Ethnicity and Diversity and their impact on the performance of doctors.

A Report for the National Clinical Assessment Authority.

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1. Introduction

1.1 Project brief

The National Clinical Assessment Authority (NCAA) is carrying out an overview of factors of potential influence on doctors' performance. As part of that work, the NCAA requested us to examine the following six areas with respect to ethnicity and diversity:

1. To list and describe possible factors of potential influence on a doctor's performance ('factors');
2. To consider the extent to which factors affect performance;
3. To consider the extent to which factors affect the remediability of poor performance;
4. To identify existing methods for assessment of factors;
5. To suggest methods and procedures for the NCAA to use to assess factors and their impact on the performance if doctors referred to them;
6. To identify factors for which early intervention is effective as a preventive measure.

1.2 Background to the study

Esmail's work on describing the effects of racism in the medical profession has identified some of the key issues that the NCAA is seeking to understand in relation to assessing the impact of ethnicity and diversity on the performance of doctors. Of particular relevance is work that Esmail and Everington published in 1994 which suggested that ethnic minority doctors were more likely than white doctors to be brought before the professional conduct committee (PCC) of the GMC.[1] By reviewing nearly 10 years of cases covering 412 of physicians brought before the PCC, they were able to show that ethnic minority doctors were six times more likely to be charged with an offence when compared to their white colleagues. A subsequent inquiry commissioned by the GMC and carried out by Isobel Allen from the Policy Studies Institute over the course of nearly six years has confirmed the thrust of Esmail's findings.[2] [3] However, it seems that the GMC is no nearer to understanding why there is a preponderance of ethnic minority doctors present in its disciplinary procedures.

The specific issue that we need to explore is whether there is any evidence to show that ethnicity and diversity per se, mediated through racism has an impact on the performance of doctors. This is particularly relevant to the NCAA, which has a remit to advise and support the NHS in situations where concerns are raised about the performance of clinicians.

When a clinician is referred to the NCAA, it is important for it to consider as part of its overall assessment of referral, whether there is any evidence that issues such as racial or even gender discrimination are contributory factors either in the referral process or in the chain of events that led to the raising of concerns about the performance of the clinician. It is the potential for racial discrimination in the assessment of performance of clinicians that we are seeking to address in this report. How might race affect performance and assessment of a clinician? What is the evidence that race may be a factor in the assessment of the performance of a clinician? Are there any mechanisms by which the NCAA can assess the impact of racism on the performance and assessment of clinicians?

2. Finding the information

The scope of this project covered a wide range of different research disciplines and therefore it was important that the literature search used a range of different information sources that covered the research disciplines outside of the medical field.

2.1 How we approached the task

Some of the research issues have been studied by the medical community itself, and are therefore documented by the bio-medical databases such as Medline and Embase. However, research may have been undertaken by other disciplines such as sociology, psychology, management and economics both directly into the activities of medical practitioners but also on other professions or groups of people that may be relevant to this study and may have been published in journals not covered by the bio-medical databases.

The first stage of the literature search was to identify the major search concepts and terms (keywords) for use when searching the reference databases. Initially the NCAA literature search document provided to us was analysed to identify “keywords” or phrases but this included few references for research articles that had analysed the impact of race, ethnicity or racism on doctor’s performance. We found that only 3 of the 213 articles obtained for this review were included in the original NCAA literature search.

Subsequently, a series of search terms and phrases were developed (See Appendix 1 for the full list). These search terms were systematically applied to 6 different databases. These included: Medline, Embase, ISI Web of Knowledge (Social Science Citation Index), ABI Inform (Management information), Psyc Info (Psychological) and SIGLE (Grey Literature). Appendix 1 also provides details of the number of “hits” or articles that were identified for each term within the different databases.

These figures provide a very basic indication of the "usefulness" and relevance of each database for literature on this area.

The literature search strategy also made use of the citation indexes to search in greater depth for research work by specific researchers and citations of key articles as well as the "bullseye" search technique of identifying key articles and following up the articles referred to in those articles.

All the references identified were organised within the Reference Manager citation software programme.

