Instructions

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General
Medical
Council

Supporting inclusive healthcare environments

The GMC, equality, diversity & inclusion

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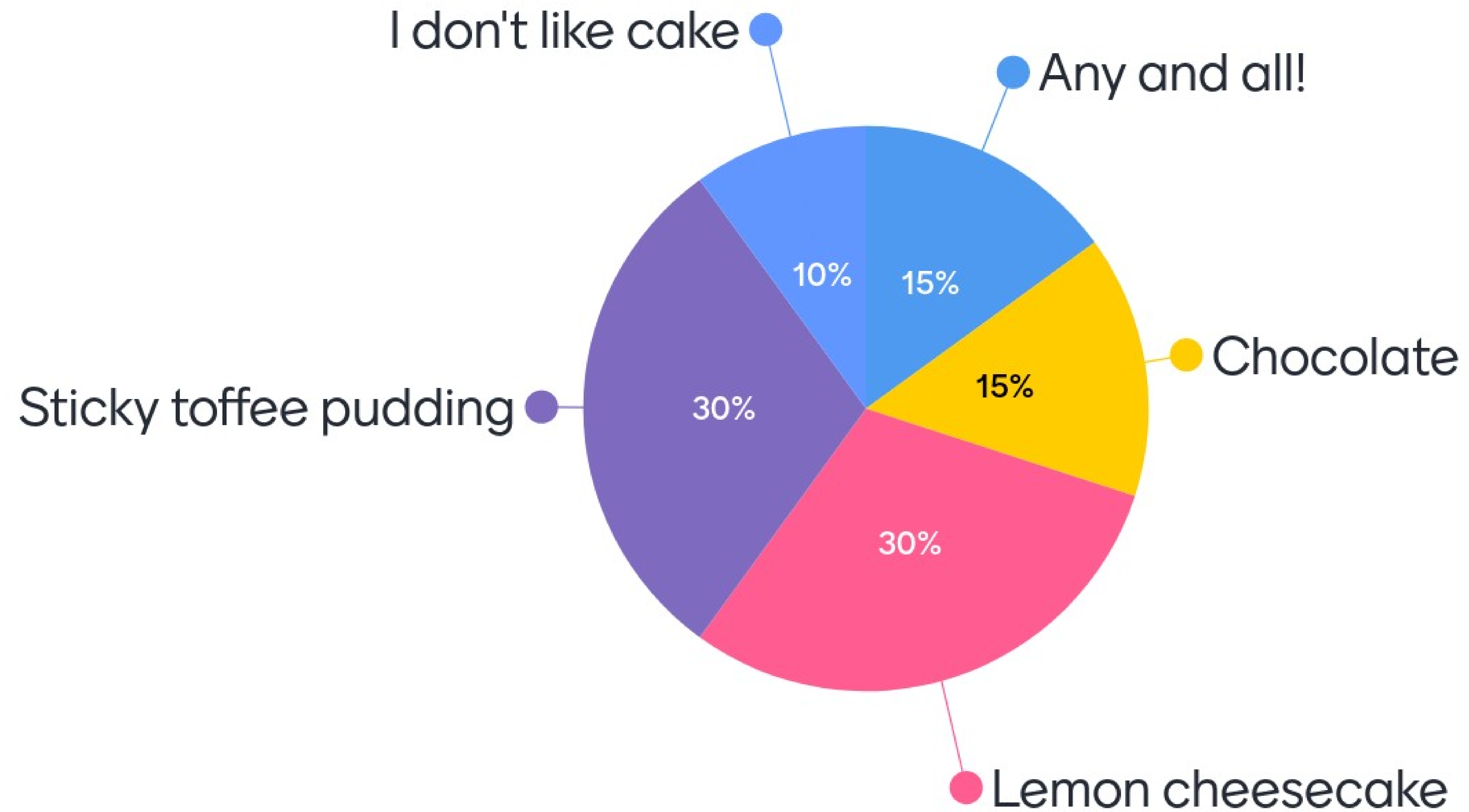
Aims of today's session

- To run a bite-size session on the report Fair to Refer? and our response to it
- To get support from the group in encouraging colleagues to participate in future sessions
- To seek advice from the group in how to take this work forward
- To offer any appropriate support to the group for its own work

What's your favourite kind of cake?



