Tackling Racism in Medical Careers: The Role of Consultants – Policy Paper

November 2005
In February 2004 the CCSC issued the consultation document *Tackling Racism in Medical Careers: The Role of Consultants*. Forty-seven responses were received from a wide variety of stakeholders, including collective responses from BMA committees, regional consultants and specialists committees, medical staff committees, local negotiating committees, members of the CCSC, the medical royal colleges, the British International Doctors Association, the King’s Fund and the Commission for Racial Equality, as well as individual responses from a number of interested parties. Not all respondents gave answers for every question. A paper, *Responses*, was produced in December 2004 to summarise the results of the consultation and draw some conclusions from the responses to the questions. This *Policy Paper* has been constructed from the basis of the consultation results and the CCSC Policy Subcommittee’s consideration of them and aims to outline the CCSC’s policy in relation to the issue.

The topic of racism and of discrimination in general, is one which engenders a diversity of opinions and views. Its themes and relating issues are frequently of considerable importance to individuals and discussion of the subject can produce a wide variety of responses. This was reflected in the CCSC consultation. Every effort has been made to incorporate and consider all comments received when drawing conclusions. However, it should be noted that the policy outlined below is necessarily broad in its nature. The lack of specificity should in no way be seen as a rejection of any specific suggestions or proposals which were received during the consultation, but rather as an attempt to bring together a consensus opinion on a challenging and demanding topic.

Copies of the consultation *Tackling Racism in Medical Careers: the Role of Consultants* and of the *Responses* paper are available from the secretariat on request.

I would like to thank Natalie Saunderson for researching and drafting all the Subcommittee’s documents on this issue, David Cloke and Hilary Forrester for the support they have given and the members of the Policy Subcommittee for their contributions.

*Alan Russell*

*Chairman*

*Policy Subcommittee*

*Central Consultants and Specialists Committee*

*November 2005*
Racism in the medical profession has long been a concern of individual consultants and their professional organisations. Indeed, the BMA’s annual representative meeting in 2003 called on the General Medical Council (GMC) to take specific action in this area by resolving that:

‘racism expressed by doctors or medical students should be regarded as a matter of serious professional misconduct.’

In addition, a number of essays, discussion documents and reports have been produced in recent years concerning the topic of racism in the medical profession. They attempt to investigate the extent of the problem, its effect on individual consultants and also outline potential solutions. There have also been a number of general investigations into the issue of racism in modern society, much of it arising from the Stephen Lawrence Inquiry Report and the resultant Race Relations Amendment Act 2000.

As part of its duty to ‘consider and act in matters affecting those engaged in consultant and hospital practice’ the then general purposes subcommittee of the Central Consultants and Specialists Committee identified racism as a priority area of work. The subcommittee decided to start by producing a consultation document as a supplement to the ‘top down’ initiatives previously produced by the profession. The document was also intended as a supplement to the BMA’s guidance *Dealing with discrimination: guidelines for BMA members* (June 2003). It was an attempt to encourage local debate and to enable consultants and their colleagues to come up with potential solutions to racism and consider the ways in which it affects and limits the careers of doctors from ethnic minorities. It focused on six key areas, and posed questions for consideration by the profession. The policy proposals below derive from the responses received to the questions posed in each of these areas and the CCSC’s consideration of them.
Policy Proposals

1. Medical Schools

1.1 Many of the recent studies on racism in the medical profession have shown that the effects of racism first become apparent in medical schools, particularly in relation to the applications process. In 1998, Professor I C McManus published a paper on the subject in the *British Medical Journal*, indicating that applicants from ethnic minority groups could find themselves disadvantaged when applying to study medicine. Figures released in 1999, which showed that only 15 per cent of ethnic minority applicants won places in medical schools, compared to 55 per cent of white applicants, supported this conclusion.