2.2 Limitations of the information sources and the databases

The strengths and weaknesses of the information sources being utilised should inform any literature search process. Not understanding the weaknesses and omissions of citation databases can lead to partial or ineffective literature searches.

Coverage

With today's online access to very powerful medical reference databases, such as Medline and Embase, it is easy to forget that such databases do not contain all the answers. For instance, in 1999 it was reported that Medline abstracted from some 3,957 journals (serials) and Embase some 3,772 journals. The number of "unique" journals for each database were 2,117 and 1,993 respectively.[4] Thus the two databases between them abstracted from some 4110 journals. This is a very large number of journals, however it has been estimated that there are at least 20,000+[5] mainstream bio-medical journals which means that these two databases are abstracting from about 20% of the available bio-medical journals. In other words, any search only has a 1 in 5 chance of finding an article published in a mainstream bio-medical journal.

Indexing - MeSH headings

When using large databases such as Medline or Embase, many searchers restrict their search terms to the MeSH subject headings in an attempt to restrict the often large numbers of references retrieved by their searches. This can be effective but also has sometimes unforeseen consequences. For example, the Medline database does not have a MeSH heading term for racism. The databases "equivalent" term is "Prejudice" which in Medline's Subject Heading tree is listed under "Psychology, Social", and then under the term "morals". It is unclear why Medline does not have a defined term for racism, or such a definition within the legal or legislation Subject headings. However, what is clear is that restricting searches to "keywords" that may not exist in the database will receive misleading search results.

All the databases searches where carried out between August – October 2003.

2.3 How we categorised the articles that we found

There is a significant body of research, particularly in the United States, that has analysed how ethnicity or race have affected the health services delivered to different

groups of patients. Much of this research has concentrated on identifying the economic or social factors that may influence or cause these disparities in delivered health services. Very little of this research examined or identified the barriers or factors that may exist at either an organisational (health service) or personal (doctor or physician) level that may be involved.

Our literature search identified 287 references of which 213 where obtained for the purposes of this review. We read the abstracts of all 287 articles and identified 213 that we felt had relevance to the broad issue of racism in health and the specific remit of this review. These 213 articles were sorted into the three broad categories described below after discussion by both authors. Whilst the grading or categorising of articles was subjective it was a useful process for focussing on the key areas of interest for the review. In addition, it was also clear that many of the articles could have been classified under more than one of the broad categories.

It was important to consider the focus of the project for the NCAA as this would impact on the search terms and concepts used. Specifically, three broad categories of the term "performance" were considered:

a) Personal performance – was the review considering whether there are any differences between the way that ethnic minority doctors perform operations, misbehave, are sick, incompetent etc. This category also included some of the research papers on the large body of published research, particularly from the USA during the 1970s and 1980s that investigated 'race differences' in relation to workplace evaluation, performance and promotion.

b) Physician's personal bias – for example: prejudice of doctors in the form of being less willing to interact with members of minority groups, clinical uncertainty associated with doctors' differential interpretation of symptoms from minority patients, or stereotypes doctors hold of patients. As well as prejudice or bias towards other groups.

c) Structural / systemic ways that prevent ethnic minority doctors from performing. For example: barriers, discrimination, and institutional racism.

This process identified 68 articles in the C) Category (Structural / systemic ways), 44 articles in the B) category (Physician's personal bias) and 23 in the A) Category (Personal performance). The remaining articles were categorised as "Not relevant to this review" (13) and "Noted" (63). The "Noted" group consisted of articles that may have had useful background information but were not directly relevant to the remit of this study.

Appendix 2 provides citation and abstract details of all the articles (by category). Articles on research within all three categories were read and categorised as described above. However, the primary focus of the literature search and review process was on Category C. The results are discussed in more detail below and citations and abstracts for all the references are available in Appendix 2.

3. Ethnicity and Diversity and their impact on the performance of doctors.

This section examines how racism affects the performance of doctors through the impact of institutional racism, racism and the assessment of clinicians performance and racial differences in the assessment of clinicians.

