
APEX

ON EQUAL TERMS

Achieving racial equality in medicine

Examining the relationship between ethnicity and doctors is complex. Whilst many institutional barriers have been removed and much has improved, there are still areas that cause concern. Addressing these issues will require cultural and behavioural change.

KEY POINTS

- Historically, ethnic minority doctors have suffered discrimination.
- Research into the issue was often shunned.
- Many doctors suffered experiences of systemic prejudice, overt racism and harassment, which impeded their careers.
- There are signs of improvement in medical school applications, in consultant appointments and in Clinical Excellence Awards but some serious concerns remain.
- Doctors born in Africa but based in the United Kingdom have higher death rates than United Kingdom-born doctors.
- Non-white doctors more often live in high-deprivation areas.
- A clear commitment to promoting and ensuring racial equality in medicine is needed from the most senior levels in the NHS and national professional bodies.

Racial discrimination is the unfavourable treatment of an individual or group on the grounds of race, colour, nationality or ethnic and national origin. The Equality and Human Rights Commission refers to the four main types of racial discrimination, as defined in the Race Relations Act 1976 (and subsequent amendments): direct racial discrimination, indirect racial discrimination, victimisation and harassment.

A number of seminal studies and investigations in the late 1980s and early 1990s raised very serious questions about racial discrimination in medicine and in the employment of doctors in the NHS.

Racial discrimination in job and student selection

Professor Joe Collier and other academic clinicians at St George's Hospital Medical School, London, carried out a study in 1986 showing evidence of racism in the selection procedures for medical school. A subsequent investigation by the Commission for Racial Equality confirmed the findings. It found that a computer used for processing applications to the medical school was programmed to give differential and less favourable weighting to female and ethnic minority candidates. When the same student's details were entered twice, once as a 'male Caucasian' and again as 'female non-Caucasian', the ranking given by the computer differed dramatically. As a result of the Commission's enquiry, in the autumn of 1989, the then Universities Central Council on Admissions began routinely collecting ethnicity data from applicants. The analysis again suggested that ethnic minority medical school applicants were disadvantaged when compared with white candidates.

> "I was ostracised, became invisible, told that I had brought the organisation into disrepute, reminded repeatedly how much my actions would cost the organisation in both financial and image terms, and was told that the school would now face the risk of being overrun by poor quality students and that by my actions I had forfeited any chance of promotion." Professor Joe Collier, *British Medical Journal,* 1999

Collier suffered greatly for drawing media attention to discrimination in the selection process at St George's.

In 1994, Professor Aneez Esmail and Dr Sam Everington examined the ethnicity data collected by medical schools for the Universities and Colleges Admissions Service. In 1995, they published an article in the *British Medical Journal* showing that white candidates had very different acceptance rates from ethnic minority candidates, naming individual medical schools for the first time. Their league table showed that while some medical schools appeared not to discriminate against ethnic minority applicants, most did.

This study was important because it attempted to control for A-level grade, challenging the assumption that ethnic minority applicants were unsuccessful because they were weaker academically. Even controlling for this, ethnic minority students appeared to be disadvantaged compared with their white counterparts when applying to medical school. Indeed, white candidates with lower A-level grades were more likely to be accepted to study medicine.

Exposing racism threatens doctors' careers

Following publication of the 1993 paper in the *British Medical Journal* revealing the existence of racism in the job selection procedures, Esmail and Everington were reported to the General Medical Council for unacceptable professional conduct and then arrested for making fraudulent job applications. Although criminal charges were dropped, the authors were advised not to continue their research.

"Discrimination against ethnic minority candidates is still prevalent five years after we first highlighted the problem and despite numerous public commitments by the profession's leaders and employers to deal with it. The discrimination is being practised by consultants, who are responsible for short-listing junior posts."

Aneez Esmail and Sam Everington, *British Medical Journal,* 1997

Esmail and Everington moved on to study selection procedures for junior doctors in the NHS. They sent matched applications in response to 50 advertisements for senior house officer posts. They found that applicants with an Asian name were significantly less likely to be short-listed than identical applicants with an English name. Their research almost cost them their careers.

Esmail and Everington repeated their study in March and April 1997. They found that only 36% of candidates with Asian names were short-listed, compared with 52% with English names.

Around the same time, selection procedures for NHS consultants and senior registrars were scrutinised by the Commission for Racial Equality. It concluded that there was 'great cause for concern'.

General Medical Council procedures

Another field that was extensively reviewed around the same time was the General Medical Council's fitness to practise procedures.

The Policy Studies Institute found that, at each stage of the General Medical Council's disciplinary procedures, an increasing proportion of international medical graduates was referred to the next stage. The most important factor was the higher proportion of referrals received about international medical graduates from public bodies. There were also differences in the nature of the allegations against international medical graduates compared with United Kingdom graduates. However, neither factor, separately or in combination, provided a complete explanation.

