BMA

Delivering racial equality in medicine

British Medical Association
bma.org.uk

Foreword

The founding principle of the NHS – that everyone should have access to healthcare irrespective of who you are or your ability to pay – has been a wellspring of pride for our nation. It has served for more than 70 years as an inspiration to many around the world fighting for the same right to a universal healthcare which values the equality and dignity of everyone.

It is therefore a bitter and shameful reality that these principles are not afforded to the very people who work within the NHS. That we have a health service which does not treat its own workforce equally, but where doctors routinely experience indignity, unfairness and discrimination on a daily basis.

Racism has for too long been allowed to blight lives and careers of those in the medical profession. It is a truth made even more tragic given that many people who arrive in the UK to work for the NHS, and to share their talents, are often inspired by our spoken commitment to equality, but let down by this crushing reality. This report reveals the true extent of race inequality and discrimination within the health service, the experiences of those doctors who have suffered its effects, and who are suffering today, and the catastrophic consequences of racism on patient care.

Experiences of racism begin from the very onset of training, where ethnic minority medical students report bullying and harassment at four times the rate of white peers. It continues after they qualify as a doctor where they are additionally twice as likely to be referred for disciplinary processes, are less supported to pass postgraduate examinations, and face an ethnicity pay gap.

Our report depicts the scale of their adverse experience in the workplace, being overlooked for promotion, forced to change their chosen specialty, feelings of isolation, exclusion and being unsafe at work. Six in ten respondents to the BMA's survey from Asian backgrounds, 57% from Black backgrounds, 45% from Mixed backgrounds reported that racism has had an impact on career progression.

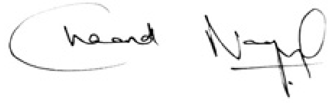
Experiencing racism is extremely distressing, with 60% of those doctors surveyed reporting that their mental wellbeing had suffered as a result, with many suffering depression, low self-esteem and anxiety. There is evidence that incivility can affect the functioning of doctors, and consequently this is having an adverse impact on patient care and services.

It is no surprise that more than almost one third of doctors have left or are considering leaving the NHS due to experiences of racism in the last two years. This terrifying statistic should serve today as a much-needed wake-up call for all those accountable for the health service. With a backlog of care never seen before in the history of the NHS, and acute workforce shortages, we cannot afford to lose even a single doctor from caring for patients. Instead of harnessing the diverse experiences and realising the full potential of our global workforce for the benefit of patients, all of this is squandered by too little action to address the root causes of this problem.

Worryingly, seven-in-ten of our colleagues don't feel confident reporting their negative experiences due to fear of recrimination or worry that they will be perceived as a troublemaker. This means that they suffer in silence, and the true extent of racism is neither exposed nor addressed.

It is clear that racism is wrecking the lives of doctors, affecting patient care and threatening services with potential loss of staff right at this moment. The time for talk is over. Our report makes a range of clear recommendation for change which demand action across the health system, from Government to NHS organisations, leaders and other institutions.

William Beveridge, in his foundational report of 1942, in the middle of a war not yet won, and which ultimately led to the creation of the NHS, said "a revolutionary moment in the world's history is a time for revolutions". Around the world we are witnessing another stage in the long struggle for equal and civil rights. As healthcare leaders, let this be our moment to deliver on that old promise which over 70 years ago changed our society. Let's finally do all we can to guarantee equality and dignity for all healthcare workers.



Chaand Nagpaul, BMA council chair

Contents

Foreword 1

Introduction 4

1. Background – defining the issue 5

2. What the evidence tells us 6

3. How do we elevate the racial equality agenda? Key themes 13

4. At the BMA 17

5. Recommendations 18

Annex 1: Definitions 22

Introduction

This report encapsulates this moment in time when we must acknowledge awareness of the disparities between ethnic groups and move positively towards addressing the root causes of racial discrimination in medicine.

This report presents a high-level overview of the barriers that are preventing racial equality in the medical profession. It draws on the findings of the BMA's *Racism in Medicine* survey – one of the largest of its kind on the experience of racism in the medical profession – and summary of key evidence on barriers to and initiatives to support career progression for ethnic minority doctors. It also draws on the report *Why are we still here?*, a piece of research commissioned by the BMA examining the barriers to career progression for ethnic minority doctors.

Through summarising the evidence, this report aims to provide a pathway to achieve fair outcomes for all doctors across education and training, with key themes and recommendations to address disparities in the medical profession based on race.

These recommendations are under five themes:

1. Being explicit about the need for change
2. Improving racial literacy
3. Investment in root cause analysis and evaluation of interventions
4. Improving reporting processes
5. Increasing accountability

Our key recommendation is for **regulators, employers, training providers and government bodies to publicly state how they are working towards the aim of having a just and inclusive learning culture**, acknowledging that this is the foundation on which to build all actions to deliver racial equality and achieve fair referrals in medicine.

In addition, we are calling for:
- Employers and managers to listen to staff who experience racial discrimination and to have policies in place to support everyone who witnesses and experiences discrimination, bullying, and harassment to report it.
- Medical education to be tailored to meet the needs of the ethnically diverse UK population.
- Standardised induction for International Medical Graduates to be rolled out in all trusts.

The full list of recommendations is in section 5 of this document.

Employers, regulators, education providers and the Government have a duty of care to address the concerns of those who work within the health service. We must demonstrate that we value doctors from all ethnic backgrounds and hold organisations and leaders to account.

1. Background – Defining the issue

Racism is complex and varied across all elements of society, persistent and historical in nature. In 2020 the world was rocked by the shocking images of George Floyd being murdered by a policeman in the United States. This sparked conversations internationally about the nature and manifestation of racism and the structural factors that led to this unbelievable act of dehumanisation and fatal outcome. This tragic event occurred in the context of seemingly inexplicably different health outcomes for different racial groups during the first wave of the Covid-19 pandemic. At the time the BMA monitored the deaths of doctors, with our data showing that 85% of doctors who died from COVID-19 in the UK were from ethnic minority backgrounds. We now know this was in part due to lack of access to risk assessments and poor access to protective equipment (PPE).

Currently, 41.9% of the medical workforce are from ethnic minority backgrounds. The NHS owes its continued existence to the ethnic minority doctors who have been the backbone of our health service since its inception. The need for effective action to achieve racial equality is crucial to ensure that health services in the UK are equitable, fair, and inclusive for all healthcare workers and patients in the future.