3.1 Understanding the impact of institutional racism

It is not the purpose of this report to make the case that racism is a problem in the NHS. The Macpherson report of an inquiry into the racist murder of Stephen Lawrence found that the failure of the Metropolitan Police to solve this murder resulted from incompetence and 'institutional racism'. The report defined institutional racism as the collective failure of an organisation to provide appropriate and professional services to people because of their colour, culture or ethnic origin.[6] The Stephen Lawrence case and the Inquiry Report stimulated extensive debate on the existence of institutional racism and the inadequacies of equal opportunities policies throughout the public sector in Britain, including the National Health Service.[7] The Department of Health commissioned its own report to examine the nature and extent of issues facing ethnic minority communities in health and social care and to assess the strengths and weaknesses of what it was doing.[8] The issues affecting racism and the medical profession are usefully summarised in a book published by the Kings Fund[9] and in the body of work published by Esmail.[10 11 12 13]

However the recognition that institutional racism is a problem is critical to understanding not only mechanisms by which performance of doctors may be affected but also in devising programmes for assessment which take account of race.

King provides a useful conceptual analysis of institutional racism and the medical health complex.[14] King argues that the concept of institutional racism helps to clarify and distinguish between the actions of individuals who discriminate and racial stratification resulting from structural impediments and processes. Institutional racism is less of an indictment of individuals working within institutions than it is of the systematic operation of an institution. However, because physicians possess a considerable amount of influence, autonomy and decision-making authority, the actions, consequences and intent of individual authority figures should not be minimised.

The institutional racism paradigm addresses the issue of effect and practice rather than intent and by doing so emphasises the group as opposed to the individual consequences of racial discrimination. It examines the impact of external factors and incorporates history and ideology as major determinants of racial inequality. This means that issues external to the organisation, such as the perception of overseas qualified doctors and their training by other doctors, the problems faced by overseas qualified doctors in career progression within medicine and differentials in the allocation of discretionary points and awards does exert an influence on the organisation and how its ethnic minority staff are perceived and perceive themselves. There is also a need to recognise the importance of the national and historical context. The way in which ethnic minority doctors came to Britain, their experiences in this

country and the way they continue to perceive themselves in the medical profession can all be relevant and can have an impact on the assessment process.

However there is a problem with using institutional racism as a paradigm to understand why ethnic minorities may be disadvantaged in the NHS. Institutional racism is less overt, far subtler and less identifiable in terms of its impact on individuals. It is therefore difficult to quantify and assess. Because it originates in the operation of established and respected forces in society it receives far less public condemnation than individual racism. Dovidio and Gaertner described the rise of 'aversive racism', characterised by people who 'endorse egalitarian values, who regard themselves as non-prejudiced, but who discriminate in subtle rationalisable ways'.[15] To get a handle on this when carrying out an assessment is obviously going to be very difficult.

3.2 Racism and assessing the performance of clinicians

To understand how race may impact on performance we can learn a lot from literature on racial inequalities in health. This has been usefully summarised by James Nazroo.[16] and by Karlsen and Nazroo.[17]

Although differences in health across ethnic groups have been widely documented in the USA and the UK the causes of these inequalities is contested. Nazroo argues that there is a new body of evidence that suggests that social and economic inequalities, underpinned by racism are fundamental causes of ethnic inequalities in health. Central to this evidence is the experience and awareness of racism in the lives of ethnic minority people.

Eighty percent of Black respondents in a US study reported experiencing racial discrimination at some time in their lives.[18] Findings in the UK Fourth National Survey of Ethnic Minorities suggested widespread experiences of racial harassment and discrimination among ethnic minority people in the United Kingdom. This experience has also been documented for ethnic minority staff in the NHS.[19] Qualitative investigations of experiences of racial harassment and discrimination in the United Kingdom have found that for many people experiences of interpersonal racism are part of everyday life, that the way that they lead their lives is constrained by fear of racial harassment and that being made to feel different is routine and expected.[20] [21] The experience of ethnic minority doctors is not different and has been documented in a report commissioned by the Chief Medical Officer.[22]

If experiences of racism impact on health, then there is a strong theoretical basis for saying that it can also be attributed to the development of stress and work-related stress.

