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.

Fair to refer?

REDUCING DISPROPORTIONALITY IN FITNESS TO PRACTISE CONCERNS REPORTED TO THE GMC

ACKNOWLEDGMENTS

We gratefully acknowledge the dedicated NHS professionals who told their stories and gave time and energy in other ways to support this work. We also thank Ghiyas Somra and Fatima Tresh for their support in conducting this research.

EXECUTIVE SUMMARY & RECOMMENDATIONS

Summary Background, Aims & Objectives

This research was commissioned to understand why some groups of doctors are referred to the General Medical Council (GMC) for fitness to practise concerns more, or less, than others by their employers or contractors and what can be done about it.

In the UK, certain groups of doctors are more likely to be subjected by employers and healthcare providers to formal local disciplinary process. These groups of doctors are also more likely to be referred to the UK regulator, the GMC by their employers or healthcare providers. In particular, Black, Asian and Minority Ethnic (BAME) doctors, overseas graduates, older male doctors and some non-specialist doctors are more likely than their counterparts to be referred to the GMC by employers or healthcare providers. BAME doctors have more than double the rate of being referred by an employer compared to white doctors.[1] Non-UK doctors have 2.5 times higher rate of being referred by an employer compared to UK graduate doctors.[2] Previous research and analyses have not identified substantive evidence of bias in decision-making by the GMC, yet concerns remain regarding the considerable differences in the patterns of complaints about different groups of doctors received by the regulator.

This independent research aims to identify the factors that lead to, and consequential processes adopted prior to, employers making a decision to refer a doctor to the GMC for fitness to practise (FtP) concerns. Further, this study seeks to understand how these factors may contribute to patterns of disproportionality (that is, the over and under representation of certain types of doctors) in referrals from employers, and makes recommendations for change with a view to reducing these patterns of disproportionality.

Although the NHS is a national service, each nation has services structured and governed in slightly different ways and there is wide variation in their culture and approach. Our recommendations seek to address factors we have identified as common, but we are conscious that some Trusts will have strong, positive leadership and an inclusive culture and may have already addressed some or all of the recommendations while others will not have addressed any. Similarly, more or less progress will have been made across the four nations of the UK. Our intent is to improve consistency across all NHS Trusts, Boards and Health Boards in relation to the issues raised in this review by ensuring all NHS Trusts, Boards and Health Boards model the approach of those doing good work in this area, and, that there is similar impact across the UK.

[1] 1.1% of BAME doctors were referred to the GMC by employers 2012–17 compared to 0.5% of white doctors.
[2] 1.2% of non-UK graduate doctors were referred to the GMC by employers 2012–17 compared to 0.5% of UK graduate doctors.

Brief Methodology

First, we conducted a rapid literature review to inform our approach to the primary stages of our research, examining the small body of relevant published evidence available in grey and academic peer reviewed literature.

Then, we conducted interviews and focus groups with primary care samples, and adopted a case study approach at an organisational level for secondary care. The relatively small absolute number of doctors referred by any individual employer to the GMC favoured a qualitative approach. A qualitative and case study methodology allowed us to gather rich insights into lived experiences and explore organisational processes within their context to help explain how underlying mechanisms may accumulate or interact to drive differential referral rates for certain groups of doctors.

A total of 262 individuals participated in the study, comprising 221 from secondary care and 41 participants from primary care in all four nations. Our sample included Specialty and Associate Specialist (SAS) and locum doctors and General Practitioners (GPs) across Black, Asian, Minority Ethnic and White ethnicities, who were overseas and UK graduates, as well as Consultants, Responsible Officers (ROs), Medical Directors (MDs), Human Resources Directors (HRDs) and Clinical Directors.

Key Findings & Recommendations

The literature review indicated that possible explanations of disproportionality in referrals into the GMC's FtP process include a combination of individual (or micro) factors that are specific to the doctor and factors that relate to a doctor's working environment (meso, or institutional factors). The literature review steered us towards a number of factors for the primary research, including differences in the workplace in perceptions and treatment of groups of doctors based on their place of primary qualification training, race/ethnicity, age; perceptions of 'fit' to their working environment depending on organisational cultures; nature of leadership and the role of HR, and the impact of local decision-making frameworks and processes.

Why are referrals from employers and healthcare providers to the GMC likely to affect certain groups of doctors disproportionately?

Our research found that the factors likely to account for disproportionate representation of certain groups of doctors in GMC FtP referrals are multiple and intricately linked. The findings suggest that it is combinations of these multiple factors that lead to observed differential referral rates, that is, the under-representation and over-representation of some types of doctors in referrals by employers or healthcare providers into the GMC FtP process. These factors are outlined in the summary on the following page (see also Figures 1 and 2 on page 35):

We make four recommendations for addressing these issues:

1. Providing comprehensive support for doctors new to the UK or the NHS or whose role is likely to isolate them (including SAS doctors and locums)
2. Ensuring engaged and positive leadership more consistently across the NHS

3. Creating working environments that focus on learning and accountability rather than blame
4. Developing a programme of work to deliver, measure and evaluate the delivery of these recommendations.

These are set out on page 6 with some anonymised “vignettes” of our interviewees’ experiences. Many of the recommendations build on examples of good practice we encountered during our fieldwork; this gives us confidence that, if implemented appropriately, these recommendations can have a wider positive impact across the NHS.

IS IT FAIR TO REFER?

We found that the factors likely to account for disproportionate representation of certain groups of doctors in FtP referrals are multiple and intricately linked. These factors are evident on the one hand as 'risk factors' for certain groups of doctors and on the other hand as 'protective factors' for others. These factors layer upon each other to create a cumulative positive impact for some doctors, and a cumulative negative impact for others. The likelihood of experiencing risk factors is associated with, and underpinned by, a pervasive theme we observed relating to insider/outsider dynamics. If protective factors are present for everyone (i.e. not just accessible to those doctors who happen to be insiders), then these protective factors neutralise the likelihood of experiencing risk factors facing some doctors (see page 35).

Your pathway into UK medical practice may pre-determine your outsider status and the level of support you receive from the outset, starting with induction. A doctor who fails to have a supportive start to UK medical practice, can then continue to experience further disadvantage as an outsider. We found that evading conversations regarding concerns relating to a doctor's practice (in particular regarding conduct) was a primary factor. The lack of timely, direct and honest feedback, that is sensitive to difference, can have a huge impact on a doctor's opportunity to demonstrate learning from mistakes and improvements to their practice. Further exclusion from ongoing socialisation support, often referred to as learning the informal rules of the NHS, is an additional factor.

We also found that working patterns and contractual arrangements in the medical profession are an additional contributory factor because BAME doctors can often experience isolated or segregated working in certain roles or locations. The prevailing organisational culture also plays a part in explaining disproportionate FtP referrals, with certain cultures looking to find an individual to blame when something goes wrong, rather than trying to learn from the mistake so it doesn't happen again whilst appropriately considering accountability.

What is clear is that significant opportunity for addressing the risk of bias in the referral process is beyond the scope of doctors from the over-represented group, and rather lies with the leadership within each organisation to provide frequent, direct and honest feedback across difference, design ongoing socialisation support, integrate certain roles and teams, role model senior leadership cohesion, adopt a learning focused culture in response to mistakes and implement strategies for inclusion that counter insider/outsider groupings and hierarchies.

Recommendations[3]

Recommendation 1: Support for Doctors

Introduce a UK wide framework and standards for the provision of feedback to, the effective induction of, and the ongoing support of, all doctors

Employers

Employers should train staff who lead, manage, supervise or educate doctors to give and receive feedback across difference ensuring they are equipped to have difficult conversations, use technology appropriately (e.g. Datix) and understand how bias influences giving and receiving feedback.

Employers should provide every doctor with effective induction and ongoing support that reflects national standards with enhanced induction for doctors who are new to the UK, new to the NHS or at risk of isolation in their roles (including overseas qualified doctors, locums and SAS doctors). Enhanced induction should include allocating a mentor (who will also sign off their induction).

Employers should introduce a mechanism whereby, before a formal complaint process is initiated, someone who is impartial to the issues involved and understands diversity, evaluates whether a formal response is necessary.

Employers should introduce a process to ensure that any new arrangements to contract with locum agencies requires agencies to follow good practice in supporting locums (e.g. the guidance in England "Supporting locums and doctors in short term placements" or equivalent in the other nations). Employers should review all existing contracts to ensure compliance.

Employers should establish a protocol to ensure that early termination of locum contracts by healthcare providers is recorded and concerns investigated with the outcome communicated to the doctor's locum agency and Responsible Officer and discussed with the GMC's Employer Liaison Adviser (ELA).

Employers should ensure effective arrangements for SAS doctors by:

- Promoting, monitoring and publishing their implementation of the 4 national SAS charters
- Giving SAS doctors equivalent opportunities to access the learning and development that is provided to other doctors
- Publishing and monitoring the proportion of SAS doctors involved in disciplinary procedures and GMC referrals

[3] The word 'should' throughout these recommendations is used to describe how the relevant organisation(s) will implement the recommendation referred to.

General Medical Council

The GMC should work with other relevant bodies to facilitate the joint development of frameworks and standards that will apply across the UK for the provision of feedback to, the effective induction of, and the ongoing support of, all doctors to (a) include minimum standards for all doctors with an enhanced induction for doctors who are new to the UK, new to the NHS or at risk of isolation in their roles (including overseas qualified doctors, locums and SAS doctors) and (b) to identify how those minimum standards can be measured and enforced. This should include continuing to progress plans to extend the GMC's Welcome to UK Practice Programme.

National organisations across the UK

NHS England, NHS Wales, NHS Boards (Scotland), and the Health and Social Care Board (Northern Ireland) should work with the GMC to develop a framework and standards for the provision of feedback to, the effective induction of, and the ongoing support of, all doctors with an enhanced induction for doctors who are new to the UK, new to the NHS or at risk of isolation in their roles (including overseas qualified doctors, locums and SAS doctors), with measurable requirements.

System regulators, improvement bodies and system partners should work with GMC to determine methods of measurement and enforcement of the requirements for feedback, induction and support defined within the national frameworks.

System regulators, improvement bodies and system partners should as soon as practically possible ensure that a random representative and inclusive sample of doctors at risk of being isolated in their roles (e.g. non-UK graduates, locums and SAS doctors) are confidentially consulted during inspections.

System regulators, improvement bodies and system partners should check that employers have in place and are using an impartial check before a formal complaint process is initiated. They should also ensure that employers establish a protocol to record early termination of locum contracts by healthcare providers. Details of any concerns investigated and the outcome of investigations should be communicated to the doctor's locum agency and the RO and discussed with the GMC's Employer Liaison Adviser.

Health administrations across the UK should work with membership bodies who support NHS employers to develop a short pro-forma exit report for commenting on positive or negative aspects of a locum's performance. This should be encouraged for use with all locums and required for all contracts longer than one week and/or where specific concerns have been identified. The form should be shared with the locum agency, the doctor's RO and the locum's next employer.

Health administrations across the UK should work with the GMC to review and update the Responsible Officer Regulations that exist across the UK to ensure that there is improved support for locums, information sharing between ROs and expanded clinical governance responsibilities for ROs.

Vignette

Social 'induction' and support

Organisation A recognised that though they were reliant on overseas trained doctors, the social and personal support they provided to such doctors was patchy.

They appointed a part-time member of staff whose sole role is to ensure that every doctor who joins the trust from overseas is met personally when they arrive in the city. This dedicated member of staff takes responsibility for ensuring, when met, that the new doctor's immediate accommodation needs are sorted.

Over the next few days the staff member ensures every new overseas trained doctor:

- Has support if needed to open a bank account
- Gets advice on where to live longer term
- Is given support on everyday matters such staff typically worry about – such as locating a GP, nursery or school, and support if the doctor's partner was looking for work
- Is connected with a local community group from their country of origin and/or doctors from their country of origin, to assist with acclimatisation

This role was alongside other organisational initiatives to ensure new overseas trained doctors were supported and integrated into the workforce

The Responsible Officer said "We realised that doctors were bringing to work a whole range of worries which could distract them from a focus on induction and their new job, which was sometimes very stressful. It also helped to prevent any isolation or loneliness in early days. We found it really helped with the steep social and language learning curve that entirely competent doctors might otherwise face and greatly assisted with the parallel professional induction we put in place".

Vignette

Implementing the SAS Charter

Organisation B recognised its secondary care services were dependent on SAS doctors but, despite this, SAS doctors were not provided with appropriate support and opportunities.

The Medical Director engaged with SAS doctors to discuss how they could adopt the principles of the SAS Charter, trying to ensure that training opportunities for SAS doctors were increased and Continuous Professional Development built into job plans. A former SAS, now Clinical Director who was overseas trained, took responsibility for leading this.

The organisation's Medical Director took the significant and symbolic step of having their appraisal undertaken by an SAS doctor. SAS staff in this organisation were significantly more "upbeat" compared to other organisations.

Recommendation 2: Assessing doctors' performance and responding to concerns

Identify and address systemic issues that may affect doctors' professional performance. When undertaking an assessment of a doctor's performance or responding to a concern, take into account the context in which they work with a focus on learning not blame.

Employers

The leadership within health systems, organisations and the boards of every organisation that employs doctors should review and identify negative subcultures that occur between different demographically diverse groups, engage with these groups and take constructive steps address any issues.

Employers and healthcare providers should identify systemic issues, address them and take them into account when assessing performance, and ensure these assessments are conducted within the principles of a 'Just Culture' approach, including (a) ensuring that a review is carried out of any systemic issues following a patient safety incident; and (b) steps are taken to prevent recurrence.

General Medical Council

The GMC should ensure that the process for referrals to the GMC from employers requires ROs to confirm:

- Action taken to assess any environmental pressures and systems issues, and action taken to improve them
- Checks carried out to ensure a GMC referral are appropriate
- For non-UK qualified doctors, what training has been provided to the doctor in relation to expectations relating to demonstrating insight when something goes wrong.

ROs should ensure local processes take account of cultural nuances when assessing insight and remediation.

National organisations across the UK

Health administrations across the UK should review and report on the process for responding to concerns about doctors (for example the PAG process in England) to ensure that the focus is on learning and accountability not blame, and complies with the GMC's 'Principles of a good investigation'.

Health administrations across the UK should work with the GMC and service regulators, improvement bodies and system partners to undertake a rapid review of the overlap between investigations conducted by different agencies concerned with Fitness to Practise, safety and performance to minimise duplication.

Health administrations across the UK should ensure that NHS organisations identify systemic issues, address them and take them into account when assessing performance.

In primary care this will include:

- Introducing a process to systematically identify all practices likely to be experiencing above average pressures (e.g. via data regarding above average sized patient lists; demographic characteristics of patient lists associated with increased demand). This information should be shared with the GMC, system regulators, improvement bodies and other system partners
- Undertaking interventions to provide additional support to, and new ways of working for, practices experiencing above average pressures (e.g. considering evidence of good practice from current schemes)
- Taking information regarding such pressures into account when undertaking any process involving assessment of an individual doctor's practice or of the practice more generally

Vignette

Proactive intervention with struggling GP practices

One Clinical Commissioning Group developed a dashboard that enabled them to systematically identify GP practices likely to be experiencing above average pressures. This seemed to be a formal way of collating the informal intelligence that Responsible Officers covering primary care will have acquired to a greater or lesser degree.

