, there may*
> *be some opportunities that you won't feel that you can put yourself forward for unless*
> *someone suggests them to you. Other people, people from Caucasian backgrounds*
> *won't do that. They will put themselves forward. It's connected with the way you*
> *perceive other people's behaviour towards you. I second guess myself a lot.*

<div align="right">Female Black doctor</div>

5.6 IMPACT OF ADDRESSING INEQUALITY

A small number of ethnic minority participants discussed how their experiences of trying to tackle inequality within trusts had impacted negatively on their career progression. Participants raised two issues in particular.

First, a small number relayed how, being excluded from a range of leadership and development opportunities, they had been asked to support the development of ethnic minority networks or equality working groups. Most suggested this had pigeonholed them as being 'experts' in equality and narrowed the range of 'stretch' opportunities they were subsequently offered. Participants also claimed that equalities work is deemed less serious or demanding than the projects other, invariably white, colleagues work on, so experience gained through this work – an ability to affect organizational culture, for example, or an ability to negotiate with other colleagues – is given less weight than it should. This hampers promotion as less credence is given to this experience on application forms.

Secondly, participants discussed at some length how speaking up about equality issues is often viewed negatively by other senior leaders. One experienced clinician claimed:

> *Anyone who puts their head above the parapet and speaks out is then labelled as a troublemaker or whatever. And so the learned experience for them is to stay quiet and just accept things as they are, just be happy with what you've got, which is terrible***.**
>
> <div align="right">Strategic partner 9</div>

This pointed was echoed by another system leader:

> *People are uncomfortable speaking about it. They're uncomfortable speaking about it, one, because they feel isolated. The other is probably especially for those who come from other countries, it's a sense of shame. It's not easy to talk about negative experiences. And third is, as I said, the discomfort, because if you do speak about something negative, you feel somehow you will experience a more negative adverse experience.*
>
> <div align="right">Strategic partner 2</div>

In addition to the above factors, participants also raised a number of issues which they felt had prevented the sector tackling progression disparities in the past:

5.7 FEAR OF TALKING ABOUT RACE

Throughout all our interviews, both white and ethnic minority doctors highlighted how reluctant the sector is to have honest conversation about race. Participants discussed at length how discussions about inequality, privilege, and racism can generate uncomfortable emotions, such as fear, guilt, and anger. In addition, some participants suggested some colleagues are simply not interested in discussing the impact of ethnicity on their fellow doctors:

> *It may be intentional, maybe unintentional, but I think [discussing bias] is where the discomfort comes, because it means that people have to look inward and people find that very difficult. And in some cases it's long ingrained behaviours that they may not be aware of. But I think the major thing is people being worried about being labelled as racist is what makes it discomforting to discuss it.*
>
> <div align="right">Strategic partner 10</div>

> *I suppose the biggest challenge is that the system doesn't want to necessarily acknowledge that race discrimination exists. And so it's not looking at it from that lens. It's looking at it from the aspect of has that person acted in the way that they are expected to do as professional people as opposed to coming from a certain background? And yet the end result seems to go against that individual from whatever that background may be.*
>
> <div align="right">Strategic partner 11</div>

In particular, participants suggested it is difficult for (white) colleagues to accept they may be discriminating against ethnic minority staff, albeit unconsciously:

> *We had a conversation about how tests are designed in a particular way and therefore they're inherently biased. That will be really uncomfortable for some people. They say, 'but the system's fine, the system's not biased', and it's all objective and even. But people can unconsciously do things that are not very nice and we're still living with the legacy of it now. In the context of the culture that is based on – that history of discrimination and racism – people do set things up and structures and systems that are biased and people get very uncomfortable talking about it in that way. It's much easier to say it's just the individual's fault.*
>
> Strategic partner 14

Participants suggested as a result of this, senior leaders are often unaware of how and where inequality exists in their organisations. A culture of not raising concerns has led many ethnic minority doctors to remain silent about their experiences:

> *What you have is a culture of fear, of speaking out generally for everyone. And you have a culture where people feel they will be blamed for speaking out. That is the culture. Now, when you have a culture where people feel blame or sense of blame, if they speak out, it will disproportionately impact on those who are at the lowest tier of the ladder and who are the most vulnerable or feel most vulnerable. And so you won't speak out because you feel that if you do speak out, you will be scapegoated. And the system does do that. So I think that people don't feel comfortable speaking out anyway. But also I don't think there is space the NHS is highly pressured and talking about racism would be probably an inconvenience to just getting on and discharging people, patients quickly out of hospital because the government saying you've got to reach a target to recover from the backlog. So I don't think people are comfortable talking about real emotion and issues because the environment doesn't lend itself to such a dialogue.*
>
> Strategic partner 12

This was echoed by other senior leaders, who were clear that the prevalence of these emotions can make it difficult to encourage discussions about discrimination:

> *We've need to support people to learn about how you engage in these conversations in the right way. I think it's a really interesting experience when somebody does get it wrong because on the one hand we kind of advocate learning, not blame, but on the other hand, there is a real sense of… when do people actually start getting some of these behaviours right and how do you balance that? Because you want people to continue to engage with the subject and to be active in the organisation, be actively anti-racist, but managing staff through that phase …can be difficult to manage.*
>
> Strategic partner 13

Ethnic minority participants discussed how they 'managed' discussions around discrimination and the strategies they employed to raise concerns about their treatment. As

mentioned above, many felt burdened with 'explaining' how racism can manifest itself in modern workplaces and staff relationships. Some participants expressed frustration with this, and suggested it further alienated them from their work:

> *I also get a little bit weary of being told that I have to help colleagues have a conversation with me. I think, frankly, you can't see me as a colleague and another citizen who just warrants a certain conversation and it almost does yourself as a non-ethnic minority person disrespect that you can't. You know, I can have a conversation with a woman. I don't have any idea of what it feels like to not have the privilege of being a man, but I think I can have a conversation with a woman perfectly reasonably. But to assume that you have to walk on eggshells around us because you're worried that we're so bloody sensitive or that I've got to help you with this. Well, piss off.'*
>
> Strategic partner 15

It is clear, however, that many ethnic minority doctors are wary of discussing their (racialised) experiences with their colleagues, mainly for fear of upsetting them. One participant explained his dilemma in this way:

> *You don't want to accuse everybody as being racist, for instance, because that's not conducive to a good working relationship. So often I think it's a softer side which causes the problems, not really the seventies overt racism and the problem is these soft things continue, even the overt things. So, you'll have known the recent, the last year or two, the report from Aberdeen Medical School about the extent of racism.* [see information box, below]. *There's a similar one in [redacted].*
>
> Strategic partner 4

HUNDREDS BACK CALL FOR CHANGE OVER RACISM CLAIMS AT ABERDEEN MEDICAL SCHOOL

June 18, 2020, 1:22 pm

Aberdeen University

Medical students have called for change at Aberdeen University amid claims that racism is not being treated seriously enough.

Hundreds of students at the institution's School of Medicine have called for urgent change in the culture and curriculum to address the underlying issues affecting them. An open letter from the organisation's Black Medical Society (BMS) includes a number of first-hand accounts from people who claim they have experienced racism on university premises or during a medical placement.

One person said they had been left "terrified" to speak out, while another claimed to have witnessed a "completely unnecessary and derogatory comment" being made.

The letter also contains an account from someone who said a patient referred to them in a racially offensive manner while they worked a night shift. The student said: "Instead of saying anything, the staff just laughed."

www.pressandjournal.co.uk/fp/education/higher-education/2270168/hundreds-back-call-for-change-over-racism-claims-at-aberdeen-medical-school/

5.8 ATTITUDES WITHIN ETHNIC GROUPS

A number of interviewees, especially more senior ones, described experiences where they felt some ethnic minority colleagues sometimes held other ethnic minority colleagues to a higher standard than white colleagues. There was a sense that sometimes ethnic minority staff need to be doing more to support each other. One senior clinician expressed her disappointment thus:

> *That thing about how we don't necessarily work to promote each other, to support each other, not promote, but we don't provide the sponsorship or the informal networking that in the way that other people do that that helps them and leaves us disadvantaged. And we act like we think that the game is all fair and the playing field is level when we know it's not. And then but rather than tilting it in our own favour, we just carry on acting like it's somehow going to work out, which it doesn't necessarily*
>
> Strategic partner 24

Sometimes some of the worst people and the worst challenge are people from your own background who actually scrutinise you even more than the other people. Now, that's not to be too negative about people from my own background, because balancing that off, there are also lots of supportive and developing people. But I do think that that's interesting.