Post and Weddington described the nature of work-related stress and coping related specifically to racism experienced by African-American family physicians[23] in a small qualitative study. They described stress related to physician's experiences with racism in medicine, doubt and a strong desire to prove oneself in the medical environment. In their study, racism covered how ethnic minority doctors were perceived by others and also racist treatment by colleagues, patients, healthcare

organisations, office staff and the community. In relation to racism, living in a hostile environment also produced significant stress and strain. Doubt was expressed as uncertainty towards dealing with the racial issue and experiencing doubt from others, especially doubt from others concerning the ethnic minority doctors' capacity for success. They also underscored the importance of race and culture in the stress and coping processes. The authors commented on the fact that the responses they elicited did not emerge until direct questions on the relationship between being African-American and stress and coping were presented. This has direct relevance to the NCAA assessment process – it is unlikely that ethnic minority doctors will admit to racism unless directly questioned about it.

In a study of prevalence of ethnic harassment in a study of U.S. women physicians Corbie-Smith and colleagues described the lifetime prevalence and correlates of ethnic harassment in U.S. women physicians.[24] The survey covered 4,501 female physicians and there was a 58% response rate. Of the responding physicians, 62% of blacks reported having experienced ethnic harassment. Foreign-born doctors reported significantly more harassment during training and practice. The authors point out that their data confirm reports in other studies which identified that African-American, Asian and foreign-born residents were more likely to report ethnic harassment with prevalence as high as eight times that of white residents. They point out that an emerging literature describes the effect of perceived discrimination or harassment on mental health with racial discrimination being negatively associated with a sense of personal well-being and positively associated with higher levels of psychological distress. In their study harassment was associated with severe work stress in Asian physicians.

Stress as a contributory factor in affecting performance is usefully summarised by Levey.[25] The conceptual and measurement problems associated with treating prejudice as stress is discussed by Meyer.[26] The causal link between stress and burnout has been well described by McManus.[27] These are articles are not discussed in detail in this report because they are not directly related to the brief that we have set ourselves.

However, there is an additional problem in assessing the impact of race in the performance of an individual. Research shows that people's interpretation of what constitutes racism will vary: whether an experience is seen to be a function of an individual's own position or something else will be a consequence of his or her own history of intergroup interactions, as well as a response to the 'objective' experience. People report perceiving greater discrimination directed toward their group as a whole than toward themselves personally as members of that group – the personal/group discrimination discrepancy.[28] In effect the individual may consciously not want to discuss or recognise the discrimination he or she experiences. This obviously has implications for the NCAA because in any assessment of a clinician some attempt will need to be made as to the impact of racism both on the individual and the extent that the individual feels that he or she is part of a wider group that is subject to discrimination.

Race is therefore an important source of stress for those affected by it and can impact on health. Although there are no studies that show the direct relationship between race as a source of stress and its effect on performance, there is a strong theoretical basis for considering race as an important contributory factor in an assessment of a physician whose performance raises cause for concern. That assessment needs to take into account the effect of interpersonal discrimination and the effects of institutional racism.

3.3 Organisational issues in the assessment of clinicians.

Partly because of inquiries such as the one into the death of Stephen Lawrence and partly because of work by social epidemiologists like Krieger in the U.S [29] [30] [31] and Nazroo in the U.K, [32] there is a greater understanding of the role of institutional racism and the impact that racism has on health.

However, researchers have paid little attention to the organisational impact of race and ethnicity. Barriers to equal employment opportunity can exist at recruitment, job entry and promotion. As described in the earlier section on institutional racism, the source of barriers is rarely overt bigotry, but rather more subtle and indirect forms of discrimination that might not even be recognised by its perpetrators.

Empirical studies that have been conducted are almost exclusively U.S. based, and have focused on differences between whites and blacks in recruitment, promotion prospects and differential job assessments. They are almost exclusively based in the management field and we could find no articles directly related to the differential assessment of clinicians.

There is considerable evidence that raters evaluate job performance of blacks less favourably than the job performance of whites, especially when the raters are themselves white. There is also evidence that black manager's experience restricted advancement opportunities [33] [34] [35] and report extensive dissatisfaction and frustration with their careers.[36] The role of organisational experiences in producing these negative outcomes remains largely unexplored.