Using a range of data such as average sized patient lists, clinical quality data, and demographic characteristics of patient lists associated with increased demand, monitored regularly almost in real time, this enabled the CCG to undertake interventions to provide additional support to practices experiencing above average pressures. Using the analogy that "it is better to fix the car when the brakes need checking not after it's crashed" this enabled specific support (for example limited funding and direct supportive discussions with GP practices) when staff sickness or turnover might easily have turned a problem into a crisis.

In another part of the UK, there was an active policy of pairing nearby smaller practices so that they might introduce a division of labour with each practice specialising in certain interventions rather than, as previously, both doing the same intervention less well individually.

Recommendation 3: Leadership

Senior leaders to engage regularly with all staff, listening to and taking action in response to concerns regarding fairness. Implement a strategy of active inclusion and mechanisms to mitigate the risk of disproportionality in discipline and referral processes

Employers

The leadership within health systems, organisations and the boards of every organisation that employs doctors should review the leadership style within their organisations and introduce a programme to support leaders to establish and maintain a positive and inclusive working environment. The programme should be designed in consultation with staff and include content on open engagement with staff, positive cohesive team working and meeting the needs of diverse staff.

The leadership and boards of every organisation that employs doctors should implement inclusive engagement sessions with a visible lead from clinical leaders (including medical directors) and board members to consider the findings of this review. HR Directors and ROs collectively should develop a plan to implement initiatives to demonstrate the worth of staff who feel undervalued (e.g. mentoring and inclusive professional networking).

The leadership and boards of every organisation that employs doctors, and clinical leaders should regularly discuss and assess how the organisation meets the needs of a diverse workforce. Discussions should include addressing the areas of their organisation where there are risks of bias (including favouritism) and introducing specific safeguards to resolve these. The outcomes of these discussions should be shared with staff.

The leadership and boards of every organisation that employs doctors should review the representation of decision makers in local complaints processes and develop a time bound plan to ensure decision makers reflect an agreed and locally appropriate benchmark for diverse representation.

General Medical Council

The GMC (through its ELS) should engage with the RO community to raise awareness of the issues raised in this report.

GMC ELAs should raise with ROs any concerns about fairness in their organisation and discuss the recommendations of this review widely.

National organisations across the UK

Providers of NHS leadership programmes on equality, diversity and inclusion across the UK should consider how the findings of this review can be incorporated into relevant programmes.

System regulators, improvement bodies and system partners should ensure that leaders are engaging with staff and responding to staff concerns. They should ensure that providers have a programme to support leaders that includes engagement with staff, positive cohesive team working and meeting the needs of diverse staff.

Those responsible for inspection regimes should (a) embed routine assessment or inspection of workforce inclusion within every organisation that employs doctors; (b) strengthen assessment criteria to ensure all aspects of the public sector equality duty are complied with.

Those with a role for supporting staff to raise concerns (e.g. the National Guardian for the NHS in England), should consider how they can contribute to addressing the findings in this report. Where such roles don't exist, system partners when reviewing their approaches should give due regard to the findings of this review.

Health administrations across the UK should work with membership bodies who support NHS employers to develop resources for supporting employers to implement the recommendations in this report. Support should include how to robustly respond to racism and discrimination towards doctors from patients/carers/family members.

Recommendation 4: Delivery, monitoring and evaluation

Establish a UK-wide mechanism to deliver the recommendations, share good practice and undertake ongoing monitoring of data concerning the key issues identified in this study.

Employers

ROs should monitor and challenge patterns of disproportionality in performance concerns in their organisation. They should be able to demonstrate that their processes are fair if challenged.

General Medical Council

The GMC should establish a Programme Board to include the health administrations of the four UK nations and including organisations from each country of the UK to oversee delivery of the recommendations at national and local level. The GMC should publish a combined four country plan, and where possible, include a social partnership approach to implementation.

The GMC should collaborate with system partners to collate, support them to evaluate, and promote examples of 'what works' to reduce risks of disproportionate referrals, and pilot approaches to resolve concerns locally.

The GMC should require its ELAs to share good practice and raise awareness with ROs of the importance of acknowledging and mitigating the risk of bias.

Where a referral is received from an employer/provider which does not result in the GMC opening an investigation, the ELA and RO should have a discussion to identify learning in relation to the origin of the referral.

The GMC should require its ELAs to discuss with ROs data about referral rates and patterns in investigation outcomes regularly; data should include how the designated body compares to others.

The GMC should publish aggregate data by country, region and employer/healthcare provider and other referring organisations on the diversity of referred doctors and the GMC's response to those referrals. Wherever reasonably practicable, there should be an expectation that other diversity data that might help understand patterns of referrals should be published.

National organisations across the UK

Health administrations of the four UK nations should work with the GMC to develop and agree appropriate plans of action in each country, with responsibilities clearly identified for delivering the recommendations in this report. The action plans should build on examples of good practice where they exist in each country, and should set challenging but achievable timetables for delivery.

Health administrations across the UK should ensure that data including the composition of leadership teams, the proportion subject to disciplinary action and referral levels to the GMC, and other issues outlined in this review, are collated, analysed and published.

These recommendations are proposed in line with some of the principles for conducting evidence-based diversity and inclusion (see Box 3 in main report on page 69).

Contents

INTRODUCTION

In the UK, certain groups of doctors are more likely to be subjected to formal investigations before referral to a local disciplinary process. Notably, BAME doctors have more than double the rate of being referred by an employer compared to white doctors[4]. Non-UK doctors have 2.5 times higher rate of being referred by an employer compared to UK graduate doctors.[5] These groups are also more likely to be referred to the regulator, the General Medical Council (GMC) by their employers or healthcare providers, for subsequent formal disciplinary action. Independent studies have found no evidence of bias in GMC decision-making (Regan de Bere el al., 2014). Nevertheless, concerns remain regarding differences in the patterns of referrals of different groups of doctors to the GMC by employers and healthcare providers. In particular, amongst doctors who are neither GPs, nor specialists, and not in training, BAME doctors are slightly more likely to be referred than White doctors, and overseas graduates more likely to be referred than UK graduates. Other groups over-represented in the GMC fitness to practise (FtP) procedures include older male doctors, some non-specialist doctors, certain specialties (Occupational Health, Obstetrics and Gynaecology, Surgery, Psychiatry) and locums (GMC's *State of medical education and practice in the UK* reports, 2017, 2018).

Disproportionality in referrals by employers and healthcare providers into the FtP process has a significant impact because although referrals from employers have been steadily falling in recent years and now comprise 4.3% of referrals (GMC, 2018), referrals from employers, healthcare providers and Persons Acting in a Public Capacity are far more likely than complaints from the public to be investigated by the GMC (84% compared with 16%) and to subsequently lead to sanction (GMC Fitness to Practise statistics, 2017). The negative effects of these sanctions on doctors for patient care are also well-documented. For example, sanctioned doctors increase "hedging" behaviours, such as over-referral of patients, reluctance to handle perceived high-risk cases, and recommend more invasive procedures even when these are contrary to their professional judgement (BMJ 2015; Bourne et al., 2015). Further, when doctors' practices are investigated, whether formally or informally, there are adverse implications for their careers, reputation and wellbeing (Chamberlain, 2016).

This research aims to identify the factors that lead to, and consequential processes adopted by employers or healthcare providers prior to a decision to refer a doctor to the GMC for FtP concerns. Further, this study seeks to understand how these factors may contribute to patterns of disproportionality (that is, the over and under representation of certain types of doctors) in referrals from employers. To explore these issues, the following questions guided our research.

Research Questions

1. What factors influence referrals into fitness to practise processes?
2. How do employers identify incidents of concern that may warrant referral to the GMC?

[4] 1.1% of BAME doctors were referred to the GMC by employers 2012–17 compared to 0.5% of white doctors.
[5] 1.2% of non-UK graduate doctors were referred to the GMC by employers 2012–17 compared to 0.5% of UK graduate doctors.

3. How are these incidents handled internally, and how are decisions to refer to the GMC taken?
4. How may clinical leadership influence the way in which designated bodies (employers or other bodies) identify and respond to concerns that might result in referrals to the GMC?
5. What good practice might be shared more widely, with the GMC and employers?
6. How can the GMC, clinical leaders, and management work together to help develop workplaces in which doctors' interactions with the GMC, and local processes that feed into GMC action, are appropriate and fair, with a view to reducing the observed differences in patterns of referrals for different groups of doctors?

The above questions guided all stages of our research, including attendance at meetings and conferences to gather soft intelligence, secondary data analysis (a rapid literature review) and primary data collection (using a qualitative methodology).

In the following section, we provide additional context regarding the over-representation of some groups of doctors before describing our Methodology.

OVER-REPRESENTATION OF SOME GROUPS OF DOCTORS

A continuing source of concern over the last two decades has been the treatment and experiences of BAME doctors in the UK, including their entry to medical school (Esmail and Everington, 1993), postgraduate Royal College of General Practitioners (RCGP) exams outcomes (Esmail et al., 2014), and the impact of the discretionary points award scheme for doctors (Esmail, 2003).

Across all healthcare professional regulators, the rates at which registrants are referred into the Fitness to Practise processes are higher for BAME registrants than they are for white registrants. (West 2016; GMC, 2018; General Pharmaceutical Council, 2018; Nursing & Midwifery Council [NMC], 2018).

A quarter of BAME GPs surveyed reported experiencing discrimination from patients at least monthly, with three quarters saying they faced racial discrimination from their patients at some point. One quarter said that they felt discriminated against by a practice they had applied to join (Mahase, *Pulse May 2018*). BAME GP partners are more likely to receive 'inadequate' CQC ratings (Mahase, *Pulse May 2018*).

Seven of the nine doctors convicted of gross negligence manslaughter since 2004 have been BAME (Williams 2018).

In England, where comprehensive data exist, for National Health Service (NHS) staff as a whole (all staff groups taken together), BAME staff are more likely to enter local disciplinary processes. In 70% of NHS Trusts, the likelihood of BAME staff entering the local disciplinary process is more than for White staff. In over a quarter of NHS Trusts, the likelihood of BAME staff entering the disciplinary process is more than twice as high as for white staff (Equality and Diversity Council, 2019).

Employer referrals to the GMC are a small proportion of referrals received compared to other sources of complaints. The numbers referred have declined in recent years.

Table 1. Complaints to GMC received by source 2012-17

Source	2012	2017	Change
Public	5500	5005	-10%
Employer	604	328	-46%
Other doctor	597	762	+28%
Self-referral	292	577	+98%
Other	1621	869	-46%

Source: GMC The State of Medical Education and Training 2012-17

However, employer referrals have a much greater significance within the GMC Fitness to Practice processes because a much higher proportion of complaints received are likely to be investigated. Thus, 77% of employer referrals are likely to result in a GMC investigation compared to just 9% of complaints from members of the public and 19% resulting from complaints by doctors about other doctors.

Overall, the GMC's data and other studies consistently show patterns of over-representation of some groups of doctors in complaints made and concerns reported. The likelihood of a doctor being complained about, or having a concern about them raised, varies according to factors including gender, specialty, type of contract, age, ethnicity and place of Primary Medical Qualification. BME doctors have more than double the rate of being referred by an employer to the GMC compared to white doctors.[6] Non-UK doctors have 2.5 times higher rate of being referred by an employer to the GMC compared to UK graduate doctors.[7]

Key findings include:

- Men (White and BAME) are much more complained about than women (White and BAME)
- Amongst doctors who are neither GPs, nor specialists, and not in training, BAME doctors are slightly more complained about than White doctors
- Doctors who are international medical graduates (IMG) are more complained about than doctors who trained in the UK or the EEA
- The category of GPs most complained about are BAME doctors whose place of Primary Medical Qualification was either EEA or IMG
    - Rates of complaints about male GPs are twice as high as against female GPs
    - Older GPs, particularly older BAME GPs, are more complained about than younger GPs
    - Between 2012 and 2016 just under a quarter of IMG BAME GPs were complained about, compared to 17% of their UK BAME counterparts
- Most groups of doctors are more likely to be more complained about by members of the public than their employer. However, for Speciality and Associate Specialist (SAS) doctors, the overall referral rates of complaints are lower; these doctors are more likely to be referred by employers than members of the public
- For specialist doctors, the likelihood of White EEA doctors being complained about is the lowest.
- Specialist locums are as likely to be complained about as permanent specialist members of staff and twice as likely to be investigated
- White doctors who are neither specialist nor GP and in training are complained about slightly less (4%) than BME doctors (5%) across 2012-2017.

[6] 1.1% of BAME doctors were referred to the GMC by employers 2012–17 compared to 0.5% of white doctors.
[7] 1.2% of non-UK graduate doctors were referred to the GMC by employers 2012–17 compared to 0.5% of UK graduate doctors.

- The likelihood of older doctors being complained about is higher than for younger doctors and is slightly lower (15%) for older white doctors than it is for BAME older doctors (18%) across 2012-2017
- There is significant variation in complaints received by speciality with doctors working in occupational medicine, obstetrics and gynaecology, psychiatry, surgery in particular likely to be complained about.

(Data from *The state of medical education and practice in the UK,* GMC, 2017, 2018 and *What our data tells us about locum doctors.* GMC Working Paper April 2018).

LITERATURE REVIEW

Literature review methodology

First, we conducted a rapid literature review to answer the research questions and inform our approach to the empirical stages of our research. We examined evidence from grey and academic peer-reviewed literature. The aim of this initial examination of literary evidence was to:

1. Avoid duplication of any extant findings from previous studies relating to the research topic
2. Capture an initial overview of themes emerging from previous work on the research topic
3. Inform site selection and formulate questions for the empirical phase of the project

In the first stage of the literature search, we reviewed 18 pieces of grey literature. These consisted of reports produced by private and public-sector organisations, including previous reports commissioned by the GMC relating to FtP referrals. Selection was based on the articles and reports meeting the following criteria:

- A clearly defined topic that relates to the research focus,
- Outcomes, conclusions or recommendations emanating from the evidence, and
- Published by a UK institution (such as the UK Government, a charity or private organisation such as the GMC or NHS Resolution [formally National Clinical Assessment Service; NCAS])

For the second stage, we collated data from peer reviewed academic sources. We applied search terms relating to the research questions (on page 17 to 18) to 21 databases, yielding 139 peer-reviewed journal sources of academic literature whose abstracts were screened. Search terms, search results, key decisions (e.g. the rationale for excluding/including certain literature) and final net resources are in the Appendix. Seven peer reviewed sources met the following set criteria:

- Addressed one or more of the research questions
- Covered the UK or countries with comparable medical FtP frameworks (includes USA, New Zealand, Australia)
- Concerned doctors or other professions with comparable FtP regulations (nursing, aviation, police)
- Published between 2002-2019
- Published in English

The small number of peer reviewed academic sources exploring FtP concerns has previously been highlighted by Ellen and colleagues (2013). These authors suggest that the lack of peer-reviewed evidence may reflect legal and practical technicalities in publishing FtP cases, rather than represent lack of evidence of disproportionality in referrals. As a result of the limited number of articles identified, a snowball technique was used to gather additional sources that met our review criteria. The list of references consulted is provided in the Appendix.

Literature Review Findings

Factors that influence referrals into the FtP process typically fall into two categories – individual (micro) and institutional (meso). Individual, or micro, factors constitute attributes that are specific to the doctor (e.g. their

practice type, personal qualities, ethnicity, age, etc). Institutional, or meso, factors constitute aspects of the working environment and the context surrounding referrals which makes them more or less likely to occur.