Strategic partner 25

Another system leader had a similar experience:

Of course, now that I am in a position where I could be part of that, I don't bother, I'm not insecure. But what I was trying to understand why they were doing like this. So there is a lot of there was a lot of sense of insecurity. They wanted to show themselves more than what the other panel was. They wanted to be more strict, partly because they didn't have an easy way in. Why should anybody else have an easy way in? And they felt they had to prove to their counterparts of white colour that they are equally better, equal them, better than or whatever.

Strategic partner 26

A third system leader made a similar point:

I think this has been reported before, where your own colleagues actually think that when you're in a high position. They question why you've got there, how you've got there. And so you lose that credibility within your own…you don't get that support from your own ethnic minority professionals. And that was the same in in the West Midlands. And I think some people perhaps feel that maybe you shouldn't have got to that position. So you get it from both sides, you get some sort of discrimination from the host community, but you also get it from your own colleagues as well.

Strategic partner 4

This was reported as being compounded by attitudes towards female clinicians in some communities:

Women from certain ethnic minorities do face discrimination and often discrimination from men from their own ethnic backgrounds as well. So I think they have an added problem that there is discrimination across the piece. So a man might feel an ethnic minority man might feel supported by other ethnic minorities around them. But I'm not sure that ethnic minority women are going to feel quite as supported necessarily by other ethnic minority colleagues, especially if the men come from cultures where equality isn't the norm. So and again, I come back to the IMG experience, I don't think we should be blaming people if they've been brought up in a certain culture and a way of thinking, and then they come to this country. I think we have to be careful to help them adjust and understand equality before blaming them

Strategic partner 2

A medical director similarly highlighted the importance of intersectionality in such issues:

> *Some of the issues I get to hear about is how subtle and sophisticated race discrimination can be. And it's a case of opportunities that would be presented to someone who is white as opposed to someone who's from a different who's from a ethnic minority group. And that can be quite subtle. And it's also about behaviours, and this can go both ways. So in the different ethnic minority communities, there are different cultures. So how you sort of respond to hierarchy or put yourself forward for things is very different. So this and especially there's also a gender bias in this as well in that if you're a ethnic minority female, there may be some opportunities that you won't feel that you need to put yourself forward for unless someone suggests them to you.*

Strategic partner 1

A similar point was made by another senior leader who indicated that this was a priority which needs to be addressed if women who face this type of 'mindset' from colleagues and peers are to achieve their potential:

> *There are issues in our own cultures which are not right and it doesn't translate well. So let me give you a very personal example… South Asian men, in general, quite high on the misogyny scale. We all know that, right? It's very well recognized among certain sectors. Women need to cook, end of story. Don't do anything: cook. You bring that style into a leadership role, which some people have done. You are in trouble straightaway. Quite rightly too.*

Strategic partner 26

5.9 THE IMPORTANCE OF INCLUSIVE MEDICAL ENGAGEMENT AND MEDICAL LEADERSHIP

There is an established evidence base showing the importance and connection between medical engagement, medical leadership, and their contributory roles in helping to sustain generative cultures within health and care. Increasingly this contribution also results in the delivery of consistent, high-quality, safe, and efficient care.[14] [15] [16] [17]

In addition, reports into the failings at Morecambe Bay[18] and the recent findings from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust[19] not only continue to demonstrate the importance of clinical and medical leadership, but crucially also highlight the importance of providing access to leadership development opportunities, training, and support for all doctors including junior and SAS doctors.

Some of the strongest themes emerging from the interviews relate to the challenges and barriers to progression faced by many ethnic minority and internationally trained doctors in being able to achieve parity of esteem with their white counterparts throughout their career journeys. This inequity impacts their ability to attain and be successful in medical leadership roles.

> *I ended up becoming the surgical lead in our department, which is predominantly led by all white management. And I can assure you that I never had this view (that I'm a non-white leader, you know), because you don't have these perceptions. But that perception was created from the day I accepted the leadership role. And, you know, at every step, every conversation used to end up reminding me that, oh, you need to have more discussions with your colleagues because they perceive you as someone who's an outsider. I never got the confidence that I needed to perhaps progress in my role'*
>
> Strategic partner 22

This account and many other reflections in this study refute the narrative offered in the Commission on Race and Ethnic Disparities report[20] which highlights and 'celebrates the 'onward march of minorities into positions of power and responsibility in professions such as …medicine'. We found clogged or blocked pipelines, concrete ceilings, and an absence of ethnic minorities in positions of power and influence. Where such leaders exist in the system we heard first-hand accounts of the sacrifices made to retain such positions which included adjusting their behaviour to 'fit in':

> *I have had to modulate my behaviour at work because I know that others will feel challenged if I illustrate an alternative way to, for example, manage a patient. I find that I am labelled 'difficult' if I offer an alternative or frankly disagree with some of my white colleagues. There is often more than one way to manage a patient. Most of us were trained at different universities and have had different levels of clinical experience and exposure. In my experience, black or ethnic minority doctors who disagree or express a different view are often labelled 'difficult'.*
>
> Male Black doctor

An inclusive approach to medical engagement and therefore medical leadership is crucial to create an environment in which *all* doctors feel able to contribute to the management, leadership and improvement of services. This candid reflection from a senior established leader- who identifies as being white, male and middle aged offers a powerful call to action:

> *From the patient's perspective, I think it can mean that we don't understand our patients properly and therefore we don't design services around our patients in the way we should. I think there were other issues about getting the right health care to people if we don't understand the world in which they live because we live in a different world*
>
> Strategic partner 9

The role of medical leadership (doctors in leadership and followership roles) has been highlighted as one factor contributing to high performing health care cultures, which in turn leads to safer and more effective care. Doctors in medical management and leadership roles (like their clinical colleagues) bring a relentless focus on patient care.

Individuals who are afforded access to leadership development opportunities, quality improvement and clinical governance activities, projects such as the transformation of the

Electronic Patient Record (EPR), etc are more visible and therefore have a greater chance of being appointed to, and recognised in, formal medical leadership roles. At the individual, organisation, and system level there needs to be greater equity of opportunity if we are committed to inclusive medical leadership.

5.10 OVERALL IMPACT ON STAFF WELLBEING

The data on the impact of poor treatment, notably, racism on the health and wellbeing of doctors in particular and people in general is well researched:

> *For those who are affected, not being able to talk about it, not being able to talk about any trauma or any negative experience… it affects your mental health. For some, it will lead to depression. For others, anxiety, a sense of exclusion. It may well affect your clinical performance. We know from a report [Fair to Refer] that burnout can affect your clinical performance. Well, it doesn't have to just be burnout, it can be any sort of negative experience... So, I think what ends up happening is you may well find yourself not able to perform as well. So that, again, affects your career progression. But even worse than that, you may find that you do things that maybe you may be involved in, things go wrong, and then you can't even speak about that. So you may be the victim and that's when you look at why [ethnic minority] doctors complained about more traumatic… Some of these complaints may even be around poor performance, but that poor performance is a result of a mental state that doesn't give you the ability to perform well.*
>
> Strategic partner 12

> *The mental health impact on individuals is huge. I think about 20% of doctors are thinking of leaving their career because of the impact on them and it's having an impact. Or now when you look at retention in the NHS, this just becomes an additive reason on top of everything else. Why bother? I'm done. I may as well retire early. I may as well reduce my hours, why should I work harder? And so forth. So it has a very real service impact as well as the mental health impact.*
>
> Strategic partner 2

When ethnic minority staff face race discrimination it impacts adversely on patient care and safety. The doctors and leaders we spoke to were very conscious of this.

