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THE BOTTOM LINE

Partha Kar: Racism in the medical workforce—five initial steps

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It's been 10 months since the initial report of the Medical Workforce Race Equality Standard[1] was greeted with a mixture of shock, surprise, a shrug of the shoulder, ignorance, and people asking, "What next?" The clamour for more data around inequalities facing doctors from ethnic minority backgrounds has been frustrating, maybe even designed to stall progress. A lack of data is not what has held back efforts to tackle inequalities.

Enough time has been spent debating how to tackle them. While leaders talk about this wicked problem, people in committees pontificate . . . and it's time to start, somewhere. The desire to create measures that everyone agrees on (a nigh impossible task) may be one reason why progress has been glacial at best. We need to start with a clear, focused plan to improve certain markers of inequality and accountability. It's no longer a question of who will bell the cat, but about starting the work without fear of retribution or hampering career prospects. And we need to tackle it together—NHS England, NHS Employers, the General Medical Council (GMC), the BMA, and the Academy of Medical Royal Colleges—and hold people accountable.

Firstly, GMC referrals. We know that these are skewed on the basis of ethnic background. We need "blind" independent panels and snap audits of the process undertaken by the GMC nationally, as a standard. That includes blinding the person's name, sex, etc, so no bias can come into question. We need to track data, tackle prejudice based referrals at source, make the findings public—and, if healthcare organisations decide against routinely publishing them, ask why.

Secondly, I've written before about the need to introduce something like the Rooney rule,[2] a US National Football League policy requiring teams to interview ethnic minority candidates for head coaching jobs and other senior roles. Let's start with that for medical director or clinical director roles: this is not a quota on the appointments themselves but on the shortlisted panel, to that ensure it reflects the workforce. Let the recruitment decision then go before a mixed, independent panel, where the shortlisted candidates reflect the background staff population (40% non-white) and the best person gets the job.

Thirdly, let's also look at medical royal colleges and specialist societies. Does the leadership reflect their membership? We can't change the structure of NHS medical leadership if the royal colleges don't do the same. The same goes for NHS England and its clinical leadership. Does the ambition to tackle inequality go beyond a few hashtags and shiny documents? Let's publicly challenge organisations on their records, and let's get colleagues to apply.

Fourthly, it's time to have a clear, standardised way to support international medical graduates. The increased rates of GMC referrals among these doctors are not some coincidence, and plenty hinges on the support they receive, or rather the lack of it. Some excellent work is done by the GMC, and it's time we got behind that work as a system.

Finally, it would be remiss not to mention SAS doctors (specialty doctors and associate specialists), who are so often overlooked for leadership positions, autonomous functioning, or educational roles. Here sits a rich resource the NHS has somehow found difficult to develop as an ally, or often to even acknowledge. This inexplicable blind spot has developed over decades. It's time to change this and bring parity, with clear support from all concerned for this group to be recognised in senior posts and educational roles.

The NHS's history is littered with stories of doctors from overseas being asked, or pushed, to take on "staff grade" roles, developed as a second class role for those not deemed good enough to be consultants. Apart from the sheer nonsense of that sentiment—based firmly in a cauldron of racial superiority, often with snobbery about training programmes—times have changed. No longer should this role be seen as anyone's poor cousin: it's a key part of improving the Medical Workforce Race Equality Standard.

So, there we have it—a starting point of five action points. Five will be nowhere near enough, but we need to start somewhere. The key is bringing in accountability, policies with teeth, and the ability to challenge those who don't join the journey. The pace can be frustrating, but in the words of Martin Luther King, "We must accept finite disappointment but never lose infinite hope."

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1 NHS England. Medical Workforce Race Equality Standard (MWRES): WRES indicators for the medical workforce 2020. Jul 2021. https://www.england.nhs.uk/wp-content/uploads/2021/07/MWRES-DIGITAL-2020_FINAL.pdf

2 Kar P. Partha Kar: To tackle racism, the NHS needs policies with teeth. *BMJ* 2020;369:m2583. https://www.bmj.com/content/369/bmj.m2583. doi: 10.1136/bmj.m2583 pmid: 32605918