Having controlled for other factors, there was no explanation for the Preliminary Proceedings Committee sending relatively more international medical graduates to the Professional Conduct Committee. In other words, once within the General Medical Council, international medical graduates were more likely than their United Kingdom counterparts to be referred to the disciplinary procedures.

The final Policy Studies Institute analysis of General Medical Council referrals compared the years 1999–2001 with 1997 and 1998. The disparities between international and United Kingdom medical graduates had persisted. A similarly high proportion of international medical graduates was referred to the Preliminary Proceedings Committee in both time periods, and there was an increase in the proportion of international medical graduates referred to the Professional Conduct Committee – 58% in 2001 (compared with 54% in 1999).

The 2003 Policy Studies Institute report reached similar conclusions to previous reports. Whilst it found no evidence of either direct or indirect bias or discrimination, however, decision-making procedures at the General Medical Council were not sufficiently clear and objective to rule out racial bias conclusively. Differences in outcomes between complaints relating to international and United Kingdom medical graduates were still not fully explained.

The General Medical Council completely overhauled its fitness to practise procedures, and replacement procedures were introduced in late 2004. There are two stages – the investigation stage and the adjudication stage. All decisions at the investigation stage are made against published criteria and are subject to regular quality assurance and audit. Adjudication stage hearings are held in public, other than those concerned solely with the doctor's physical or mental health. All decisions are subject to judicial review, and all findings of impairment are subject to appeal to the courts, thereby providing important safeguards against unfairness. The proportionate over-representation of international medical graduates continues to be evident within the reformed procedures.

Chief Medical Officer project

I began to look at the whole subject of racial discrimination in medicine and the NHS in 2002 and was greatly assisted by an expert working group. In addition to examining research studies and data analysing patterns and trends, I commissioned a study of attitudes and experiences of black and ethnic minority doctors working in the NHS.

In this study carried out by MORI, 10 key conclusions based on interviewees' experiences emerged.

- The subtle, constant and unintentional nature of racism made it difficult to challenge.
- Victims of racist attitudes and behaviour were unwilling to complain, fearing recrimination.
- Racism was sensed to be less widespread than in the 1960s and 1970s.
- NHS diversity and ethnicity policies were perceived as tokenistic.
- An 'old school' culture perpetuated some racist attitudes in the NHS.
- There was a lack of mentors and other support mechanisms for ethnic minority doctors.
- There were doubts about the integrity of NHS recruitment procedures.
- Difficulties were experienced in finding employment in a chosen specialty.
- There were concerns that ethnic minority doctors were forced to work in more deprived areas.
- Those with international qualifications felt more disadvantaged than colleagues with United Kingdom qualifications.

These key findings were supported by accounts of individual experience and I

Case history

A consultant of Asian origin and a graduate from a United Kingdom medical school compares his career experiences of selection for specialist registrar and consultant posts in the South of England with those in the North.

"I was born, raised and educated in the United Kingdom and I graduated from a United Kingdom medical school in 1994. I had a smooth passage through house officer and medical senior house officer jobs. It was only after passing the exam for Membership of the Royal College of Physicians when looking for a specialist registrar position in 1998 that I began to encounter difficulty. One friendly consultant I knew warned me that, whilst well qualified for career progression, I could meet obstacles because of ethnicity. 'You can't be as good as your competitors,' he said. 'You have to be better than them.'

"Initially I dismissed such thoughts but, after one particular interview for a Locum Appointment for Training post, I was left with the impression that he was speaking some truth. Part of the interview focused on whether I would 'go home' after my specialist registrar post – somewhat confusing for me as home to me is the United Kingdom! Though no other statements relating to ethnicity were made, the interview was conducted in such a way as to make it clear that I would not get a job in that unit.

"Having worked in the geographical area both clinically and academically, I applied for a local post in autumn 2000. With three years' senior house officer clinical experience (including 12 months in the relevant field) and a doctoral thesis in preparation, several conference presentations and papers pending publication, I felt suitably qualified. I was short-listed and attended pre-interview visits at several hospitals.

"The interview, however, was a very different, almost hostile affair. One interviewer criticised me for a lack of clinical experience, which baffled me as I had equivalent experience to most of the other candidates. Another interviewer criticised me for not having worked outside the South of England. When he had first raised the issue during a pre-interview visit a few days earlier, I had enquired about the possibility of a period of 'out-of-programme' training to address this problem. At the time, he agreed it was a good idea. But, during the interview, when I repeated the suggestion, he looked at his colleagues and said 'I don't think we like the sound of that!' Of course, I felt very confused.