Individual (Micro) Factors

IMG and EEA Doctors

Concurrent with Dyer's (2009) findings, Tiffin and colleagues (2017), note that international medical graduates, including those from the European Economic Area, are at higher risk of being censured through the GMC's FtP process than UK graduates. These doctors are at increased chance of being subjected to more serious sanctions throughout the investigative process, with consequences being slightly higher for those from outside the EEA. This high-risk status may be associated with concerns about communication skills, cultural competence, clinical knowledge and the skills required to deliver what is considered safe and quality care in a UK context. Although there is no empirical consensus over which factors pose the highest risk, there is evidence that nationality contributes to bias against medical graduates with comparable education, experience and personality, with those from developed (Western countries) often being evaluated as more competent and trustworthy by colleagues and patients compared to non-Western counterparts (Esmail & Everington, 1994; Louis, Lalonde & Esses, 2007).

Race and ethnicity

As a demographic group, BAME doctors comprise IMGs and UK graduates of Black, Asian or Minority Ethnic heritage. Authors such as Beecham (2000) and Humphrey (2009) have explored the role of ethnic-based discrimination in FtP-related processes. Research suggests that 'coming from abroad' presents a stronger risk factor for referrals by employers or healthcare providers to the GMC than ethnicity. Further, groups with a higher rate of receiving a sanction or a warning include GPs with no recorded ethnicity (GMC, 2017). Nonetheless, *Understanding employers' referral of doctors to the GMC* (GMC, 2017) highlights potential paradoxical experiences for BAME doctors. On the one hand, minority ethnicity is seen by some as a protective factor against referral, i.e. the fear of being labelled as racist may suppress reporting against BAME doctors. On the other hand, minority ethnic status is also seen as increasing one's vulnerability to being reported, due to unconscious bias and lack of strong support networks for BAME doctors. Nunez-Smith and colleagues (2007) investigated the impact of race on physicians of African descent. In support of the paradox, they concluded that positive experiences, such as support from colleagues and feelings of making a difference in the profession, are contrasted against assumptions of incompetence, increased scrutiny, lack of support and mentorship, being passed over for leadership opportunities and unfair treatment from colleagues and patients. Fear of allegations of racism may explain employers' reluctance to initiate early informal intervention, ultimately leading to the overuse of formal procedures that lead to disproportional FtP referral rates.

Issues of racial bias are conflated with achievement across different groups. For example, the differential attainment levels in medical education across ethnic groups makes it challenging to separate subjective evaluations from objective performance. The relationship between ethnicity and performance in higher

education is well-documented, with initial research driven by ethnic minority students' higher failure rate in clinical exams compared to their white peers (Dillner, 1995). Woolf (2011) found disparities in attainment across medical schools, types of exams and levels of study, with lower success rates for minority ethnic students. One explanation for these outcomes is stereotype threat (Woolf, 26), defined as an individual's reduced performance due to their increased anxiety about confirming negative stereotypes (Steele, 1992; 1997). Thus, patterns of underperformance observed in this population appears to be influenced by bias.

Age

Oliver (2016; 2017) highlights mental health, burnout, the lack of flexible working, administrative burden of revalidation and the changing nature of work as some of the challenges facing older doctors. Additionally, ageism, including stereotyped perceptions of older people, may exacerbate these challenges. The GMC's *State of medical education and practice in the UK* (2017) highlighted some newer or younger doctors' perceptions that doctors approaching retirement have a less reflective attitude while working to standards of practice that have changed, and do not keep up with these changes to make practice safer. This could explain older consultants being more likely to be reported by newer consultants. However, the GMC's revalidation report (2017) found that deferral of revalidation was higher for both younger doctors (under 30) and older doctors (over 70), with the fewest deferrals happening for doctors in their 50s and 60s, men and white doctors.

Doctors who are not permanent NHS employees

Taking revalidation forward (GMC 2017) raised concerns over locums and doctors in private practice where there are sometimes ambiguous and inconsistent accountability structures, systems for sharing information and opportunities for appraisal. There is an ongoing debate surrounding the management of locum doctors, with responsibility often being left with locum agencies who may not have capacity or interest to follow up on concerns. Furthermore, groups working outside of the NHS (e.g. in universities, research institutes and in independent practice) face challenges in engaging with the appraisal process. A 2018 report *Evaluating the regulatory impact of medical revalidation* reported that the chances of a doctor with no prescribed connection receiving an appraisal in the previous 12 months was found to be four times lower than for those with a connection.

Fit

What it takes to 'fit in' is a consistent theme relating to the treatment of doctors. Groups of doctors who do not 'fit in' are at greater risk of being negatively reviewed by their peers. Potential explanations include personality clashes with team members or more broadly because they are deemed to be outside the cultural norm. Doctors who 'fit in' at both micro and meso levels (e.g. those with the 'right' personality who represent and enact individual-level and institutional-level attributes expected of doctors), may benefit from a different (i.e. higher) threshold for criticism by colleagues (GMC Report, 2017). However, some reports also highlight that not fitting in, by enacting the "alpha male" type can also protect doctors from being referred, as colleagues may fear potential backlash. As such, complaints for those who do not fit in are contingent on the individual's behaviour towards, and reactions from, their colleagues.

For the primary research, the review findings on potential contributing micro-level factors informed our sensitivity to perceptions and treatment of groups of doctors based on place of training, race/ethnicity, age, and attitudes towards what it takes to 'fit in', and how these may influence disproportional referral rates.

Institutional (Meso) Factors

The challenges faced by doctors are not limited to the micro-level. Additional cultural, systemic or contextual factors (formal and informal) likely contribute to the higher risk of referrals. For comprehensive understanding, focus needs to include structures and processes of NHS employers, the GMC and related governance structures and institutions. Nevertheless, such focus requires a recognition that the NHS systems are complex, dynamic and characterised by differences in sizes and types of healthcare organisations handling complex high-risk cases involving multiple stakeholder interactions; all compounded by internal and external pressures and scrutiny, both institutional and public (Vauhan & Ghalea, 2017). As such, drawing conclusions about the role of single factors is challenging.

Unconscious or Implicit bias

Esmail and Everington (1994) examined 294 cases of professional misconduct raised between 1982 and 1991, and found that BAME doctors disproportionately received complaints and were charged with conduct-related offenses. Recent GMC and NMC reports show higher rates of referrals for BAME registrants than would be expected given the makeup of the respective registers (The Williams Report, 2018). In parallel, some groups of doctors are at lower risk of being complained about. It is likely that these persistent patterns are due to implicit negative and positive biases, i.e., " views and opinions that we are unaware of which are automatically activated and frequently operate outside conscious awareness and affect our everyday behaviour and decision making" (Atewologun et al., 2017, p.4-5). However, unconscious bias is challenging to measure, diagnose, and address (Atewologun et al., 2017). Research on disproportionality in the professions (Ellen et al., 2013*)* reveals the difficulty institutions and individuals face in providing evidence for unconscious bias, racial stereotypes and indirect discrimination, posing major obstacles in racial discrimination cases and other attempts at redress.

Cultures and safety

Ninety-five per cent of UK doctors report working in fear of making medical mistakes, 55% report worrying about being blamed for errors that could be attributed to the pressures in their work environments and wider institutional failures, while 75% report being cautious about recording their practice reflections, worrying these may be used against them at some point (Wise, 2018). These illustrations point to concerns over a culture of blame that undermines learning and reflection. Similar concerns are highlighted in the 2018 Williams review into gross negligence manslaughter in healthcare, citing the negative impact of fear and a blame culture on doctors' psychological wellbeing, confidence in practice, and patient safety.

Other industries (e.g. aviation) have adopted a framework focused on learning from events where mistakes may have been made but blaming individuals is avoided. Where a reckless or deliberate act takes place, accountability is essential, with the objective to balance public safety and the psychological safety of staff. (Chaffer, Kline, Woodward 2019 forthcoming). Similarly, in UK medical practice, Donaldson (2002) proposed that improvements in patient safety should focus much more on the environment within which doctors work, and on learning, not blame. Subsequent NHS reports (e.g. Berwick, 2013) backed this proposal. The growing influence of "human factors" science in healthcare has led to an understanding that human beings make mistakes, that things may not go as planned, and that it is important to learn from mistakes. Those who support this approach seek to anticipate and minimise potential for errors or failures and take steps to prevent and minimise any impact (Dekker, 2012). Several factors affect human behaviour and performance including the design of systems, processes, and equipment, and environmental factors such as fatigue, workload, team relationships and communication.

The framework for handling concerns about doctors' practice, behaviour, or health, *Maintaining High Professional Standards in the New NHS* (MHPS, 2003) in England, was influenced by Donaldson's (2002) analysis. It is followed with slight variation across the four nations of the UK. All employers of doctors are required to follow principles that guide the disciplinary procedures, such as MHPS. The Practitioner Performance Advice (PPA) service of NHS Resolution provides guidance and support for employers on how to handle complaints and concerns (though this is no longer funded in Scotland). Guidance on *How to conduct a local performance investigation: An NCAS Good Practice Guide* (2010) sets out a framework of process, timelines, and an approach that emphasises learning (rather than blame and punishment) in response to error. The guide emphasises that the initial response to any incident, complaint or concern should seek to ensure the doctor's engagement and to distinguish acceptable variation of practice from significant difference from accepted standards.

The NHS's 'Just Culture' encourages employees to speak up and report incidences rather than fear blame, with the promise of a fair, open and learning-driven response (NHS Improvement, 2018). A key component of the Just Culture is recognising intention (or not) to cause harm as a factor to be taken into consideration when responding to incidences. Nonetheless, the recognition of intention (to cause harm) relies on subjective and potentially biased evaluations, providing an opportunity for individual (micro) level factors to have an effect. In a culture where individuals are blamed for errors caused or contributed to by such factors, 'outsiders', who are perceived not to fit in or belong, are likely to be more at risk of scapegoating. This provides additional potential explanations for why some groups are more likely to be investigated, and their risk of being sanctioned increased (Ghaffur, 2004; Pearn Kandola, 2010).

Perceived role of leadership & HR

Size of employer affects how disciplinary (and potentially referral) processes are created and implemented. Larger NHS Trusts, Boards and Health Boards have larger pools of doctors, hence comparisons of histories of conduct and capabilities is often possible, making it easier to identify patterns and determine thresholds for investigations and referrals. Also, organisational leaders and Human Resources professionals are often seen

as the custodians of distributive fairness and equitable reward and recognition, who should follow transparent and clear procedures to make logical decisions (e.g. during appraisals) linked to those rewards (Harvard Business Review, 2018). Thus, where leadership and HR are skilled and confident with their local processes, experiences of handling FtP cases may lead to fewer referrals. On the other hand, smaller employers may face challenges in implementing key monitoring processes such as medical revalidation that may bring to light potential FtP issues (GMC, 2017).

Decision-making frameworks

In complex organisations such as the NHS, significant decisions with potential consequences tend to be made by groups of people in authority rather than individuals. Mannion and Thompson (2014) highlight the dangers of group decision-making biases such as *groupthink, social loafing, group polarization* and *escalation of commitment* playing out at the micro-level in clinical teams, and the possible impact of these biases on patient safety. These authors also emphasise that decision-making frameworks are generally underpinned by underlying broader culture, values and social norms (including social biases).

GMC-commissioned research by Rand Europe in 2017 investigating how organisations who make high stakes decisions try to ensure that those decisions are fair, encouraged improving delegation, clear communication with staff about support available when issues occur, and nurturing an open communication and learning culture. The Williams Report (2018) recommends regulators should review how the impact on public confidence is assessed in reaching fitness to practise decisions about individual healthcare professionals, and develop guidance to support consistent decision making in this area.

The 2017 GMC commissioned report by Community Research notes the benefits of the work done by the GMC Employer Liaison Service with Responsible Officers and local Employer Liaison Advisers collaborating to make sense of guidance on processes and facilitate decision-making around thresholds for referrals to the GMC.

Utilisation of local process, and thresholds for referrals

Formal and informal investigations at the point of incidence aim to collect evidence to determine if professional misconduct has occurred. The evidence gathered forms a basis on which the decision to progress a case into a referral to the GMC is made (Humphrey, 2009). The 2017 GMC report by Community Research shows a high preference among doctors for the use of local (formal and informal) processes to explore disciplinary issues before they are escalated. Lessons can also be learnt from work done for the Metropolitan Police by Ghaffur (2004) that found that BAME police officers were nearly twice as likely to be subjected to internal sanctions and warnings. The reasons cited for these sanctions were the propensity of managers to initiate formal processes quickly against BAME colleagues, managers' lack of familiarity with how to maximise local processes, and the variability in how codes of conduct are interpreted with regards to diverse groups within the organisation.

Similarly, Pearn Kandola (2010) found a higher prevalence of local referrals of BAME solicitors for investigations. Cases of BAME solicitors were escalated faster by the regulator through the investigation process compared to solicitors in the non-BAME population.

For the primary research, the review findings on potential contributing meso-level factors informed our sensitivity to institutional differences in culture, bias, leadership and the role of HR, as well as the use of decision-making frameworks and effectiveness of local processes (including the extent to which local processes follow MHPS and PPA guidance), and how these may influence disproportional referral rates.

Strengths and limitations of the Rapid Literature Review

The review met the intended objectives of informing the empirical stages of the study. We adopted an overt and reproducible search technique for the academic literature, with clear inclusion and exclusion criteria to increase objectivity. The additional snowballing technique of literature search allowed for comparisons and additional insights from other regulated professions such as aviation, law, the police and nursing. Some of the grey literature was recommended by stakeholders during the initial informal data gathering phase. Although this carries a risk of bias, examining these sources helped avoid duplication of previous research already commissioned by the GMC, and allowed us to design the study within the context of pre-existing documented best practice policies and recommendations.

PRIMARY RESEARCH

Methodology

In conjunction with the Literature Review, we gathered soft intelligence from the field. Both activities helped us shape our selection of primary care samples, secondary care case study locations, and the interview questions. We gathered initial data through immersion as well as semi-structured and unstructured interactions with stakeholders in the sector. We sought soft intelligence as a way to get acquainted with the field, to supplement the Rapid Literature Review and further inform case study selection. The soft intelligence gathering involved extensive discussions with a range of people by attending events and stakeholder meetings (over 5 conferences and forums), and meeting with over 15 officials including from the British Medical Association, HR Directors, NHS Resolution (formerly NCAS), GMC Regional Liaison Service, GMC Employer Liaison Service, Devolved Administrations, Responsible Officers, and locum agency personnel plus a number of doctors with specialist knowledge of the sector.

We approached secondary and primary care slightly differently. We followed a case study approach for secondary care (involving, for each site, interviews, focus groups, analysis of some documentation and public data). We conducted interviews and focus groups with primary care samples. A case study approach was particularly appropriate for this study. It allowed us to explore the 'how' and 'why' of organisational processes within their context by providing rich data to understand how underlying mechanisms may accumulate or interact to drive differential referral rates and why this may occur for different groups (Hartley, 2004). Alternative approaches, such as a direct comparison of employers, detaches the context from the processes being explored. Additionally, the small number of cases of reporting at the level of each individual employers favours rich data gathering on lived experiences, as there is insufficient data for statistical analyses.

Secondary care

In secondary care, NHS employers of doctors were selected for site case studies. At each location, in-depth interviews and focus groups with multiple stakeholders at all levels were undertaken. Additional interviews and focus groups were conducted with specific stakeholders who were underrepresented in the field work (e.g. black doctors).

Case study selection

We used different methods to select Trusts in England and employers in the devolved nations. In England a mix of Trusts were selected on the basis of metrics that indicated they were "well-led" and above average on engagement and equality metrics, or were improving in those respects. We used these criteria because, firstly, we believe such Trusts would be more likely to share their experiences openly and honestly. Secondly, alongside exploring the causes of disproportionate referrals, we believe such a mix would provide opportunities to explore how some Trusts might work to mitigate the risks of inappropriate referrals.