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Our functions

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Demystifying fitness to practise

Referrals by source: 2012 - 2020

30000
25000
20000
15000
10000
5000
0

26767
17391
5627
3749
2827
2529
26
272
3572
1232
251
688
520
8
160

Total
Investigated
Referred
Closed

PUBLIC
EMPLOYERS
DOCTORS
POLICE

Closed Referred Investigated Total

The issue doctors are most commonly erased or suspended for is?...

Allegations leading to suspension or erasure

- Criminality
  - Sexual issues (18%)
  - Fraud (17%)
  - Harassment (14%)
  - Violence (7.1%)

- Dishonesty / Probity (7.9%)
- Professional performance (6.6%)
- Substance misuse (6.6%)*
- Mental health / behavioural issues (5.2%) *
- Teamworking (4.2%)

*Suspension only

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Fair to Refer?

Background, findings and recommendations

FAIR TO REFER?

June 2019

Reducing disproportionality in fitness to practise concerns reported to the GMC

This independent research conducted by Dr. Doyin Atewologun & Roger Kline, with Margaret Ochieng, was commissioned by the General Medical Council to understand why some groups of doctors are referred to the GMC for fitness to practise concerns more, or less, than others by their employers or contractors and what can be done about it.

The protected characteristics

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Context of *Fair to Refer?*

- Disproportionate number of BME and IMGs in disciplinary action and employer referrals to us:
  - BME doctors twice as likely to be referred by employers
  - Doctors qualifying outside of the UK three times more likely to be referred

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Will disproportionate referral of BME and IMG doctors be addressed?