"I felt that the odds were stacked against me during the interview and I wasn't surprised to be unsuccessful. The 'official' explanation was insufficient clinical experience compared with the other (Caucasian) candidates. After five months in a Locum Appointment for Training post, which subsequently became available, I applied for another specialist registrar post in the same region. My boss encouraged me to apply.

"But again, the interview had a negative tone with much general criticism. What did surprise me, however, was the depressing feedback given by one of the interviewers: 'On a different day, with a different interview panel, you would have sailed through that interview and got the job.' Yet the successful applicant had only recently passed the Membership of the Royal College of Physicians exam and had no research experience either. Indeed, I had taught her when she was a final year medical student!

"I applied for a job in Yorkshire and was amazed at the difference in attitude towards me during the interview. The Yorkshire panel were friendly, enthusiastic and showed me a degree of respect that I was quite unused to. For the first time, I felt as if I was being judged on merit alone. I was offered the post, accepted it and thoroughly enjoyed my work there. At no point in that post did I feel that I was not treated on merit.

"After completing my specialist registrar rotation, I applied for consultant posts. With a limited number of posts available in Yorkshire, I looked to the South again. I was worried that I would face the same problems as before.

"At one hospital in the South that I visited, I met a consultant who had interviewed me several years ago. He came up to me looking embarrassed and said that he felt he must apologise to me for the way I was treated during those interviews. He added that they had since realised that they had been mistaken in not appointing me.

"In the end, I had a successful interview and have taken up an appointment. This time the interview was very fair. I don't know whether my earlier experiences were due to racial discrimination as nothing seemed overt – it was always 'covert'. However, my experiences were strange, hurtful and stressful and certainly nearly dissuaded me from my chosen career path. I would like to highlight the positive experiences I had in Yorkshire as an example for everyone to follow."

spoke personally to a number of ethnic minority doctors about their careers in the NHS. Some had profoundly negative experiences, particularly those who had been in the country a long time. It is clear that they had suffered disadvantage and episodic humiliation.

At the start of the 21st century, the following conclusions could be drawn on racial equality in medicine:

- Recruitment procedures lacked objectivity and transparency, allowing the opportunity for racism to occur in selection for posts.
- Ethnic minority doctors found it more difficult to gain senior and management posts in the profession.
- Ethnic minority doctors found it difficult to find employment in their chosen specialty.
- Ethnic minority doctors worked in economically deprived parts of the country.
- In certain situations, country of qualification added to the disadvantage experienced by ethnic minority doctors.
- Ethnic minority doctors received insufficient reward and recognition.
- There was a lack of ethnic minority role models at senior levels, particularly with respect to doctors from black ethnic groups.

In addition, the evidence I found revealed certain common themes with respect to the nature of racism:

- Racism, though it can be overt and intentional, is more often subtle and unintentional. This makes it difficult to distinguish from other forms of discrimination and difficult to challenge.
- Racism is sustained by a culture of silence and fear in which doctors are

reluctant to complain for fear of being labelled as 'troublemakers'.

- Racism is more complex than generally perceived, often tied up with social and cultural issues.
- Racism was not generally perceived to be widespread but was generally thought of as existing or surviving in 'pockets'.

Legislation and NHS policies

A wide range of new policies, plans and legislation has now been put in place,

The search for role models

"If you are a boxer, then you look at, say, Muhammad Ali or Lennox Lewis; you can identify with them, but you can't if that someone is of a different race. I never used to be interested in golf until Tiger Woods came along. You could see black people relating to him because he is like them. So role models tend to be people like you. So for me, there was never a role model in hospital medicine."

Male consultant

Unequal opportunities

"I never saw one black face beyond medical school in Liverpool. Maybe they weren't good enough but I found it difficult to believe that there was nobody good enough. I still see very few black doctors in all the jobs I have held so far."

Male consultant

Timeline of publications, policy and legislation on racial equality

1948	Arrival of the SS Empire Windrush from the Caribbean – post-war immigration in response to UK labour shortages, including over 50,000 vacancies for nursing staff.
1960	Ministry of Health appeals to Commonwealth citizens to staff the massively expanding health service, with more than 18,000 doctors from the Indian subcontinent answering this call.
1965	Race Relations Act.
1968	Race Relations Act.
1976	Race Relations Act. Commission for Racial Equality established.
1999	Publication of the Stephen Lawrence Inquiry Report.
2000	Race Relations (Amendment) Act.
2001	*Race Equality in the Department of Health*.
2002	*Putting Race Equality to Work in the NHS: A resource for action*.
2003	*Delivering Race Equality: A framework for action*. Race Relations Act 1976 (Amendment) Regulations. Employment Equality (Religion or Belief) Regulations.
2004	*Fairness for All: A new commission for equality and human rights*. *Race Equality Guide*. *Sharing the Challenges, Sharing the Benefits: Equality and diversity in the medical workforce*.
2005	*Improving Opportunity, Strengthening Society: The Government's strategy to increase race equality and community cohesion*. *Equality and Diversity in Employment*, NHS Employers. Department of Health *Race Equality Scheme 2005–08*. *Equal Values: Equal Outcomes*.
2006	Department of Health *Race Equality Scheme 2006–09*. *A Practical Guide to Ethnic Monitoring in the NHS and Social Care*. *Single Equality Schemes: A discussion paper for NHS organisations*. Equality Act. Racial and Religious Hatred Act.
2007	*A Lot Done, A Lot to Do*, Commission for Racial Equality. Equality and Human Rights Commission established.
2008	NHS *Single Equality Scheme*.