We first created a long list of 26 Trusts using the following criteria:

1. **NHS staff survey metrics, specifically:**
    a. The overall staff engagement score
    b. The percentage of staff experiencing harassment, bullying or abuse from other staff in last 12 months
    c. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
    d. Staff confidence and security in reporting unsafe clinical practice
    e. Organisation and management interest in and action on health and wellbeing

Trusts were selected on the basis that the 2017 trust data for these metrics were above the NHS average, and the 2017 trust data were better than, or not significantly worse than[8], the 2016 data. Further, trusts were expected at the minimum to meet the requirement to be above the NHS average with the 2017 metric and no worse than the 2016 metric for at least four of the five indicators.

2. **The Electronic Staff Record for workforce disciplinary data 2016-17**[9]

The minimum level for inclusion was for trusts within which BAME staff (in 2016-17) were less than 1.3 times more likely to enter the disciplinary process compared to white staff (national average was 1.37); and, no greater than 1.5% BAME staff disciplined in total.

3. **Care Quality Commission (CQC) rating on the "Well Led" domain in the last 2 years**

The minimum level for inclusion was a rating of good or outstanding in the most recent grading.

Final Selection

The provisional long list distinguished those that met four of the five standards in Criteria 1 and each of the standards in Criteria 2 and 3 (where there was a recent 2 year inspection). This list was analysed by region and type of trust to check for a reasonable spread of sample across the NHS in these respects.

Table 2: Type of Trust and Region

Type	**Mental health**	**Acute**	**Acute specialist**	**Community**
Long list	6	13	3	3
Final list	2	8	1	1
Region	**North**	**Midlands and East**	**London**	**South**
Long list	11	3	5	6
Final list	6	2	2	2

[8] As defined by Picker, see http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2018/

[9] We did not separately identify disciplinary action by medical staff. If we had, the numbers would be too small to be statistically meaningful.

This long list was reasonably representative of types of trust but not sufficiently representative of two regions - London, and Midlands and East. In reducing the long list of 25 to a short list of 12 trusts we sought to ensure the final selection was more representative by region but remained representative by Trust type (Table 1).

Devolved Nations

There were insufficient data for selecting employers in the devolved nations using the above approach. Our final selection was on the basis of soft local intelligence to identify one employer in each nation that would be likely to share their experiences openly and honestly. All three sites approached by this method agreed to take part and appeared to share candidly.

In total, 15 case study sites employing doctors were visited.

Primary care

For primary care, one to one interviews with General Practitioners (almost all of whom were partners and salaried GPs, rather than locums) and two focus groups (with black doctors from primary and secondary care and GP Trainees) were conducted.

Sampling & Participants

A total of 262 individuals contributed to the formal data collection. This comprised 221 participants in secondary care and 41 participants in primary care (for a full break-down of participant demographics please refer to Appendix). For secondary care, staff across different roles and positions were interviewed or participated in focus groups at each case study site, typically comprising the following:

- Responsible Officer
- Medical Director
- Human Resources Director (none with a medical qualification)
- Clinical Directors
- Consultants
- SAS Doctors
- Locums

Data collection

Across primary and secondary care, interviews and focus groups followed a semi-structured approach. Interviews were one to 1.5 hours long; focus groups were 1.5 to two hours long. Qualitative methods are best suited to explore experience and views in depth regarding the how and why of complex, likely interrelated, factors. Further, interviews and focus groups are advantageous for rich data collection with groups in large organisations such as the NHS (King, 2004). Additionally, the flexibility of interview and focus group techniques for answering focused, specific questions as well as broader issues, allows for different levels of meaning to be explored. The questions that guided this approach can be found in the Appendix. Each organisations policies were also reviewed where possible for the researchers to compare a) the formal

policy and the processes described by participants and b) the policies across each organisation. Data were collected over 4 months from November 2018 to February 2019.

As the purpose of the research was to understand the general issues, rather than to identify problems at an individual or organisational level, no personally identifiable indicators are shared. Further, this assured anonymity, countered potential social desirability bias, and provided participants with a psychologically safe space to share their views freely.

Data analysis

All interviews and focus groups (with one exception) were audio-recorded. The first three site visits were transcribed in full. As far as possible, and if we deemed this would not risk anonymity, ethnic category and role were attributed to speakers; this was not possible for every voice. Due to the large amounts of data available, selective interviews/focus group recordings from subsequent site visits were transcribed on agreement following discussion with the full research team where we deemed the data provided deeper understanding and additional insights. This approach was taken to avoid data saturation; the point at which no new information is being discovered. At the minimum at least two researchers attended or listened to each audio-recorded session.

Analysis was conducted through an iterative process of navigating between the literature review findings, template analysis of the transcriptions and active ongoing discussions amongst the research team. About one third of the way through data collection, the steps we followed were:

1. The researchers met to identify and synthesise the emerging findings. During this stage, a comprehensive set of key themes were identified.
2. To ensure that all themes had been encompassed in the comprehensive list, researchers analysed additional transcripts to extend or nuance the overarching themes.
3. One researcher developed a coding strategy for the analysis of transcripts. Excerpts from interview and focus group transcripts depicting key themes were grouped for supporting evidence.
4. Analysis continued until theoretical saturation was reached.

KEY FINDINGS

Why are referrals from designated bodies to the GMC likely to affect certain groups of doctors disproportionately?

IS IT FAIR TO REFER?

We found that the factors likely to account for disproportionate representation of certain groups of doctors in FtP referrals are multiple and intricately linked. These factors are evident on the one hand as 'risk factors' for certain groups of doctors and on the other hand as 'protective factors' for others. These factors layer upon each other to create a cumulative positive impact for some doctors, and a cumulative negative impact for others. The likelihood of experiencing risk factors is associated with, and underpinned by, a pervasive theme we observed relating to insider/outsider dynamics. If protective factors are present for everyone (i.e. not just accessible to those doctors who happen to be insiders), then these protective factors neutralise the likelihood of experiencing risk factors facing some doctors.

Your pathway into UK medical practice may pre-determine your outsider status and the level of support you receive from the outset, starting with induction. A doctor who fails to have a supportive start to UK medical practice, can then continue to experience further disadvantage as an outsider. We found that evading conversations regarding concerns relating to a doctor's practice (in particular regarding conduct) was a primary factor. The lack of timely, direct and honest feedback, that is sensitive to difference, can have a huge impact on a doctor's opportunity to demonstrate learning from mistakes and improvements to their practice. Further exclusion from ongoing socialisation support, often referred to as learning the informal rules of the NHS, is an additional factor.

We also found that working patterns and contractual arrangements in the medical profession are an additional contributory factor because BAME doctors can often experience isolated or segregated working in certain roles or locations. The prevailing organisational culture also plays a part in explaining disproportionate FtP referrals, with certain cultures looking to find an individual to blame when something goes wrong, rather than trying to learn from the mistake so it doesn't happen again whilst appropriately considering accountability.

What is clear is that significant opportunity for addressing the risk of bias in the referral process is beyond the scope of doctors from the over-represented group, and rather lies with the leadership within each organisation to provide frequent, direct and honest feedback across difference, design ongoing socialisation support, integrate certain roles and teams, role model senior leadership cohesion, adopt a learning focused culture in response to mistakes and implement strategies for inclusion that counter insider/outsider groupings and hierarchies.

We find that the factors likely to account for disproportionate representation of certain groups of doctors in FtP referrals are multiple and intricately linked. It is difficult to disentangle each factor, and readers will find interconnections across themes. It is the multiplicity and simultaneity of these risk factors that are likely to increase the likelihood of referral of some doctors to the GMC's FtP process. In parallel to the risk factors are protective factors that offer multiple layers of buffering, thus accounting for the under-representation of some types of doctors in the same system.

We believe, like Woolf and colleagues (2016), that readers of this report will find it helpful to visualise these factors as additional layers of effects, occurring from interpersonal (micro) phenomena to organisational (meso) and to structural (macro). The layers of risk and neutralising/ protective factors are presented in Figures 1 and 2 below.

If protective factors are present for everyone (i.e. not just accessible to those doctors who happen to be insiders), they can be described as neutralising factors. However, if one group primarily benefits from these factors (e.g. white male surgeons who attended elite UK medical schools), we deem these protective factors as they shield some doctors while leaving others susceptible to disproportionate action. It is important to note that these risk/protective factors are not intrinsically associated with certain types of doctors. For example, being an IMG or EEA doctor is not a cause of working in a blame culture per se. However, a combination of factors may mean that such doctors may be more likely to be recruited to organisations that are struggling with difficulties in staff retention. Moreover, since such doctors experience lower exam attainment, they have less choice in training placements leading to less success in competing for more attractive posts in more affirmative environments. Subsequently, they may be more likely to be recruited into organisations that are not performing well.

What is clear is that, overall, the significant opportunity for addressing the risk of bias in the referral process lies beyond the scope of the over-represented doctors, and rather lies with the leadership within each organisation with regards to providing frequent, direct and honest feedback across difference, designing ongoing socialisation support, integrating certain roles and teams, role modelling senior leadership cohesion, adopting a learning focused culture in response to mistakes and implementing strategies for inclusion that counter insider/outsider groupings and hierarchies.

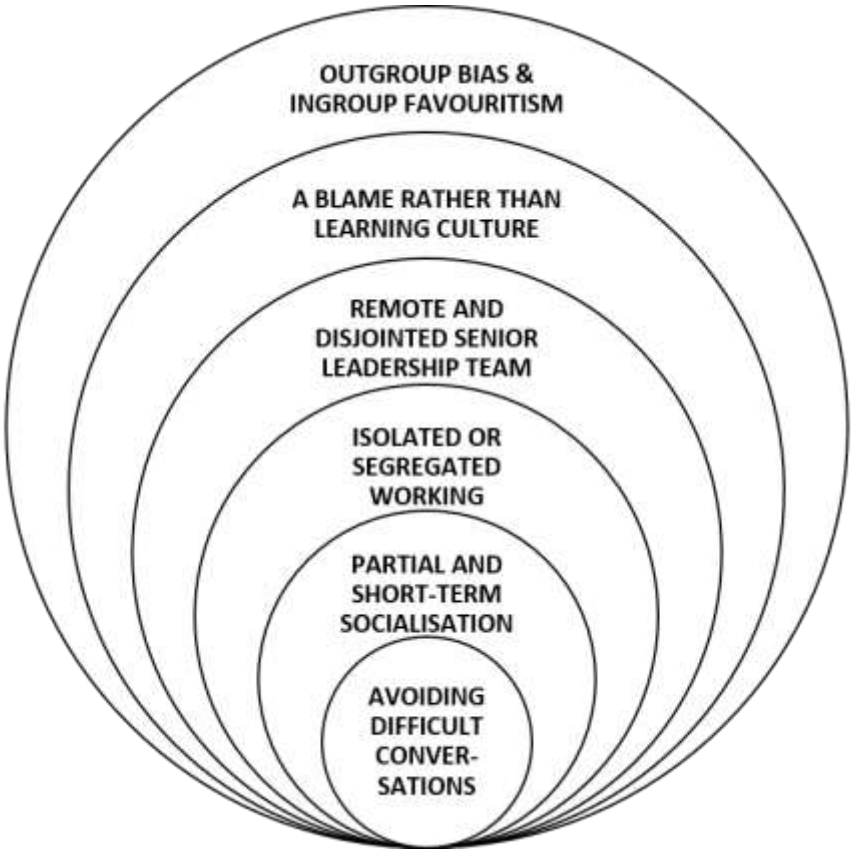

Figure 1: Risk factors

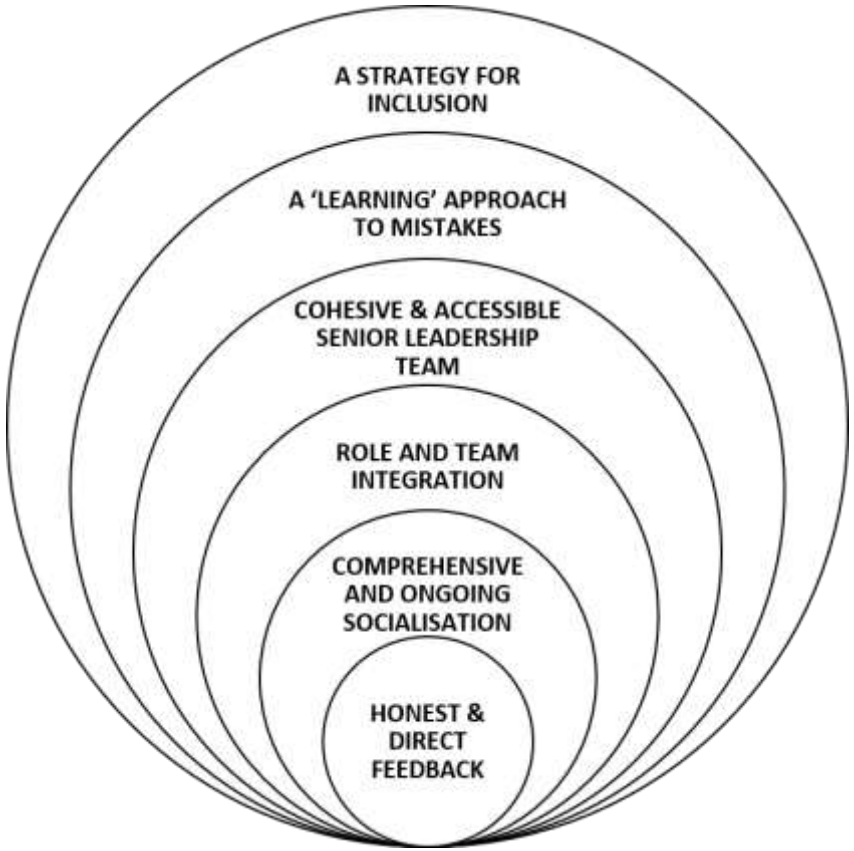

Figure 2: Protective/Neutralising factors

DETAILED FINDINGS

1. Avoiding difficult conversations

Evading conversations regarding concerns relating to a doctor's practice (in particular regarding conduct) was a primary factor linked to over-representation of some groups in FtP complaints. Participants agreed there was often hesitation in having difficult conversations, and this 'feedback gap' was exacerbated when the feedback was across socio-demographic difference (e.g. relating to national or cultural factors) and/or when the focal doctors were otherwise considered "not one of us" (as in the case of locums).

For example, colleagues may notice differences in practice but not feel they have the skill to tackle this directly, using humour instead:

> *People that have trained outside the UK …are more likely to investigate more. They do more tests and they place more reliance on the results of those tests and less reliance upon clinical acumen and risk.....…those doctors are rarely challenged. They're sometimes mocked in a sort of pseudo-friendly way at a meeting, you know when you have cost-savings meetings you talk about who orders the most tests and the doctors can be mocked in public, as part of a joke, and they'll often engage in that joke as well.* ***BAME consultant***

A number of participants explained that the skill to have these direct conversations needed to be instilled. Participants observed there was a lack of training in providing direct feedback.

> *There is no formal training that is required to have those kind of conversations. There are obviously courses … I've done training to be a mentor, which kind of touched on some of those techniques and skills that you can use. But in terms of preparing you for the role, there's nothing really official.* ***White Clinical Director***

Despite acknowledging the challenges and infrequency of having difficult conversations, most participants understood how crucial it was for professional development and patient care. Prompt, immediate, ongoing feedback is critical for learning but is, however, more challenging between unfamiliar parties or those considered outsiders.