1.2 Various initiatives have been introduced in recent years to combat this problem, such as reducing the number of applications allowed per student and bringing the application deadline forward to give selectors extra time to consider applications. The BMA has suggested that, in addition to this, the syllabus at these institutions needed to be re-thought to tackle the problem of racism, for example, by including cultural diversity. A BMA conference on this topic held in 1997 additionally concluded that procedures to monitor and publish ethnicity data and to scrutinise admissions and recruitment systems should be established to ensure racial discrimination did not occur. The BMA's annual representative meeting in 2003 went further and declared that ‘medical schools should incorporate anti-racism education as part of undergraduate medical teaching.’

1.3 The CCSC believes that particular efforts are needed to encourage members of minority communities and disadvantaged individuals to apply for medical schools. Teaching hospitals, schools and perhaps ethnic minority organisations should all have a role to play in this activity. The CCSC would encourage consultants to participate in this work.

1.4 The CCSC notes, however, that outreach efforts would only be appropriate if they were intended to ensure that disadvantaged applicants have equal (not better) opportunities. The principle should always be upheld that applicants to medical school should be selected on the basis of their abilities. The CCSC does not believe targets or quotas for ethnic minority applicants are appropriate, but would support the proper monitoring of the applications process. The CCSC will encourage the BMA to work with the Department of Health and NHS Employers to implement the commitments in this area outlined in the publication *Equal values: equal outcomes: a partnership action plan for the medical and dental workforce*.

---

2 Health call for medical school race enquiry (8 June 1999), www.news.bbc.co.uk
4 Available at the following web address: http://www.nhsemployers.org/docs/equal_values_outcomes.pdf
1.5 The CCSC recognises that the anonymisation of application forms might have a limited impact in some cases as it might still be possible, for example, to determine an applicant's ethnic background from information they give on the form, and because many medical schools conduct application interviews. However, the CCSC believes that application forms should be anonymised at the short-listing stage. The CCSC will support the BMA Medical Students Committee in any work it undertakes to pursue this matter, for example with the University and Colleges Admissions Service.

1.6 The CCSC believes that the appropriateness of the interview procedures can and should be monitored through structural processes, including obtaining feedback from panel members and applicants, and through use of independent organisations such as the medical royal colleges. Members of interview panels should have training in racial equality and diversity issues. The CCSC will pursue this matter with the Council of Heads of Medical Schools, which was one of the respondents to the original consultation.

1.7 The CCSC believes that the syllabus in medical schools should be re-worked to tackle the problem of racism. Options for topics to incorporate include cultural diversity, doctor/patient relationships and relationships between colleagues. The Committee welcomes recent efforts made by medical schools to address issues of equality in accordance with the GMC’s *The Duties of a Doctor* and supports the BMA Equal Opportunities Committee's ongoing work in this area.

2. Postgraduate Training and Registration

2.1 Studies have revealed this to be an area of great concern to doctors. Many have in the past reported serious flaws with the Professional Linguistic Assessment Board (PLAB) test required to be taken by all doctors from outside the European Union (EU) and the European Economic Area (EEA) before they can register with the GMC. It is worth noting, however, that the test has recently been overhauled, and reports from individual doctors now suggest that it has been significantly improved.

2.2 Following the PLAB test, doctors from outside the EU/EEA currently face two types of training programmes. The standard higher specialist training programme leads to entry to the specialist register held by the GMC. However, many of these doctors have been directed specifically towards Type II training, on the assumption that they would return to their country of origin once training had been completed. Type II training frequently restricted doctors’ ability to become consultants and led to disenchantment with the medical profession. This ultimately created two ‘classes’ of doctor based on ethnicity, and this, in turn, affected the profession's perception of ethnic minority doctors, regardless of whether they were originally from the UK or abroad.

---

2.3 The CCSC has previously focused on the area of training and registration, and passed the following resolutions at the 1996 conference of representatives of senior hospital medical staff.

*That this conference urges that the length of permit free training should allow the completion of specialist training programmes.*

*That this conference believes that the problems raised by the Calman Report regarding overseas visiting registrars should be addressed as a matter of urgency.*

*That this conference urges that the number of specialist registrars should be sufficient for the medium term needs for career posts while also providing quality training for overseas doctors.*

2.4 The CCSC believes that having two types of training adversely affects relations between doctors and that a separate training route for doctors who intend to return to their home country is not appropriate. The Committee will work with the BMA’s Junior Doctors Committee and Staff and Associate Specialist Committee to take this matter forward via their ongoing work regarding Modernising Medical Careers.