In a meta-analysis of ratee effects, Kraiger and Ford[37] found that white raters assigned higher performance evaluations scores to other whites, than to ratees of other races, particularly in field studies where blacks were only a small percentage of the total workforce. Cox and Nkomo found no differences between blacks and whites in overall performance ratings, but found differences in the criteria used to determine overall performance.[38]

The potential for biased perceptions and stereotyping may be greater for the promotion potential decision than the job performance evaluation because in the former case the supervisor has less information available to him or her. Since managers have insufficient information about a candidate for job performance they look for signal of ability.[39] One signal of ability is the individuals past attainments, both educational and job-related.

Landau's work shows that race and gender were significantly related to promotional ratings despite controlling for age, education, organisational tenure, salary grade, and type of position and satisfaction with career support. This provides some evidence that biased perceptions and stereotyping may be influencing the promotional assessment process. However, in Landau's study, they only accounted for 25% of variance suggesting that important variable are omitted. It is interesting to note that Landau did not specifically look at the issue of racism, making her open to criticism that by focusing on differences with an attempt to find an explicable factor she ignored the effect of racism.

In terms of their experience in organisations, ethnic minorities have been described as suffering from a triple jeopardy.[40] They have to cope with negative racial stereotypes (for example in the UK physician context, overseas qualified doctors from South Asia are frequently perceived to have inferior qualifications and any postgraduate qualifications that they obtain in their own countries are often downgraded). They may be a minority or sometimes the only person in a workgroup (this is less common in the UK, but is a problem at senior executive levels in the NHS – for example at medical or clinical director level). Finally they may be regarded as tokens, having obtained their position solely due to positive discrimination. For example, as ethnic minority doctors advance in organisations they become more of a threat to established white jobholders as competition increases (especially in areas such as obtaining discretionary pay awards). At the top of a hierarchy they are more likely to be in solo roles, or only one of their kind in a workgroup and more likely to be perceived as tokens. Possibilities for biased perceptions and evaluations of their performance may increase particularly if, contrary to stereotypical belief, they are extremely high fliers.

4. How to assess the problem of institutional racism in organisations

Sandy Jeanquart-Barone and Uma Sekaran have developed a causal model for testing the precursors of institutional racism based on a review of the literature.[41] They found three independent variables – supervisory support (help and career support given to employees, procedural justice (fairness of compensation) and indoctrination (the extent to which employees are expected to conform to the norms of the majority group in the system, as important measures of institutional racism in organisations.

They developed measures based on Barbarin and Gilbert's (1981) Climate for Racism Scale, *(we were not able to obtain this paper for the review)*. The scale assesses the acceptance of minorities in the system, their participation in decision making and the extent to which cultural diversity is respected in the organisation. They also looked at the supportive climate of an organisation based on a scale developed by Wallach denoting the extent to which an atmosphere of mutual help, trust, psychological safety and relationship orientation exist in the system.[42] For assessing perceived supervisory discrimination (the unfair treatment of the employee by his or her immediate supervisor) they used the Institute of Social Responsibility Scale (1973). *(we were not able to obtain this paper for the review).* For assessing the degree of career support an employee receives from his or her supervisor, they used a measure developed by Greenhaus, Parasuraman and Wormley.[43] For procedural justice, referring to the perceived fairness of the means used to determine the amount of compensation an employee receives they used a scale developed by Folger and Konovsky.[44] For indoctrination, which referred to the extent to which the employees' values mesh with the values of the organisation, they used a scale developed by Hood (1989) *(we were not able to obtain this paper for the review)*.

Although their analysis only covered 146 employees (they only obtained a 12% response rate in a sample of 1,500) their work does provide some important theoretical perspectives on the measurement of institutional racism. They found that a lack of a supportive climate and perceived discrimination were significant direct paths to institutional racism and suggested that organisations can reduce the extent of perceived institutional racism by providing an organisational climate that is conducive to the effective functioning of all employees and enforcing non-discriminatory standards.