Strongly disagree

I am optimistic that it will be

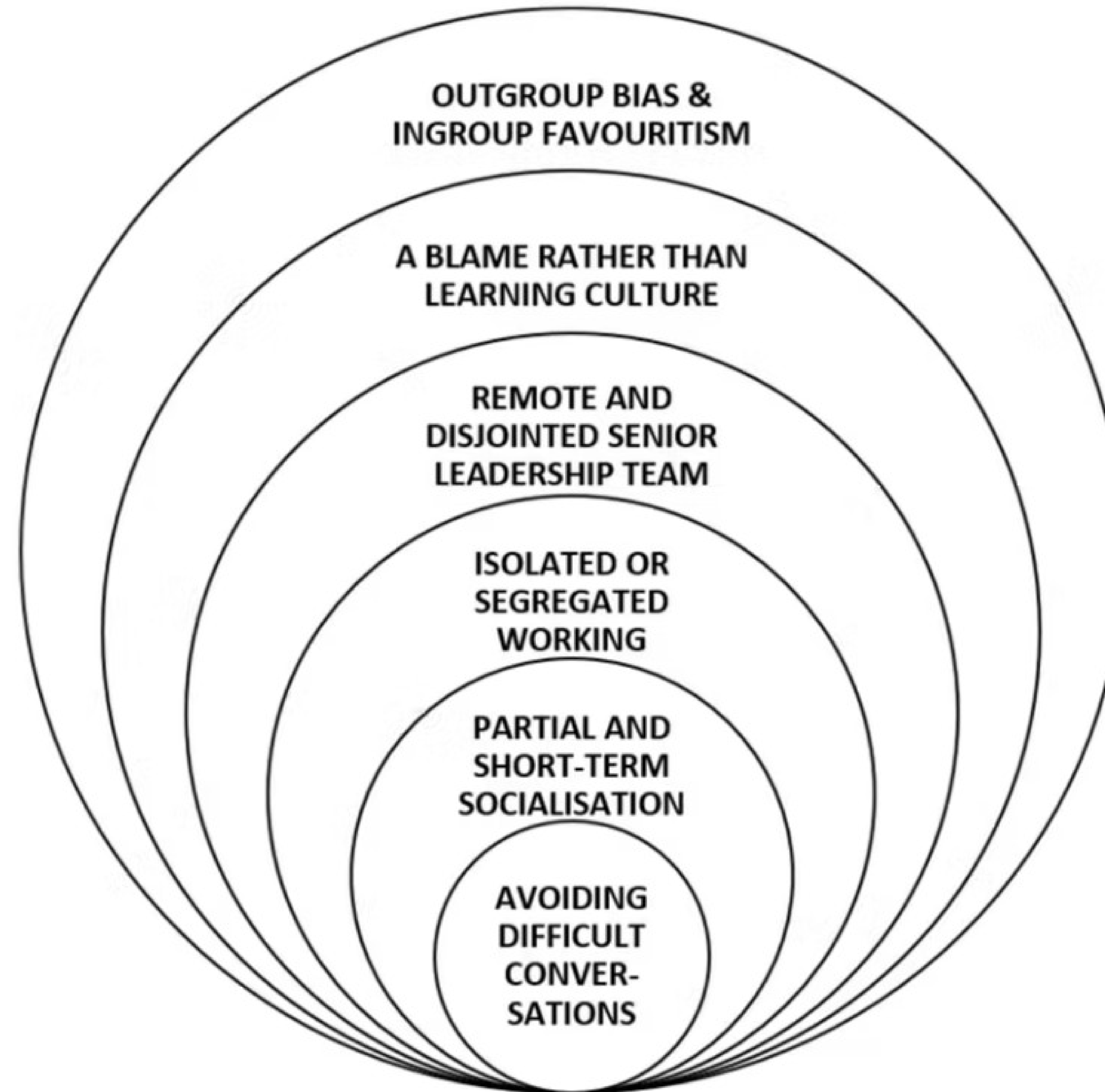
4.6

Strongly agree

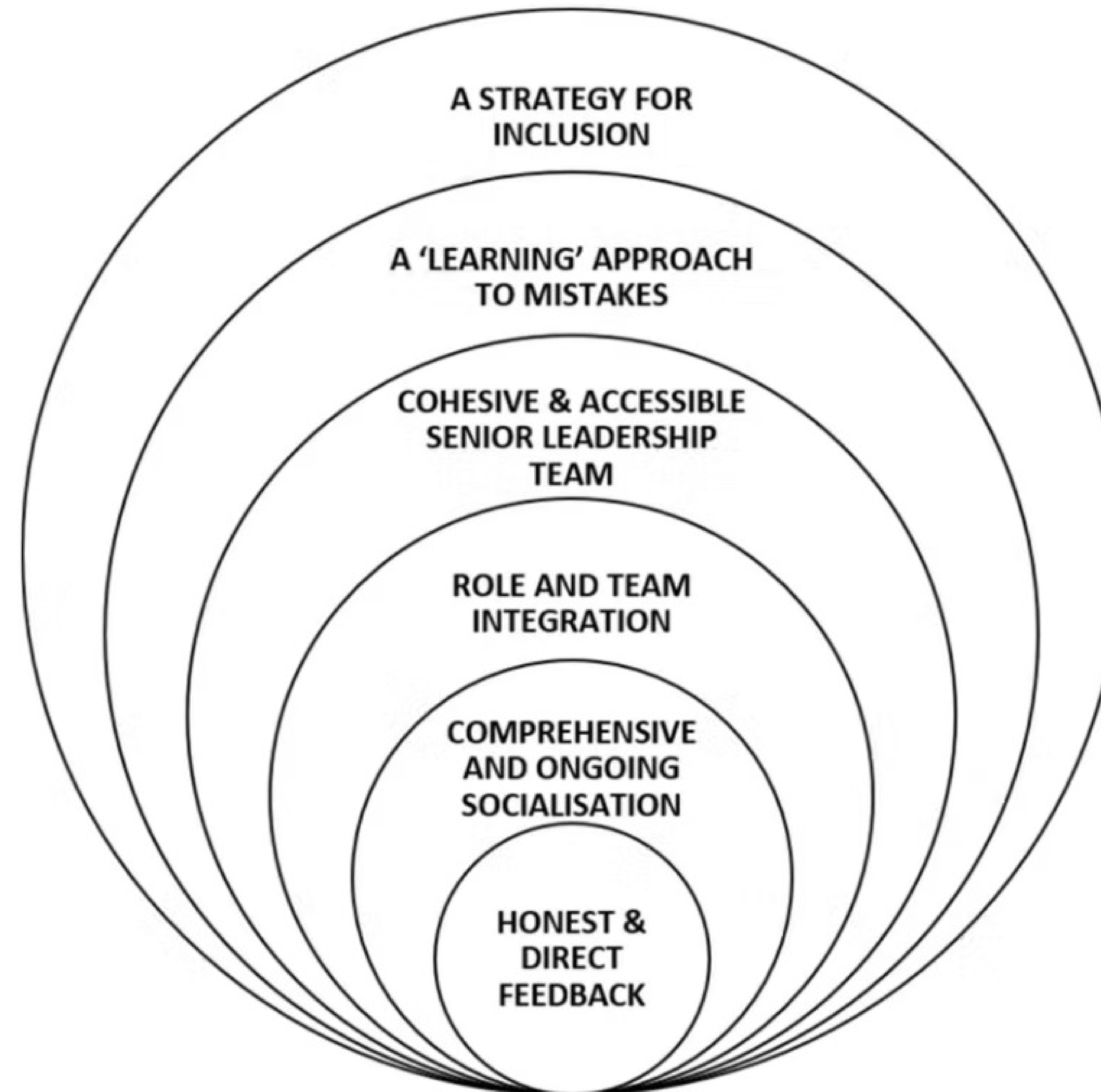
4.6

5

Risk factors leading to disproportionate referral



Protective / neutralising factors



Which of the risk factors have you seen or experienced?

Out-group bias / In-group favouritism	Blame not learning culture	Remote / disjointed senior management team	Isolated / segregated roles	Partial / short–term socialisation (poor induction)	Avoiding difficult conversations
0	0	0	0	0	0

Recommendations of *Fair to Refer?*

1. Effective induction and ongoing support
2. Frequent informal feedback for all doctors
3. Address systemic issues that may affect performance
4. Leaders be inclusive and intervene early
5. Local responses focus on learning and accountability, not blame
6. Introduce local mechanisms to reduce disproportionality
7. Share good practice in reducing disproportionality
8. Local ED&I monitoring (composition of leadership teams, disciplinary action and referrals to the GMC)
9. Delivery and monitoring mechanisms

1. Effective induction and ongoing support

- UK framework for *all* doctors
  - Enhanced induction
  - Evaluation of complaints
  - Contracts with locum agencies
  - FtP processes for locum doctors
  - Special support for SAS doctors
  - Ongoing support for all doctors

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3. Address issues that may affect performance

- Consider context
- Learning not blame
  - Identify negative subcultures
  - Identify and address systemic issues