> *I think a system designed by white people, mainly for white people… and I think it's hard when the language isn't yours and the culture isn't yours or you don't feel it's yours. And it's difficult to have sharp elbows when you don't fully belong in that system. And then the third prong, is that staff don't look like our patients and that is a problem on a number of levels. From the patient's perspective, I think it can mean that we don't understand our patients properly and therefore we don't design services around our patients in the way we should. I think there were other issues about getting the right health care to people if we don't understand the world in which they live because we live in a different world.*
>
> Strategic partner 9

[13] Clance, Pauline Rose (1985) *The Impostor Phenomenon: Overcoming the Fear That Haunts Your Success*: Peachtree Pub

[14] Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust public inquiry:* The Stationery Office; London

[15] Keogh B (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report: NHS England*

[16] Berwick D (2013) *A promise to learn – a commitment to act: improving the safety of patients in England*: Department of Health; London

[17] Nath V; Seale B; Kaur M (2014) *Medical revalidation: from compliance to commitment*: The King's Fund, London

[18] Kirkup B (2015) *The Report of the Morecambe Bay Investigation*

[19] Ockenden et al (2022) *Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust-final report*

[20] Commission of Race and Ethnic Disparities (2021) *The Report of the Commission on Race and Ethnic Disparities*

CHALLENGES FACING SPECIFIC COHORTS

In addition to the structural challenges facing ethnic minority doctors outlined in the preceding sections, specific challenges and concerns were raised by participants regarding two particular type of doctor:

- international medical graduates
- staff and associate specialist grade (SAS) doctors

6.1 INTERNATIONAL MEDICAL GRADUATES

The number of international medical graduate (IMG) doctors in the NHS is growing and now constitute over one third of all doctors working in the NHS. Their experience has been the subject of several reports, including *Fair to Refer* (by two of the authors of this report) which describes how IMG colleagues experience being 'othered' with consequences including disproportionate referrals to the GMC. Their experiences were mentioned at every stage of the research process, and, while there is some overlap with the experiences of UK-born ethnic minority colleagues, many features of their career development bear special note.

First, numerous comments were made about the failure of the NHS (on the whole) to provide effective induction:

> *Take the example of people coming brand new to the country to start a training programme of whatever specialty they come in. And then from day one, many of them may well be on call. They might be the ward doctor. They've never worked in this country. And so if I was to go to Sri Lanka to work, for instance, I wouldn't have a clue of what I'm supposed to do. Who do I give the Bloods to? How am I supposed to address the nurses or the doctors or patients or whatever? And I'm bound to fail. And that's what we do. We set them up to fail right from day one. And we all agree what they need. Many of these doctors, they're not only doctors, any healthcare professional coming in is probably a minimum of three months as a supernumerary person to get acclimatized to what's going on so that they can understand, you know, if they're taking bloods or whatever because the power systems are different.*
>
> *If you're from India or Pakistan, the power differential between a patient and a doctor is different to what it is in the UK. So for them to learn those sort of things takes a bit of time. And instead what we have is they come in day one, they're on the ward and within a week we get calls from some of their consultants to say this doctor is not up to scratch.*
>
> <div align="right">Strategic partner 4</div>

The assumptions made or inferred once doctors are labelled as IMGs are unjustified. UK-qualified doctors experience a different reception and induction when they make equivalent

moves to Australia or Canada, for example. The working assumption of UK-qualified doctors is they know what they are doing and just need a period of time to understand 'how we do things around here'. The opposite is true, however, for how IMG, locally employed (LE), and SAS doctors are perceived. It was common for interviewees to highlight the language that is often used to talk about these types of doctor:

> *'You know, they haven't got the knowledge'. 'They don't know what they're doing'. And you think, 'well, they've been here a week… [so] they haven't got a clue what they're doing'. 'Well, why have you sent me these doctors?' 'Because they've passed the tests and been recruited to so'. So I think the system doesn't help itself. They know what the solutions are. But because of money, primarily those solutions aren't put in.*
>
> Strategic partner 2

Several senior leaders noted the consequence of this approach:

> *We pay down the road because this person then needs potentially an extension to their training. So we're happy to fund that, but we weren't happy to fund the initial bit, which would have stopped them from actually failing. And many of these people…most of them, they're intelligent, knowledgeable people. And then suddenly they're presented here and they're made to feel as though they're not up to scratch. And that's why increasingly, I think, 'international medical graduate' has negative connotations. Instead of a doctor who's new to the country and the system needs to adjust to make sure that we can support them, to help them to succeed.*
>
> Strategic partner 20

Interviewees remarked on the contrast between the treatment of arriving IMG doctors and that given in some other countries:

> *There are nations where they pick you up from the airport when you come to work in that country. There are countries that actually celebrate the fact that you're coming to work and will have a three-month induction in some nations. And of course, this isn't just the induction, it's the ongoing mentoring.*
>
> Strategic partner 13

Participant also suggested perceptions around the 'professionalism' of IMG doctors are shaped by cultural perspectives and biases. For example:

> *There are cultural differences associated with coming into the UK and how health services work. One way it exhibits itself… [is] the attitude towards hierarchy – deference – which can be interpreted as unprofessionalism, but it is just doing things different. Immediate local clinical leaders are uncomfortable having those conversations about that until people are seen as being in a particular box which necessitates a conversations.*
>
> Strategic partner 8

IMG doctors were also more likely than UK-born participants to talk about experiencing overt discrimination. As outlined in section 4.4, the experience of being 'othered' can lead to a profound disengagement from the system. This was no less the case with IMG participants:

> *I went to an interview in the days when I used to have a turban and a beard. I sounded like I came from the UK because of my accent was a broad Midland one at the time. I went to an interview and when I walked in, I saw all the heads look up and then look up at me again and say, 'that's not the person I spoke to on the phone.'*
>
> Strategic partner 17

Furthermore, it was felt by some that the prejudice facing IMG doctors is somehow seen as more acceptable. To an extent, this is evidenced in the way government and senior leaders within the sector talk about them. As such, IMGs find themselves 'othered' not only by their colleagues, but by policy makers at a national level:

> *I would actually start at the top: I mean the government and how it talks about doctors who come from overseas. If you use language like Dido Harding did[21] it doesn't help. It doesn't help. And if you have wider immigration policy that somehow looks at people from other countries as a being a burden on us, rather than a positive, I don't think it helps*
>
> Strategic partner 2

The effect of this exclusion is not only that doctors detach themselves from the system, but that their potential is overlooked by leaders and managers:

> *The consequence [of this] on the individual is one of pain, unfairness and morally wrong. But there is an impact on the health service, which is one that just doesn't capitalize on the potential talent of our workforce. And that's where I can't understand the government. There are people who come here who are at the height of their career in their country of origin – so skilled, knowledgeable – who are treated in a demeaning way when they're here because of the way they speak. I just find it bizarre.*
>
> Strategic partner 12

6.2 SAS GRADE DOCTORS

Staff and associate specialist grade (SAS) doctors are significant members of the NHS's medical workforce. The GMC register (as at 23 September 2021) showed that SAS and locally employed (LE) doctors make up almost 30% of all doctors. They have postgraduate qualifications, are fellows and members of royal colleges, and many work at a very senior level. SAS doctors predominantly identify as coming from diverse backgrounds: indeed, the majority are from ethnic minority backgrounds.

Many SAS doctors contributed to this research during phases 1 and 2. Their lived experiences and aspirations are significant and as a group more needs to be done to

recognise their contribution and potential. SAS doctors have a core role to play in quality improvement, governance, and medical leadership. The barriers to progression facing all doctors from ethnic minority backgrounds were amplified in the SAS doctor cohort due to their lack of visibility and voice in their employing organisations. As one SAS doctor put it:

> *I feel they take us for granted in the sense that we are very subservient and will probably be very passive in approach and will do what we are told. That's what I feel. I think when we try to negotiate our way politely, we're just kind of thrown to the back of the queue. And I think stereotyping again has a role to play here and we are probably given a difficult job and we are not given the support to deliver. I think we were never given training for management right from the beginning and now we are towards our peak, now this is the first time that any initiative was created to help us develop. We haven't got management experience because that's the way our job plans have been written.*
>
> Female Arab doctor

A number of participants discussed how SAS doctors are viewed within the hierarchical structures of the NHS. Many reflected on how 'demeaning' the term 'middle grade' doctor is, especially for those who are senior in experience and who contribute, it was argued, more hours in direct patient and user care and contact:

> *More ethnic minority doctors will end up in the staff and associate specialist grade compared to being consultants. And there's not only a disparity in the pay scale of being a SAS doctor versus being a hospital consultant, but there are other knock-on impacts that affect your income. SAS doctors are not eligible for Clinical Excellence Awards. And I mean, it's not strange we talk about clinical excellence and actually these SAS doctors probably deserve recognition of clinical as much because they are actually doing clinical work to a much greater degree than their consultant colleagues. But they're not eligible for this. And the Clinical Excellence Awards can increase the consultant's salary, which is at the moment, I think £117,000. They can jump up to £180,000. These are not small increments. So these are opportunities that are not available for SAS doctors who are stuck at the highest level, and that's only for those at the highest level, at about £85k. I recently met a very senior SAS doctor in [redacted], doing the work of a consultant who's earning £68k. That's less than a GP… And no matter how excellent that doctor is, there's no looking to getting any further reward.*
>
> Strategic partner 12

> *The NHS is very hierarchical. We make assumptions that if you don't become a consultant you are a lesser person and a failure even though we depend on many thousands of staff who work as doctors but don't become consultants. The assumption starts at medical school – the goal is to become a consultant. The hierarchy of importance that results does not assist patient care especially as it is internalised by doctors who either may look down on those who do not become co0nsultants or may feel let down or a failure if they don't become one.*
>
> Strategic partner 21

In February 2022 the Academy of Medical Royal Colleges suggested that changes are needed to recognise the positive choice made by doctors deciding to contribute as SAS doctors. This role gives some the opportunity (as we have heard) to better find work/life balance. Equally important is the need to treat SAS doctors as a heterogeneous group with individual aspirations and ambitions which need to be recognised, including the opportunity to deliver high quality patient care.

THE IMPACT OF RACISM AGAINST DOCTORS ON PATIENT CARE AND SAFETY

Race discrimination against doctors, including in career progression, will trigger risks to patient care and safety.

- if career progression is biased it is likely to result in patients not being treated by the best available doctors
- if career progression is biased it is likely to result in less diverse leadership teams and an absence of inclusion within those teams, with a potentially adverse impact on patient care and safety and organisations being led by doctors who may not be the best available.
- if disciplinary action and referrals to the GMC are influenced by racial bias that will undermine the confidence of ethnic minority doctors to progress their careers and encourage a culture of blame not learning
- if ethnic minority doctors are less likely to be listened to and more likely to be adversely treated when they raise concerns that will make it less likely such staff will raise concerns or admit mistakes
- if ethnic minority doctors are more likely to be bullied at work that is likely to undermine effective team working and psychological safety with potential adverse consequences for patient safety and care – and undermine the confidence of ethnic minority doctors to take on leadership positions
- if ethnic minority medical students' and doctors' career progression is adversely impacted by race discrimination that will affect their physical and mental health and wellbeing*

* Karlsen, S and Nazroo, J (2002) 'Agency and structure: the impact of ethnic identity and racism on the health of ethnic minority people' in Sociology of Health and Illness *Volume 24, Issue1 2002 Pages 1-20.*

[21] Hinscliff, G (2021) 'Dido Harding's pledge to cut overseas NHS staff is a kick in the teeth' in *The Guardian,* 21 June 2021. Available at: www.theguardian.com/commentisfree/2021/jun/21/dido-harding-overseas-nhs-staff-nhs-england

CONCLUSIONS

There have been almost 200 reports on the discrimination facing ethnic minority doctors and medical students in the UK. Some have added to our understanding of the challenge discrimination presents. Many are gathering dust.

This report was commissioned to better understand the barriers to career progression for Black and Ethnic minority doctors and how to mitigate or remove them.

Discrimination is immoral, unlawful, and undermines both the care and safety of patients and the health and wellbeing of those subjected to it. The proportion of UK doctors of ethnic minority heritage is rising and is a very substantial proportion of the total medical workforce. The discrimination they face was repeatedly evidenced in our research.

Our research sought to better understand how both doctors on the frontline and system leaders, both white and of ethnic minority heritage, see those challenges as a time when the diversity of the NHS medical workforce has changed.

In seeking to signpost a credible way forward we have drawn on our detailed research and cross-referenced it to two other strands of evidence:
- the extensive but often ignored research evidence on 'what works' and what doesn't in this field
- the work being led by national bodies (particularly the GMC at UK level and HEE within England, recognising that similar work is being pursued in the other nations of the UK)

Rather than set out an extensive list of detailed interventions, we felt it would be more useful to set out the principles that should be followed from which a range of interventions might be drawn or developed with some confidence. Any intervention should consider the context and circumstances particular to that individual, organisation, or system.

7.1 PRINCIPLES TO BE APPLIED IN ALL CONTEXTS

1. **Managers and leaders at every level need to apply themselves to understanding the causes of racism and in particular the more subtle acts of discrimination within recruitment and career progression which constitute 'institutional racism'.**

   Institutional racism is 'the collective failure of an organisation to provide a professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racial stereotyping.[22]

Resistance to this concept often comes from an assumption that for behaviours or treatment to count as racist, they must be underpinned by overt or intentional prejudice. This is not true in law, and not true in practice. Some decisions that disadvantage individuals are no doubt deliberate acts of discrimination based on that individual's protected characteristics. Often, however, decisions are made due to biases and assumptions that research shows the perpetrator is probably unaware of.

Though the 2021 Commission on Race and Ethnic Disparities report (see page 3, above) purports to show that institutional racism does not exist, a range of responses and subsequent evidence strongly argue it does across a range of public services (see, for example, NHS WRES data; the failure to address discrimination in education[23]; and the view held by some very senior police officers that 'British policing is institutionally racist [and] until we admit it we'll never win back trust'[24]).

2. **It is not sufficient to be a 'non-racist'. To effectively dismantle the barriers to ethnic minority doctors' career progression requires an anti-racist approach.**

Although a growing number of organisations understand this and are adopting 'anti-racist' statements, there is a lot of controversy about anti-racism (often predicated on the false belief that 'anti-racist' equates to 'anti-white'). In reality an anti-racist approach is about being proactive about addressing the causes of racism – not just mitigating its effects and impact.

The challenge that underpins the theory is a recognition that 'we' have constructed a view of what is 'normal' and that this is based on pseudo-scientific data about white superiority. These beliefs play out in our beliefs and behaviours creating a racial hierarchy across our whole society.

Anti-racist action therefore is located in recognising systemic discrimination, recognising race as a social construct, and critically re-appraising racialised action. We often defer to a very narrow definition of racism and see it as deliberate acts motivated by prejudice. This is misguided and contributes to an environment where white people can hate being called racist, more than they (they) hate racism.

Structural racism operates through formal and informal habits and norms that subtly and consistently disparage, limit, and dehumanise individuals who hold white privilege. These ideas, like internalised oppression and internalised superiority, reinforce myths and fears about the 'other' and continually foster the stereotypes that form part of the ingredient for discrimination.

When it comes to change, many organisations recognise that their policies and processes can routinely discriminate – but it is often the understanding of those who maintain and reinforce them that needs to be addressed. Dismantling racial discrimination requires us first to admit that it exists. Anti-racist action requires us to understand how it is perpetuated and disrupt the root cause. Most importantly, anti-racism recognises that white people are not

'outside' of race and that they too have a responsibility to address and 'fight' racial discrimination, rather than offloading this responsibility to those who are racialised.

An understanding and commitment to anti-racism enables individuals and organisations to more rigorously and sustainably address race discrimination in both its overt and its covert forms. To do so leaders must be prepared to be made uncomfortable about the causes of racism and its impact and their own past roles in sustaining or allowing discrimination.

Employers, system leaders, and all those involved at any level within medical schools should be expected to understand why equity in access, treatment, and progression is an indispensable element of effective and safe healthcare. Furthermore, there should be a clear expectation that they will model the behaviours they expect of others. Leaders should be able to (and should be required to) advocate the benefits of equity and asked to expand on how they are achieving it. This is crucially important as support from top management and rewards for increasing diversity are two key factors in determining the success of diversity programmes.[25]

3. **An inclusive culture is essential. A culture of inclusion and psychological safety is not an optional extra but essential if any improvements in representation are to be sustainable and the benefits of improved representation leveraged effectively.**

Inclusion is the extent to which staff believe they are a valued member of the work group, in which they receive fair and equitable treatment, and believe they are encouraged to contribute to the effectiveness of that group. Inclusive organisations are more likely to be 'psychologically safe' workplaces where staff feel confident in expressing their true selves, raising concerns, and admitting mistakes without fear of being unfairly judged.[26] The GMC-commissioned report *Fair to Refer* found:

- Doctors in diverse groups do not always receive effective, honest or timely feedback because some managers avoid difficult conversations, particularly where that manager is from a different ethnic group to the doctor. This means that concerns may not be addressed early and can therefore develop.

