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Dear Ms Saunderson

TACKLING RACISM IN MEDICAL CAREERS: the role of consultants

Thank you for the opportunity to comment on the BMA's consultation considering ways to tackle racism in medical careers and the impact of racism on ethnic minority doctors.

The King's Fund

The King's Fund is an independent charitable foundation working for better health, especially in London. The Fund promotes public policies that have a beneficial impact on health, and improve the organisation, quality, and accessibility of health and social care. It also provides expert and financial resources for developing services, communities and their leadership.

It seeks to improve health particularly for the people of London, while recognising that much is be to learned from elsewhere in the UK and overseas, and that the health of Londoners and the quality of their health care services are influenced by national policy and global events.

Response to the issues

This response is largely based on the King's Fund 2001 publication: Racism in Medicine: An Agenda for Change, (edited by N. Coker); other publications mentioned in this work; the Race Relations (Amendment) Act 2000 as well as other relevant information.

As discussed with you, the King's Fund has responded broadly to some questions posed in the six sections of the consultation document, rather than to each question in each section of the document.

Background and evidence

There is evidence from a range of sources which show that racial discrimination was and still is a factor in the selection of students to medical schools. The King's Fund publication: Racism in Medicine: An Agenda for Change, (edited by N. Coker) includes the findings from several reports, which are worth repeating below.

For example, racism in medical careers first emerged in 1987[1] when the allegation was investigated by the Commission for Race Equality and the claim upheld. After this, McManus et al (1989[2] and 1995[3]) found that minority ethnic applicants may be disadvantaged because they had foreign -sounding names. In 1995, Esmail et al[4] found that *'differential disadvantage to minority ethnic applicants wanting to study medicine.'* Another study by McManus in 1998[5] found conclusively that *'structural differences in <u>some</u> medical schools meant that applicants from minority ethnic groups to those schools were disadvantaged.'* This study also showed that *'the degree of disadvantage did not relate to the proportion of applicants from minority ethnic groups and that the disadvantage occurred despite minority ethnic applicants having similar grades and academic qualifications to white applicants.'*

More recently, the findings of a study by Cooke et el (2003)[6] indicated that doctors from ethnic minority groups experienced racism regardless of whether or not they were trained in the UK. They indicated that racism is manifested in the professions in two ways:

- Access to training and careers
- Norms of acceptable behaviour of consultants

However, doctors do not work in a vacuum. The work they do is set within the wider NHS, which serves a very diverse UK population. For example, data from the 2001 census shows an increase in the minority ethnic population to 4.5 million (7.6%) of the total population, a suggested increase of 44 per cent between 1991 and 2001. Figures also show that the ethnic minority population groups comprise almost half of the local population of some parts of the UK, e.g. the London region, where they comprise 29% of all residents.

Having a medical workforce that reflects the diverse population is essential to providing health care which can respond to the needs of both staff and patients. Claims of racism can therefore have far reaching and damaging consequences, not only for ethnic minority doctors and or white doctors, but also for the diverse population groups accessing health care in the UK.

Whilst the King's Fund is pleased that the BMA has initiated this consultation, we cannot help but to ask why the medical establishment has made so little progress to date in overcoming the barriers to access, selection and promotion of ethnic minority applicants and doctors.

There is a need for large scale changes to the medical profession's career framework. These changes should be set within a wider context of organisational and cultural change throughout the medical profession, the NHS and the BMA.

Broadly speaking, there should be an ongoing systematic review of the structure of the entire application and career progression processes.

The evidence shows that many ethnic minority applicants are unsuccessful in their applications for medical schools, and once trained/educated, find it difficult to gain promotion to consultant grade. The latter is important in that it reflects some of the problems experienced by ethnic minority NHS staff generally, who also find it difficult to progress to executive and senior management roles. The very existence of the *Breaking Through Programme*, launched last October by the Department of Health to build capacity of minority ethnic staff for executive posts in the NHS shows the extent of the problem of racism in the health services generally.