  - Engage with their workforce
  - Take issues into account

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6. Local mechanisms to reduce disproportionality

- Active inclusion of BME and IMG doctors
  - Maintain a positive and inclusive working environment
  - Ensure diversity of decision makers

The recommendations in Fair to Refer? ...

Strongly disagree

... are the right ones

5.8

Strongly agree

5.8

13

The GMC's response to *Fair to Refer?*

Strategic EDI Forum

- Raising issues and concerns
- Advising on policies and strategies
- Discussing our priorities and progress

Organisations

- Association of Pakistani Physicians of Northern Europe
- Association of Cameroonian Doctors in the UK
- BME Doctors Forum Chair
- BMA SAS Doctors Committee
- Black Medical Society
- British Association of Physicians of Indian Origin
- British International Doctors' Association
- British Medical Association
- Catholic Medical Association
- Christian Medical Fellowship
- Disabled Doctors Network
- Doctors' Support Network
- GLADD (The LGBT Association of Doctors and Dentists)
- Jewish Medical Association
- Medical Association of Nigerians Across Great Britain
- Medical Women's Federation
- Melanin Medics
- Muslim Doctors Association
- UK Sikh Doctors Association
- Women in Surgery

GMC ED&I Strategy - targets

- Eliminate disproportionate complaints from employers about ethnic minority doctors by 2026

- Eradicate disadvantage and discrimination in medical education and training by 2031

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The GMC's targets ...

