General Medical Council

GMC submission to RCS England's independent panel into diversity of professional leadership

Our role

The GMC's role is to protect patients and improve medical education and practice across the UK. As part of this, we decide which doctors are qualified to work in the UK, we oversee UK medical education and training, and we set the standards that doctors need to follow throughout their careers. We also take action where necessary to prevent a doctor from putting the safety of patients – or the public's confidence in the profession – at risk.

Importance of diverse professional leadership

The evidence is clear – doctors are better supported and patients are safer when there is inclusive, compassionate leadership creating positive cultures. This was made clear in independent research we published in 2019:

- *Caring for doctors, caring for patients: How to transform UK healthcare environments to support doctors and medical students to care for patients*, by Dame Denise Coia and Professor Michael West[*]. This identifies the need for autonomy, belonging and control for doctors in their workplaces.

- *Fair to refer?*[†] *Reducing disproportionality in fitness to practise concerns reported to the GMC*, Dr Doyin Atewologun and Roger Kline. This identifies factors leading to disproportionate referrals for certain groups and provides recommendations to address them.

- *How doctors in senior leadership roles establish and maintain a positive patient-centred culture,* by Dr Suzanne Shale[‡]. This identifies doctors' pathways into leadership, and the type of support and training needed at crucial points.

[*] https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf
[†] https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf
[‡] https://www.gmc-uk.org/-/media/documents/how-doctors-in-senior-leadership-roles-establish-and-maintain-a-positive-patient-centred-cu-79633866.pdf

Supporting more inclusive and diverse leadership is a priority for the GMC and we look forward to working with RCS England and others to achieve this.

Data on diversity in surgery

In response to your question around hurdles that may influence career choices into and out of surgery, some of the GMC data around the surgical specialty may give some insight. For more detail, we have published the results of our annual *National training surveys*[*] recently which give detail of trainee experiences during the pandemic, and our annual *State of medical education and practice* report will be published towards the end of this month.

The data is not complete, and we are not the only organisation to hold it. Therefore, it's critical that the system works together to have a complete picture of relevant data, such as demographic data or information on pay gaps. Existing initiatives, such as NHS England's workforce race equality dataset can help here, and we are providing GMC data to support this.

Demographic data

- The surgery specialty has a slightly lower proportion of international medical graduates (IMGs), than the average (21.3% compared to 27.5% of all licensed doctors)

- In surgery, over a third of all trainees are female (34.8%) and the proportion of consultants who are female increased from 9% in 2012 to 14% in 2020. This compares against the broader population of trainees where just over half are female (56.6%) and the proportion of consultants who are female increased from 31% in 2013 to 37% in 2020. The programmes in 2020 with the highest proportion of female doctors in training are paediatric (53.0%) and plastic surgery (39.1%). The lowest proportions are seen in oral and maxilla-facial surgery (20.0%) and trauma and orthopaedic surgery (18.2%)

GMC referrals for surgery

- The data highlights that black and minority ethnic (BME) surgeons appear to be referred to the GMC more frequently than their white colleagues (from 2012-2018 21.8% of BME surgeons were referred to the GMC, compared to 17.1% of white surgeons). This is a worse ratio than for overall doctors (11.8% of BME doctors, 10.7% of white doctors referred). However, this is a complex picture and other demographic variables also need to be considered. For example, male surgeons are more complained about than female surgeons (over the same date range, 19% of males and 9% of females were referred), and a higher proportion of white

[*] https://www.gmc-uk.org/education/how-we-quality-assure/national-training-surveys

surgeons are female than BME surgeons (7% of BME surgeons are female, and 15% of white surgeons are). Similar interlinked relationships exist between age and place of qualification so it is problematic to assume the entire difference in these rates of being referred to the GMC is due to ethnicity alone, and further work is required to understand the scale of disparity.

SAS & LE Survey

- The GMC's 2019 survey of SAS and locally employed doctors showed a higher proportion of doctors in surgical specialties reported bullying, undermining and harassment (32.0%) than the average across all specialties (26.7%). Of those who reported bullying, two-thirds (65.8%) reported the behaviour coming from a consultant – and the most common behaviours described were 'Belittling and humiliation' (59.1%), 'Rudeness and incivility' (59.1%) and 'Threatening or insulting comments or behaviour' (38.6%)

Trainee data

- 2019 national training survey results suggest that trainees in surgery have higher than average risk of burnout (with 52% being in the high or moderate risk categories), and that BME doctors in surgical training experienced a higher rate of bullying than white trainees (10.2% vs 6.0%).

- White UK F2 applicants are more likely to be deemed appointable to core surgical training than BME applicants (80.4% of white UK graduates were appointable between 2012 and 2019, compared to 70.5% of UK BME graduates, and IMG BME doctors were the least likely with 40.6% deemed appointable).

Role for RCS England

In response to your question on what the College could do to better to support those who face discrimination, prejudice or bias, we have included some suggestions below based on our research and ongoing work. In addition, there are lots of initiatives being taken forward on this agenda, for example the NHS People Plan in England, and we would encourage various stakeholders to work together on these to add value jointly rather than duplicate efforts.

While the pandemic has highlighted inequalities, it has also led to positive changes in compassionate leadership and positive environments. We need to retain this good practice and continue the momentum for this positive change.