- Some doctors are provided with inadequate induction and/or ongoing support in transitioning to new social, cultural and professional environments.

- Doctors working in isolated or segregated roles or locations lack exposure to learning experiences, senior mentors, support and resources.

- Some leadership teams are remote and inaccessible, not seeking the views of less senior staff and not welcoming challenge and this can allow divisive cultures to develop.

- Some organisational cultures respond to things going wrong by trying to identify who to blame rather than focusing on learning. This creates particular risks for doctors who are 'outsiders'.

- In groups and out groups exist in medicine including relating to qualifications (including by country and within the UK by medical school) and ethnicity (including within ethnic

minority populations). Members of ingroups can receive favourable treatment and those in out groups are at risk of bias and stereotyping.

The report made recommendations in four key areas:

- improving induction, feedback and support for doctors new to the UK or the NHS or whose role is likely to isolate them (such as SAS doctors and locums)

- addressing the systemic issues that prevent a focus on learning, rather than blame, when something goes wrong

- ensuring engaged, positive and inclusive leadership is more consistent across the NHS

- developing a UK-wide mechanism to ensure delivery of the recommendations

The GMC, in collaboration with other system leaders, has developed a comprehensive programme to implement these recommendations. Its success (or otherwise) is directly relevant to removing some of the barriers to career progression for ethnic minority doctors.[27]

4. **Difficulty talking about race and discussing issues with ethnic minority colleagues is a major contributor to the lack of honest discussion and organisational commitment on race equity. All those in any position of responsibility should be expected to learn how to create the conditions of trust that underpin effective conversations and learn how to undertake them.**

When appraisals and feedback occur given across a difference of protected characteristic, discussion and feedback are susceptible to 'protective hesitancy', notably but not exclusively with ethnic minority applicants and direct reports. Protective hesitancy can lead to dishonest feedback of the 'benevolent kindness' variety which, during selection or promotion, the applicant will spot as being false (and useless) such as 'you were very good, but on the day someone else was better.' In response, candidates may decide there is no point in pursuing the conversation but will be demoralised because what they required was specific advice on what could have been done better together with suggestions (or support) on how to improve next time.

Thomas[28] explored 'protective hesitancy' whereby white mentors could be defensive and hesitant in giving honest feedback to mentees of colour. He found that ethnic minority staff advance more rapidly in their careers when they have mentors who understand and openly acknowledge how race (both in terms of privilege and oppression) can be a major factor in the trainees' institutional environment as well as in their mentoring relationship.

Gündemir et al[29] found that where Black staff fail to secure a new job or a request for promotion, the explanation they receive is often vague and barely justifies the credibility of the unfavourable outcome. This in turn fails to eliminate any perceived implicit racial bias or ulterior political motive.

The fear of 'saying the wrong thing' is easily spotted and may naturally prompt a reciprocal closing down of the conversation. Similarly, when giving critical feedback to women, male managers may be especially worried about how the feedback will be received.[30]

5. **Bias plays a crucial role in 'bringing alive' race discrimination. It impacts every stage of career progression. There is a wealth of research demonstrating this and how granular attention must be paid to how it is mitigated or removed. The NHS in all four countries needs to develop, share, and monitor the implementation of an evidence-based strategy which emphasises debiasing processes, inserting accountability, and developing clear goals. All this needs to be underpinned by leaders adopting an anti-racist approach towards these issues**.

One place to start in examining how bias may be built into the system is to conduct an audit of pay gaps by ethnic group. Though there is no statutory requirement to measure and publicise the ethnicity pay gap within organisations, good practice dictates this should be action across the medical profession within individual employers.

There is little information available about the ethnic pay gap for doctors in the UK. Such work needs to take account of the significance of intersectionality.

The following examples represent a small sample of a very large body of research on the impact of bias on career progression (supplemented by the evidence om 'stretch opportunities' below):

Assessments
Correll[31] found that in assessments, the performance of women and ethnic minority staff — when objectively equal to that of their white male counterparts—is judged as lower both when individuals evaluate others and when they evaluate themselves. Greenhaus and Parasuraman[32] found that the achievements of ethnic minority managers were more likely to be attributed to help from others (rather than ability or effort) than were the achievements of white managers.

Career trajectory assumptions for ethnic minority staff
A common failing is to prefer applicants with a faster career trajectory, or more prior 'acting up' and secondment opportunities, even though the evidence is clear that some groups of staff (notably ethnic minority staff, and women with childcare responsibilities) may not had similar opportunities.[33]

Panel decisions
Rivera[34] found that panels rarely see race as a factor in their decisions but instead use ambiguous assessment criteria to filter out people who 'aren't like them'. People in marginalized racial and ethnic groups are deemed more often than white people to be 'not the right cultural fit' or 'not ready' for high-level roles. They are then taken out of the running because their 'communication style' is somehow off the mark.

Members of professions who view themselves as 'objective' and dealing in 'facts' (such as scientists, doctors, and accountants) may be especially prone to unconscious bias.[35] When decision makers believe that some people (e.g. white, male) are more competent than other people (women, ethnic minority) that can impact on whether we interpret their past performance as evidence of future ability. That may well lead to some (white, male) people gaining more development opportunities and better appraisals, compared other groups of people.[36] Similarly, Uhlmann and Cohen describe how job discrimination can occur where recruiters redefine merit in a manner congenial to the idiosyncratic credentials of individual applicants from desired groups.[37]

6. **Data is a bedrock of an effective strategy. Doctors, employers, and system leaders must approach data using a problem-sensing approach, not a comfort-seeking one.**

That means listening carefully and sympathetically to the lived experience of staff however uncomfortable that may be. It means the analysis of data must be granular and consider not only access but experience, progress, and retention using a lens of equity and drawing on the available research to highlight potential concerns. The analysis must be informed by an understanding of how race discrimination arises, how it surfaces, and its impact. Without this focus it will be difficult to know what data it is crucial to understand. Employers and training institutions should be accountable and transparent when publishing relevant data, including their annual assessment outcomes by ethnicity (and other protected characteristics).

Without reliable and relevant data, it is impossible to determine if progress is being made (or not) and to identify where support is needed and what are the most appropriate forms of accountability to insert.

7. **Support and encouragement to doctors and medical students can take many forms and is very important. However, this is not a substitute for those with authority at employer and system level (including regulators) taking action to remove or mitigate institutional and system drivers of discrimination. Those in positions of responsibility at all levels must constantly consider whether the support, encouragement, treatment and opportunities that ethnic minority doctors and students receive compares to that of their white equivalents.**

When providing support, it is essential it is underpinned by evidence showing it is the most effective intervention available. There is a growing evidence based demonstrating how some forms of support may be of little use whilst others need to incorporate an understanding of anti-racism to be effective. Coaching, action learning groups, mentoring and being linked to networks will have an important part to play. Medical schools need to scrutinise differences in learning experience and outcomes and eliminate them. Employers need to similarly scrutinise the development opportunities and support that ethnic minority doctors receive to eliminate the differences between white and ethnic minority doctors both at junior doctors and consultant level. Particular attention must be paid to the support and encouragement provided to international medical graduates since the evidence is overwhelming that there is

a substantial, career-limiting gap between the support and encouragement they receive from recruitment, through induction and during employment.

8. **Stretch opportunities such as 'acting up', secondments, and involvement in projects are a crucial part of career progression and access to them must be equitable**.

   As NHSi note, 'senior executives report their sources of key development as learning from experience in role and on the job (70%), learning from others, especially mentors, coaches and learning sets (20%), and formal coursework and training (10%).'[38] However, when looking for help with a task at work, work partners tend to be chosen not for their ability, but for their likability.[39]

   It was clear from our interviews that the 'tap on the shoulder' was a common form of access to this crucial part of career progression. Formalising access through an equity lens is essential with those responsible being held to account for patterns of disadvantage.