which directly or indirectly address the situation of doctors with ethnic minority backgrounds. The 2005 report by the NHS Confederation, *Equal Values: Equal Outcomes*, has been at the heart of redefining policy for NHS staff.

In July 2003, I included a feature on my website on the achievements of ethnic minority doctors. The doctors in the feature have achieved the highest possible levels of excellence within their specialty. They have dedicated themselves to serving patients, to improving the health of the population, to helping disadvantaged groups and to advancing medical science.

Starting to change

I have revisited the key areas that have caused concern. After a period where experience lagged behind well-intentioned action, there is evidence of improvement. However, barriers still exist. These remaining issues are the hardest to tackle, as they concern the culture of medicine and the NHS.

For example, the latest NHS Staff Survey shows that 8% of respondents had experienced some sort of discrimination at their Trust over the last 12 months. Recent Healthcare Commission reviews have found serious faults with compliance with statutory requirements for publication of information relating to race, gender and disability.

The medical profession compares well with other professions in the number of people from ethnic minority groups (see **Figure 1**).

Another positive aspect of change is the high numbers of applicants to medical school from ethnic minority groups. Since the start of the 21st century, the proportion of applicants accepted to medical school has remained higher among ethnic minority groups than their white counterparts (see **Figure 2**).

The situation is less positive when the success rate for applicants to medical school is examined. Students from ethnic minority groups are less likely to make successful applications than their white counterparts. Moreover, black students fare particularly badly: 22% of applicants are accepted compared with 50% of white applicants (see **Figure 3**).

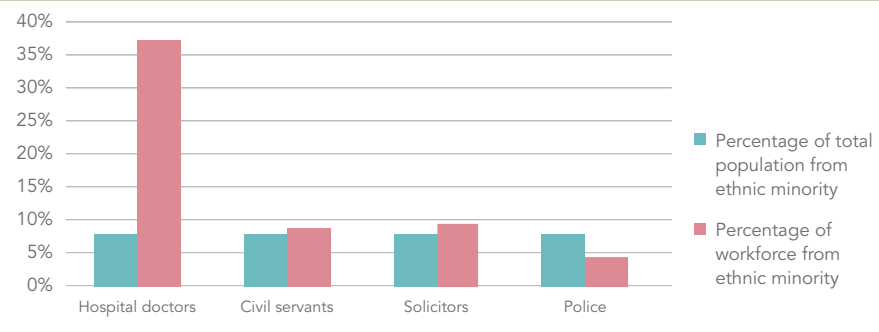
Equally, whilst attention has been focused on ethnicity, it must not be forgotten that young people from lower socioeconomic groups are seriously under-represented in medical schools.

The Healthcare Commission

An important strategic goal of the Healthcare Commission is to improve respect for diversity and to promote action to reduce inequalities in health and experience of healthcare, as outlined in *Standards for Better Health*. In particular, core standard C7e asks Trusts 'to challenge discrimination, promote equality and respect human rights'. Furthermore, Trusts are required to publish statutorily required information in relation to race, disability and gender. The Healthcare Commission has twice audited Trust websites looking for data. Such serious concerns have emerged about the lack of compliance with this standard that in 2007/08, failure to publish the information required under the Race Relations Act 1976 (as amended) or the Disability Discrimination Act 2005 will lead to the Healthcare Commission being minded to qualify the Trusts' declaration of compliance with standard C7e.