> *We forget the diversity of staff and patients at our peril. Raising difficult issues can be more difficult where there is diversity. That can be made worse if you have GPs who are clinically perfectly competent but whose training may not have picked up other issues – effective listening, expected deference from patients not arguing back, issues around the appropriate relations with nurses and administrators within practices.* ***White GP partner***

Different groups of doctors including white and BAME MDs, IMGs and BAME UK medical professionals recognised specific challenges relating to communicating critical or constructive feedback on cultural communication styles. A range of examples were given, such as of a German doctor perceived as being overly abrupt, a Greek doctor with a very tactile style and a Spanish

doctor whose manner was deemed overly expressive. Cultural stereotypes can be pervasive and become a macro, not just a micro issue with longer term, systemic implications (discussed further in Section 7). Some participants recognised their cultural communication norms differed from the dominant NHS norm, and sought to downplay this, sometimes to their detriment. The examples below illustrate a small number of participants' perspectives that their style did not fit.

> *Where I come from it's quite normal to raise your voice and get quite heated and wave your arms about, and nobody thinks anything of it. I appreciate that within the culture that we work in within the NHS that perhaps isn't considered quite fully 'normal' behaviour.* ***BAME doctor***

> *I think sometimes if you choose to raise your head above the precipice a little bit, even if it's just in terms of your personality or your characteristics or something that makes you a bit more visible than everybody else …I think you do lay yourself open. Because it's a bit more difficult then to be invisible …And I'm not a naturally quiet person. That's not who I am. But if that's the way that I need to behave to be, okay.'* ***BAME consultant***

> *I'm using a lot of body language [in this conversation], I don't use body language at work. Even my tone is very even.* ***BAME GP in Training***

A culture of avoiding difficult conversations about what may or may not be considered 'appropriate' behaviours, carries a risk that many competent professionals expend effort in self-monitoring on top of providing excellent patient care, without knowing exactly what may or may not be suitable/acceptable at work.

Another related implication of avoiding difficult conversations was the use of the Datix system (an incident reporting and risk management software used in the NHS widely but not within all organisations) to report interpersonal concerns. There were several examples across organisations of Datix entries being used to replace honest, direct, informal conversations. This happened across all types of doctors (rather than just white or UK doctors reporting BAME or IMG colleagues). Although the system has been rightly created to increase accurate recording of clinical incidents, several participants across case study sites noted that it is also used as a proxy for feedback and, worryingly, reported on a small number of occasions, was the use of Datix for retaliation.

With difficult conversations avoided, it becomes easy for concerns to escalate. Interview data suggested there was a steady build-up of incidents of unfamiliar and/or incorrect practices.

> *When there is no mentoring, you will be stepping into fire and no one tells you until you can't come back.* ***BAME SAS Doctor***

We were given a number of examples where an early conversation could have prevented such a build-up. For example:

We had an excellent senior BAME consultant who kept referring to team members as 'you people'. Eventually one of our team (himself BAME) took the consultant to one side because this was causing a lot of backchat outside meetings about their 'arrogance'. It turned out that the phrase 'you people' was a literal translation of a very polite phrase in the senior consultant's native language which had been used without realising it caused offence. She was mortified and explained at the next team meeting. But why couldn't one of us have raised this earlier? ***BAME consultant***

We've all made mistakes … we are all learning on the job. …Now if I don't have support around the time I am making those mistakes I will probably continue making those mistakes; I am not talking about big mistakes, but mistakes could lead to one thing or the other … and it just takes some additional mistake for you to fall down. And if you don't get supported around those issues or they might even see you do it but not be bothered, not want to say anything…[because they think] 'They are not like us …it's not bad yet, so just leave it'. ***BAME SAS Doctor***

Rather than deal with concerns, there were some examples given relating to short term locums' (many of whom are BAME) abrupt contract termination:

[In my experience] BME [locum] doctors' contracts are terminated abruptly. ***Employer Liaison Adviser (ELA)***

So if somebody has complained and they think it's a valid point, we just put that to the locum agency and say, 'We don't want this doctor again.' ***White Responsible Officer***

Avoiding difficult conversations may be exacerbated in the case of locums, because often no one takes sustained responsibility for their feedback and development. This was partly due to locum agency ROs managing, in some cases shared with us, portfolios comprising many hundreds or more doctors, often on top of other roles, compounded by their distance from the index site. A significant degree of 'passing the buck' seemed to exist. In response to managing unsatisfactory locums, one MD stated with conviction that *"It is the locum's RO's responsibility".* Another ELA reported that "*ROs say 'we are remote'; hospitals say 'we do not have employer duty'"* to prioritise the personal development of locum doctors, demonstrating this 'buck passing'.

If there's an issue we do get rid of them without really making any effort to see what happens afterwards. And that probably is something that I think happens pretty much everywhere from my own experiences. ***White MD***

There is a clear expectation that the locum and their agency have specific responsibilities for CPD and appraisal (through their RO, if a designated body; see Box 1).

Box 1: A locum agency's responsibilities

- Having processes to monitor the doctor's practice in relation to the work they are being supplied to do, including end of placement/exit reports and peer/colleague feedback from the doctor's placements

- Ensuring the provision of annual appraisal whether through the agency or in an organisation where the doctor is undertaking a placement

- Coordinating feedback and other information such as end of placement/exit reports and peer/colleague feedback, and sharing it with the doctor for appraisal, professional development, and the maintenance of records of such processes

- Providing a governance framework for doctors, whether or not the doctor's prescribed connection is to the agency. This includes having a programme to support the doctor's professional development in a manner appropriate to the nature and duration of the placement and provision of supporting information for appraisal

- Having processes for ensuring doctors' appraisals take place annually and that appraisal systems are quality assured

This text is taken from recent NHS England guidance but similar expectations exist in the devolved nations:
https://www.england.nhs.uk/wpcontent/uploads/2018/10/supporting_locums_doctors.pdf

We found that such support to short term locums was patchy, in stark contrast to trainees and Consultants, as illustrated in the example below.

> *Now if one of my doctors here long-term – a trainee or one of my staff grades or associate specialists or consultants [conducted this wrong procedure] I would not have referred to the GMC. You're allowed to make a mistake. …We all make mistakes. However, if you've got a locum doctor for two days – and that's all this doctor was with us for – and the first thing he does is [conduct this wrong procedure], what else can you do?* ***White MD***

In respect of trainees, for example, one consultant proudly stated how seeing trainees as their responsibility means that medical practice concerns are attended to promptly.

> *We, as a department of consultants, are very prepared to tackle the trainee when there is a small issue so it doesn't ever …doesn't really, escalate.* ***White Doctor***

Thus, significantly less effort was dedicated to developing locums' practice compared to 'one of our own'.

Once concerns had been raised, a further complication regarding how the focal doctor demonstrates 'insight' appears to be another explanation of disproportional FtP reporting. Insight reflects the degree of self-awareness displayed following feedback, and is always assessed based on other colleagues' (usually the HR or the MD) evaluation of how this is expressed. Where participants did not demonstrate insight, an issue was likely to be formalised quite quickly.

> *The ones that are probably less likely to do the 'fair cop, Gov', because they might not recognise that they had done anything…they are the ones to whom we might have to say, 'Well actually, we're going to have to move into an investigation process.* ***HR Director***

A handful of white senior professionals in NHS Trusts, Boards and Health Boards acknowledged that insight is evidenced within a specific cultural context of medical practice. An example was given of a UK doctor who had practised in the Middle East and was implored by a senior medical professional there not to accept blame. This is because, in that context, acknowledging culpability is counter-cultural to the doctor-as-expert role. This suggests that when MDs and HR professionals are seeking evidence of sufficient insight to decide whether to convert a still informal incident into a formal concern, some doctors (for example those who qualified outside the UK) may not understand the expectations in the UK in relation to acknowledging concerns and demonstrating insight, and/or may not demonstrate it in the expected way. Most of the more effective MDs we interviewed talked about wanting to see some variant of acknowledgment in the first informal chat after a concern. ("*I want someone to put their hands up quite quickly*" one MD reported). However there seemed to be a gap between that expectation and what some of our frontline BAME interviewees understood was required. Most of our participants acknowledged that at the early stages of concerns, there was likely a cultural difference in skills required to diffuse the situation.

> *I bet that certainly compared with overseas trained doctors [UK] BME GPs… knew better how to apologise if a complaint was made and understood that saying sorry was fine because (it) was not the same as admitting fault.* ***BAME GP***

In contrast, participants (both front line staff and senior clinical managers) also shared evidence of how white, UK-trained professionals could demonstrate insight and "*negotiate their way through the investigation*" as a white doctor put it. A BAME SAS doctor described that a lot of his white colleagues "*know how to communicate. They know how to get around things and talk smoothly*". There was a close but distinct boundary between demonstrating contrition (to be encouraged) vs. evading repercussions (to be avoided), as described below. In practice, however it would be impossible for MDs to tell the difference so it is difficult to indicate how much demonstrable insight is genuine contrition.

> *If you're white and you've got any nous about you, you probably know culturally what would flip it the right way for you… But if you're playing the system to dodge a bullet, I think that's wrong. If you are genuinely reflective, and you have committed an error but you have genuine insight [that's ok].* ***White MD***

Thus, avoiding difficult conversations could disadvantage certain groups and advantage others.

Overall the lack of will and skill in having "difficult conversations" was reported as a significant challenge in raising issues around behaviours and performance that may ultimately lead to disproportional referral.

2. Partial and short-term induction rather than comprehensive and ongoing socialisation

Another factor contributing to disproportional reporting is exclusion from ongoing socialisation support, often referred to as learning the informal rules of the NHS. One BAME doctor in training referred to this as learning "*not the clinical stuff, but the art of medicine…the hidden curriculum*". This learning included taken for granted knowledge regarding navigating the new local context/physical environment (e.g. moving to a new town and country) but also navigating the new social, cultural and professional environment.

The following exchange occurred in a focus group:

> *The art is how you get a history correct and a history is the basis of a diagnosis, it's how you miss information, it's how you don't document things appropriately and then they get missed. It's the art. The Art of Medicine is where things go wrong.* ***BAME Doctor in Training***
>
> *But it also extends to your interaction with your colleagues. And managers.* ***BAME Doctor***

Arriving in the UK to practise medicine for the first time is challenging and daunting. We found many NHS bodies that employ overseas doctors make inadequate provision to help them with this transition. If unsupported, the difficulties they experience during that transition can undermine both their confidence and how they settle in to their new circumstances. This can set the tone and lead to ongoing difficulties. Doctors new to UK practice appreciated specific support with the practicalities of living in the UK for example finding accommodation, establishing utilities and opening bank accounts all of which may require them to provide documentation that they do not have and are not sure how to obtain.

> *So something simple like how to rent a house, how to sort a utility bill, how to get a bank account. So an example, if they go to a bank they will say, 'What's your address?' This chap doesn't have an address. 'Can I have your past financial receipt?' He doesn't have a financial receipt. What do you do? So he's kind of stuck.* ***BAME Consultant***
>
> *It takes a lot of time to settle at work, outside work. Everything is new. So even to know very simple things which like probably every medical student knows here, how governing systems work, for example… it's completely different if you haven't been a medical student or trained in this country.* ***White Consultant***

It is important to not understate the significance of such material support – we heard several examples of how 'little things' like arranging drivers' licences and bank manager meetings meant the difference between well-being and engagement versus stress and absence for some doctors. Several of the MDs and Clinical Directors acknowledged that the initial support and socialisation was crucial and should not be taken for granted. Some organisations had staff with a dedicated responsibility to lead on this issue with a range of mechanisms – and staff – to help. As one RO put it:

> *We now realise how important for ongoing inclusion within teams sustained early support is for doctors whose PMQ is abroad. Giving everyday practical support is such a good investment whilst we are clear that the process of helping doctors adapt to NHS practices is a sustained journey, not a matter of a swift induction.* ***BAME RO***

In addition to practical support, socio-cultural induction is important. Doctors new to the system were described as needing and valuing induction and ongoing support in relation to the culturally specific aspects of practising medicine in the UK. This included understanding the role of the GMC and nuanced expectations in relation to professional ethics including consent, confidentiality and working in partnership with patients as well soft skills required for UK practice such as familiarity with expressions, how to communicate bad news, the relationships between different healthcare professionals, how to work with other professionals and expectations about demonstrating insight if something goes wrong. References to *Good Medical Practice* and *Welcome to UK Practice* were considered positive and necessary, but as yet insufficient and cannot remove the need for comprehensive workplace induction and ongoing support.

> *There is only so much you can do with PowerPoint presentations and discussion groups. You have to work alongside existing staff to pick up on the subtle but different ways in which patients are listened to, clinics are run, how consent is applied here, how a ward round is best done, how a MDT in a theatre or community setting works.* ***White Clinical Director***

Vignettes

Social 'induction' and support

Organisation A recognised that though they were reliant on overseas trained doctors, the social and personal support they provided to such doctors was patchy.

They appointed a part-time member of staff whose sole role is to ensure that every doctor who joins the trust from overseas is met personally when they arrive in the city. This dedicated member of staff takes responsibility for ensuring, when met, that the new doctor's immediate accommodation needs are sorted.

Over the next few days the staff member ensures every new overseas trained doctor:

- Has support if needed to open a bank account
- Gets advice on where to live longer term
- Is given support on everyday matters such staff typically worry about –such as locating a GP, nursery or school, and support if the doctor's partner was looking for work
- Is connected with a local community group from their country of origin and/or doctors from their country of origin, to assist with acclimatisation

This role was alongside other organisational initiatives to ensure new overseas trained doctors were supported and integrated into the workforce

The Responsible Officer said "We realised that doctors were bringing to work a whole range of worries which could distract them from a focus on induction and their new job, which was sometimes very stressful. It also helped to prevent any isolation or loneliness in early days. We found it really helped with the steep social and language learning curve that entirely competent doctors might otherwise face and greatly assisted with the parallel professional induction we put in place".

In particular, IMG doctors were often not perceived to 'know the rules' and were offered few formal learning opportunities to understand the "*hidden curriculum*" for practising "*the art of medicine*" within the UK.

> *There is no doubt that the generation of overseas doctors who came to the UK at the invitation of the UK government, full of optimism and ambition... there was little support to underpin challenges round arriving in a different culture,*

speaking English but not necessarily with an understanding of local idiom or accent, and facing significant amount of racism not just from patients but from others in the system. (UK trained) ***BAME GP***

The nuances of language, accent, hierarchy and "slang" can be very subtle and capable of causing real problems. There was a strong sense that this was under-appreciated by colleagues.

I am a UK trained and a reasonably senior surgeon. I moved 400 miles to join a hospital in the community where my wife worked. I reckon it took me two years to finally work out the nuances of language, accent, behaviours and relationships so I largely became accepted. How much longer would it take someone with a different accent who is perfectly competent but trained thousands of miles away in a different environment? ***BAME surgeon***

What people were telling me isn't what they meant. ***BAME IMG doctor***

It can be as simple as how you ask for things – not just the words but the tone. The teams we join don't always appreciate that. ***BAME MD (retired)***

People in the NHS from overseas… [are expected] to just soak up the culture as they go along ***BAME Consultant***

A number of Trust-grade doctors who are flagged as having problems are the ones who have literally just been dropped straight into the NHS. ***Clinical Director***

For IMG and EEA doctors in particular there were rich examples of how they have lost various forms of knowledge and support to which they had access in their home country, and which the NHS could focus on replenishing as soon as they arrive. Further, clinical skills might be entirely competent but the scale and pace of work might be very different, necessitating time for new norms to be acquired.