9. **When concerns exist, staff and students should feel it is safe and effective to raise them. It is crucial that those in authority at every level are proactive and preventative, intervening early and informally wherever possible. Leaders at every level should ensure that concerns are dealt with promptly and effectively (or escalated if appropriate).**

   Doctors fear reporting racist incidents either because they believe such reporting will be ineffective or because they fear it may make things worse. Those concerns are likely to be especially great amongst those students and doctors who already feel vulnerable, notably IMG and SAS doctors. An open and learning culture is being developed in a number of organisations. These cultures emphasise early informal intervention, a focus on learning not blame, and seek to identify and address specific challenges related to the treatment of ethnic minority staff:

   - Considerable evidence exists that ethnic minority staff, including doctors, who raise concerns are less likely to be listened to and more likely to be victimised if they do raise concerns[40]
   - NHS staff survey data repeatedly suggests ethnic minority staff are less confident about speaking up. Research for the National Guardians' Office concluded that ethnic minority staff are more anxious than white staff about using Freedom to Speak Up Guardians unless they are confident they would be safe in doing so.[41]

10. **Leaders must pay attention to the impact of wider adverse treatment on career progression.** It is crucial leaders focus on the wider experience of doctors and medical students that might impact on their career progression at every stage (notably, experiencing detriment by going through the disciplinary process, bullying, an adverse response to the raising of concerns, and the lack of inclusion in their teams).

The 2021 MWRES report found ethnic minority doctors report a worse experience than their white colleagues when it comes to harassment, bullying, abuse, and discrimination from staff. This trend is seen across the whole career path from medical school to consultant level. Furthermore, even when ethnic minority doctors become consultants, they report greater levels of discrimination and harassment and lower levels of feeling 'involved' at work. In addition to the evidence of the impact of more 'visible' measures such as disproportionate disciplinary action and bullying, more subtle acts and omissions can be equally damaging.

Medical students and doctors, especially those from ethnic minority backgrounds face a rising level of abuse from patients. Every organisation that trains or employs doctors must develop a clear, widely publicised approach to racist abuse of any kind, using the principles set out in the BMA guide *Managing discrimination from patients and their guardians and relatives*.[42]

11. **Training on biases (both conscious and unconscious) is important. Whilst some forms of diversity training and unconscious bias training can increase cognitive understanding of the causes of racism and its impact, such training needs to be underpinned by an anti-racist perspective. Research suggests that debiasing processes is likely to be more effective in mitigating bias, especially when allied to an emphasis on accountability.**

An analysis of over 40 years of research on diversity training evaluation outcomes found that diversity training builds people's knowledge about other groups and can affect people's beliefs and behaviour – but that these effects fade over time.[43] Indeed, it suggests that learning at a later point tends to be minimal, possibly partly because 'people feel virtuous having done the training' and so stop making the effort required to keep their prejudices in check.

The default response of employers to bias has often, recently, been to introduce unconscious bias training. However, the evidence on its impact is mixed. Unconscious bias training may assist those who wish to learn, but not necessarily those who do not wish to do so.[44] In particular, there is no evidence that a short session of online generic unconscious bias training is effective. However, specific training on the impact of bias in recruitment, close to the time of the recruitment decisions, accompanied by regular reminders can make recruiters more open to interventions that work. A comprehensive review of the literature[45] found:

- unconscious bias training is effective for awareness raising by using an IAT (Implicit Association Test) followed by a debrief or more advanced training designs such as interactive workshops

- unconscious bias training can be effective for reducing implicit bias, but it is unlikely to eliminate it

- unconscious bias training interventions are not generally designed to reduce explicit bias and those that do aim to do so have yielded mixed results

- using the IAT and educating participants on unconscious bias theory is likely to increase awareness of and reduce implicit bias

- the evidence for unconscious bias training's ability effectively to change behaviour is limited. Most of the evidence reviewed did not use valid measures of behaviour change

Research suggests it is more effective for organisations to consider how to debias *processes* rather than simply debias individual staff.[46]

12. **Clear goals with accountability and support are essential.**

It is essential clear goals are set for individual organisations (and parts of organisations). Not only should there be a clear expectation that these goals are to be meet, but support to meet them should be given. Motivation alone will not bring about the required change: goal setting is essential. Indeed, research shows goal setting has the potential to change behaviour precisely because it impacts positively on the 'why' (motivation) *and* the 'how' (knowhow and skills) of behaviour change. It can do so for individuals, teams, and organizations and can also impact the organisational climate.[47]

Foschi[48] found that the awareness of accountability acts to pre-empt the introduction of bias into hiring decisions before it happens and helps reduce stereotyping when making decisions. Similarly, Valian[49] found the awareness of accountability acts to pre-empt the introduction of bias into hiring decisions before it happens and helps challenge stereotypes when making decisions. Kalev and Dobbin[50] found that structures that embed accountability, authority, and expertise (affirmative action plans, diversity committees and taskforces, diversity managers and departments) are the most effective means of increasing the proportions of white women, Black women, and Black men in private sector management. Responsibility structures make training, performance evaluations, networking, and mentoring programs more effective.

A literature review by Priest et al[51] came to similar conclusions, claiming that 'studies from a range of contexts indicate that mandated policy interventions to promote diversity that have legal or funding consequences are associated with better outcomes than non-mandated polices without seeming to significantly harm the economic wellbeing of white men'. An example of effective goal setting in action is the 2011 UK National Institute for Health Research's announcement that it would not shortlist any NHS/university partnership for grants unless the academic department held at least a silver Athena Swan award (recognising policies to promote sex equality). There followed significant large increases in women in leadership roles and in applications for Athena Swan awards.[52]

13. **Regulators need to ensure that a core driver of their scrutiny and interventions is whether medical schools and employers are fit for purpose in actively promoting**

respectful treatment for all staff and students and equitable career progression for under-represented groups.

The GMC and HEE have responded to this challenge with an extensive programme of interventions, and with clear goals and accountability. Other regulators need to ensure their work on this issue complements and amplifies those initiatives.

What distinguishes the current GMC strategy[53] from its predecessors is its emphasis on goals and accountability. The strategy contains a very helpful range of interventions the GMC will be seeking to implement and hold training bodies and employers to account on. The strategy included expectations for all the Royal Medical Colleges and is applicable across all four nations. A number of those interventions correspond to the types of intervention proposed in this conclusion.

The most recent (2022) Annual report of the HEE Postgraduate Medical Deans Equality, Diversity and Inclusion Committee sought to step up work to tackle what their own survey report described as widespread reports of racism and microaggressions experienced by ethnic minority doctors in training with a particular focus on differential attainment.

Every institution including the equivalent bodies in devolved administrations involved in the training, employment, and career progression of ethnic minority doctors need to assure themselves and their students and doctors that they are implementing such initiatives and demonstrate this through transparent sharing of their work and outcomes. Regulators should also scrutinise and hold to account commitments impacting the progression of ethnic minority students and doctors.

14. **Retention is important. Decisions to leave medical school or employment are likely to be significantly influenced by individuals' treatment and the perceived fairness of career progression. Doctors' turnover should be examined through an equity lens.**

    Data should be regularly reviewed. Exit interviews should be conducted (but not by past line managers or supervisors). Responses should be proactively developed.

15. **A very large minority of NHS doctors are international medical graduates. Their treatment from arrival onwards is marked by discriminatory practices including within career progression. Addressing those practices is a priority for employers and system leaders.**

    The recommendations of *Fair to Refer* (see Principle 3 above) alongside the GMC and HEE strategies (and their equivalent in the other nations) will need to be relentlessly and transparently implemented. This is discussed further in section 6.1. above.

16. **SAS doctors experience occupational segregation as a crucial part of the workforce of the NHS. There is too little opportunity for career progression, with much poorer terms and conditions. Addressing this is a serious challenge and must be a priority.**

    The development in each of the four nations of SAS Charters[54] has been built upon work by the BMA: furthermore, the recent initiative by the Academy of the Medical Royal Colleges can provide a framework to expedite this work. The proportion of doctors who are SAS doctors, and the seriousness of the disproportionalities they face, makes this a priority. SAS doctors are discussed further in section 6.2. above.

17. **Doctors who identify as female experience additional discrimination. The intersectional impact of being a female ethnic minority doctor can be especially challenging and requires urgent attention.**

    As Bates[55] argues, 'patriarchy' refers to a historical system that has been designed by and for those who have always held power in our society: white, wealthy, non-disabled men. This study identifies women doctors from ethnic minority groups being disadvantaged more than their male counterparts. There is no place in society – let alone healthcare – for some of the biases and misogynistic behaviours that have been re-lived by some participants. In the same way higher education institutions are now calling time on this toxic and inappropriate culture, employing organisations in the health sector also need to dismantle the legacy of patriarchy.