Our goal with our programme of work is to change the conversation on race equality in the medical profession, to understand the causes of racial inequality, and to focus on effective solutions. This report aims to simplify the way forward to achieve fair outcomes for all doctors, across education, training, and the workplace. Our recommendations (section 5) are targeted at the organisational level to effect that change and to support organisations to become actively anti-racist in their approach.

We have looked at the journey of the doctor from medical school through their working lives. The experiences of individual doctors through this journey varies significantly. This difference of experience can sometimes be correlated to a doctor's ethnicity, race, culture, and country of qualification. Whether or not a doctor meets their potential, and their day-to-day experiences of the workplace, can be negatively impacted in a way that is linked to these characteristics. This should not be the case.

This work was prompted by the confusing conclusions of the report from the Commission on Race and Ethnic Disparities, published March 2021, that the NHS was a 'success story with significant overrepresentation of ethnic minorities in high status professional roles.'[1] This report did not recognise the systematic disadvantage and discrimination that many ethnic minority doctors have faced. Ethnic minority doctors are more than twice as likely to report that bullying is a problem in their workplace[2] and are twice as likely to be referred for fitness-to-practice processes by their employer, compared to White doctors.[3] In addition, ethnic minority doctors are nearly twice as likely not to raise patient safety concerns because of fear of being blamed.[4]

We seek to demonstrate the wealth of evidence that a doctor's race and/or ethnicity is associated with differential treatment, outcomes, and experiences; that these disparities are underpinned by interlinked factors including workplace culture, individual and organisational biases and stereotypes, poorer access to opportunities, and increased rates of bullying and harassment; and that a whole systems approach to eliminating racism in medicine based on evidence, time for root cause analysis and resources for evaluation of impact, is necessary to change a system that continues to show disparities with little change.

2. What the evidence tells us

There is a significant body of evidence that a doctor's race and/or ethnicity is associated with differential outcomes and experiences in the workplace.

Our *Racism in Medicine* survey was one of the largest surveys undertaken on the experiences of racism in the medical profession and workplace. We invited doctors and medical students from all ethnicities to complete our survey on their experiences of racism in medical workplaces, experiences of reporting racism, and the impacts of racism on wellbeing, career progression, and intentions to stay at a workplace. We also asked for respondents' views on the prevalence and drivers of racism in their workplace and the wider medical profession.

We found that:
- Just over 90% of Black and Asian respondents, 73% Mixed and 64% of White respondents said racism in the medical profession is an issue.
- 76% of the doctors surveyed experienced racism at least once in the last two years, with 17% experiencing these racist incidents on a regular basis.
- There is a low-level of reporting for racist incidents, with 71% of doctors who experienced racism choosing not to report due to a lack of confidence that the incident would be addressed or a fear they would be labelled as 'troublemakers'.
- Respondents described experiences of racism perpetrated by both patients and colleagues:

> "A patient refused to be seen by me as my name did not sound British. A supervisor did not wish to discuss the experience of the patient not wishing to be seen by me and I was met with mostly silence."
> **(Junior doctor, Mixed ethnicity, England)**

> "Patients have threatened me and called me awful names but when I complained to the management it was trivialised and I was told I could have managed the situation better and was told to do a reflection on the encounter for my appraisal."
> **(Salaried GP, Black African, England)**

> "[A senior doctor] said 'we don't negotiate with terrorists' as a joke but I didn't find it funny. You are constantly made to feel different and you are reminded every day that you are not the same as everyone even though you are just there trying to do your job."
> **(Medical Student, Arab, England)**

> "A patient suggested I can be deported if they suffer post-op complications"
> **(Consultant, Male, Other ethnic group, Scotland)**

The survey also exposes the wider implication of racist experiences:
- Nearly one third of doctors said that they either considered leaving (23%) or left their job (9%) within the past two years due to race discrimination.
- 60% of doctors who experienced racism said that the incident had negatively impacted their wellbeing, including causing depression, anxiety, and increased stress levels.
- 60% of respondents from Asian backgrounds, 57% from Black backgrounds, 45% from Mixed backgrounds, and 36% from White non-British backgrounds saw racism as a barrier to career progression compared to just 4% of White British respondents.
- Respondents who had qualified overseas were twice as likely to think that racism was a barrier to their career progression than those who had qualified in the UK (60% compared to 27%).

"Less confident to report such incidents again because no action was taken against the perpetrator. I feel uncomfortable and anxious of reprisals"
(Consultant, Black African, England)

"I was not taken seriously. Emails were ignored. I was branded and suffered work related stress and hypertension. I think of leaving this job every day."
(Consultant, Indian, England)

"I am not the same person anymore. I feel less confident with bruised self-esteem"
(GP Trainee, Asian, England)

These findings tell us definitively that the way that racism is experienced is very different dependent on ethnicity, that racism is significantly under-reported due to perceptions of negative repercussions, and that little is being done to address these issues.

We also asked for examples of positive initiatives to address discrimination. Encouragingly there were a long list of examples, such as talking about race and cultural difference, having diverse ethnicity at a leadership level and a workplace culture that supports speaking-up, and challenging discrimination are effective ways to achieve racial equality and fairness in medicine.

The report *Why are we still here?*, a piece of qualitative research commissioned by the BMA examining the barriers to career progression for ethnic minority doctors, found evidence of:
- a Eurocentric bias in the medical profession, e.g. 'hidden' or assumed leadership qualities that are culturally specific
- systematic and systemic exclusion
- everyday othering and exclusion
- lack of development opportunities
- bias in recruitment and selection processes
- double and differing standards in evaluations of performance across career stages and
- poor implementation of diversity, inclusion and equity projects which results in discrimination not being tackled and a lack of psychological safety.

Interestingly the research also points towards the factors that can be career accelerators for the majority ethnic, White British doctors, notably:
- an automatic assumption of fit based on the Eurocentric bias and
- career boosts that prepare a doctor for success in medical careers, e.g. sponsors/mentors, being 'tapped on the shoulder' for opportunities and being invited to undertake medical leadership and management training.

Our summary of key evidence on barriers to and initiatives to support career progression for ethnic minority doctors showed that there is a significant gap in published and evaluated interventions to address the disparities of ethnic minority doctors' progression into senior roles. Interventions without evaluation of their effectiveness have prevented equality of outcomes being achieved. Where there is evidence of best practice on effective interventions, these interventions are not being rolled out systematically or resourced sufficiently across the health service.

Our analysis of racial discrimination in the medical profession has not directly assessed how particular organisations are performing on eliminating racial discrimination. We acknowledge that organisations such as NHS Employers and arm's length bodies, the CQC, GMC, HEE, medical schools and Royal Colleges have to differing degrees instituted research or programmes of work to tackle discrimination. A whole systems approach is necessary to address the systemic and pervasive nature of racial discrimination. This must begin by acknowledging that systemic and structural racism exists, understanding how it manifests, and acting to address its causal factors.