Targeting ethnic minority applicants and anonymous application forms

The King's Fund takes the view that while there may be some merit in targeting ethnic minority applicants, it will not have the desired results unless procedures are in place to ensure that the system is fair, open, transparent and not racially discriminating. Training and registration will only be as good as the people administering or leading the process. We also recognise the importance of ensuring that measures focused on eliminating discrimination are also focused on protecting the public from harm. Therefore, it is our view that:

- There is a need to review, make transparent and, where indicated due to evidence of discrimination, rewrite the criteria for scoring applications and interviewing and selecting applicants.

- Standardising the scoring system of application forms alone will not be enough unless the criteria used included of all valid routes into the profession, i.e. college entry, A-level and other wider access routes

- It might also be helpful to anonymise application forms as a first measure in managing discrimination.

However, even if names were removed from the application form, it would not take much to guess the nationality of an applicant, e.g. by country of origin, where he or she was educated, particularly if (s)he was not educated in the UK.

Therefore, there should be greater clarity of what is meant by 'anonymity of application forms (apart from removing a person's name) and clear guidelines for managing this process. Medical schools and post-graduate deans may wish to consider:

- Adopting the provisions of the Race Relations Amendment Act 2000 and develop a Race Equality Scheme, with which all concerned, including ethnic minority doctors would have to comply

- Making it an obligation for consultants and interview panel members to have ongoing training in race awareness/race equality and diversity

- Recognising the benefits that ethnic minority doctors can bring to the medical profession and to the NHS, e.g. promoted through local events or a national event

- Making race equality/race awareness training an integrated part of the core of professional and continuing education training for all professionals across the institutions providing medical education

- Ensuring strong leadership in relation to managing these processes throughout the profession.

Training on race relations/race equality

There is some evidence that conventional training does not adequately prepare individuals to deal with issues of racial discrimination or provide services that are valued and respected.
However, training on issues of race and cultural awareness has long been viewed as the vehicle for changing practice. Therefore, it is important that training is experiential and directly delivered by people from a range of cultural/racial backgrounds. Medical schools should involve people from minority ethnic communities who have expertise in this field to provide training for staff.

We welcome the fact that professional training bodies including the Royal Colleges are starting to address issues of race and culture in basic training. Such initiatives should ensure that professionals are equipped with knowledge and skills at the outset of their careers, and not when they have already become part of institutionalised practices. Training on the RR(A)A 2000 should be included at the earliest stage of professional development.

We would also like to see drafted into the selection and appointment process a statement that makes it clear that meeting the requirements of the RR(A)A 2000 is just part of a wider approach to planning, commissioning and providing health services to the different communities and to medical education and training. This would show that training staff in the requirements of the RR(A)A 2000 is positive and necessary, but it is, alone, insufficient to counter the cultural and racial barriers that hinder applicants from minority ethnic communities getting into medical school or advancing to consultant grade. Training around attitudes and assumptions should also be an integral part of all staff training.

Type 1 or Type 11 Training?

The evidence suggests that the problem is not only associated with the types of medical training available, but with the advice given routinely by consultants to ethnic minority doctors, which results in them taking Type 11 training that significantly impedes their promotion to consultant.

Regardless of the training available, there is a need for a clearly written, transparent and open training and promotion process at the point of initial recruitment, selection and admission as well as in all specialities. For example, this should include aims of the two types of training, why a doctor should take Type 1 rather than Type 11 training or visa versa, in reality, what the outcomes would normally lead to and the criteria for promotion and for becoming a consultant in the UK.

Mentoring and career progression

There is no evidence that mentoring in itself would overcome discrimination, but it could offer an opportunity for doctors to meet regularly with a senior member of staff to discuss their progress and developmental needs. For a such a scheme to work would depend on how it was set up in the first instance, who was mentoring whom and how the mentors were chosen.

Doctors should be given the opportunity to choose their own mentors from a list provided, in this case, from the GMC, BMA and NHS. The mentor should normally be someone working outside the ethnic minority doctor's employing organisation, and someone with whom the doctor can develop a respectful, mutually supportive and challenging relationship.