What the GMC is doing

- The GMC has existing guidance that can support the College and others in this. For example, *Equality and diversity guidance for curricula and assessment*

systems[*] or *Leadership and management* guidance[†]. We also considered how to tackle undermining and bullying in our review *Building a supportive environment*[‡]. This was based on an exploration of surgery and obstetrics and gynaecology and identified factors contributing to positive workplace behaviours and a supportive learning environment

- Our priority areas for work to improve inclusion for doctors include:
  - Improving doctors' access to fair and timely feedback. Feedback was highlighted as a key issue in the Fair to Refer report.
  - Making training pathways fairer through our work on differential attainment.
  - Improving the fairness of employer fitness to practise referrals to the GMC.
  - Improving compassion and inclusivity within healthcare leadership.
- We are ensuring we model fair employment behaviours by: publishing targets and measures, modelling inclusive leadership and focusing on recruitment, retention and progression of BME staff.
- We have taken steps to increase the diversity of our Council. When recruiting for new members this year, we used an Executive Search agency to support our process and at the tender stage, a significant element of the scoring criteria was based on the agency's commitment to ensuring a diverse shortlist. We received nearly 600 applications with a broad representation across all protected characteristics.

The role of medical royal colleges

Based on our research reports and other work we've been involved with, we believe the RCS England could support in the following areas. We're keen to work together to address these:

1 Making training pathways fairer

Royal colleges can work with postgraduate training organisations and the GMC to use the data and information they possess to inform changes to make their education and training processes fairer and reduce differential attainment. The GMC is collaborating with the

[*] https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/equality-and-diversity-guidance-for-curricula-and-assessment-systems

[†] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/leadership-and-management-for-all-doctors

[‡] https://www.gmc-uk.org/-/media/documents/under-embargo-05-03-15-building-a-supportive-environment_pdf-59988406.pdf

Academy of Medical Royal Colleges to share practical methods that medical royal colleges can use to address differential attainment, including best practice examples – this will be published and shared with all colleges later this month.

This report draws together insights from BME trainees (including doctors training in Core Surgery and Urology) interviewed in our 2019 study 'What supported your success in training' and case studies from Medical Royal Colleges and Faculties. Over the next twelve months we will request information from colleges about the actions they are taking to tackle the ethnic attainment gap in their specialties, and to building the evidence about the effectiveness of interventions. Actions which colleges can take include:

- Being an inclusive workplace which values and actively seeks diversity within curricula development teams and college examiners.
- Raising awareness of the environmental and social factors which place additional burdens on BME doctors and contribute to the ethnic attainment gap, and role Educational Supervisors can play in building open and trusting relationships with trainees to help them deal with these challenges and access the right support.
- Ensuring good quality and targeted formative feedback throughout training which helps candidates and their trainers prepare for high stakes assessments and to develop targeted learning plans in the event of a failed exam attempt.
- Providing opportunities for formal and informal mentoring and coaching with senior colleagues and peers.

2 Providing doctors with the support and information they need, when they need it.

This is particularly important for doctors at transition points in their careers and for those new to UK practice. Our research suggests quality inductions are particularly helpful, so RCS England could consider its role in providing information here. The GMC offers *Welcome to UK Practice* courses for those new to UK practice which we have started delivering online, which may support this.

Specialty-specific support could also be helpful to address specific challenges members may face at certain points (such as RCGP's First Five programme which supports newly qualified GPs). This could include mentoring and coaching opportunities coordinated by specialty which provide members with ongoing support and advice.

3 Providing ongoing development opportunities for those in non-training roles.

Our research has highlighted the specific pressures faced by locum and SAS grade doctors, who are more likely to be international medical graduates and from a BME background. These pressures include a lack of development and training opportunities,

meaning they may struggle to develop their skillset. Opportunities supported by medical royal colleges could include development of leadership and supervision skills, even for individuals who are not members but are seeking to develop.

4 Delivering leadership standards to encourage speciality-wide compassionate and inclusive leadership, including through the use of fair and timely feedback

GMC leadership and management guidance* applies to all doctors, not just those in formal leadership roles. Medical royal colleges can play a crucial role in ensuring its members act compassionately and inclusively and in accordance with the guidance.

The independent research we commissioned (*Fair to Refer?*) highlighted the impact of feedback and evidenced how some leaders may be reluctant to provide this to colleagues of a different ethnic background to them. We will be publishing further research on this topic and will share this to inform any part that the medical royal colleges may play.

5 Encouraging members to work in supportive teams that foster a sense of belonging.

Our research has also evidenced the importance of a sense of belonging at work (See *Caring for doctors, caring for patients*). Functioning, supportive teams are essential to this, and those in locum, SAS and training roles may feel they are not a member of a team. Medical royal colleges can play a role to ensure their members (particularly those in leadership roles) are acting in an inclusive and supportive way.

6 Encouraging and supporting members to 'speak up' to raise concerns

Both *Fair to Refer?* and *Caring for doctors, caring for patients* emphasised the need for organisations to ensure that there are effective mechanisms in place for doctors to speak up about concerns such as bullying and undermining. One way that medical royal colleges could support this is by promoting the role of the Freedom to Speak up Guardian.

* https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/leadership-and-management-for-all-doctors