4.1 Organisational discrimination

In an important paper on the effect of race on organisational experiences, Greenhaus, Parasuraman and Worsley examined relationships among race, organisational experiences, job performance evaluations and career outcomes for black and white managers.[45] They found that compared to white managers, blacks felt less accepted in their organisations, perceived themselves as having less discretion on their jobs, received lower rating from their supervisors on their job performance and promotability, were more likely to have reached career plateaux and experienced lower levels of career satisfaction.

In this paper Greenhaus and colleagues introduced the term "treatment discrimination" which represents a situation in which the treatment of employees is based more on their subgroup membership than on their merit or achievements. Such discrimination can affect not only tangible phenomena such as position assignments, training opportunities, salary increases, promotions, terminations, layoffs but also subtle issues such as acceptance into work group or the availability of career enhancing and psychosocial support from supervisors and others. In effect, subgroup members who are exposed to treatment discrimination encounter organisational experiences that are less favourable to their careers than the experiences of a dominant group encounter within an organisation.

Greenhaus described the work of Kanter (1979) *(we were not able to obtain this paper for the review)* who in a theoretical examination of organisational discrimination, argued that minority members, women and other token employees have low access to opportunity and power within organisations. Kanter suggested that employees with restricted opportunities ultimately lower their aspirations and commitment and engage in behaviours that reinforces negative opinions about their potential contribution. Applying research findings on gender discrimination to racial minorities, Greenhaus also describes the work of Ilgen and Youtz (1986) *(we were not able to obtain this paper for the review)* who suggested that minority members may experience treatment discrimination in a number of respects and that such unfavourable experiences can have dysfunctional consequences for their career success. Treatment discrimination may reduce their job performance and career prospects since they would have fewer opportunities to enhance work related skills and develop supportive relationships within an organisation than other employees. The lost opportunities may be reflected in the absence of a powerful sponsor of the assignment of routine tasks, can depress minority employees' ability, motivation or both, and thereby diminish the effectiveness of their job performance. In effect, Ilgen and Youtz proposed that race differences in job performance could be explained- at least in part- by the differential treatment people in different groups experience. They further suggested that minority members may internalise an organisations negative evaluations of them and engage in 'self-limiting behaviours, for example refusing a challenging job assignment or declining an opportunity for additional training – that perpetuate performance differences between minority and non-minority employees.

According to Greenhaus, Ilgen and Youtz suggested that disparate treatment results in fewer and less favourable opportunities for minority members with regard to sponsorship, supervisory support, job discretion and acceptance. This can affect their subsequent performance in many ways.

For example, the assignment of routine, non-challenging tasks, the lack of supervisory interest in subordinate's career aspirations, and the infrequent provision for performance feedback are likely to stunt a manager's professional growth on the job: an attendant decline in the a mangers job performance is likely to occur. Moreover a manager with little job discretion or autonomy has few opportunities to exercise decision-making skills that promote effective job performance, may display low levels of work motivation and may be seen by the organisation as ineffective. The absence of a sponsor and exclusion from an organisations informal network can restrict the resources available to managers to help them perform effectively on their jobs. Career strategy behaviours can provide a focus to managers' efforts and increase

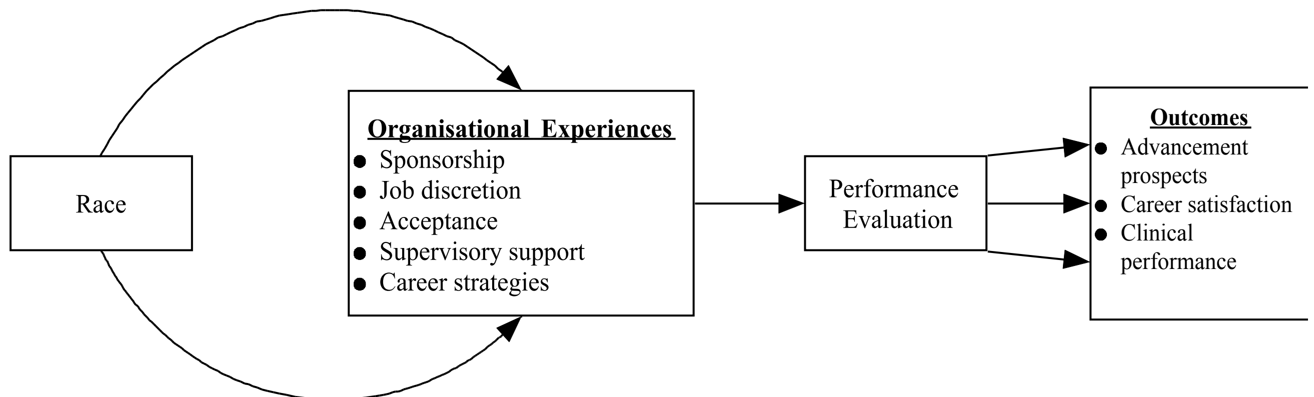
the visibility of their accomplishments. Low levels of participation in such activities can detract from job performance.