Strongly disagree

... are the right ones

5.4

Strongly agree

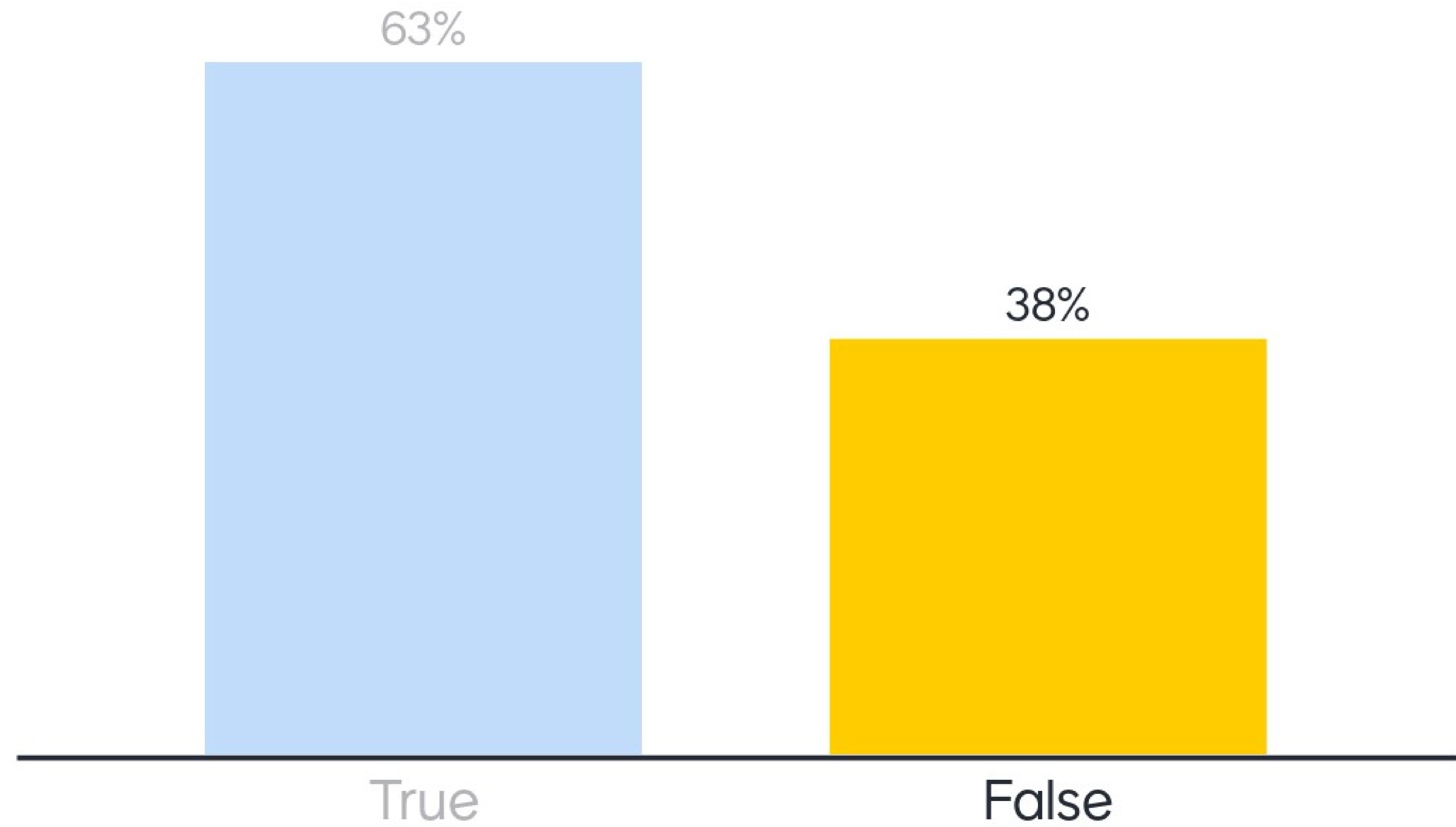
5.4

13

GMC engagement with employers and doctors

- Assessments of environmental / systems issues
- Action taken to improve these
- Checks to ensure referral appropriate
- IMGs trained in reflection?
- local processes take account of cultural nuances
- Sessions on:
  - *Fair to Refer?*
  - *Welcome to UK Practice*
  - Team Based Reflective Practice
  - *Professional Behaviours and Patient Safety*
  - *Raising and acting on concerns*
  - *Good conversations, fairer feedback*