Source: The Healthcare Commission

Figure 1: Ethnic minority representation in specific workforces compared with the percentage of the total population



Source: The Information Centre, Civil Service Statistics 2006; Solicitors with practising certificates, Trends in Solicitors Professions Annual Statistical Report 2007, The Law Society; Home Office Police Officer Strength 2007

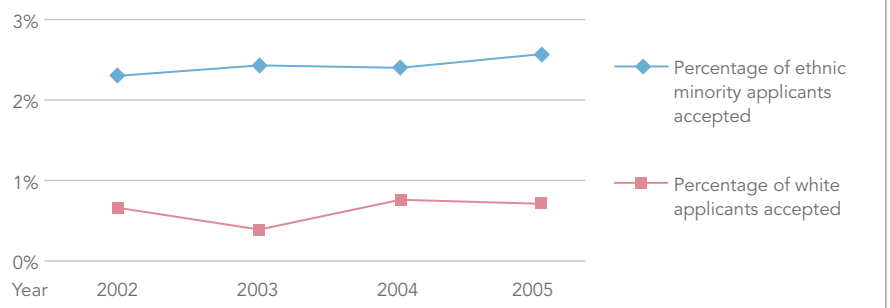
There has been an improvement in ethnic minority representation in the consultant workforce. The percentage in all age groups is at an all-time high. In particular, the percentage of ethnic minority consultants in the under 30 years age group is now at 50% (see **Figure 4**).

However, gender disparities are marked. There are fewer female than male consultants from ethnic minority groups (see **Figure 5**).

Although the proportion of ethnic minority doctors who achieve consultant status is improving, the consultant workforce is still predominantly white. The proportion of ethnic minority doctors in staff grade jobs is 59%. This is arguably a less prestigious career path. Indeed, looking at the workforce as a whole, ethnic minority doctors are the largest sub-group in non-consultant career grade jobs (see **Figure 6**) although the proportion in training grades bodes positively for the future.

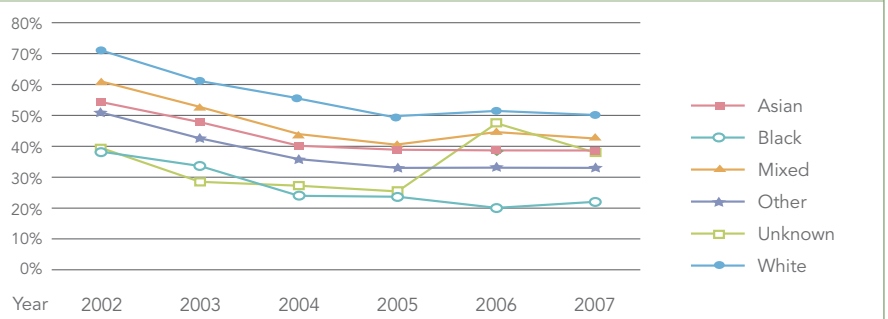
The data from the recently completed junior doctor recruitment showed that 25% of non-training grade doctors (who trained outside the United Kingdom) were successful in obtaining entry to training grades.

Figure 2: Percentage of ethnic minority population accepted for medical school in England



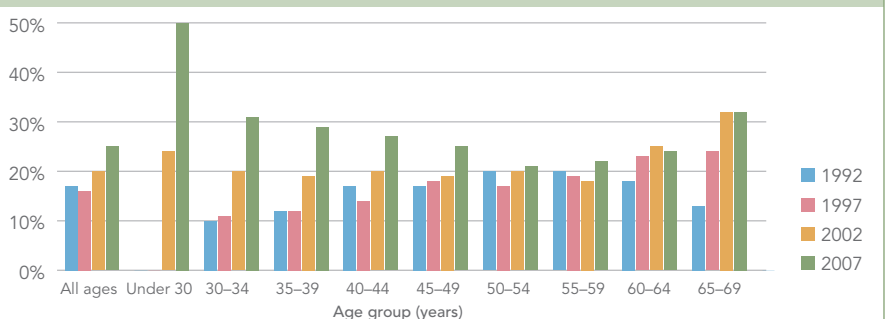
Source: The Information Centre and UCAS

Figure 3: Percentage of applicants accepted to medical school by ethnicity in England



Source: UCAS

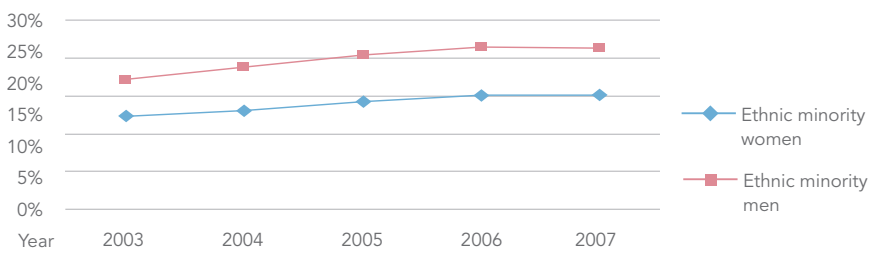
Figure 4: Percentage of ethnic minority consultants in each age group over time



In 1992 and 1997, there were zero ethnic minority consultants aged under 30 years