    The report by Daphne Romney QC on sexism at the BMA contains insights and recommendation that are applicable more widely in the NHS.[56]

18. **Notions of what constitutes an effective leader do not largely correspond with the evidence on what makes an effective leader. A major overhaul of how leaders are developed and appointed is essential.**

    It is important that all those who lead in medicine are aware of the shortcomings of an approach to leadership and engagement that ignores the rich history and contribution made outside a Eurocentric environment. That does not only impede the induction and progress of IMGs but can lead to assumptions about what there might be to learn from other models of medical leadership.

    Effective leadership requires a deep understanding of the roots and characteristics of health inequalities across all specialisms and within both the training and updating of doctors.

19. **Listening to the lived experience of ethnic minority staff at all levels and providing a serious voice to challenge and hold to account employer and system leaders is important. That requires resources. However, employers and system leaders must not**

transfer responsibility for leading or designing evidenced interventions to ethnic minority networks as a way of relinquishing responsibility themselves.

20. **Where integrated organisations exist which include employers of doctors it is essential that their governance enables them to prioritise equity for staff and patient care, with an understanding that addressing racial inequity in career progression and treatment is a key enabler of such work. When new integrated care structures are created it is essential that meticulous attention is given to the appointment processes to avoid reproducing the ethnicity gradient seen elsewhere in the NHS – and ensuring the voice of medicine is heard.**

7.2 ACTIONING THESE PRINCIPLES

Developing these principles and implementing them will require a determined effort by leaders at every level, alongside engagement with, and accountability to, staff and students.

They will require more than a commitment to being non-racist. Rather they require an active commitment to anti-racism. It will require a clear narrative, clear goals, means of support, and the insertion of accountability.

Some regulators have begun a sustained programme of work to implement initiatives that match these principles. All regulators across all four nations should be expected to collaborate and deliver similar programmes.

As such work is developed, sustained engagement with doctors and students – especially those of ethnic minority heritage – is essential, and should include staff networks as well as their trade unions and professional bodies.

Many organisations have engaged in a great deal of activity intended to respond to the increased awareness of racism and the challenge it poses to the NHS. Too many of those interventions, however, have no evidence base and appear to be unaware of the research in the field. There should be an expectation that the introduction of a given intervention is supported by evidence that can explain why this intervention is likely to be successful. Additionally, where possible, evaluations should be built into the implementation cycle of those interventions.

Iris Bohnet (Professor of Public Policy at Harvard Kennedy School) in her introduction to the Government Equalities Office guidance on gender equality made remarks that are equally applicable to race equality:

> *Human resource management must be based on rigorous evidence of what works to level the playing field. Evidence-based design of hiring practices, promotion procedures and compensation schemes helps our organisations do the right and the smart thing, creating more inclusive and better workplaces.*[57]

Reflecting on the importance of equality and inclusion, one research participant urged the NHS to:

> *make inclusion and equity a prerequisite in all that we do, not just one of many priorities. Let's change the organisational culture as well as system, structures, and processes to reflect this commitment. This must be connected to rigorous measurement, or else it won't work. We need to hold people accountable for choices being made. We need, for example, to integrate these priorities into our appraisal processes. We need to ask for visible representation to change – now. At the highest levels.*

It's a good summary of what needs to be done.

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[22] MacPherson W (1999) *The Stephen Lawrence Inquiry. Report of an Inquiry*: The Stationary Office

[23] Worth J, McLean D, and Sharp C (2022) *Racial Equality in the Teacher Workforce An Analysis of Representation and Progression Opportunities from Initial Teacher Training to Headship:* National Foundation for Educational Research

[24] Basu N (2022) 'British policing is institutionally racist. Until we admit it we'll never win back trust' in *The Guardian*, 22 May 2022: www.theguardian.com/commentisfree/2022/may/25/race-action-plan-police-accept-institutionally-racist

[25] Rynes S and Rosen B (1995) 'A field survey of factors affecting the adoption and perceived success of diversity programs' in *Personnel Psychology* Summer 1995; 48, 2

[26] Shore, L. M., Cleveland, J. N., & Sanchez, D. (2018) 'Inclusive workplaces: A review and model' in *Human Resource Management Review*, 28(2), 176–189. https://doi.org/10.1016/j.hrmr.2017.07.003

[27] Atewologun D and Kline R (2019) *Fair to Refer: Reducing disproportionality in fitness to practise concerns reported to the GMC:* GMC

[28] Thomas D (2001) 'The Truth About Mentoring Minorities: Race Matters' in *Harvard Business Review* 79, no. 4 (April 2001): 98–112

[29] Gündemir S, Homan AC, de Dreu CKW, van Vugt M (2014) 'Think Leader, Think White? Capturing and Weakening an Implicit Pro-White Leadership Bias' in *PLOS ONE* 9(1): e83915 https://doi.org/10.1371/journal.pone.0083915

[30] Ridgeway, Cecilia & Correll, Shelley (2004) 'Unpacking the Gender System: A Theoretical Perspective on Gender Beliefs and Social Relations' in *Gender & Society - GENDER SOC*. 18. 510-531. 10.1177/0891243204265269.

[31] Ridgeway, C. L., & Correll, S. J. (2004) 'Unpacking the Gender System: A Theoretical Perspective on Gender Beliefs and Social Relations in *Gender & Society*, 18, 510-531

[32] Greenhaus J and Parasuraman S (1993) 'Job Performance Attributions and Career Advancement Prospects: An Examination of Gender and Race Effects' in *Organizational Behavior and Human Decision Processes, 55, 2*

[33] Dhaliwal, S. & McKay, S. (2008) *The work-life experiences of black nurses in the UK: a report for the Royal College of Nursing*: RCN

[34] Rivera, L (2016) 'Pedigree: How Elite Students Get Elite Jobs' 10.2307/j.ctv7h0sdf.

[35] Uhlmann, Eric & Cohen, Geoffrey (2007) ''I think it, therefore it's true': Effects of self-perceived objectivity on hiring discrimination' in *Organizational Behavior and Human Decision Processes*. 104. 207-223. 10.1016/j.obhdp.2007.07.001.

[36] Correll, Shelley & Ridgeway, Cecilia (2006) 'Expectation States Theory' 10.1007/0-387-36921-X_2.

[37] Uhlmann, Ericluis & Cohen, Geoffrey (2005) 'Constructed Criteria Redefining Merit to Justify Discrimination' in *Psychological science*. 16. 474-80. 10.1111/j.0956-7976.2005.01559.x.

[38] National Improvement and Leadership Development Board (2016) *Developing People: Improving Care*

[39] Casciaro, Tiziana & Sousa Lobo, Miguel. (2005) 'Competent jerks, lovable fools, and the formation of social networks' in *Harvard Business Review*. 83. 92-9, 149.

[40] Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust public inquiry:* The Stationery Office; London

[41] Kline, R and Somra, G (2021) *Difference Matters: The impact of ethnicity on Speaking Up*: National Guardians Office

[42] BMA (2022) *Managing discrimination from patients and their guardians and relatives*

[43] Bezrukova, K., Spell, C.S., Perry, J.L., & Jehn, K.A (2016) 'A meta-analytical integration of over 40 years of research on diversity training evaluation' in *Psychological bulletin*, 142 11, 1227-1274 .

[44] Dobbin, F., & Kalev, A. (2016) 'Why Diversity Programs Fail: And What Works Better' in *Harvard Business Review*, 94, 52-60

[45] Atewologun D, Cornish, T, and Tresh F (2019) *Unconscious Bias Training; An assessment of the evidence for effectiveness*: Equality and Human Rights Commission

[46] See NHS East of England (2021) *No More Tick Boxes: A review on the evidence on how to make recruitment and career progression fairer* for more information

[47] Berkman E. T. (2018) 'The Neuroscience of Goals and Behavior Change' in *Consulting psychology journal*, *70*(1), 28–44. https://doi.org/10.1037/cpb0000094

[48] Foschi, M. (1996) 'Double Standards in the Evaluation of Men and Women' in *Social Psychology Quarterly*, *59*(3), 237–254. https://doi.org/10.2307/2787021

[49] Valian, Virginia (1998) 'Why so Slow? The Advancement of Women' in *Contemporary Sociology*. 28. 10.2307/2653855.