Appraisal of current job performance plays a significant role in organisations' assessment of an employee's promotability. Supervisors who hold a negative view of a managers job performance evaluations may give that individual smaller salary increments, less interesting assignments and less recognition that other employees, all of which detract from managers career satisfaction.

This has obvious implications for the assessment of physicians and reinforces the point that some assessment of the organisation may be important in the overall assessment of an individual because the organisation itself can have a detrimental impact on the performance of that individual.

We have attempted to develop a conceptual model for clinicians building on the work of Ilgen and Youtz and Kanter as described by Greenhaus, which suggests that race influences job performance evaluations through its effects on the organisational experiences of black and white managers. Organisational experiences mediate the relationship between job performance and evaluation.[46] The model suggested is an adaptation of that developed in the paper by Greenhaus and colleagues.

Figure 1: Proposed relationships between race, organisational experiences, performance evaluation and outcomes



Notes on figure 1:

Sponsorship: represents an aspect of an organisation's opportunity structure that can foster growth. It has been postulated that minority members are less likely than others to have access to these resources because potential mentors or sponsors, most of whom are likely to be white, tend to chose proteges who are similar to themselves in social background and with whom they can more readily identify. In respect of clinicians it may be manifested by failure to access clinical development opportunities for example study leave, sabbaticals and training.

Supportive relationships: support may take form of career guidance and information, performance feedback and challenging work assignments that promote development. In the clinical field it may be manifested by restricting clinical development, positive feedback when things go wrong and restricting opportunities to take leadership roles.

Job discretion: amount of job discretion is important indicator of the individuals potential to have power within organisation and power differentials are one aspect of the presence of institutional racism. Ethnic minority clinicians may experience low levels of job satisfaction and influence as a result of their status as an outgroup.

Informal social networks: Ethnic minority clinicians may not be fully accepted into the informal networks in their organisations. The lack of ethnic minority role models that are in senior leadership positions in the organisation may exacerbate this.

Career strategies: Subgroup members who are persistently exposed to unfavourable treatment may avoid success-producing activities and engage in self-limiting behaviours. It is possible that ethnic minority clinicians will display a less active approach to management of their careers than white counterparts.

4.2 Assessing organisational discrimination

If approximately 30% of the current medical workforce are ethnic minorities, what can health care organisations do to develop policies and practices aimed at recruiting, retaining and managing a diverse workforce. If we are to accept that assessing clinical performance is an important aspect of managing clinicians and if we accept that institutional racism can have an impact on that assessment, then how can we assess an organisation's competence. Weech-Maldonado provides a useful model as to how this can be achieved.[47]

Research in this area is scarce. Equal employment requirements are the main driver of management policy and our experience of the NHS is that few organisations can claim to positively encourage diversity practice. Cultural competency has been defined as 'an ongoing commitment or institutionalisation of appropriate practice and policies for diverse populations'.[48] If cultural competence is the goal then diversity management is the process leading to culturally competent organisations. Diversity management is therefore a strategically driven process whose emphasis is on building skills and creating policies that will address the changing demographics of the workforce and patient populations.[49] At a very basic level, in respect of the medical workforce, healthcare organisations will at least be aware of some of the issues identified in this report in relation to the assessment of ethnic minority doctors.