We might ask to see a doctor's reflective practice notes



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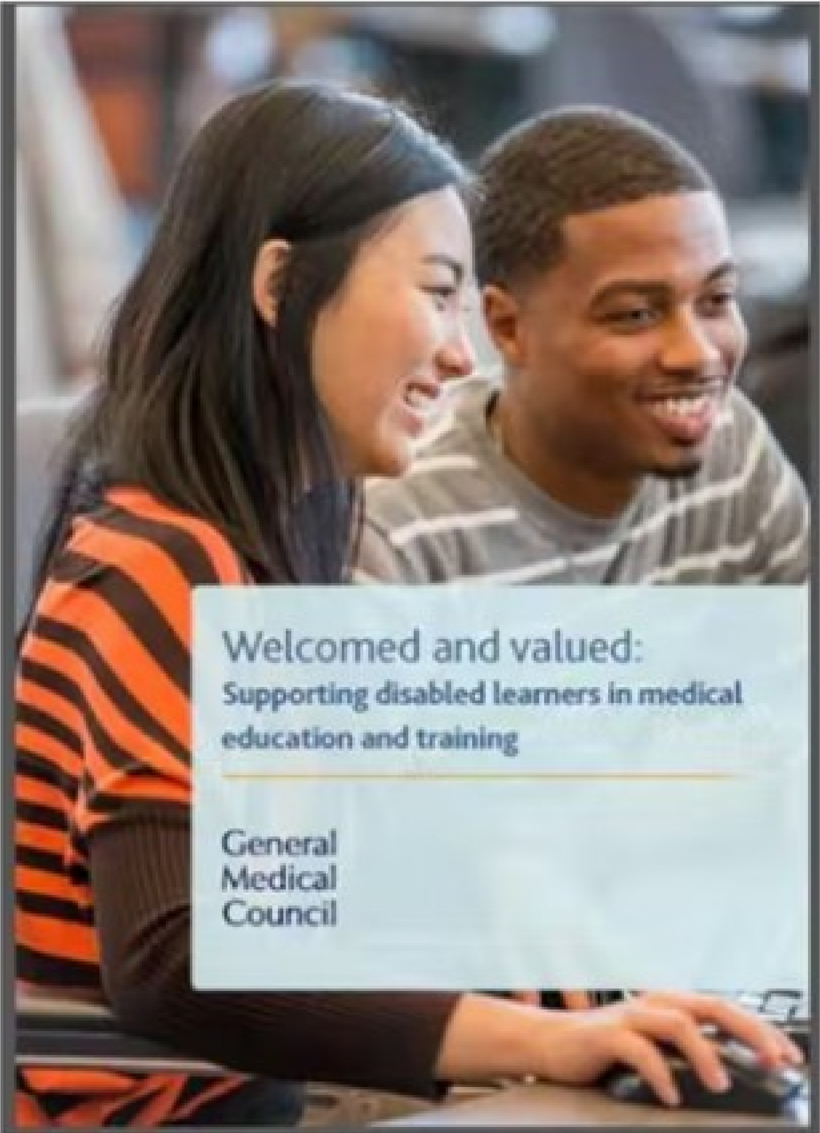
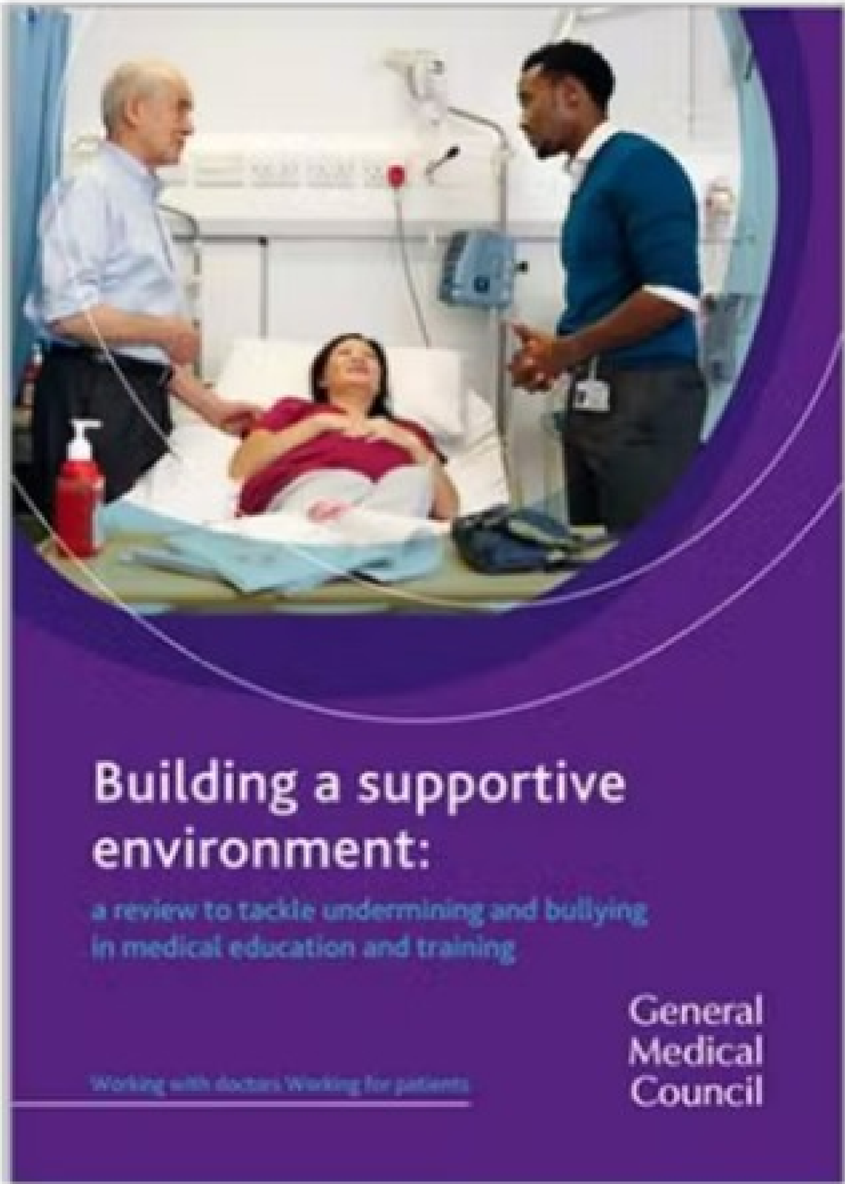
Relevant GMC education standards