[50] Kalev, A, Dobbin F, and Kelly E (2006) 'Best Practices or Best Guesses? Assessing the Efficacy of Corporate Affirmative Action and Diversity Policies' in *American Sociological Review* 71 (4):589-617.

[51] Priest, Naomi & Esmail, Aneez & Kline, Roger & Rao, Mala & Coghill, Yvonne & Williams, David (2015) 'Promoting equality for minority ethnic NHS staff-what works?' in *BMJ (Clinical research ed.)*. 351. h3297. 10.1136/bmj.h3297.

[52] Ovseiko P V, Taylor M, Gilligan R E, Birks J, Elhussein L, Rogers M et al. Effect of Athena SWAN funding incentives on women's research leadership *BMJ* 2020; 371 :m3975 doi:10.1136/bmj.m3975

[53] GMC (2022) *GMC Equality, diversity and inclusion targets, progress and priorities for 2022*

[54] See: https://www.bma.org.uk/advice-and-support/career-progression/sas-development/the-sas-charter

[55] Bates, L (2022) *Fix the System, Not Women*: Simon & Shuster

[56] Available at: https://beta-staging.bma.org.uk/news-and-opinion/report-into-sexism-at-the-bma-published

[57] Government Equalities Office (2019) *Reducing the gender pay gap and improving gender equality in organisations: Evidence-based actions for employers*

CODA (AND ACKNOWLEDGEMENTS)

The BMA commissioned this research project in 2021 to understand the barriers to progression for doctors caused by factors relating to race and ethnicity. Throughout our conversations across the three phases of the project we were focused on probing and listening to the lived experiences and insights of doctors and stakeholders with relationships and responsibilities to this agenda.

We want to applaud and appreciate the time given by the doctors and other medical professionals committed to this work in the middle of the most significant health crisis of our lifetimes. Overall, some 150 hours of voluntary time were given to share thoughts, experiences, and material.

The collective picture which emerges provides a compelling narrative and evidence of the inequities experienced by ethnic minority doctors in 2022. It was a privilege to be trusted by so many with such intimate accounts of their lived experiences. The call to action is loud and clear – attending to the moments that matter in the career life cycle of doctors begins pre-medical school and continues all the way through the career cycle. The accounts provided reinforce the need to disrupt deep-seated paradigms on race and ethnicity: when beliefs are changed, we will see different outcomes.

Our study begins at undergraduate level and moves through to accounts at the most senior levels of medical leadership. All the way through the courage, grit, and determination of those we spoke to was humbling. We believe that closing our project by foregrounding some of these voices honours their significant contributions and will stay with you, the reader.

"This is such a noble profession. It's a big honour to be a doctor. To have your hopes and dreams smashed because of an unfair system is completely wrong."

"I'm also very much aware of the heterogeneity of experiences. Now when we talk about BME groups I'm very mindful that people have very different experiences, very different backgrounds, but there's a danger that we almost homogenize people."

"We know that patients do better when you have a diverse workforce. Not just that they do better when they see clinicians from their own or a similar background, which is true. But when the entire workforce is diverse at all levels, then patients do better."

APPENDIX 1: METHODOLOGY

The research was guided by two main questions:

1. What are the factors that lead to doctors from ethnic minority backgrounds not progressing at the same rate as their white counterparts?
    a. In addition: what are the factors that lead to doctors from majority ethnic (White) backgrounds progressing at a faster rate than their ethnic minority counterparts?
2. Are there examples of effective solutions that have been implemented at the micro, meso and macro level to remove the barriers to progression?

Research was undertaken in three phases.

The aim of the first phase was to gather a wide range of themes which would be further tested in the second and third stages of the study. Due to pandemic-related concerns, our original plan to run 24 focus groups had to be adjusted. We adapted focus groups questions to survey questions and sent them to 276 doctors. We also conducted one-to-one interviews through opportunity sampling and snowball sampling. During this stage:

- 24 focus group sessions were conducted, which ranged from between 1-6 participants per session, with 60 people engaged in total
- six one-to-one interviews were undertaken
- 276 questionnaires were sent, of which 13 were returned (5%)

Participants represented a range of ethnicities, regions, and career stages. Focus group participants had the option of attending sessions aimed at particular ethnic groups or taking part in mixed-ethnicity groups.

During phase 2, 22 doctors participated in one-to-one structured interviews in which they were invited to reflect on critical moments that they felt had enabled or hindered their progression. Participants were prompted to reflect on the themes arising from phase 1.

Participants during these stages were assured confidentiality. As such quotes from these phases may be slightly modified to remove identifying information. Quotes from these phases are relayed in the main report with attributions showing the participants gender and ethnicity. To preserve anonymity, all quotes are attributed to 'doctors' regardless of whether the participant was a GP, consultant, SAS doctor, etc.

Phase 3 consisted of 25 one-to-one interviews with a range of stakeholders, including clinical directors, representatives of medical bodies, and employers who have decision-making authority over the career pathways of doctors. The aims of this phase were to:

- identify perceived institutional barriers to and opportunities for progress towards racial diversity in leadership

- reflect on the efficacy of past sectoral interventions and explore factors that may have diluted their impact

Quotes from these individuals in the main report are attributed to 'strategic partners'. While participants were assured anonymity regarding their comments, all agreed to be identified as contributors. The following table therefore provides an overview of who took part and the breadth and range of their activities:

MR AJIT ABRAHAM	Group Director for Inclusion and Equity, Barts Health NHS
DR ALISTAIR CHESSER	Group MD, Barts Health Chief Medical Officer
DR SUBODH DAVE	Dean, Royal College of Psychiatrists
DR ALYSON O'DONNELL	Chief Medical Officer, University Hospitals, Dorset
DR ANTON EMMANUEL	Professor in neuro-gastroenterology at University College London and consultant gastroenterologist at UCLH and the National Hospital for Neurology and Neurosurgery. Head of Workforce Race Equality Standard (WRES), NHS England and NHS Improvement
PROF ANEEZ ESMAIL	Professor of General Practice, University of Manchester. General Practitioner.
DR ABI FADIPE	Medical Director, Oxleas NHS Trust
DR PAUL GILLULEY	Chief Medical Officer East London NHS foundation Trust
DR CHRIS HAGAN	Medical Director, Belfast Health and Social Care Trust
DR AMIR HANNAN	Chair of West Pennines Local Medical Committee (LMC) and Association of Greater Manchester LMC
DR SANDRA HUSBANDS	Director of Public Health London Borough of Hackney and The Corporation of the City of London.
DR PARTHA KAR	Diabetes Lead, NHS England and Consultant Portsmouth Hospitals NHST
PROF AMJAD KHAN	Postgraduate General Practice Dean, Director of Postgraduate General Practice Education, Lead Dean Director for General Practice/Public Health/Occupational Medicine/Broad Based Training, Chair – Committee of General Practice Education Directors (COGPED)
PROF NAMITA KUMAR	Post Graduate Dean Health Education England NE
DR SHONDIPON LAHA	Consultant in Critical care Medicine and Anesthesia Lancashire Teaching Hospitals NHST, Honorary Clinical Professor Faculty of Health and Care and Lancashire Applied research Chair of the Intensive Care Society President of Association of North West ICUs
CLAIRE LIGHT	Head of Equality and Diversity, General Medical Council.

DR NEIL MODHA	General Practitioner, Chair of Greater Peterborough Network Federation, Co-chair of Place based board, Thistlemoor, Greater Peterborough Network and North Place board in Cambridgeshire and Peterborough system
PROF COLIN MELVILLE	Medical Director and Director Education and Standards General Medical Council
RAJESH NADKANI	Consultant Forensic Psychiatrist, Executive Medical Director, Cumbria Northumberland Tyne and Wear NHS Foundation Trust
DR CHAAND NAGPAUL	Chair British Medical Association and Chair of FREE (Forum for Racial and Ethnic Equality)
PROF KELECHI NNOAHAM	Cwm Taf Morgannwg University Health Board Director of Public Health
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PROFESSOR PUSHPINDER MANGAT	Medical Director, Health Education Wales
MR SHAHZAD RAJAH	Cardiac Surgeon and Course Lead for Harefield Cardiac Review Course
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