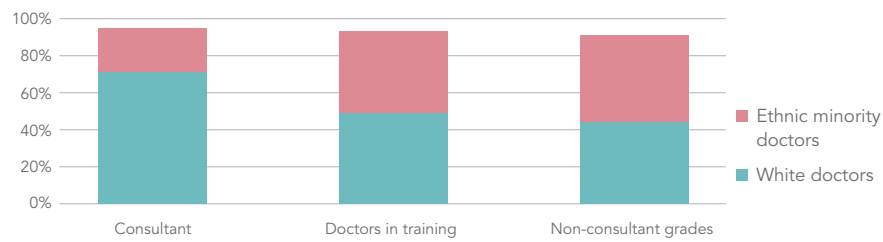
Source: The Information Centre

Figure 5: Percentage of consultants by ethnicity and gender in England



Source: Office for National Statistics

Figure 6: Proportion of ethnic minority doctors by medical grade

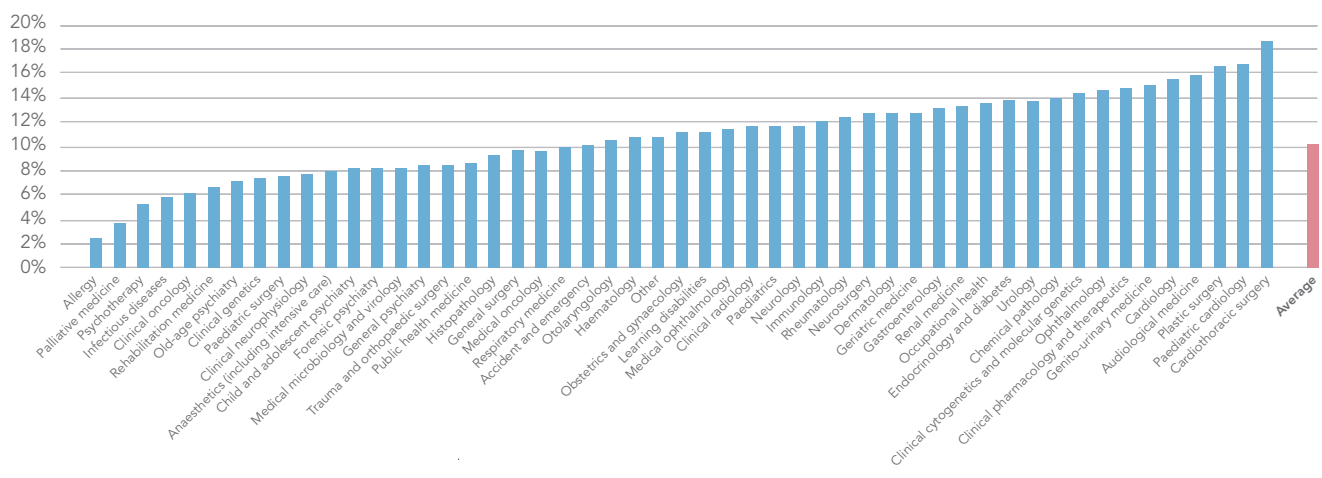


Source: The Information Centre

This picture may well change in the light of recent decisions to pursue a policy of United Kingdom self-sufficiency with respect to medical workforce needs. These policies have been subject to legal challenge. Currently, the temporary decision to amend immigration law supports this policy; as the recommendations from the recent Tooke Report – *Aspiring to Excellence* – are developed, these matters will continue to be explored.

There has been concern that ethnic minority consultants have been constrained in their choice of specialties, and over-represented in the less prestigious specialties. Although individuals may still have problems, this does not appear to be a systematic issue. There are now high numbers of consultants from ethnic minority groups in many highly competitive fields, such as cardiothoracic surgery (see **Figure 7**).

Figure 7: Proportion of consultants in different specialties who are from ethnic minority groups



Source: The Information Centre, 2005

Concern has repeatedly been expressed by practising clinicians about reward for service, through the Clinical Excellence Awards scheme (formerly the Distinction Awards). Current data do not seem to bear all of these concerns out. The scheme most often rewards doctors who have contributed to the service over longer periods. There is regional variation in the proportion of awards going to ethnic minority doctors (and women) but this may be a feature of missing data on ethnicity (see **Table 1**). It needs to be closely monitored.

Awards for all doctors are directly linked to their year of appointment (see **Figure 8**).

Statistical analyses show that United Kingdom-trained ethnic minority doctors were not significantly under-represented in Distinction Awards when time of appointment is controlled for. One group that may have been under-represented is non-United Kingdom-trained doctors who have been in the service for many decades. There are no reliable data on earlier time periods to allow this to be analysed.