Breakout groups

Case discussion & consideration of implementation of *Fair to Refer?*

Suggested questions to facilitate discussion

1. What are the issues highlighted in this case study?
2. What underlying factors led to this situation (including factors identified in Fair to Refer?)?
3. What aspects of local culture might facilitate or mitigate these factors?
4. What actions might address these underlying factors (including recommendations from Fair to Refer?)?
5. Which, if any, of these actions would it be appropriate to implement at your board?
6. What could be done to implement them at the board?

Case study 1: Jagtar

- Jagtar trained overseas. He joined the NHS as a GP 29 years ago.
- He has worked in a two handed inner city practice with a stable patient list but growing workload. Both partners work about 55 hours per week and have struggled to get as much CPD as they would like
- Both partners have had very few complaints over 29 years, and none have escalated to a formal investigation.
- Now two hospital consultants complain that a patient was referred to them later than they should have been.
- The local HSCP decides to formally investigate. This takes several weeks and causes one of the doctors to become depressed and take sick leave. The practice struggles to get cover and both partners feel besieged.
- Before the investigation concludes, both partners decide to retire. The decision to investigate, and the investigation itself, does not seem to acknowledge the challenging environment they practice in.

Case study 2: Juthi

- Juthi joined a team as a locum doctor. The team had well established permanent staff who had been good friends for the past 6 years.
- Juthi's shift pattern means her schedule did not overlap with the rest of the team. She notices she is often excluded from small, informal gestures like making tea or going for lunch.
- One day, she overhears her colleagues talking about her qualifications, questioning whether her non-UK training was at the same standard as theirs.
- In her third week a patient in her care is administered significantly wrong treatment at a very busy time. Juthi finds herself under investigation.
- As a result of the investigation, the Medical Director and RO decide that if she had been an employee they would have prioritised supervised training but they are unwilling to expend substantial resources on a disciplinary case for a short term locum and have no confidence that the locum agency would tackle what they feel is poor practice. They refer Juthi to the GMC.

Case study 3: Kebe

- Frequently treated as a second class citizen and 'non-doctor'
- Ignored on ward rounds
- Often witnesses BME and IMG colleagues, and those without a local accent receiving 'less than helpful' induction and being left alone to figure out new situations while local students and graduates are given a warm welcome with 'smooth induction' and 'hand-holding'
- No opportunity for assessments
- Assumption that non-UK qualifications less valid
- No action taken by senior colleagues to address issues
- BME and IMG doctors who are struggling, bullied or who raise concerns are assumed to deserve it and are swiftly punished, often resulting in job loss
- This culture, which includes casual racism, is set by managers
- Double-standards are common
- Leads to low self-esteem and confidence

Discussion

Will disproportionate referral of BME and IMG doctors be addressed?