Localised evidence

We are cognisant that racism can manifest differently in different geographical areas. Evidence of racial disparities in Scotland, Northern Ireland, Wales, and England, and at the regional level within nations should be researched and analysed so that local solutions based on local evidence can be developed. The BMA is a UK wide organisation, and we have evidence of racial disparities from surveys completed in Scotland and Wales.

BMA Scotland and BMA Cymru Wales conducted surveys in 2021. The findings from the Scotland survey found that non-White doctors are more likely to have to make multiple applications for posts before being successfully appointed (61% of White respondents were successful on first application compared with 50% for ethnic minorities), and that there was a significant difference between reporting of experiences of or witnessing unfair treatment and raising of complaints by ethnic minority doctors. The findings from the Wales survey found that 84% of those who said they had raised a complaint or formal grievance regarding any aspect of their employment, either in current or previous roles, said that the resolution was unsatisfactory. Within this group, 64% said it was unsatisfactory because it was not taken seriously or that processes were not completed and 20% said it was unsatisfactory because the process was completed but there was no useful resolution.

A survey of primary care professionals in the Humberside region found that 22% of respondents reported that racism and discrimination had affected their ability to train in their careers[5]. It is important to look at data in different settings, as well as geographically, such as between primary care and secondary care, as the causes and therefore interventions may be different.

NHS research

Research and surveys conducted by the NHS have consistency demonstrated disparities in treatment, experiences and outcomes for ethnic minority doctors.

The 2021 Medical Workforce Race Equality Standard (MWRES) report found that in England 'across almost all indicators, BME doctors reported a worse experience at work compared to White doctors. This trend is seen across the whole career path from medical school to consultant level'. The report showed a 7% ethnic pay gap across all doctors, that ethnic minority applicants were less likely to be accepted into medicine and dentistry training compared to White applicants; and that compared to the overall proportion of doctors in NHS trusts and CCGs, ethnic minority doctors were underrepresented in consultant, clinical director and medical director roles, and under-represented in academic positions. In 2020, ethnic minority doctors made up 41.9% of overall doctor workforce in NHS trusts and CCGs, but only 37.6% of consultant workforce, 26.4% of clinical directors, and 20.3% of medical directors are from minority ethnic backgrounds.[6]

The NHS staff survey from 2020 showed that 16.7% of ethnic minority staff experienced discrimination at work from a manager, team leader, or other colleague, compared to 6.2% of White staff. Women from ethnic minorities (16.9%) were most likely to have experienced discrimination from other staff in the previous 12 months. The survey also showed that 29% of ethnic minority staff experienced bullying, harassment or abuse from patients, compared to 26% of White staff. Women from ethnic minorities (29.5%) were most likely to have experienced harassment, bullying or abuse from patients, their relatives or the general public in the previous 12 months. The proportion of ethnic minority staff that believed their trust provides equal opportunities for career progression or promotion decreased in 2020 (69.2%) compared to 2019 (71.2%).[7]

The MWRES report also showed that ethnic minority doctors reported a worse experience than their White colleagues when it comes to harassment, bullying, abuse and discrimination from staff.

Career progression

There is broad agreement by researchers that the key barriers to career progression for ethnic minority doctors are insider/outsider dynamics, access to mentoring and role models, bullying and harassment, and bias and stereotyping. Workplace culture can act as a barrier or an enabler to career progression. The evidence suggests similar barriers for ethnic minority staff in comparable professions.

There is a persistent gap in attainment between ethnic minority and White trainee doctors and between UK and overseas qualified doctors. In 2020, GMC data showed the pass rate in postgraduate exams was 76% among White UK trainees and 64% among UK ethnic minority trainees. Among IMGs, the pass rate was 43% for IMG trainees and 46% for EEA trainees compared to 72% for UK graduates. An extensive report by the British Association of Physicians of Indian Origin (BAPIO) found that there are five primary causes of differential attainment: bias, social class and deprivation, immigration status, geographical factors, and individual factors. This impacts every stage of medical professional careers. The report sets out recommendations for how to address it ranging from celebrating the contribution of migrants and supporting flexibility to reviewing, reforming, and rethinking assessments.[8]

2019 data on MRCGP examinations found that Clinical Skills Assessment (CSA) candidates who were White UK graduates had a pass rate of 94%, whereas UK graduate ethnic minority candidates had a pass rate of 83%. For IMG CSA candidates, the figures are 50% for White candidates, and 41% for ethnic minority candidates.[9] These figures have not changed significantly since they were first published in 2009. The Royal College of Physicians (RCP) 2020 and 2021 survey of Certificate of Completion of Training (CCT) holders' career progression analysed data from the past 8 years of surveys and found consistent evidence of trainees from ethnic minority backgrounds being less successful at consultant interview, despite adjustment for potential confounding factors.[10] Transparency is evident in how the RCGP and RCP publish their data – all Royal Colleges should be similarly accountable and transparent in publishing their assessment outcomes by ethnicity.

A 2021 independent study[11] of the impact of ethnicity on job-offers in the London region, showed that one trust offered positions to 90 applicants, including 50 of the 317 White applicants for medical positions during that period. In contrast, although 418 Black candidates applied for medical positions and 65 were shortlisted, no Black doctor was offered a position at the trust during the same period. A 2019 review into the ethnicity pay-gap and workforce development at the Newcastle upon Tyne Hospitals NHS Foundation Trust found that more female ethnic minority consultants applied for the local clinical excellence awards (in the 2017/18 period) and were more likely to be awarded them, but that the value of their award was the lowest.[12]

In recent years, institutions have commissioned research or created taskforces to address disparities in outcomes for doctors on the basis of race and to understand the organisational cultures that may be the barrier to racial equality. An independent report by the Royal College of Surgeons found that 'power, over people's careers (e.g. whether they pass or fail exams, whether they receive a research grant or don't, the experience that they have in training), is concentrated in the hands of a narrow section of society who are likely to have walked in very different shoes down very different paths than those less privileged.'[13]

Patient experience, outcomes, and safety

The impact of racism is systemic and, in healthcare settings, environments that foster racism within the medical workforce inevitably impact on patients. The impact of racism on patient experience, outcomes, and safety cannot be addressed in its entirety in this report but some examples below bring the issue to light.