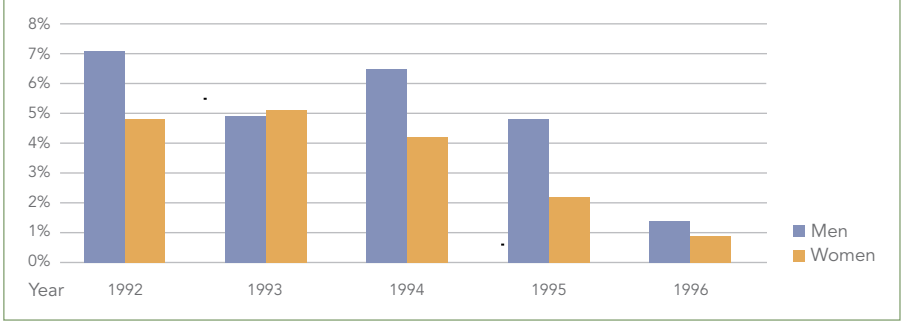
Traditionally, doctors have enjoyed better mortality experience than the general population. An analysis of the pattern for younger doctors (i.e. those aged 25–64 years) shows mortality is significantly lower for the United Kingdom-born group than for the general population. Mortality for doctors based here but born in Africa is significantly higher whilst for doctors who were born elsewhere in the world (India, Pakistan and Europe) rates are also higher but do not achieve statistical significance (see **Table 2**).

Table 1: Observed awards as a ratio of expected by gender and ethnicity

REGION	Male	Female	White	Non-White
Cheshire and Mersey	1.05	0.85	0.74	1.89
East of England	1.14	0.63	1.19	0.79
East Midlands	1.10	0.62	1.73	0.39
London North East	1.06	0.84	1.20	0.21
London North West	0.98	1.07	1.02	1.41
London South	1.11	0.74	0.74	1.04
North East	1.09	0.74	1.06	0.49
North West	1.03	0.89	1.04	0.75
South	1.21	0.42	1.02	1.19
South East	1.23	0.22	0.68	1.79
South West	1.15	0.46	0.94	1.13
West Midlands	1.11	0.58	1.13	0.52
Yorkshire and the Humber	1.10	0.58	1.11	0.55

Source: Advisory Committee on Clinical Excellence Awards

Figure 8: Percentage of consultants holding National Bronze Clinical Excellence Awards by year of appointment



Source: Advisory Committee on Clinical Excellence Awards

Table 2: Standardised mortality ratios for male doctors aged 25–64 years who are based in the United Kingdom

Country of birth	Standardised mortality ratio	Confidence limits	
		Lower	Upper
United Kingdom	91.7	85.0	98.8
India	101.1	86.9	117.1
Pakistan	127.9	89.0	177.9
Europe	103.7	76.7	137.1
Africa	158.5	134.6	185.3
Rest of the world	95.2	79.2	113.4
Non-United Kingdom	113.1	103.8	123.0
All United Kingdom population	100	n/a	n/a

Source: Office for National Statistics based on death certifications for the period 1997–2005 and population figures from the 2001 Census

Table 3: Percentage of white and non-white doctors resident in each deprivation quintile

Deprivation quintile	White	Non-white
1 (most deprived)	8%	14%
2	13%	19%
3	20%	20%
4	27%	23%
5 (least deprived)	32%	24%
Total	100%	100%

Source: Office for National Statistics

Analyses of the patterns of residence of doctors according to the deprivation rating of areas show that the proportion of non-white doctors increases as deprivation increases, perhaps providing some explanation for the poorer health of doctors of non-United Kingdom origin (see Table 3).

Conclusions

Racial discrimination in all its forms is against the law in this country. It is therefore the obligation of all organisations – NHS employers, professional bodies, regulators – to ensure that such discrimination does not take place.

The review of evidence and experience in this report shows that much has been done to address the serious problems that existed in the past and scarred the lives and careers of many black and ethnic minority doctors, particularly those who came to Britain from other countries.

The whole field of race and medicine is changing and developing. The evidence base for drawing conclusions about its current state is unsatisfactory. The range of official statistics that gather varied data on ethnicity is improving but is still very limited in its scope. Rigorous research studies are thin on the ground. Reports of doctors' individual experiences are often reported as fragmented anecdotes and stay below the surface, discussed in professional networks but seldom formally acknowledged as a barometer of the prevailing culture.

As a result, any diagnoses of the current position tend to be simplistic and over-generalised. It is widely acknowledged that many doctors who come to practise medicine in this country from overseas (particularly those settling in the 1950s, 1960s and 1970s) suffered financial hardship, serious barriers to career progression, and ended up in less competitive specialties of medicine and less affluent parts of the country. More than that, many reported hostile and racist experiences from their colleagues and those in positions of authority.

Conversely, it is now often said that the problems of racism in medicine and the NHS are largely behind us and that United Kingdom-graduate doctors from ethnic minority backgrounds are on an equal footing with their white counterparts and suffer no discrimination or disadvantage.