A survey in the USA (which is now five years old), on career attainment among healthcare executives across different races/ethnicity confirms that there is considerable room for improvement in the cultural and diversity climates of healthcare organisations.[50] Research examining diversity management practice is scarce. Weech-Maldonado only identified three studies which examined diversity management practice in healthcare organisations - one using a case study methodology and two others using survey methodology. These studies have focused on human resource issues in diversity management. Each of the three studies found that relatively few hospitals had implemented diversity management programs even when hospitals considered diversity management programs an important organisational issue. One of the studies found that all of the hospitals that they studied hospital fitted a 'pluralistic profile' in which they were not actively managing diversity management policies were primarily concerned with compliance-orientated strategies.[51] This is an observation that has also been made by Culley in her study of equal opportunities policies and nursing employment in the NHS.[52]

Weecha-Maldonado addresses some of these issues in a study carried out on the diversity management practices of Pennsylvania Hospitals. Using a conceptual framework, first proposed by Dreachslin in 1996 and developed further in 1999[53] he suggests a five stage theoretical model for organisational change, from affirmative action to valuing diversity. The five stages are:

1. Discovery: Emerging awareness of racial and ethnic diversity as a significant strategic issue.

2. Assessment: Systematic evaluation of organisational climate and culture vis-à-vis racial and ethnic diversity.

3. Exploration: Systematic training initiatives to improve the healthcare organisation's ability to effectively manage diversity.

4. Transformation: Fundamental change in organisational practices, resulting in a culture and climate in which racial and ethnic diversity is valued.

5. Revitalisation: Renewal and expansion of racial and ethnic diversity initiatives to reward change agents and to include additional identity groups among the hospital's diversity initiatives.

Each stage is characterised by different diversity management practices or behaviourally based performance indicators. These include planning indicators, stakeholder satisfaction indicators, diversity training indicators, human resources indicators, healthcare delivery indicators, and organisational change indicators. Healthcare organisations are expected to be at different stages of Dreachslin's change process, and a natural progression is expected from one diversity stage to the other. Based on his survey results, which found that hospitals in Pennsylvania had been relatively inactive with respect to diversity management practices, he suggested four areas that merited special attention for hospitals seeking to adopt diversity management practices for their workforce. These were:

1. Establishing diversity training programs for clinical and staff personnel.

2. Instituting human resources practices aimed at recruitment and retention of minorities at all levels.

3. Using structural mechanisms such as task force or quality improvement committee to monitor the racial/ethnic diversity climate.

4. Implementing control systems that reward management and clinicians for meeting diversity goals.

It can be seen that there is a model, which can be used to benchmark an organisation and its responsiveness to diversity practices. We would argue that an organisational assessment in some cases when concerns are raised about the performance of some ethnic minority physicians may be an essential part of the overall assessment of that person's competence, because of the potential impact of racism.

5. Conclusion

We have reviewed a large body of literature on the impact that racism may have on the performance and assessment of clinicians. We argue that that an understanding of racism in the NHS is critical to understanding how and why performance assessment of ethnic minority clinicians may be affected. We concentrate on the impact of

institutional racism as opposed to interpersonal racism. We describe how organisational issues may impact on the assessment of clinicians and describe how organisational discrimination can be assessed.

Current evidence of referrals to the NCAA suggests that ethnic minority clinicians are not over-represented in hospital referrals though they may be over-represented in referrals affecting GPs. With respect to hospital referrals the experience is different to that of the GMC and may partly be due the current assessment process of the NCAA. Our knowledge of the assessment process suggests that it is robust and evidence based. This may be because the process explicitly takes some account of organisational issues.

We would argue that based on the current experience of ethnic minorities in the NHS an assessment of a clinicians performance needs to be seen against the background of the organisation's own experience and performance in relation to its ethnicity and diversity policies. When a clinician's performance is called in question because there are gross violations in the standards of care then it is highly unlikely that organisational factors will be relevant. However in marginal cases such issues may become more important both in the assessment of the physician and in the remedial action taken. What is clear is that we cannot ignore the individual's experience of racism both as a precursor of poor performance and in the subsequent assessment that takes place.

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