A paper published by the NHS Race and Health Observatory (RHO) reviewed evidence of racism against patients in the NHS. It found that there are systemic issues leading to inequity in treatment and poor experience with health services that have inevitably led to a deep mistrust of the NHS. Some of the many examples included ethnic minority groups being less likely to be referred to psychological therapies by their GPs compared with White British people, Black women being four times more likely to die in childbirth than White women, and Asian women being twice as likely to die in childbirth than White women. A consistent theme in the experiences of patients from ethnic minority groups are experiences of negative interactions, stereotyping, discrimination, and cultural insensitivity.[14]

Understanding of the causes of health inequalities linked to race is developing as more research is funded and targeted at analysing these causes. A position statement on racial disparities in women's healthcare by the Royal College of Obstetricians and Gynaecologists stated clearly, 'racial bias leads to poorer health outcomes and experiences for Black, Asian and minority ethnic women. Implicit racial bias from medical staff can hinder consultations, negatively influence treatment options and can ultimately result in Black, Asian and minority ethnic women avoiding interactions with health services. More research is needed to better understand the impact of racial bias in women's healthcare and how it can be eradicated.'[15] The need to better understand causal factors was again highlighted in a recent report by the organisation Birthrights, stating concern that most initiatives to address racial disparities in maternal mortality rates 'overlook the role of systemic racism or perpetuate the view that Black and Brown bodies are the problem and clinical interventions offer the only cure.'[16]

Organisational cultures and racism in medicine

The majority of referrals to the GMC against ethnic minority doctors come from their employers, not patients. The *Fair to Refer* report, commissioned for the GMC, found that doctors from ethnic minority backgrounds are twice as likely to be referred to fitness to practice proceedings by their employer and that IMG doctors are two and a half times as likely to be referred to fitness to practice proceedings by their employer. A key contributing factor identified in this report was that organisations often have a 'blame culture' rather than learning from mistakes.

Ethnic minority GPs in England reported poor experiences of the CQC inspection process and outcomes. They were also more likely to report that the inspection process had an adverse impact on their physical and mental health and on their personal and/or family life. CQC research identified some contributary factors, such as ethnic-minority led GP practices being more likely to be in more challenging socio-economically deprived areas and facing greater recruitment and funding issues.[17]

Our 2018 *Caring, Supportive and Collaborative* survey of over 8,000 doctors found that ethnic minority doctors were more than twice as likely as their White colleagues to say that bullying, harassment and undermining is a problem at their work. The same survey found that ethnic minority doctors were twice as likely as White doctors to say they would not feel confident about raising concerns about patient safety, as they feared being blamed or that they would suffer adverse consequences.[18]

Similarly, our *Racism in Medicine* survey found that 37% of respondents from Black backgrounds, 37% from Asian backgrounds, 34% from other backgrounds, 22% from Mixed backgrounds, 22% from White non-British backgrounds had been bullied due to their ethnicity, compared to 5% from White British backgrounds. Bullying was most often perpetrated by senior doctors, with 68% of those who had been bullied reporting that they had been bullied by senior doctor.

Surveys can provide rich data and information to learn from when looked at through an intersectional lens. The BMA's 2020 survey of disabled doctors and medical students found ethnic disparities in their experiences – doctors and medical students from ethnic minority backgrounds were less likely to report a supportive environment than their White colleagues.[19]

The BMA bullying and harassment project and report from 2019 identified that doctors suffered from anxiety, self-doubt, isolation, shame, depression and demotivation, which ultimately had a negative effect on career development. Additionally, doctors were fearful to seek help from colleagues or raise concerns. At an organisational level we found that bullying and harassment resulted in an increase in turnover and sickness absence, loss of productivity, and more resources spent on resolution/litigation, as well as overall reputational damage.

The BMA documented that 85% of doctors who died from COVID-19 in the UK were from ethnic minority backgrounds. Our surveys of members during the pandemic found that doctors from ethnic minority backgrounds were more likely to feel pressured to work without adequate PPE, that risk assessments were more likely to be inadequate and not acted upon and that ethnic minority doctors were more afraid to speak out about safety concerns for fear of recrimination, or it affecting their careers. The pervasive and structural nature of racism in this instance led to fatal consequences for doctors on the frontline.

The findings from our surveys into racism and other forms of discrimination show that the impact is the same when looking at a workplace that features unchecked discrimination and abuse, and that the importance of creating civil inclusive workplace with a 'just and learning culture' model is crucial.

The Civility Saves Lives campaign looked at the impact of incivility on staff and on patient care. It found that having a civil work environment reduces errors and stress and fosters excellence. Almost all excellence in healthcare is dependent on teams, and teams work best when all members feel safe and have a voice. Incivility causes an average 61% reduction in the cognitive ability of the recipient and a 20% reduction in the cognitive ability of bystanders.[20]

Every NHS trust in England has a Freedom to Speak Up Guardian who is part of a national network led by the National Guardian for England. The National Guardians' Office (NGO) looked at people's experiences of accessing their Freedom to Speak Up Guardian and whether ethnicity has an impact. The research found that Black and minority ethnic workers who had spoken up reported that they thought Freedom to Speak Up Guardians had a good understanding of discrimination and bias, were empathetic, and had good listening skills.[21] All medical professionals should have access to some form of independent pathway for raising concerns.

International medical graduates (IMGs)

International medical graduates have a poorer experience than UK graduates and this can be compounded by racial discrimination. The evidence shows disparities throughout an IMG doctor's career and in their day-to-day experiences, with the added burdens of an inflexible and costly immigration system; setting up a new life with the challenges of navigating housing, finances, and employment systems in a different country; and being isolated from friends and family. This is compounded by inadequate inductions into workplaces, restricted access to training pathways, and potential challenges in adapting to cultural differences in medical practice. There is a significant theme throughout the research about the differences of experiences of IMG doctors compared to UK graduates which speaks to the heart of this problem: a healthcare system that has recruited IMG doctors since its inception is failing to support them to have a fair and fulfilling work experience in the UK.

There is a need for more nuanced research that identifies barriers that specifically relate to being an IMG. The nature of how IMGs are recruited and deployed into the healthcare system has led to IMGs being more likely to fill certain roles, such as Specialty and Associate Specialist (SAS) and Locally Employed Doctor (LED) positions.

The GMC's survey of SAS doctors found that 30% of SAS and 23% of their locally employed (LE) counterparts had been bullied, undermined or harassed at work in the last year, either by colleagues or by patients and their families. Rudeness, incivility, belittling and humiliation were the most common types of undermining behaviour reported.