It is difficult to draw hard and fast conclusions. Clearly there have been many improvements, particularly for ethnic minority doctors who are graduates of United Kingdom medical

schools. Their career prospects are good and they appear to be as well rewarded in the Clinical Excellence Awards Scheme as their peers.

On the other hand, there remains considerable cause for concern. The experiences of too many individual doctors are negative. The recent NHS Staff Survey identifies that just over one in ten staff from ethnic minority backgrounds have experienced some discrimination in the past year. Furthermore, the Healthcare Commission reports suggest that reporting of statutory obligations on ethnicity, gender and disability are not being met. Equally, whilst a higher proportion of people from ethnic minorities do apply to medical school than their white counterparts, they are still less successful at being awarded medical school places. Whilst it does appear that barriers to entry to the consultant workforce have eased, there are still more ethnic minority doctors in non-consultant grades than their white counterparts. Furthermore, new analyses appear to suggest that not only do non-United Kingdom-born doctors die younger, but also that non-white doctors more often live in disadvantaged areas of the country, suffering exposure to the health impact of social and environmental deprivation.

It is clear that many ethnic minority doctors have felt that there are insufficient role models to inspire them and give them the confidence that they too can aspire to the highest echelons of British medicine. Although things are changing (for example, with ethnic minority doctors elected to the office of medical Royal College President), it is important that formal support structures be in place to enable equality of aspiration. Both NHS organisations and the professional bodies themselves can address this by investing in leadership programmes and mentorship schemes for ethnic minority doctors. Mentoring schemes in the past have sometimes fallen down because mentors are allocated who have no real passion for the task and the relationship with their mentee lapses into apathy or disuse. Mentorship schemes have an important part to play but they should allow mentees choice of mentor and mentors themselves should have support and training.

One area that has caused concern is the disproportionate extent to which international medical graduate doctors are referred into the General Medical Council's procedures by persons acting in a public capacity (including NHS referrals). The General Medical Council is committed to understanding how doctors from different backgrounds – place of qualification, ethnicity and nationality – are dealt with under its fitness to practise procedures.

In 2007, the General Medical Council commissioned a preliminary audit of decision-making within the investigation stage of its fitness to practise procedures, carried out by King's College London. This found that cases were handled "in a way that is transparent, consistent and appropriate in terms of the guidance and criteria provided by the General Medical Council". Further studies are under way. The General Medical Council, in partnership with the Economic and Social Research Council, has commissioned an independent programme of academic research that addresses questions relating to the nature, quality and delivery of medical regulation, working with key researchers in the field including Professor Aneez Esmail.

Although cases of direct bullying and racial harassment may be less worrisome than in the past, it is important that a high level of awareness is maintained so that they are recognised, surfaced and dealt with as a priority. A zero tolerance approach by NHS organisations, supported by medical professional leaders at local and national level, would be a major force for cultural change. Furthermore, individuals – particularly those in recruitment – need to be extremely sensitive to cultural diversity.

In order that we continue to listen to concerns of ethnic minority doctors, I will host an annual 'round table' for doctors from ethnic minority groups to take stock, listen to views and plan action.

These are complex issues, with multiple underlying factors at play. It is clear from work done outside the field of medicine that addressing the remaining factors calls for a sustained effort focusing less on institutional barriers and more on attitude and culture. These data should be a wake-up call to each and every NHS staff member. Just as the NHS prides itself on being amongst the most equitable healthcare providers in the world, so too should we strive to be the most equitable healthcare system in which to work.

"It is difficult to draw hard and fast conclusions about ethnicity and medicine. It is clear that there have been many improvements, particularly for ethnic minority doctors who are graduates of United Kingdom medical schools. On the other hand, there remains cause for concern."

RECOMMENDATIONS

- A mentorship scheme should be developed for ethnic minority doctors to choose their mentor. Mentors should receive training in equality issues.
- Medical directors of NHS organisations should support any doctor raising concerns about incidents of direct or indirect discrimination (including the protection of whistleblowers) and NHS employers should establish a zero tolerance campaign. NHS Staff Survey data should be regularly tracked.
- NHS chairs, chief executives, directors of public health, medical directors and clinical directors should include a personal 'stretch' target relating to medical workforce race equality.
- The General Medical Council and the Postgraduate Medical Education and Training Board should develop guidelines for inclusion of equality and diversity in medical curricula.
- The General Medical Council should continue to promote collection of ethnicity data.
- Ethnicity data should be collected and shared amongst the necessary bodies (subject to confidentiality laws).
- The Department of Health and Department for Children, Schools and Families (Aimhigher) should increase access to medicine among disadvantaged ethnic minority groups.
- The higher mortality rates of black doctors in the United Kingdom should be investigated.
- Appointment boards should receive training in equality and race awareness issues.
- The new Care Quality Commission should continue formal assessment of the quality of diversity and equity in healthcare organisations and make public those that fall short.