2.5 The CCSC believes that information concerning the PLAB test needs to be more widely circulated in order to determine whether the changes recently introduced to the test have made it less discriminatory towards doctors from non-EU/EEA countries. The Committee notes the GMC’s recent efforts in this area and will seek to encourage the BMA to work with NHS Employers to review and modernise further the PLAB process as outlined in the publication *Equal values: equal outcomes: a partnership action plan for the medical and dental workforce* http://www.nhsemployers.org/docs/equal_values_outcomes.pdf

2.6 The CCSC believes that the concerns regarding the PLAB test could be tackled by requiring all new doctors (including those new to the UK) to take a communication skills test and notes that communications skills training is an important component included in the proposed curriculum for foundation programmes.

2.7 The CCSC believes that a uniform training and registration system for the GMC should be introduced, perhaps in the form of a common examination or assessment and with care being taken to make it flexible. The CCSC notes that the GMC is currently considering the question of national assessment to refine its policy in this area.
3. The Appointment Process

3.1 The BMA’s *The consultant handbook* summarises the current guidance on consultant appointment procedures. It states that there is strong emphasis throughout the National Health Service Executive’s good practice guidance on the need for employers to ensure that their procedures are seen to be fair. It highlights the important role that chairmen of Advisory Appointment Committees (AACs) have to play in ensuring that AAC members act fairly. It also notes that all members of AACs should have received training in the short-listing and selection of applicants by interview, with specific regard to the use of fair and non-discriminatory interviewing and selection techniques. It further reports that decisions on the suitability of candidates should relate to the agreed selection criteria and should rely on facts rather than impressions. It is partly for these reasons that the CCSC is concerned that Foundation Trusts are not required to abide by these regulations. The Committee believes that this decision should be reversed.

3.2 Despite this guidance, the appointment process was highlighted by the *Racism in the medical profession* survey as lacking transparency and, thereby, working to the disadvantage of ethnic minority doctors and those who had qualified outside the UK. In particular, the survey concluded that the existence of obscure selection criteria means that progression is effectively governed by a patronage system, as opposed to one based on competency. It recommended that the system be made more explicit. Other members of the medical profession, such as refugee doctors, have recently expressed similar concerns. It has also been noted that the CV and interview process is not always familiar to doctors from other countries.

3.3 The King’s Fund has additionally produced research in this area, reporting the results of Esmail and Everington’s pilot study which found that British-trained doctors with ‘foreign-sounding’ names were less likely to be short-listed for hospital posts.

3.4 The CCSC believes that the appointment procedures themselves do not need substantial alteration, however, equality of opportunity in the process of advertising vacancies and training of AAC members need to be emphasised and action taken when best practice has not been followed. The CCSC notes that the BMA Equal Opportunities Committee is currently exploring options for providing careers support for international graduates. In addition, the Department of Health is working with the GMC, the BMA and the royal colleges to develop a central database of international medical graduates who are registered and seeking employment and to develop a single information portal for international medical graduates giving them consistent, accurate and high quality information about employment before they come to the UK.
3.5 The CCSC believes that there should be a standard application form for all medical posts which it is possible to anonymise before consideration. There should be greater standardisation of the scoring system. At the very least elements of the scoring systems should be standardised to assist the appointment process. The Committee believes that NHS Employers should oversee the standardisation process and will seek to engage with them in this area.

3.6 The CCSC believes that selection criteria could be made more explicit in a number of ways, including by making sure the process is open, transparent and subject to external scrutiny, by having clear person and job specifications, by publishing well-defined appointment criteria, by setting out measures through which the criteria are to be assessed and by outlining the reasons for failure to candidates.

3.7 The CCSC believes that members of Advisory Appointment Committees should be given more appropriate training in recruitment procedures. This could include training on equal opportunities, diversity awareness and discrimination of all types, objective and clear ways of scoring the appointment process and the training options available to non-EEC doctors. The CCSC notes that the Royal Colleges produce detailed guidance for their representatives on AACs, though these do vary from college to college.