The experiences of IMGs and the cohorts of doctors with high numbers of IMGs in position must be looked at distinctly, because these cohorts are more likely to include ethnic minority doctors.[22] Whether at an interpersonal level (behaviours) or systemically (policies), understanding how racism manifests for IMGs in particular is essential to taking the next step towards meaningful change.

The evidence is clear that a lack of comprehensive induction processes for IMG doctors can act as a significant barrier. The MWRES 2020 data report also recommended inductions for IMG doctors as a key area of action needed in the NHS in England.

Intersectionality

Our *Racism in Medicine* survey sought to understand where the intersection of different protected characteristics compounded the impact of discrimination. Over a quarter of respondents (28%) said experiences of racism were exacerbated by gender and three in ten respondents (30%) said that racism they had experienced was linked to religion, with respondents highlighting Islamophobic, Antisemitic or other faith-based discrimination. An analysis of the ethnicity and gender pay gaps among hospital and community health service doctors in England between 2016-2020 showed that for this cohort of doctors, Indian men slightly out-earn White men and Bangladeshi women have a 40% pay gap. The conclusion for this particular analysis was that gender groups from all ethnicities earn less than White men on average, except for Indian men, and that these differences cannot be explained by characteristics that can be measured.[23]

The intersection of race with religion is particularly notable with instances of Antisemitism and Islamophobia often indistinguishable from racism. One 2021 survey found that almost 4 in 10 Muslim healthcare practitioners had received verbal abuse from colleagues around their faith and that almost half of respondents reported they had thoughts of leaving their job.[24]

Another clear example of how intersectionality impacts at the individual level is the case of Dr. Bawa Garba, a Muslim woman who was referred to the GMC. The GMC commissioned research into the factors that may have contributed at a structural level to cause the extraneous investigation into the case of Dr. Bawa Garba and to look into the reasons why IMGs and doctors from certain ethnic minority groups were more likely to be referred to the GMC. One finding from the report was that 'in groups and out groups exist in medicine including relating to qualifications (including by country and within the UK by medical school) and ethnicity. Members of in groups can receive favourable treatment and those in out groups are at risk of bias and stereotyping.'[25] Being of a certain ethnicity, gender or religion could all compound the likeliness of being put in the 'out group'. The report made several recommendations, some of which are repeated in this document.

3. How do we deliver the racial equality agenda? Key themes

The key findings and evidence presented in this report point to a need for overarching recommendations in five key areas to accelerate our progress towards racial equality:

1. Being explicit about the need for change
2. Improving racial literacy
3. Investment in root cause analysis and evaluation of interventions
4. Improving reporting processes
5. Increasing accountability

1. Being explicit about the need for change

Discrimination or harassment of individuals or groups based on race, religion, ancestry, place of origin, ethnic origin, nationality, or any other identity is intolerable and has no place in our society. This is something that most people will agree with, but explanations of why this is important to tackle are less likely to be explained. All people from all backgrounds who operate in the healthcare sector must understand the benefits but also the cost of not a) changing a culture that allows racial discrimination to exist at a structural level and b) recognising that the medical workforce is ethnically diverse and that diversity is a positive benefit.

The feedback in our *Racism in Medicine* survey shows that in many instances the purpose of interventions, such as positive action programmes or listening events with ethnic minority staff, are not widely understood and are considered by some as giving unwarranted opportunities and special treatment to ethnic minority individuals. More time and investment are needed to explain the benefits of an inclusive and diverse workforce and how any proposed steps will lead to that. In addition, organisations and the UK government should be explicit about the structural nature and impact of racism at the societal, institutional, and interpersonal levels.

There must be a shared understanding of 'why' change must occur. The universal benefit for change is not always clearly presented to the people who need to be brought on to the journey. If racial equality in the UK is the antidote to the status quo, the benefits for all groups must be communicated clearly and simply.

The benefits to racial equality in medicine are:

1. **Retention.** Doctors who are suffering from racial abuse want to leave their roles. The NHS needs to retain its doctors and must therefore create a workplace that values doctors from all ethnic, cultural, and qualification backgrounds, as they have always been and will be part of the UK's healthcare workforce.
2. **Ethnic diversity**. The ethnic diversity of the medical workforce is positive. Evidence shows that diverse teams and leadership lead to improved problem solving, engagement, and retention.[26, 27]
3. **Doctors reaching their full potential**. Doctors will be able to achieve and prosper in their careers to reach their full-potential unhindered by racial discrimination. Patients will benefit from a doctor who is able to perform to their best ability and provide an excellent healthcare service.
4. **Patient safety in healthcare**. The evidence consistently shows that doctors from ethnic minority backgrounds feel less able to speak-up due various reasons, including distrust in the system that does not address racist incidents. Regulators have a duty to protect patients. If they are hindered by racist policies, they will not be fulfilling their role of patient protection.
5. **Improved patient care**. An ethnically diverse and racially literate healthcare workforce leads to more equal health outcomes for patients from all ethnic backgrounds. By improving the medical curricula to consider the needs of all ethnic groups in the

UK, racial disparities in healthcare outcomes will reduce, both through improving knowledge at a clinical level and by reducing racial bias and discrimination against patients at an interpersonal level.

6. **Wellbeing**. The impact of racism on the individual can impact on productivity, clinical performance, safety, mental health, and relationships. People work best in inclusive working environments where they feel valued and fairly treated.
7. **Efficiency**. Time and monetary savings can be made when a workforce is inclusive and there is improved civility in the training and working environment.

2. Improving racial literacy

Literacy is defined as knowledge or skills in a specific area. In a racially diverse society and medical profession, racial literacy is an essential skill for work and everyday life. However, people across the UK are working from different definitions of what racism is and how it manifests. Race, as defined by the Equality Act 2010,[a] includes colour, national origin, nationality, ethnicity and ethnic origin, and through case law also caste. The terms 'race' and 'racism' include broad categories of this classification. It is essential that we acknowledge that racism includes the intersection of gender, race, colour, ethnicity, and faith, and that there are unique differences between the manifestation and impact of colour-based racism, Antisemitism, Islamophobia and cultural discrimination.

Additionally, race as defined by the Equality Act 2010 does not take account of the complex interplay of factors which may be manifesting at a micro (interpersonal), meso (institutional), and macro (societal) level. This interplay of factors was identified in research into differential attainment, which highlighted the need to move beyond a 'deficit model', 'whereby differences are attributed to deficits in students such as poorer previous attainment, lower motivation, poorer preparation for university'.[28] However, the majority of interventions still focus on supposed deficits at an individual level – such as mentoring, additional learning programmes, and staff networks. These types of action can be positive, but they must be complemented by actions that will tackle structural disparities to remove the barriers and root cause of disparities between ethnicities.