You'll have, in your outpatient clinic [in India] 200 patients sitting outside and you'll see each of them for five minutes. …Here you would see them for 35 minutes or 30 minutes. …And some people who move [to the UK] have already done their practice for several years before they have come here into either training positions or something, and then they find that big shift and they can't undo what they have learnt easily. So it takes some time. ***BAME Consultant***

Navigating a new physical environment, compounded with decoding an unfamiliar socio-cultural context, can contribute to stress and social isolation which create additional barriers to learning, feedback and ultimately can prompt colleagues to note concerns relating to a doctor's practice. One within-BAME difference is that the majority of BAME doctors are of Asian (especially Indian, Pakistani and Sri Lankan) heritage, middle class and even second-generation medical professionals. It is possible that Asian UK doctors can access a family network of medical professionals with NHS insight in a way that other minority groups (e.g. of African nationality) may not do.

Overall, successful employers invested substantially in immersive support to which they attributed their relatively low cases of fitness to practise concerns.

> *For the first two months what we needed to do was have them understand and familiarise themselves with the NHS and the systems, so they were paid but shadowing someone, worked alongside another doctor. And they didn't have that sort of responsibility of having to make all the decisions whilst they got their heads around all the different complexities of the NHS and how the systems work. And they would also have a particular tutor actually who supports overseas medical graduates and specific training, which tends to be quite bespoke.* ***Clinical Lead***

> *We've put in place a placement officer … she's put together a very robust package of everything around someone being placed somewhere, ensuring that they're in the right location, that their kids' schools are sorted, that when they turn up their electricity's on, all the way through to meeting people at the airport.* ***Clinical Director***

> *[They've had] lots of experience abroad but when they arrived here they were completely new… they had communication induction, cultural induction, how to work induction…. It literally felt like you were going through med school for them but it's actually been really valuable doing that.* ***Doctor***

However, it is apparent that in some (possibly many) organisations, resource pressures impact on how long they think that any acclimatisation process can be sustained. But it is clear that failure to properly acclimatise doctors is linked to fitness to practise concerns and therefore safety and more significant resource issues in the long run, suggesting that a mandatory support system or additional UK-wide support needs to be considered.

> *We'd love to spend more time with staff in supernumerary roles and better induction but frankly the pressures are such, especially in some departments, that as soon as possible we have to get new staff onto the front line.* ***White MD***

Thus, our research indicates significant concerns regarding the inadequate induction provided by the NHS and individual employers to doctors whose PMQ was gained overseas. In particular, participants perceived that induction and socialisation practices failed to fill the gap between differences in past and current clinical practice and context. However, we found a number of organisations that appeared to have developed effective approaches to address this need. Examples included:

- Dedicated support to ensure rapid assistance with accommodation, bank accounts, car hire, schools and nursery, familiarisation with the locality and putting in touch with colleagues from the same "overseas" community and a "buddy" (e.g. in the same speciality) who can help IMGs acclimatise to accent, nuances of language, behaviours

Vignette

Professional induction

Organisation E decided that a short supernumerary period, intensive mentoring and team support for newly arrived overseas trained doctors would more than pay for itself in reduced turnover and sustained quality of work. The previous generic induction for all doctors was felt to leave too much to chance. As one clinical director put it "the issue is rarely the general clinical skills of newly arrived doctors. It is more making sure that they understand the social dimensions of NHS practice which might be quite different to their training".

On arrival, an initial assessment is made, based on their interview, as to the likely training and support needs of each newly arrived overseas doctor. They are assigned a mentor and a buddy. The buddy will be from the specialism and ideally the team they are joining, whereas the mentor may be a doctor from elsewhere in the organisation. Within each specialism a judgement is made as to whether a supernumerary period is needed and the duration estimated. That period is not only used to assess their clinical skills and experience but to ensure that local practices and procedures are understood such as local protocols (especially in environments such as an operating theatre), how to do a ward round, how to work with more senior and more junior doctors, working with other professionals, differences in the doctor patient relationship, in confidentiality and consent. Much of this consisted of observation alongside supervised working. Turnover is exceptionally low and morale very high.

One clinical director explained "Some doctors may only need a week but others really need longer. It is unreasonable to expect someone to travel halfway across the world, land in a different social and clinical environment, social mores and language and not expect there to be challenges. We try to put ourselves in their shoes".

- Immediate and ongoing support with understanding NHS processes and culture in particular (beyond Good Medical Practice) notably an assessment process focusing not only on clinical skills (narrowly defined) but on wider NHS norms including
    - expected behaviours within teams, with junior doctors, with other members of the multi-disciplinary team, with non-clinical staff;
    - what to do if a mistake is made (by yourself or others) and what your expectations of the NHS Trust, Board or Health Board and team should be

- A period of paid supernumerary status with length depending on levels of clinical skill and familiarity with workforce and clinical culture
- Online 'on boarding' (to give opportunities to navigate systems and processes in advance of one's first day on the job)
- Ensuring the team being joined is clear about their responsibilities to assist new colleagues' early days learning
- Restricting overseas trained doctors from working alone or being on call until agreed by the buddy/mentor, team and the doctor

3. Isolated or Segregated working

Another contribution to disproportionality in FtP referrals relates to the working patterns and contractual arrangements found in the medical profession. With regards to secondary care, this theme relates to individual doctors who work in isolation and move across many different teams (primarily locums), and working teams located on small or distant sites separate from the main location within a larger organisation. For primary care, this theme relates to BAME GPs, who often experience isolated working in challenging areas.

This theme highlights working arrangements that might affect disproportional FtP referral rates, which we found can be differentiated from (but are related to) broader in group/out group social dynamics (described in Theme 6). Overall, our findings suggest that isolation makes some doctors vulnerable and unsupported. While cohesive teams are a powerful solution to that, they ought to operate on a just, constructive culture with positive leadership. Further, the trends in the NHS are such that factors such as gender, age, and ethnicity co-vary with specialism. This can lead to working groups that are homogenous on multiple dimensions. In this case, cultural homogeneity can exacerbate dysfunctional teams as in the case of inter-caste tensions a small minority of our interviewees shared with us.

Individual secondary care doctors working in isolation. Our data suggests that the doctors at greatest risk of isolation are locum doctors and to a lesser degree SAS doctors. It is not unusual for locum doctors to be based on night shift work and work under significant work load pressures that limit their contact with permanent colleagues. Additionally, SAS doctors were often categorised as isolated, experiencing lower levels of supervision and receiving cursory appraisal. One BAME SAS doctor (below) described the group as being "*systematically isolated*".

> *I don't get to congregate with other hospital doctors unless I make a real effort because during the time when everybody else is at MDT or everyone else is at something else, that's the time I'm running for theatre or whatever…So often we're deliberately, structurally, systemically isolated out…you're on your own.*
> ***BAME SAS doctor***

Locums and SAS doctors' roles may include ward hopping or working across multiple teams so that for each shift they are working with different people. That means that they may have nobody to talk to or get emotional support from in relation to day to day challenges. Thus, particularly in the case of locums, we have a group of doctors often isolated from their work colleagues by virtue

of their working arrangements, who also experience low social contact (Theme 2) which is exacerbated by the diffused responsibility for their learning and developmental relationships (from local agencies and employers).

Working teams in secondary care separated from main site

Isolation at the level of the working team meant that with some employers, subcultures developed which in some cases were excluded from the main site oversight.

> *We still operate in silos with people with similar protected characteristics that don't really talk about it. It's not as if we don't talk to our colleagues but I think we prefer to stick to our own. We're very tribal.* ***Clinical Director***

Sometimes these working teams with strong identities also come into conflict with others, leading to formal complaints about medical practice. One white MD (below) described two tribes in their organisation "*who work philosophically very differently*" – on the one hand, "*non-Caucasian, non-British educated and traditional*" tribe, versus "*Caucasian, British educated and modern*".

> *You had a group who were…more acute…their focus was on the queue, the front door, the turnaround, moving things fast…a philosophical leaning towards being really realistic about what care was offered and putting ceilings on care. …The other group who were more traditional, they were a bit more cautious in the decision making, and definitely more inclined to offer treatment and to pursue treatment even if that was towards the end of somebody's life if they felt that it was the right thing to do, or if it was what the family wanted. …Now clearly if you've got a really functional team, what you have is you have those adult conversations … and you have your consensus positions, and if you've got a case that's particularly difficult, you put it in the open and you have the conversation. [Instead, it] all became this group going, 'That person died who didn't need to,' and this [other] group going, 'You've done all those interventions and you shouldn't have.'*

Across case study sites there was some indication that sometimes these working teams formed "*fiefdoms*" that were then seen as "*untouchable*" by the rest of the organisation. In the extreme, in these fiefdoms, mistakes are potentially "*covered up*", and are never reported, therefore ultimately invisible to the rest of the system.

> *I think our tribalism does affect reporting frequency and patterns. And I think our tribalism also affects how we investigate… most of our services are site-based and we're very proud of our site. Well that's one of our tribes, is our site. But a lot of our support services, like pharmacy and radiology, are provided pan-Trust. And there is a tension between the site-based services and Trust services. And that will play out in discussion or investigation of incidents, for instance. On both sides. So if we see something as a 'yet another' …[from a certain] pan-site division… with a rolled-eye feeling, we will go for it with full strength, whereas if something*

similar happened on-site we might have dealt with it more internally with less vigour, perhaps. ***Clinical Director***

A final team-related theme concerned taking the group's performance into consideration when making decisions. One senior BAME consultant described how he had been asked to investigate an incident involving a junior BAME consultant. Both were international medical graduates:

> *I was asked by the MD if I would conduct an investigation into an incident that had been flagged up by the doctor himself. I was a bit surprised as this incident was an expected occasional risk in the particular procedure and I was not aware of such a mistake being formally investigated previously. I did conduct the investigation nevertheless. I discovered no harm had resulted, that the doctor himself had flagged the mistake via Datix as soon as it happened. Out of curiosity I asked to see copies of previous Datix reports and any previous formal investigations into such mistakes. There were several Datix reports in the previous two years but not a single formal investigation. As far as I could see all, or almost all, of the doctors who had made this mistake previously were White. No one was able to explain why this particular incident warranted an investigation when none of the others did.*

Further, this senior consultant said that rather than just scrutinise the records of this individual BME doctor he asked to see the records of the immediate team as well. He explained:

> *(*Rather than just focus on one individual's records*), if there were shortcomings in several other team members' records then I avoid the risk of confirmation bias in the investigation.*

Another MD made a similar point about the risk of confirmation bias in drawing conclusions from one team member's record without cross referencing other team members' records.

<u>Primary care (GP) doctors working in isolation</u>

As in secondary care, there seemed to be a conflation of gender, ethnicity and age and rural/urban nature of the practice. For example, Esmail and colleagues (2017) explored the characteristics of IMG and EEA qualified GPs in England and found they comprised 21% of the total numbers of GPs, with the largest percentage in East England (30%). IMG and EEA qualified GPs were more likely than UK qualified doctors to be working in practices with higher median patient location deprivation with lower GP-to-patient ratios. There is some evidence that these areas of high deprivation have a higher proportion of IMG doctors who in turn are more likely to be over 50 years old (Taylor & Esmail, 1999)

IMG and BAME GPs are found disproportionately in inner city areas, ex-mining communities and coastal towns (Simpson et al., 2010) These GPs are also more likely to be older (Blane et al., 2015).

Such GPs will in addition face the more general pressures GPs as a whole are under with heavier workloads. Four out of five GPs felt the increased multi-morbidity of patients has had a negative

effect on their work (GMC 2018). When patients presented with multiple issues, some doctors felt they only had time to deal with the main or first issue being presented. Significantly GPs have reduced engagement in other activities that in the long term may be critical to an effective health system or to doctors' CPD (GMC 2018)

> *I was conscious of the difference between white and black doctors when I started out as a GP. In this area, the black doctors were primarily in single handed or small GP practices whereas the white doctors were predominantly in much larger group practices. … There was a widespread view that it was harder for BME doctors to join them and when they did they might find additional conditions on their contract e.g. longer probationary periods.* ***BAME GP***

Another GP noted:

> *I know of a number of instances where BME overseas doctors tried to join larger white practices and failed to get in…. these doctors might have been a bit nervous about bringing in a complete stranger into what was, in effect, the family firm. But it did mean there grew a perception that in some places there was a degree of segregation.* ***BAME GP***

Within primary care, GPs who work in more deprived areas may be particularly prone to the impact of the heavy workloads experienced by GPs as a whole. Further, a disproportionate number of BAME doctors work in such areas, and are more likely to work in smaller practices in those areas. A substantial proportion of those doctors are also overseas doctors by Primary Medical Qualification. A combination of such factors means doctors in such practices may be at greater risk of referral when scrutinised by regulators or those responsible for commissioning services, and we heard several examples where doctors felt that is what they had witnessed or experienced. Interviewees in particular drew our attention to the fact that there is a cohort of older doctors who are BAME (mix of IMGs and UK trained) who took up roles 30-40 years ago predominantly, who

- Are disproportionately in smaller practices in more challenging/deprived areas
- Experience professional isolation, longer hours and more sessions (11-hour days, 5 days a week) with additional capitation funding not sufficient to compensate for multiple co-morbidities
- Are less likely to engage with such courses as those delivered by LMC, CCG, RCGP due to cover problems

This may contribute to explaining why older doctors are more likely to be referred

> *You can see why single handed practices in particular might find themselves under scrutiny since the pressures would be almost intolerable for a number of reasons. Firstly single handed (or two handed) practices in more deprived areas are largely run by older GP partners – white and black. A substantial number of*

the ones I knew were doctors who trained abroad, often without additional GP vocational training. After 30 or so years of working eleven hour days with limited cover capacity, professional isolation, reduced opportunities for CPD or just meeting professionally or socially with other GPs, you would be worn out and it was quite likely your practice risked becoming out of date. ***GP BAME partner***

If you are a BME doctor, working on your own or in very small practice in in an inner city or deprived area it is almost inevitable you will be under immense pressure due to workload and be professionally isolated. Even if you have the same size list as other GP practices the work demands from a poorer practice population with lower life expectancy, a multiplicity of conditions, often with mental health issues. That means patients may be more likely to visit the surgery more often, you will find yourself dealing with several issues which cannot be dealt with in 10 minutes and that leads to frustration all round. If patients get frustrated they may be more likely to complain. Sometimes even more so if they are white and you are black. If you can't take time out for mixing professionally (or even socially) then your practice risks becoming out of date and you may lose the curiosity that drew you into medicine in the first place.… ***BAME GP partner and former CCG chair***

In particular there was a sense from some that there was very little contextual understanding of certain GPs' work environments.