Strongly disagree

I am optimistic that it will be

5.5

Strongly agree

5.5

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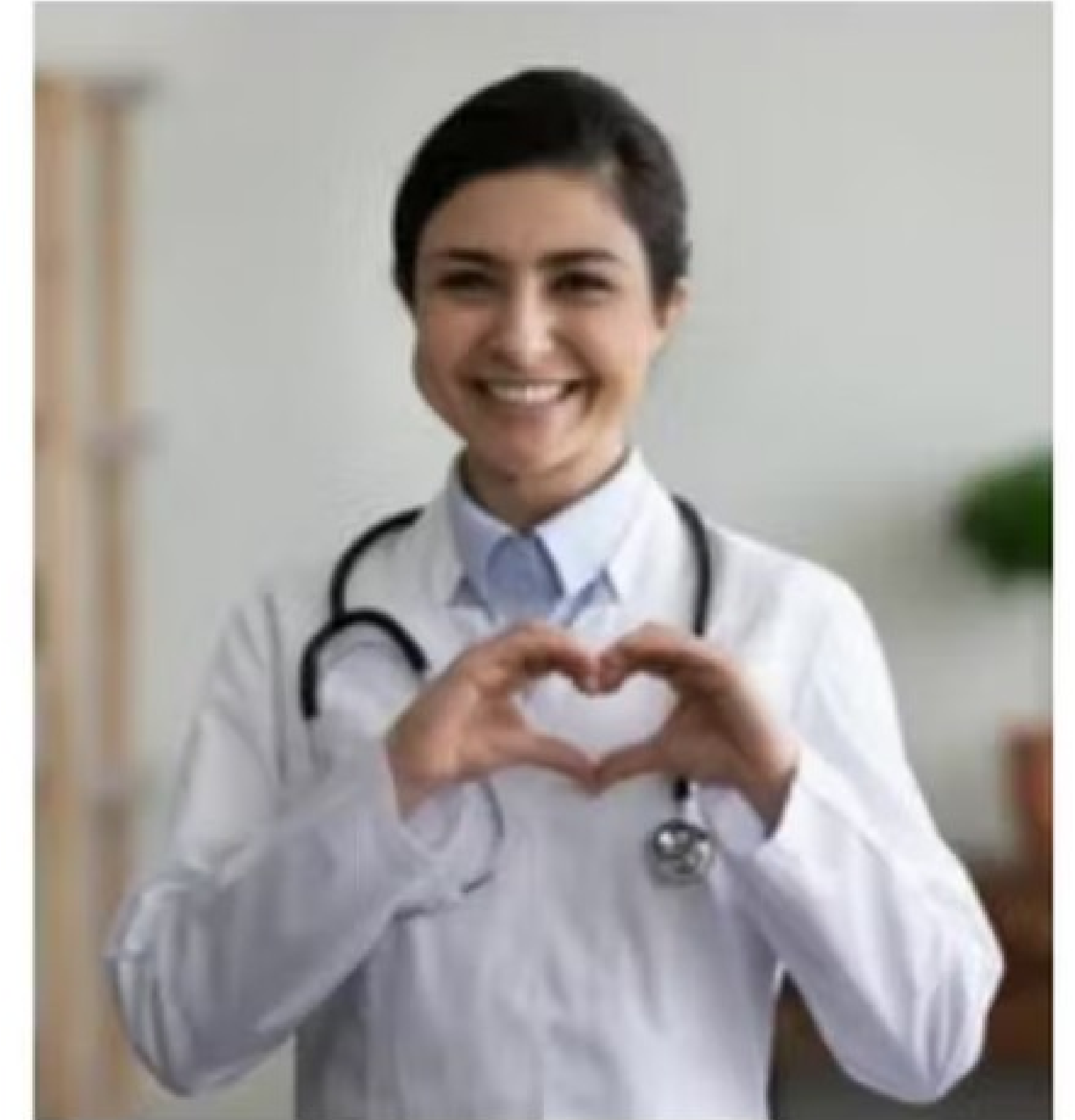
Be kind to your patients

Be kind to your colleagues

Be kind to yourself



Please give us your feedback

https://www.smartsurvey.co.uk/s/doctors/

Thank you

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