Racism is broad and touches all areas in medicine. Our recommendations look at discrimination as a whole sector/system problem. When addressing any disparity, the environment, structure, and related policies must be analysed for that particular disparity. Multi-factorial research is essential to understanding how to address disparities, for example when looking at intersectional considerations such as social determinants and other protected characteristics. Organisations play a significant role in managing the policies and processes where disparities exist. However, organisations do not exist in isolation – medicine as a profession and organisations are part of a wider healthcare system. Therefore, a whole systems approach is crucial to address the problems.

It is evident that a better understanding of the nature of racism is a key factor in addressing racial disparities. This involves building understanding of how racism manifests and impacts on a doctor's wellbeing and progression as well as the general working environment. Linked to this is the need for decision-makers or gatekeepers to understand the nature of racism and where it could impact on their decisions or need to be considered in organisational policies and learning materials. If we do not have a joint understanding of the cause, size, and scope of the racism in the medical profession, we will not achieve change because there will be consistent disagreements about what the process of change will look like, or even at a fundamental level that the outcome of racial equality is necessary or possible.
Improved racial literacy could in turn improve the historic difficulties in bringing cases of discrimination through the employment tribunal systems, where the presentation, investigation and assessment of evidence related to racial discrimination would be

a The Equality Act 2010 applies only to England, Scotland, and Wales. For definitions of racial discrimination in Northern Irish law, see The Race Relations (Northern Ireland) Order 1997.

strengthened. It should not be taboo to better understand and identify racism where it exists or has existed, and we must endeavour to better understand and tackle racism, not bury it.

3. Investment in root cause analysis and evaluation of interventions

There is significant evidence of disparities in outcome linked to race. However, evidence is limited on both the causes of those disparities and the effectiveness of interventions to address them. This has resulted in a cycle of presenting disparities without putting the correct resources towards tackling them.

Interventions taken to address racism in the past do not necessarily address its root causes, which often stem from structural factors. When a disparity has been identified there must be more time and resource spent to define the issue. Understanding the root cause of any disparity will mean looking at all the evidence, including the different characteristics involved in the context of that disparity. While the Commission on Racial and Ethnic Disparities report did make a link to some broader factors such as socio-economic factors, all the relevant factors must be considered to understand the true cause of that disparity.

Effective evaluation and ongoing assessment of interventions are crucial. Actions that are taken to address disparities in race equality are often not well resourced, do not often set clear evaluation frameworks, and are not often evidence based. In the workplace, the field of equality, diversity, and inclusion (EDI) has been growing over the past 30 years and has in that time developed expected actions: create a strategy/action plan, establish a staff network, monitor staff demographics and satisfaction. However, our summary of key evidence on barriers to and initiatives to support career progression for ethnic minority doctors showed that there is little evaluation of the effectiveness of interventions. For example, affinity/staff networks can be helpful, but all staff networks are not the same. Networks are funded differently, sit in different parts of an organisational structure and have different remits. For a staff network to aid in addressing disparities between ethnic minorities in an organisation the staff network has to be seen as a forum for ethnic minority views and voices, have a direct communication link to the leaders in an organisation, not be a replacement for the organisation in doing the work to manage EDI in the organisation, and be resourced appropriately.

Targeted research and data analysis are essential to enable targeted action. Disaggregated data by each ethnic group can show significant differences. Where there is ethnic diversity, often the majority have a diametrically opposed experience to the minority groups, and it is easier to analyse data when the numbers of the minority are added together. However, this can veil the differences that do exist and prevent organisations from establishing an understanding of what is causing these differences. This was evident in our *Racism in Medicine* survey findings, which showed there was a significant difference in the responses from the White British and White non-British doctors.

4. Improving reporting processes

Policies and processes to report instances of racial discrimination are not working. Our surveys show that people will not report discrimination for fear of it affecting their career, backlash, or nothing being done. For certain types of racism, such as institutional racism, there aren't any reporting systems bar judicial review.

Evidence from our surveys and wider research show that racism is often assumed to just be 'part of the job' for thousands of ethnic minority doctors and healthcare workers. All organisations must acknowledge that their workplace environment may not be conducive to open reporting, and any investigation into racism (whether interpersonal or institutional) should involve investigators who are trained to recognise how racism manifests and to actively encourage doctors to report behaviours and policies that are discriminatory. This includes those incidents that may be viewed as microaggressions or not serious enough to report – recognising that a workplace culture that allows these 'low-level' issues to go unchecked will lead to a downward spiralling culture where more

serious incidents also go unchecked.

The findings from our surveys show that some of the reasons people do not report discrimination is due to the belief that they will not be believed or that no action will be taken. Therefore, going hand in hand with the need for healthcare workers to have the 'freedom to speak-up', as the key point of learning from the Francis Inquiry and the Berwick review into patient safety, additional action must be taken to tackle the failure of organisations to listen. Reporting processes must include a stage of listening and evaluation of action by organisations, which should be reported and accountable at Board level. In addition, employers should monitor and have independent scrutiny of their referrals to Maintaining High Professional Standards in the NHS (MHPS) and the GMC.

5. Increasing accountability

Our findings show that racism continues to be prevalent in medicine. We must now make organisations and leadership accountable for changing these outcomes and the negative narrative that surrounds meaningful action to promote equality for ethnic minority groups.

It is essential that the need to reduce unlawful racial disparities is presented in organisational structures with the same weight as health and safety discussions. If an organisation values racial equality, it should be able to show within its governance, risk-management, and finance structures how much resource has been dedicated to addressing racism. This applies whether that organisation is an employer, educational provider, regulator, or government body.

A key element of accountability is being accountable for action taken as well as action not taken. Our recommendations also echoes recommendations from research or reports into racism in medicine that have not been taken forward. The cycle of research and reports into disparities with no accountability for learning and progress by the individuals and organisations accountable must stop.

Evidence suggests persistent differential attainment is in part caused by problems in training and work environment culture. Differential attainment, even amongst UK trained ethnic minority doctors, is not due to a lack of ability, but to a lack of support, inclusion, and feedback, which affects their confidence and learning.[29] Attainment in assessments can have a significant impact on a doctor's career pathway options and progression. The progression of doctors into senior positions is complicated but the different pathways and the roles of the medical schools, Royal Colleges, HEE and equivalent bodies, the NHS and other gate-keeping bodies can be equality impact assessed at an individual level to ascertain where adjustments to policies should be made to lead to fair progression. These bodies should be made accountable for addressing the attainment gaps that cannot be explained.