When I hear of appraisers, NHS England, the RO team or CQC judging them, I often don't feel they are being judged in the context they are working. They are being judged by doctors, generally, who have lighter workloads, work less sessions, work in larger and more supportive practices, who are better networked, who know the rules. … But they should be aware of them and judge GP practice contextually. When practice is criticised is it because it is poor or simply because it falls below the gold standard these external judges think they practice by. Sometimes "good enough" can be perfectly safe given the context and is likely to be better than driving a GP out of general practice. ***Recently retired GP partner***

One positive intervention which appears to help address the challenges facing GP practices in deprived areas has been the Deep End project which originated in Scotland (supported by the RCGP) and which has now extended to parts of northern England and Ireland. It is formed of the practices serving the 100 most deprived populations in Scotland and acts as a supportive network to overcome the challenges facing such practices. Its work includes support for social prescribing and increasing the clinical time available for GPs under pressure (https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/)
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4. Remote and disjointed (rather than approachable and unified) senior leadership teams

Another contribution to rates of FtP concerns relates to the role of an approachable and unified senior leadership team, a *"flattened hierarchy"* in regular communication with each other to share informal updates and challenges, role modelling openness and transparency, beyond the MD. This was described by one MD as his leadership team having a "*strong collective identity*". Evidence suggested that such outcomes were enabled by size of NHS Trusts, Boards and Health Boards, single site location and the support of ELAs in informal sense making of issues of concern.

Ongoing intelligence gathering, described by one MD as having "*visibility into colleagues' practice*", helped to identify concerns early and "*nip things in the bud*" or "*diffuse things*" as another MD described. One clinical lead described their approach to catching issues early as based on promptness and accessibility and team/collaboration:

> *Say one of the assistant medical directors had a concern about a colleague. They would pick the phone up, I would expect within hours, to the associate medical director or to me. …We're available and we're all taken those phone calls at quarter to five on a Friday.*

Further, a connected team provided regular access to senior staff for junior staff, reinforcing a safe learning culture (discussed under Theme 5). There were a number of strong positive descriptions about some of the organisations we visited. There were descriptions of management being available and accessible, senior leaders being called by name rather than title:

> *You can directly contact them. They are very visible on emails, the office. You can just talk to them whatever the issue.* ***BAME Doctor***

And

> *[We have] a Chief Executive that prides himself on openness and integration and talking to people and getting from the shop floor to most places****. BAME MD***

Another leader described the effort required for senior leaders to do this:

> *[Regarding] having the more junior members of staff being empowered to speak up, it's having the time to meet with them in a non-threatening environment, sitting down with them, getting them to utilise a freedom to speak up guardian, getting them to engage with trainee feedback…But it all takes time.* ***White Clinical Director***

There was some awareness that additional effort is required to communicate to one's front line staff that this was the senior leadership team's style. One consultant acknowledged that "*culturally, for some, to pick up the phone at three o'clock in the morning and wake your consultant up would be really very hard to do*" reinforcing the responsibility of leadership to be explicit about approach.

Vignette

Implementing the SAS Charter

Organisation B recognised its secondary care services were dependent on SAS doctors but, despite this, SAS doctors were not provided with appropriate support and opportunities.

The Medical Director engaged with SAS doctors to discuss how they could adopt the principles of the SAS Charter, trying to ensure that training opportunities for SAS doctors were increased and Continuous Professional Development built into job plans. A former SAS, now Clinical Director who was overseas trained, took responsibility for leading this.

The organisation's Medical Director took the significant and symbolic step of having their appraisal undertaken by an SAS doctor. SAS staff in this organisation were significantly more "upbeat" compared to other organisations.

Some attributed this transparent and approachable leadership style to the size of NHS Trusts, Boards and Health Boards (one MD described their Trust as "*a village*" compared to other "*cities*") that came with a degree of intimacy and directness that was not replicated in many other places we visited. The ability of the senior management team to respond appropriately to concerns and make judgements about issues as they emerged was supported by their Employer Liaison Adviser (ELA). In a number of organisations, there was a view by senior management that the introduction by the GMC of their ELA system had been a positive initiative. Although there was awareness that due to their regulatory function this relationship could not be seen as "*too cosy*" (as cautioned by an MD).

> *The ELAs give a really helpful challenge. They've made us think a bit harder about our threshold for referral and are frequently used to check whether our approach is the right one. They are very good at getting us to really think hard about whether a concern is best referred to the GMC or can (and should) be dealt with locally.* ***Responsible Officer***

We were conscious that the organisations we visited were expected to be more open and demonstrate better practice on the whole. A number of those interviewed contrasted their current organisation with others they had worked in, in which the senior leadership team was less cohesive.

> *I've worked in HR in three NHS organisations at senior level. In this one, clinical directors, HR, the MD and the RO are comfortable challenging each other. In both my previous organisations it was more hierarchical with the MD (who was also the RO) being the dominant character.* ***White HR Director***

Some doctors expressed an anxiety about the use of appraisals, particularly in the light of the Bawa Garba case. It is unusual for concerns to come to light through the appraisal processes. The GMC has provided guidance on this stating that "we do not ask a doctor to provide their reflective notes in order to investigate a concern about them." Appraisals should not be the main way that concerns about doctors are identified and managed. Healthcare providers should have clinical governance systems including incident reporting, complaints systems and investigation processes in place to identify and manage concerns which, in some cases, may include referral to the GMC. (GMC, Disclosure of reflective notes [ND]).

5. A 'blame' culture rather than a learning culture

Going beyond the interpersonal and team, the prevailing organisational culture also plays a part in explaining disproportionate FtP matters. Although blame cultures were reported across primary and secondary care, the predominant source for this theme was from GPs. Likely reflective of our sampling strategy of visiting open and learning organisations, there were several examples of what a learning culture looked like with implications for apportioning responsibility of mistakes to the system rather than the individual.

Vignette

Rapid response to investigations

Organisation C developed a particular approach to "mistakes" or poor behaviours informed by 'human factors' science (i.e. when considering something that has gone wrong, trying to identify the range of individual, team and environmental factors that may have contributed).

This organisation sought to systematically train all managers in an approach that was built around speedy intervention. Within hours of an "incident" involving a doctor occurring that might require any kind of investigation, a specifically trained doctor conducted an initial scoping exercise to determine whether further investigation was needed and within three days a preliminary assessment was completed.

A focus on "what could be learnt to prevent it happening again" rather than "who should be held responsible" underpinned such scoping and investigation, whilst retaining consideration of accountability. The entire approach was informed by soft intelligence and data suggesting which teams, or departments, might need additional support. The result was a significant reduction in disciplinary investigations and almost no referrals to the GMC.

In contrast, there was a sense from some GPs we interviewed that assessments were conducted with *"a culture of 'we will find something wrong with you"* that was exacerbated by little

acknowledgment of the context in which they worked (as discussed in Theme 3). Thus, single handed practice GPs, a good number of whom are staffed by older Asian doctors working in isolation, embedded in a blame culture, with multiple sources of scrutiny, are more likely to fall foul of FtP concerns.

There was acknowledgment that some organisations had "*defensive*" cultures, identified by its medical professionals as being "*anxious and scared*". For GPs, some felt that this was sometimes linked with an under appreciation in appraisals of the context in which some GPs operated.

> *All doctors make mistakes. I'm not saying poor doctors should not be identified and the issues tackled but this should happen in a supportive way wherever possible and it just didn't feel like this to many people… although the GP or practice would always be told there was no presumption of guilt it often felt like that.* ***GP partner***

> *Following a patient complaint, the GMC decided 'no case to answer' very quickly. However, the PAG ordered a Records review … this led to further investigations and although eventually no further action was taken it led to this GP deciding to retire six months later due to impact of this process….There is no learning just punishment* ***BAME GP and LMC member***

> *There is a real risk in the current climate of using mistakes in behaviour or practice as an opportunity to remove single handed GPs – something that would suit some CCGs – and even the local GP competition. We should treat all doctors – in whatever sphere they are – with compassion. It doesn't feel like that at present.* ***BAME GP***

There seemed to be significant variation in approach by Performance Advisory Groups (PAGs) in England. Some were reported as not always appreciating the context GPs worked in and being too quick to find blame. A main cause of distress several (BAME and White) GPs in England reported was that a single concern may prompt different parallel inquiries. There was insufficient data to make similar conclusions about other nations.

And,

> *A perfectly healthy and capable GP, aged 70 from a BME IMG background…there was complaint by a patient …[the advice was] within the range of reasonable advice and from which no harm came. Nevertheless, he was then invited to a meeting with the NHS England performance team with two managers and a clinical adviser. He described the meeting as an interrogation which was bullying in tone. The outcome of the meeting was a 'records review' …[their] approach seemed to be that they were determined to find something. … The next thing he knew there was a CQC inspection looking at aspects of his premises. They didn't look at the quality of his care in the consulting room or the very positive views of patients. He found himself locked out of his premises. Eventually the pressure of*

two ongoing investigations and waiting for the outcomes led this doctor to resign as a GP. No Fitness to Practise allegations were ever brought against him but the NHS has lost a good GP. ***BAME GP***

We are in a tougher environment. I feel appraisers and CQC inspectors don't appreciate the pressures we are under. They hold us to a standard it is harder for us to reach. In turn I'm sure we sometimes come across as defensive but that's because we don't feel our pressures are understood. ***BAME GP***

Vignette

Proactive intervention with struggling GP practices

One Clinical Commissioning Group developed a dashboard that enabled them to systematically identify GP practices likely to be experiencing above average pressures. This seemed to be a formal way of collating the informal intelligence that Responsible Officers covering primary care will have acquired to a greater or lesser degree.

Using a range of data such as average sized patient lists, clinical quality data, and demographic characteristics of patient lists associated with increased demand, monitored regularly almost in real time, this enabled the CCG to undertake interventions to provide additional support to practices experiencing above average pressures. Using the analogy that "it is better to fix the car when the brakes need checking not after it's crashed" this enabled specific support (for example limited funding and direct supportive discussions with GP practices) when staff sickness or turnover might easily have turned a problem into a crisis.

In another part of the UK, there was an active policy of pairing nearby smaller practices so that they might introduce a division of labour with each practice specialising in certain interventions rather than, as previously, both doing the same intervention less well individually.

A learning culture should be based on human factors science, with a high level of understanding of the impact that environmental pressures and substandard systems have on individual performance. The views we heard suggested that the understanding of human factors and the presence of a learning culture in England may be patchy and we heard criticism that scrutiny of GPs in England did not always take account of the pressures that exist in the environment in which they are practising when assessing their performance We were unable to conclude how widespread such concerns were (or were not) but were certainly also aware that some parts of England appeared to be significantly closer to a more proportionate and learning approach than others.

We observed several secondary care organisations in which there was good understanding of human factors science, with an emphasis on early intervention and a reluctance to commence extended formal procedures unless really necessary. We observed instances of a psychologically safe context, recognised by various participants as one in which "*openness and discussion and learning from errors is encouraged*" and in which concerns were dealt with as "*a learning event rather than pointing the finger*", and one in which *"people will take care of you if things go wrong*."

As one participant described,

> *It is about not blaming someone when something goes wrong. It's not automatically someone's fault. You can't say, 'Right, you should have done this, you should have done that.' It's about, 'What should we have done better?' And sometimes people do something really awful and you can't get away from that, but not assuming that's the case all the time. And looking at the processes rather than looking at the people.* ***SAS doctor***

Another clinical director (below) described:

> *The culture of the organisation is a supportive one. So it's more, 'What is happening to this individual? What are the immediate effects on patient safety?' But then, 'How can we support this colleague to progress this?' It's not actually, 'Do we have to investigate?'*

A small number of participants were sceptical of the ability of the medical profession to embrace such a reflective learning approach. One participant described it as an "*arrogance of excellence*" in medicine. This professional arrogance keeps members of the profession (old, new, UK, and outside UK) believing in a sense of self-competence and self-efficacy, that acts as a barrier to a learning approach based on human factors science and potentially reduces the value of 'not knowing', and learning beyond technical expertise. A similar sentiment, describing medicine as a perfectionist culture is described below:

> *Medicine is very perfectionist …There are very few places that have genuinely embraced the concept that we make mistakes and these are the outcomes and we can talk about our failings. ..For somebody to actually say, 'You know what, I genuinely don't know how the consultation works and how do I learn these things?' …If that is fundamentally dealt with then it doesn't matter what background or whatever, [anyone is].* ***BAME GP in training****.*

Although there was mention of formal training in just and learning cultures, awareness of the benefits of a learning approach to mistakes was left too much to the individual to acquire. One senior PAG member described themselves as being "*on a journey*" to adapt human factors learning into their decision making. One MD came to an understanding that their approach to records reviews was likely affected by confirmation bias.

> *If someone had made a significant mistake or a series of mistakes my default position was to do a records review of that individual. But then I realised I was*

missing the point. It was only if I did a records review of the immediate team as a whole that I could have any confidence that an individual's problem with their records or performance was not actually a systemic problem which might apply to the team as a whole. I was at risk of just looking for evidence that confirmed my original suspicion rather than seeing the bigger picture. So I stopped doing it, it was a biased approach. ***MD mental health trust***

A number of senior leaders (not all) acknowledged the importance of understanding the different backgrounds of their staff. In one particular organisation, the senior leadership team was diverse and the Directors interviewed highlighted the benefits of cultural diversity in the senior leadership team. For example in addition to adopting a learning approach, it was not unusual for senior leaders to inquire specifically about the potential role of cultural differences when analysing issues that had come to their attention. Here consultants and SAS doctors (BAME and white) described belonging to a supportive and inclusive culture.

Other indicators of a safe space in which learning was the preferred response to understanding things not going as planned included:

- Explicit emphasis on early and informal intervention wherever possible, informed by an understanding of human factors and "just culture"
- Focus on decision making as a collective process that welcomes challenge and incorporates feedback from those who may be more at risk from such processes
- Ensuring those responsible for investigating and managing incidents or behaviours understand that avoiding difficult conversations early on may lead to a later risk of unnecessary, biased and drawn out formal investigations
- Explicit attention to the risks of extended or late investigations to patient safety and staff well being
- Close co-operation with the GMC Employer Liaison Advisers welcoming their challenge and advice as appropriate
- Normalisation of mistakes (while not compromising patient safety) such as showing a video montage of senior medical professionals sharing career histories including, "When I made this mistake, this happened, and this was the consequence…"
- A newsletter reporting frankly what incidents have happened, what was the consequence and the learning outcome
- One CCG had developed a comprehensive, preventative early warning system with a "dashboard" of intelligence drawn from a range of data to provide support for GP practices prior to regulator or contractor intervention. This Manchester Health and Social Care Commissioning "early warning" system (not a performance management system) felt like a step up from a purely informal soft intelligence system and appeared to have positive results

Overall, our research found, in line with the literature, that organisations whose governance emphasised early intervention, human factors science and an emphasis on learning not blame

appeared better placed to act in a preventative proactive way prior to any need to make a referral to the GMC.

6. Out group bias & in group favouritism

A final and pervasive theme that explains the over-representation of some doctors and under-representation of others in the FtP process relates to the broad social process of insider/outsider dynamics. As one BAME doctor said "*If you have Group A and Group B, there's always a better one*". This theme touches on other themes previously raised including the feedback gap, differential socialisation and segregated working. However, we highlight this as a separate socio-structural (macro) theme to draw attention to findings specifically linked to insider/outsider dynamics including othering, biases and in-group privileges.

Insider/outsider dynamics lead to certain groups of doctors being perceived as the 'other'. This theme was particularly prevalent in the SAS doctors' narratives. However, the research indicated it was not simply a case of one fault line between two clearly demarcated groups; data suggested hierarchies based on qualifications (spanning region, country, university type and medical school) and skin tone (spanning ethnicities and castes; including racial hierarchies within the BAME community (Asian above Black; high caste above low caste). A BAME SAS doctor highlighted the inherent "*gradeism*" within the medical profession. These hierarchies perpetuate beliefs about certain groups' medical practice.