Some general comments and measures that might be helpful regarding career progression:

- Standardise all application forms for all medical posts
- Make transparent the required competence, development likely to be provided whilst in post and expectations of the role generally to all involved, including applicants, interviewees and consultants. This opens up the channels for a more informed approach for applicants for such posts
- Provide feedback to those doctors who are unsuccessful to enable them to develop those areas that will help them to reapply, if appropriate, at a later date
- Help candidates trained outside the UK to prepare for interview, clearly spelling out the type of CV required and interview process for medical post; giving guidance to doctors who do not understand the UK application system and or referring them to other organisations where they might obtain help with CV writing/interview skills. This information could be set out in advance in written materials and on the website of the GMC and medical schools as appropriate
- Have an external Human Resource Director on all appointment and interview panels
- Implement changes
- Follow through and monitor changes to ensure engagement with the process and achievement of desired outcomes

These measures should help to eradicate discrimination of ethnic minority doctors both during initial training, appointments to higher training posts and when applying for a consultant post.

Roles/Responsibilities of post-graduate deans and the NTN

There are some concerns about the over-representation of ethnic minority doctors in associate specialist and staff grade positions. We understand that national training numbers (NTN) are for doctors in training posts. However, it seems that there was an attempt to introduce a form of positive action for staff grade and associate specialist doctors by providing them with an NTN, which is not normally offered to this grade of doctors. The question is why have they been ignored? And what is causing the delay?

It is also worth considering:

- what sanctions or levers, if any, might be applied to medical schools to enable them to comply
- whether over-representation of ethnic minority doctors in staff grades and associate specialist roles is due also to inflexibility in the specialist registrar training programmes and, if so, how this might be overcome.

Part-time training would not only help the staff grade and associate specialist doctors. It may also enable female doctors (with child care commitments) and others who may be disadvantaged by the current training system to continue to pursue a medical career and this could help to retain UK trained doctors in the profession.

In summary, we believe that minority ethnic doctors have an important role to play in the national health service. However, they need to be given the opportunity to do so and this may require a serious overhaul of the career progression processes, admission and selection procedures; and sound investment in training and development in race equality awareness.

Medical schools could be given some incentives for putting the procedures in place and encouraged to share good practice between them. Sanctioning medical schools who fail to comply may be appropriate, but we would want to encourage them to act through persuasion and encouragement rather than just through legislation as to do so would be detrimental to sustainable long-term improvements in delivering race equality in medical careers. In this regard, we would suggest that these factors are built into a performance management framework for such medical schools.

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[1] Collier, J., and Burke, A., 1987 Racial and Sexual Discrimination in the Selection of Students to Medical Schools. Cited in Coker, N., (ed) *Racism in Medicine: An Agenda for Change*. London: King's Fund Publication.

[2] McManus, I.C., Richards, P., Maitlis, S, L., (1989) Prospective study of the disadvantage of people from minority ethnic groups applying to medical schools in the United Kingdom. Cited in Coker, N., (ed) *Racism in Medicine: An Agenda for Change*. London: King's Fund Publication

[3] McManus, I.C., Richards, P., Winder, B., Sproston, K., Styles, V., (1995) Medical Schools applicants from minority ethnic groups: identifying if and when they are disadvantaged. Cited in Coker, N., (ed) *Racism in Medicine: An Agenda for Change*. London: King's Fund Publication

[4] Esmail, A., Nelson, P., Primarolo, D., & Toma, T., (1995) Acceptance into medical school and racial discrimination. Cited in Coker, N., (ed) *Racism in Medicine: An Agenda for Change*. London: King's Fund Publication

[5] McManus, I.C., (1998) McManus, I.C., et al ., (1995) Factors affecting likelihood of applicants being offered a place in medical schools in the United Kingdom in 1996 and 1997: retrospective study. Cited in Coker, N., (ed) *Racism in Medicine: An Agenda for Change*. London: King's Fund Publication

[6] Cooke, L., Salford, H., Leonard, P., (2003) Racism in the medical profession: the experience of UK graduates. London: Health Policy and Research Unit. BMA.

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