The healthcare system is not one system. We refer to 'the NHS' – but the healthcare ecosystem is made up of many organisations that have different roles and most importantly different aims, governance and leaders. Accountability means each organisation taking responsibility for the part of the ecosystem that they have got influence over.

4. At the BMA

This report builds on a programme of work by the BMA to understand and address racial disparities in medicine. We have various workstreams to address the different themes that have been highlighted in this report. We use our voice to raise awareness of the value of ethnic minority doctors and IMGs through our engagement with regulators, employers, and educators, and through our media work.

We have guidance and advice for doctors who are facing discrimination through our employment advice services, as well as a wellbeing service for all medical students and doctors.

Our Forum for Race and Ethnic Equality (FREE) is working at a national and local level to network and listen to concerns from doctors from ethnic minority backgrounds.

The BMA's racial harassment charter for medical schools was launched in 2022. All medical schools in the UK committed to preventing and addressing racial harassment at medical school and on clinical placements. Our work with medical schools to implement the racial harassment charter will be updated this year when we assess the progress of all medical schools on their implementation of the charter.

We lobby government and work with stakeholders to push for racial equality. We lobbied government for indefinite leave to remain for the dependents of doctors who died on the Covid-19 frontline and exemption from the health surcharge for healthcare workers (achieved in May 2020). In 2020, the BMA submitted written and oral evidence to the Commission on Race and Ethnic Disparities (CRED). Our analysis of the CRED report, *A missed opportunity*, detailed our support for the recommendations in the report, alongside our disappointment about the narrative that supported it and the missed opportunity to address structural racism. The UK Government recently published its response to the CRED report, that seemed to focus on tackling the symptoms of racism not the causes.

We also engage widely with stakeholders, sitting on the GMC's BME Doctors Forum, as well as relevant NHSEI and CQC steering groups. Our report Differential attainment – Making medical training fairer for all, set a path for our engagement work with stakeholders to address differential attainment in medical training and our commissioned research into the barriers into progression for ethnic minority doctors will build on our understanding of the effective solutions to tackle these persistent disparities.

We launched a workstream to tackle key issues faced by IMG doctors, which included launching an LED toolkit to improve employment standards for IMGs in unsecure roles, and having LED representatives on our local negotiating committees.

More widely our work on health disparities and the disproportionate impact of Covid-19 on ethnic minorities supports racial equality in health for the UK population as a whole.

This report marks a line in our programme of work where we have consolidated our broad workstreams and sets out some clear actions that can be taken forward to move closer towards the goal of racial equality. We will communicate the findings from the research and survey reports with doctors and organisations in the medical profession. We will continue to lobby government to recognise structural racism and how it manifests in the NHS and medical profession.

5. Recommendations

Our recommendations are targeted at organisations in the medical profession's ecosystem. Organisations and institutions can take effective action to achieve change by recognising the complexity of this problem, and that racial discrimination can exist at an interpersonal, organisational, and societal level. Although these recommendation target organisations, it is individuals in positions of power who are the gatekeepers of resources and decide whether progress will be made.

Number	Theme	Recommendation
1	Being explicit about the need for change	Initiatives to achieve racial equality must always be presented with a strong explanation for the need for change and the benefits to the individual and collective (patients and doctors), the organisation and the medical profession.
2	Being explicit about the need for change	Centralised guidance on debiasing recruitment, HR processes, and objective and fair regulatory referral procedures must be embedded across all organisations in the medical profession.
3	Being explicit about the need for change	The value and historical contribution of IMGs in the healthcare sector must be promoted to counteract the negative societal narrative about migrants in the UK.
4	Improving racial literacy	Leaders, decision-makers, investigators, and inspectors in all disciplinary or regulatory processes must be trained to identify how racism manifests in the regulation of the medical profession and the wider healthcare environment (NHS trusts, CQC, GMC, NHS Resolution and equivalent devolved bodies, e.g. HIW, HSC trusts/NHS boards). For example, training should include how racism manifests in decisions about progression and/or referrals to regulators.
5	Improving racial literacy	A Eurocentric approach to medicine, as well as a narrative at a societal level that devalues and dehumanises people from non-UK countries and with visible difference linked to historical colonial relationships, creates stereotypes that lead to discriminatory behaviours towards ethnic minority and international medical graduates. – Equality, diversity and inclusion (EDI) training should be mandatory in medical school curricula and should include the topic of racial bias and how it manifests in medicine (for patients of different ethnic groups) and organisational cultures (with colleagues in the workplace). – EDI for all NHS staff and medical academics should be regularly evaluated for effectiveness. EDI training should include information and support for people on how to be fair and supportive to colleagues and patients that staff do not share a protected characteristic with (e.g. allyship/bystander awareness).
6	Improving racial literacy	The medical curricula at undergraduate and post-graduate level should include the subject of health inequalities. This should include some discussion/analysis of the determinants of health inequalities on the basis of race and how they can be addressed by targeted interventions, resource allocation and at the point of individual care.

Number	Theme	Recommendation
7	Investment in root cause analysis and evaluation of interventions	The key to effective action is monitoring and evaluating impact. All interventions or actions to address racial disparity should not be started unless they have a structure of evaluation surrounding it. Four questions should be included at the point of action planning: 1. Who (person role and organisation) is responsible for delivery and progress of this initiative? 2. How will the initiative be funded? 3. How will success be measured? 4. When will results be expected?
8	Investment in root cause analysis and evaluation of interventions	We are aware that there is little information available about the ethnicity pay gap for doctors in the UK. The BMA's commentary on the Independent Review into Gender Pay Gaps in Medicine in England highlighted that more work must be done to understand the differences in the gender pay gap at the intersection of different protected characteristics, including race and disability. All data analysis by protected characteristic should where possible look at the intersections between different characteristic to understand the barriers that must be tackled.
9	Investment in root cause analysis and evaluation of interventions	All quality assurance measures for employers in the NHS should include consideration of staff experiences and other indicators by ethnicity. Satisfaction surveys and focus groups of ethnically representative medical students and doctors should be used to measure the impact of initiatives to tackle racial discrimination.
10	Improving reporting processes	Doctors fear reporting racist incidents. Medical students and doctors must have access to independent reporting structures. Medical schools, colleges, and employers must: – Make sure there is a designated person that people can discuss concerns with informally and in confidence. – Improve awareness of and reach of Freedom to Speak Up Guardians. – Provide independent avenues for raising concerns (such as Freedom to Speak Up Guardians) that are accessible to all doctors. SAS, LED, and IMG doctors should be targeted with information about how to raise concerns. – Provide alternative means of resolution, such as mediation. – Set clearly defined processes for early intervention to tackle low-level, unprofessional behaviours. – All staff inductions into NHS trusts and devolved equivalents (including students on work placements and doctors on short term contracts) should include information about how to raise concerns and about Freedom to Speak Up Guardians or similar services.