3.8 The CCSC believes that it would be difficult for AACs to reflect the ethnic origins and gender of applicants, because of the small pool of interviewers available and time restrictions in setting up the panel. However, the Committee feels that more efforts should be made to ensure that AACs have a generally balanced membership and to encourage and facilitate ethnic minority doctors to participate. The CCSC will seek to encourage the Department of Health to seed-fund the training of doctors in this area.

3.9 The CCSC believes that appointment procedures should be audited to national standards, possibly using existing equal opportunities forms, have independent reviews and transparent procedures and statistics. The Committee believes that this process should be coordinated by NHS Employers and will seek to liaise with them on this point.
4. **Mentoring and Career Progression**

4.1 Following resolutions passed at the BMA's conference of senior hospital medical staff and annual representative meeting in 1999, the CCSC's then non-consultant career grade subcommittee carried out a survey designed to explore the range of racially-motivated behaviours experienced by staff grade and associate specialist doctors. The chairman of the subcommittee reported its findings to the BMA racial equality committee in April 2000. He outlined the fact that many reports had been received concerning the lengths to which some doctors had gone to gain a higher training post, in response to advice and promises given by consultants. It appeared that many staff grade and associate specialist doctors believed that they had done everything that had been asked of them and had still not been appointed to higher training posts. The report further suggested that, although all registrars were supposed to be written to by the regional postgraduate deans to offer them a national training number (NTN), many ethnic minority registrars had not been offered NTNs in this way.

4.2 The King's Fund report of 2001 also referred to this sense of frustration resulting from the nature of career advice that had been received. It described how staff grade and associate specialist doctors had previously received advice that they would never obtain a consultant post in their chosen specialty because of their ethnic origin. It stated, however, that some felt that at the very least this was honest advice.

4.3 Such concerns regarding career progression also extend to appraisal, the distribution of higher awards and referrals to the GMC and the National Clinical Assessment Authority (now National Clinical Assessment Service (NCAS)). There is significant concern among ethnic minority doctors and their representatives that disproportionate numbers of such doctors are referred to the GMC and the NCAS. Conversely, several surveys have shown that the number of higher awards and discretionary points awarded to doctors from ethnic minority communities is proportionately less than for the rest of the profession. It is also noted that they are under-represented on the awarding committees. The British International Doctors Association called for a full study of the 2002 awards round in terms of the ethnic breakdown of recipients.

4.4 The CCSC believes that doctors are not adequately trained and supported to mentor a person from a different ethnic background and that this can be linked with a need to improve training for mentoring on a more general basis. The Committee would like to see the BMA consider producing further guidance on the issue and notes the ongoing work on this topic by the BMA's Board of Medical Education. NHS Employers has recently published a report entitled *Towards a framework for mentoring in the NHS* (June 2005) and will be exploring ways to develop this work as part of the partnership action plan *Equal values, equal outcomes*. 
4.5 The CCSC believes that various professionals would be appropriate to fulfil the role of a mentor, although it should ideally not be the responsibility of the clinical director. It is imperative that whoever fulfils the role of a mentor should be appropriately trained for the role. The Committee would like to see the BMA investigate employing a full time member of staff tasked with encouraging the profession to lead on the development of mentoring.

4.6 The CCSC believes that there is substantial potential to improve the advice on career progression which is given to doctors, regardless of ethnic origin. This could perhaps take the form of incorporating advice on career progression into appraisals. The Committee will encourage the BMA to investigate establishing a careers advice service for doctors.

4.7 The CCSC has noted the suggestion that additional training, perhaps along the lines of the retainer/returner scheme, would assist doctors whose career progress has been damaged by racism. However, the Committee has concerns that such doctors would be further stigmatised in such circumstances. The Committee will therefore liaise with the BMA Doctors for Doctors Unit on the potential for conducting research in this area.

4.8 Whilst noting that there is concern about it being used to impede career progression, the CCSC would support the appraisal process being used to improve the career progress of ethnic minority doctors. The Committee notes the reviews of the appraisal and revalidation processes which are currently being undertaken and will seek to feed this point into these reviews.

4.9 The CCSC would like to see more efforts being made to make consultants aware of the existence of the race equality scheme in their trust and would support the Commission for Racial Equality conducting reviews where a trust’s Race Equality Policy was not being adequately communicated to staff. The Committee will also encourage the BMA to work with NHS Employers to implement the commitment outlined in Equal values, equal outcomes to ‘actively recruit NHS trusts to the Positively Diverse programme, promote its principles to the NHS and engage the medical and dental workforces in that process.’

4.10 The CCSC believes that more efforts should be made by trusts to monitor the ethnic origin of recipients of local clinical excellence awards. The Committee notes that the BMA Equal Opportunities Committee is currently undertaking activity in this area.
5. **Locum Appointments**

5.1 The practice of ethnic minority doctors working as locum consultants on a long-term basis has been a subject of concern in recent years. Despite their skills and experience (Department of Health guidance states that locums should be on the specialist register), locums have no security of tenure and have traditionally been paid a fixed income regardless of length of service. However, the new consultant contract does enable them to progress up the pay scale on the accumulation of the appropriate period of service for each point, subject to fulfilling the standard progression requirements.

5.2 The data available on the number and location of locum consultants is limited. According to the Department of Health there were over 1,500 locum consultants in England in September 2004. However, as the association is reliant on doctors informing it of their professional status, the BMA's database has only 473 locum consultants on record.

5.3 There is a perception that a disproportionate number of locum consultants are ethnic minority doctors. For this reason, locum appointments are often considered as part of the wider discussion concerning racial discrimination. The CCSC believes that, whilst there is significant circumstantial evidence that locum consultant posts held are disproportionately by ethnic minority doctors, there is no reliable data on this. The Committee would like the issue to be subject to further research by the BMA's Equal Opportunities Committee in conjunction with the CCSC and the Staff and Associate Specialists Committee.

5.4 The CCSC believes that the requirement for locums to be on the Specialist Register and to pass an Advisory Appointment Committee before obtaining a substantive consultant post should be maintained. More consideration is needed of the question of whether long-term locum consultants should be offered a substantive post, subject to completing one or two successful appraisals.

5.5 The CCSC would like to see the BMA do more to support locum consultants and is actively considering what form that support should take. We would welcome the views of locum consultants on this issue and would encourage them to inform the BMA of their professional status so that they can be involved in whatever further action is taken.
6. The Use of the Term ‘Overseas’

6.1 The CCSC Policy Subcommittee has recently considered arguments that the persistence of the term ‘overseas’ is inappropriate for use in training, appointment and other medical vocabularies. Many doctors believe that assumptions regarding the quality of training available outside the UK means that the use of the term ‘overseas’ implies ‘second class’. In addition, Black and Asian British doctors are also often mistakenly labelled as ‘overseas’.

6.2 The CCSC is concerned about the use of the term ‘overseas’, because (as noted in paragraph 2.2 above) it has become associated with negative assumptions about a person’s ability and attitude. The CCSC therefore believes that the phrase ‘overseas doctor’ should no longer be used. Where required, more appropriate terms could include ‘international doctors’ or ‘doctors with international qualifications’. The Committee would like to see this term included in the next revision of the BMA Equal Opportunities Committee’s Non-discriminatory language guide.
Respondents

The CCSC would like to thank the following respondents to the original consultation *Tackling Racism in Medical Careers: The Role of Consultants*

- P Anderson
- C Bhrolchain
- G Boswell
- K Brent
- J Calvert
- B De Souza
- C Godden
- J Gosalakkal
- E Jehangir
- J Jenkins
- A Kothare
- A Morrison
- I Osman
- R Primhak
- R Rawlins
- S Reyes De Beaman
- P Robin
- P Rowe
- D Russell
- S Sadiq
- D Scott
- A Sherwood
- R Thomas
- J Tobin
- Three anonymous responses

BMA Board of Medical Education
BMA Equal Opportunities Committee
BMA Scotland
Summary of Conclusions from the Consultation Tackling Racism in Medical Careers: the Role of Consultants

1 Medical Schools

- Particular efforts should be made to encourage members of minority communities and disadvantaged individuals to apply for medical schools. Teaching Hospitals, schools and perhaps ethnic minority organisations should all have a role to play in this activity. However, outreach efforts would only be appropriate if they were intended to ensure that disadvantaged applicants have equal (not better) opportunities.