Number	Theme	Recommendation
11	Improving reporting processes	Going hand in hand with the need for healthcare workers to have the 'freedom to speak-up', additional action must be taken to tackle the failure of organisations to listen. Reporting processes must include a stage of listening and evaluation of action by organisations. This should be reported and accountable at the board level.
12	Improving reporting processes	All organisations across healthcare must provide clear processes and policies for reporting discrimination, bullying, and harassment. This should include: – Mandatory training on discrimination, bullying and harassment and how to report them. – Active bystander training that encourages all staff to identify issues and report concerns in a just and learning environment. – Clear policies and processes with a step-by-step approach differentiating between discrimination from colleagues and from patients. See the BMA's guidance on discrimination from patients and their guardians/relatives.
13	Improving reporting processes	Employers should monitor and have independent scrutiny of their referrals to Maintaining High Professional Standards in the NHS (MHPS) and the GMC.
14	Increasing accountability	A just and inclusive learning culture is the foundation on which to build all actions to deliver racial equality and achieve fair referrals. All organisations must publicly acknowledge how they are working towards this aim.
15	Increasing accountability	The journey of a doctor through disciplinary and referral processes should have checks and balances to ensure fairness. All bodies in the healthcare system should have the same methodology for investigating concerns. There are examples of best practice that can be incorporated into all local processes, e.g. the Barts Health NHS Trust pre-disciplinary checklist detailed in the NHS Resolution Being Fair guidance. Centralised statutory guidance is needed that directs organisations to ensure a just and learning culture is the aim of the reporting process.
16	Increasing accountability	Regulators, employers, training providers and government bodies must acknowledge the complexity of structural racial discrimination in medicine and agree joint actions to tackle it, with an oversight group with an independent chair to hold those organisations to account.
17	Increasing accountability	All organisations responsible for the progression of doctors must publish their outcomes by ethnicity (and other intersectional protected characteristics). This should be accompanied with targets and board accountability for lack of progress.
18	Increasing accountability	Prioritise inclusive leadership: – Make inclusivity a core competency for leaders in their recruitment and performance management, something they are expected to demonstrate and be held accountable for. – Leaders' objectives should have clearly defined and measurable targets to reduce racial inequalities.

Number	Theme	Recommendation
19	Increasing accountability	All training pathways should review where discrimination and bias may influence the progression of doctors. The progression pathways should be formalised to include systems for monitoring which person work and projects are allocated to, for equitable distribution of development opportunities. The systems should include checkpoints for second opinions to openly challenge bias (in an open and learning culture).
20	Increasing accountability	All colleges should be accountable and transparent in publishing their annual assessment outcomes by ethnicity (and other protected characteristics).
21	Increasing accountability	All IMGs should be given access to appropriate induction at a local level – and access to ongoing support – to ensure patient safety and that IMG doctors have an equal start to their UK practice. Relevant bodies (GMC, HEE, and NHS Employers and devolved equivalents) must provide a commitment and plan for how they will embed comprehensive induction, mentoring and ongoing support for these healthcare workers.
22	Increasing accountability	Extend the Medical Workforce Race Equality Standard (MWRES): – To be annualised – To include primary care – Include a requirement for all royal colleges to report their data – Development of a similar report for the devolved nations – MWRES ethnicity data to be reported by ethnic or racial groups – Data to be provided and analysed at a trust level
23	Increasing accountability	Employers and regulators should be accountable for understanding the differentials for doctors by ethnicity and take action. All bodies with a public function should publish equality impact assessments of their policies which directly impact education, training, and the working lives of doctors.

Annex 1: Definitions

Note that all the definitions and sources listed here are in constant flux, with critique about their validity from different parties. These definitions and source links should not be read as definitive but as a guide to the types of issues that are being discussed when these terms are referred to.

Structural racism

Structural racism exists in the social, economic, educational, and political systems in society and manifests in the processes that lead to disadvantage in accessing economic, physical, and social resources.

Systemic racism

Systemic racism refers to interconnected organisations, or wider society which exhibit racist or discriminatory processes, policies, attitudes or behaviours.

Institutional racism

Institutional racism refers to the ways in which racism is legitimated by discriminatory policies and norms embedded in large institutions and captures a broad range of practices that perpetuate differential access to services, and opportunities within institutions.

The Macpherson reported defined institutional racism as 'The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people'.[30]

Interpersonal racism

Interpersonal racism refers to discriminatory treatment during personal interactions, such as verbal or physical abuse but also refers to acts of ignoring or avoiding people due their ethnic background.

International Medical Graduates (IMGs)

Being an IMG is not a protected characteristic as defined by the Equality Act 2010, however IMGs are more likely to share the protected characteristic of having a nationality from outside the UK and are more likely to be from ethnic minority (in the UK) population groups – both of which are covered by the protected characteristic of race under the Equality Act 2010. If there are notable disparities for IMGs comparted to UK graduates, this could be noted as potential racial disparity – but the context and data would have to be analysed to conclusively make that link.

Antisemitism[31]

Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities.

Islamophobia[32]

Islamophobia is rooted in racism and is a type of racism that targets expressions of Muslimness or perceived Muslimness.

Intersectionality[33]

The term was conceptualised and coined by Kimberlé Williams Crenshaw in a paper in 1989. It describes the way multiple marginalised identities overlap and interact to compound and amplify experiences of discrimination and oppression.

Legally the Equality Act 2010[b] defines four types of racial discrimination.

1. Being treated worse than another person in a similar situation because of your race (direct discrimination).
2. When an organisation has a particular policy or practice that puts people from a certain racial group at a disadvantage (indirect discrimination).
3. When someone is made to feel humiliated, offended or degraded in relation to their race (harassment).
4. Being treated badly because you have made a complaint of racism (victimisation).

In addition, in criminal law, race hate is a range of criminal behaviour where the perpetrator is motivated by hostility or demonstrates hostility towards a person's race.

b The Equality Act 2010 does not apply in Northern Ireland, but they have very similar equality requirements spread across several pieces of legislation. For example, Section 75 of the Northern Ireland Act 1998 also includes consideration of 'political opinion' as a protected characteristic.

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