- There should not be targets or quotas for ethnic minority applicants, though the applications process should be properly monitored.

- Whilst recognising that in some cases this might have a limited impact, application forms should be anonymised at the short-listing stage.

- Members of interview panels should have training in racial equality and diversity issues.

- The appropriateness of the interview procedures can and should be monitored through structural processes, including obtaining feedback from panel members and applicants, and through use of independent organisations, such as the Medical Royal Colleges.

- The syllabus should be re-worked to tackle the problem of racism. Options for topics to incorporate include cultural diversity, doctor/patient relationships and relationships between colleagues.

2 Postgraduate Training and Registration

- Having two types of training does adversely affect relations between doctors and relations could improve if Type II training was abolished.

- Information concerning the PLAB test needs to be more widely circulated in order to determine whether the changes recently introduced to the test have made it less discriminatory towards doctors from non-EU/EEA countries. All new doctors should be asked to take a communication skills test.

- A uniform training and registration system for the GMC should be introduced, perhaps in the form of a common examination or assessment, and with care being taken to make it flexible.
3 The Appointment Process

- The process of advertising vacancies does not appear to need substantial change, though equality of opportunity should be emphasised.

- There should be a standard application form for all medical posts which it is possible to anonymise before consideration. There should be greater standardisation of the scoring system. At the very least elements of the scoring systems should be standardised to assist the appointment process.

- Selection criteria could be made more explicit in a number of ways, including by making sure the process is open, transparent and subject to external scrutiny, by having clear person and job specifications, by publishing well defined appointment criteria, by setting out measures through which the criteria are to be assessed and by outlining the reasons for failure to candidates.

- Members of AACs should be given more appropriate training in recruitment procedures. This could include training on equal opportunities, diversity awareness and discrimination of all types, objective and clear ways of scoring the appointment process and the training options available to non-EEC doctors.

- It would be difficult for AACs to reflect the ethnic origins and gender of applicants, because of the small pool of interviewers available and time restrictions in setting up the panel. However, more efforts should be made to ensure that AACs have a generally balanced membership and to encourage and facilitate ethnic minority doctors to participate.

- Appointment procedures should be audited to national standards, possibly using existing equal opportunities forms, have independent reviews and transparent procedures and statistics.

4 Mentoring and Career Progression

- Doctors are not adequately trained and supported to mentor a person from a different ethnic background. The BMA should consider producing further guidance on the issue.

- Various people could fulfil the role of a mentor, although it should ideally not be the responsibility of the clinical director.

- There is substantial potential to improve the advice on career progression which is given to doctors, regardless of ethnic origin.
• It is not clear whether additional training, perhaps along the lines of the retainer/returner scheme, would assist doctors whose career progress has been damaged by racism as they could be stigmatised.

• The appraisal process should be used to improve the career progress of ethnic minority doctors, though there is concern about it being used to impede career progression.

• More efforts should be made to make consultants aware of the existence of a race equality scheme in their trust.

• More efforts should be made by trusts to monitor the ethnic origin of recipients of local clinical excellence awards (formerly discretionary points).

5 Locum Appointments

• Whilst there is significant circumstantial evidence that locum consultant posts are disproportionately held by ethnic minority doctors, there is no reliable data on this. The issue should be subject to further research.

• There is no agreement on whether long-term locum consultants should be offered a substantive post, subject to completing one or two successful appraisals, though it is reasonably clear that respondents believed that the requirement of being on the Specialist Register and passing an AAC should be maintained.

• The BMA should do more to support locum consultants.

6 The Use of the Term ‘Overseas’

• There are concerns about the use of the term ‘overseas’, because it has become associated with negative assumptions about a person’s ability and attitude.

• The phrase ‘overseas doctor’ should no longer be used. Where required, more appropriate terms could include ‘international doctors’, or ‘doctors with international qualifications’.