Many of the groups that are disproportionally affected in referrals to the GMC are commonly perceived as lower status outsiders. Drawing broadly (but not universally) from our extensive interviews, IMG doctors are typically seen by some of their colleagues as having "*not as good medical qualifications*", locum doctors typically deemed by clinical and non-clinical managers as "*not one of our employees*", and SAS doctors perceive their peers see them as "*not good enough to be consultants.*" Examples of these outgroup professional stereotypes are below.

The quote below illustrates the hierarchy regarding place of Primary Medical Qualification with implications for different types of overseas graduates.

> *When you're long-listing and shortlisting you view qualifications from outside the UK as less valid than qualifications within the UK... An Indian medical qualification is viewed as inferior to a European medical qualification, which is viewed as inferior to a UK qualification.* ***Clinical Director***

In a focus group of consultants and SAS doctors in one organisation, the following comments were made regarding locums:

> *Female doctor: They're only used in desperate situations, so I think if people need them...*
> *Male doctor: They're a commodity, aren't they? They're almost traded between trusts.*
> *Female doctor: Absolutely.*

Male doctor: And they're not privy to portfolios, workplace-based assessments. They're seen as a service provision rather than a trainee who needs important guidance

With regards to SAS doctors, we found contrasting experiences of being perceived as 'the other'. On one hand, several individuals expressed a sense of belonging and inclusion in the organisation at which they were interviewed. This demonstrated the impact of efforts certain case study sites had made to actively integrate SAS doctors (we provide examples of this later in this section). On the other hand, there was a strong narrative (from SAS doctors and non SAS doctors) that this group faced strong outgroup bias and exclusion, with SAS doctors viewed as "*workhorses*", "*invisible labour*", "*second class citizens*" and "*nameless and faceless*". Notably, this narrative was absent in Scotland. For example, in a focus group of consultants and SAS doctors in one organisation, the following comments were made:

(Male doctor): There is a sense that they are sometimes used as workhorses. And medicine's quite hierarchical and there could be a sense to which you are doctors but you're not quite...
(Female doctor): You're not proper doctors.
(Male doctor): You're not quite real doctors; you're SAS doctors.
(Female doctor): So, you've failed at becoming a consultant.

And, from one participant in a focus group of all SAS doctors:

As SAS doctors we often feel we are treated as second class citizens. In our own Trust almost one third of the doctors are SAS doctors but we seem almost invisible. We don't get the same opportunities for development and a minority of consultants really look down their noses at us. I know that lots of my colleagues are convinced that if anything goes wrong it will be treated more seriously than if a consultant did the same thing. ***BAME SAS doctor***

These examples indicate potential exploitation of SAS doctors and locums. When we consider that both these groups have high BAME representation, it amplifies the impact on certain doctors, indicating a system that exploits a primarily BAME resource. Further there was frustration from respondents that these hierarchies and boundaries are rigid, minimising the chances of transition from a lower perceived role (e.g. SAS) to a higher level role (Consultant).

Box 2: SAS doctors

Staff grade, specialty, and associate specialist (SAS doctors) constitute one in five of all doctors with a licence to practise. These doctors are not in training and not on either the GP register or the Specialist Register. They have a range of medical experience, with many reasons for not being on the Specialist or GP registers. Many are from BAME backgrounds and large numbers are IMG or EEA graduates. These doctors are far more likely to be male than female in all but the youngest age groups (though not in Scotland). They do not work in primary care

SAS doctors have been particularly dissatisfied with the value their organisation places on their work, the opportunities they have to use their skills, the amount of responsibility they have and the support they receive from their colleagues whilst three quarters reported they have had to work more hours than in their job plan in the past year. (BMA 2015. 2017) BMA SAS doctor survey (2015)

GMC data does not distinguish SAS doctors from a wider group of doctors who are neither specialist nor in training. Career doctors on neither register and not in training (primarily but not exclusively SAS doctors) are less complained about than other register types. However a much greater proportion of the complaints made about this group of doctors come from their employers compared to other register types. Less than half of complaints came from the public whereas across all register types, the public contribute the greatest proportion of complaints. Complaints from doctors' employers accounted for almost a quarter of complaints about these doctors. More than half of these complaints result in a full investigation unlike complaints about specialists or GPs. https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/specialty-and-associate-specialists-and-locally-employed-doctors

What sustains these insider/outsider dynamics that have a particular impact on some types of doctors? There was some indication that the lower status of some doctors was justified due to perceived differences in competence. However, the quotes below illustrate how perceptions of competence closely intertwine with intergroup relations. That is, difference leads to marginalisation which in turn limits group members' access to experience and learning through feedback and ultimately affects assessments of competence; all themes considered earlier in this report.

> *People are often more dismissive of [IMG doctors'] opinions and their knowledge. And I think that's partly because the way they approach medical problems is often different from the way that UK graduates approach medical problems. … Because of that different approach, they're potentially marginalised.* ***Consultant***

> *[Regarding locums] I think you've got a real sort of wicked triangle there, where you've got people who are potentially overseas trained, who are not getting into a long term post where actually there will be sort of oversight, structure, professional development, and who are then mobile…where you don't sort of get integrated.* ***Clinical Director***

> *It can be very difficult for a locum to operate effectively if the practice does not have the time or inclination to ensure they are familiar with 'how things work*

here'…. If things are done differently and the locum does not have easy access to advice from GP colleagues then professional interaction may be minimal, limiting the sharing of information or the asking of questions. ***White GP***

So you're my manager. I'm either one of us or I'm an outsider…Well then there's a series of value judgements that are made, which are some explicit and some implicit but they're closely related to each other, about the value of your work and the implications of challenging your behaviour in your work, on your productivity. ***Clinical Director***

The SAS doctors in focus groups regularly contrasted their treatment with that of consultants with "*halos*" who were automatically given credibility; some suggesting that consultants wield the power or threat of referrals over them. Some SAS doctors certainly move on to become consultants or registrars (27% said they planned to in a recent survey [BMA SAS survey 2015]). However, the pressures on them prompted 75 per cent of respondents to the same survey to report having to give up time for Supporting Professional Activities to fulfil clinical duties.

SAS doctors in Scotland seemed more optimistic about their chances of becoming consultants. We noted differences in demographic composition in Scotland where SAS doctors are more likely to be White and more likely to be female. We observed White female doctors becoming SAS doctors as a career choice; there also was a more proactive approach to SAS professional/career development in Scotland, an apparent reflection of the sustained development effort by the Scottish Deanery.

Thus, despite being deemed to have met the standards for medical practice in the UK, IMG, locums and SAS doctors navigate additional hurdles. They have to grapple with colleagues' perceptions about where/how they qualified to meet the standards (in the past), as well as manage challenging everyday interactions vis a vis colleagues in "more substantive" posts (in the present). This means that stereotypes that some types of doctors are both not like us nor as good as us, are sustained. Many interviewees emphasised that these stereotypes were irrespective of professional capability. Moreover, several participants accounted for differences in local assessments of FtP as down to bias and racism.

It's not always unconscious bias. I think it's often conscious bias. ***White consultant***

One [reason for disproportionality in the FtP process] is [skin] colour and second is they are perceived as lesser. And they are only perceived as lesser, they are not lesser. ***BAME Doctor***

I suspect quite a lot of judgements about doctors are based on how they carry themselves, how easy you find it is to blend in. …You can be a perfectly competent clinician but that doesn't mean you are safe from suspicion. ***BAME GP***

There is widespread view that there is a risk of bias by appraisers, CQC inspections, and performance list teams. Certainly CQC inspections are much

more likely to fail BME practices and the CQC should be curious about that not just dismiss the possibility of bias. ***BAME GP***

Further, we found that while there was no substantive hesitation in talking about racial bias in our interviews, many doctors were reticent to make overt claims of bias to their employers. Linking to Theme 1 (avoiding difficult conversations), one explanation provided by BAME doctors in a focus group is a fear of raising complaints against white counterparts:

There are several instances where actually the ethnic minority doctors don't even complain about their white British colleagues. ***BAME Consultant***

On the whole Asian doctors kept their heads down because they could see no point in openly challenging the racism they met. They did not feel they would be supported. (UK trained) ***BAME GP***

[After informal conduct query], going forward I'm just extremely careful now to just be as quiet as I possibly can, stay out of people's way. ***BAME consultant***

Keep your head below. If you stand up for your rights, they will frame you. ***BAME SAS Doctor***

In the focus group of BAME and IMG doctors, they also indicated many shied away from refuting or challenging accusations due to a fear of repercussions.

If they speak up they're worried about how that is going to backfire on them, which is why they don't do it … we are not timid characters, it's the fear, the system makes us fearful of repercussions. ***BAME consultant***

The quote below from a Black doctor in training describes how socio-economic status (valuing for job security where there are few opportunities) plus a cultural directive to not "*cause any trouble*" can contribute to avoidance of challenge, even if the role requirements are challenging (as is experienced by many locum and SAS doctors):

If you already know that the jobs are limited… a lot of black people when you grow up you are told to stay under the radar, don't cause trouble with the powers that be or authority figures, because it doesn't tend to go well for you. … Therefore, if you know that statistically, for example, you're more likely to get into trouble with the GMC etc. or you are replaceable because you are not even in the training programme, you don't even count, all of that is happening, if there are issues with that role, you are not likely to cause any trouble. because maybe the issues of that role are still not being dealt with, so eventually maybe it… becomes a question of when will something go wrong rather than will something go wrong. ***BAME Trainee GP***

This fear was contrasted by the confidence that comes from knowing you're in the in-group and things will be 'sorted out':

When you are in a state of fear you are more likely to withdraw from the situation as compared to if somebody was in the situation of confidence that 'he is my man or my woman… [we] could have a beer tonight and sort it out'. ***BAME Doctor***

The quote below captures one of the SAS doctors' comments from the focus group of the implications of not being protected or defended when you're "othered", to which many concurred:

We are othered in very many different ways. When somebody has the title of a consultant, they must be brilliant and good because they've got to that job. But if you're a SAS doctor, no-one really knows what SAS means. You're just not quite good enough, and if you're just not quite good enough who's going to come and defend you? Who is going to come and stand up for you? ***BAME SAS Doctor***

Another doctor referred to the Bawa Garba case to illustrate the differences between how out-group and in-group members may navigate potentially challenging contexts:

If it was a white doctor, she would have gone to [Occupational Health], and actually told them, 'I can't come back' or, 'I'm going to come back phased in'. 'That's my right. I've got my GP daddy, brothers who are telling me that you need to go to [Occupational Health] and this is what you need to tell them. So she wouldn't [have been] put in a position where this poor black doctor says, 'I don't want to cause any trouble here, I will accept to do this shift, I will accept… ***BAME SAS Doctor***

This suggests that bias and stereotypes regarding some groups' competence is compounded by a fear of challenge by these groups (because they have less power). This is likely to contribute ultimately to the over-referral of certain types of doctors in the FtP process. We recognise that anxieties around "political correctness" and not "naming race" are broader social phenomena. Further, data suggest that hesitation to name racism as a form of outgroup bias was seen as pervasive across the NHS systems:

I don't think doctors get nearly enough (indeed hardly any if at all) training on how to deal specifically with racism from patients – or even other colleagues … The medical profession doesn't like to talk about this but it is a reality. I think it is really important that all those involved in healthcare - including those who inspect or regulate us – understand that bias can easily creep in even if open racism is less frequent. ***BAME GP partner***

In addition to the above risk factors increasing the chance of outsiders being reported to the GMC, are protective factors that decrease the chance of insiders being reported. Examples of how this happened include insiders comprising strong cohesive and non-diverse working teams and supporting and coaching each other through difficulties. Thus, participants described "*tribes*" formed where colleagues (particularly but not only white doctors) have attended UK medical schools with each other, trained together, lived together and dated or married each other. This

shared socio-historical field leads to strong in-group identification, as demonstrated by relative homogeneity within the group, long period of identification, and the development of norms which are opaque to outsiders.

> *Now our senior management team in this hospital, lots of our consultants were all in the same year at medical school... I think it does affect how they work. They go for dinner together. They have their own personal relationships outside of work, but that means that their work relationships are closer. People that went to either X or Y Medical School, people that have trained at XXX, there's a club. But it's a very natural club if you've been at those schools together, you're going to club together, you're going to do things together 'cause it's a forge, you know? It's a crucible … I think it surfaces as more decision-making happening behind the scenes.* ***Clinical Lead***

Another reason to explain the under-representation of some types of doctors in FtP reporting that was less often presented, but nonetheless present across more than one location, was the recognition that some professionals in powerful positions, such as "*substantive consultant posts*" were perhaps 'too big to fail'.

> *If you're a surgeon and you've behaved appallingly, I've got the option of suspending you and having to recruit somebody else …[Alternatively we could say] 'That's just the way he is. You have to work around him. I agree that wasn't acceptable and I really sympathise but we're not going to be able to change that and he's a fantastic surgeon, so can you just try and work around him a bit?' I mean, those really are conversations that still happen. (****White Clinical Director)***

The currency carried by certain posts include publications, media presence, and an international profile that potentially outweigh the risk associated with losing them due to concerns regarding their practice. As one Clinical Director described "*a consultant surgeon takes twenty years to train and you can't just grow a new one. There's not as wide a selection of them out there".* Of course, insider/outsider status is dynamic, and always changing. Other doctors described how they may be an insider in some contexts (workplace team) but not elsewhere (e.g. committees, Royal Colleges etc.). However, some (possibly many) BAME consultants didn't see themselves as being fully insiders despite their professional status. Some BAME consultants said they had experienced feeling more marginalised as they become more senior. Strong in group identification had clear implications for potential under representation of certain doctors particularly white doctors in referrals by employers/healthcare providers to the GMC's FTP process.

> *The white British doctors …they seem to have a better line of communication with the senior managers, they seem to be trusted more by the senior managers* ***BAME Doctor***

And,

> *At the drop of a hat an ethnic minority doctor gets referred but however big a problem may be associated with a British doctor, there is just a pat on the back and they say, 'Oh, don't worry, I'll look after you. Don't do it again. Be careful'.* ***BAME Doctor***

One BAME consultant exemplified the belief held by many of our BAME participants that different standards were held for white vs BAME professionals which is captured as how "*obviously unprofessional"* versus *"dubiously unprofessional*" incidents are attended to differently depending on the group to which one belongs.

> *Sometimes it looks like resolving issues with a white doctor seems to be smoother than resolving issues with ethnic minority doctors ... one of the clinic managers dismissed all her support staff before the clinic was opened and I was seeing patients without any support. I was subjected to a disciplinary process because it was perceived that I had bullied a healthcare assistant, by calling her and asking her where she was … Later the same clinic manager cornered one of our SAS doctors in a room because she had put in a Datix about a clinic incident and asked her, 'Why did you put this clinic incident, you've upset my staff… Are you expecting us to wipe your bum down?' The SAS doctor came to me and she was very upset [but after I approached the clinical manager's manager] I realised that there was no interest in sorting this out. So you can see that something which is so obviously unprofessional and something which is dubiously unprofessional have been dealt with in completely different ways.* ***BAME Consultant***

For some of our participants the link between the intergroup dynamics and assessments of mistakes were clearly influenced by social group memberships.

> [For the] *referrals that are not that black and white … the perception of the referrer is influenced by what is presenting in front of the referrer* ***BAME Consultant***

> *There is actually something of a barrier between the white manager and the IMG doctor; it is very much a clinical relationship and a very power deferential relationship, whereas if you examine what happens between a white manager and a white doctor…there's a bit of a social context with the relationship and there's lots of small chat and there's banter, there is something around the language being shared and the accent probably is very similar, the culture and background …if there is a mistake made by a white doctor these wider factors then come into play …whereas with an IMG the moment there is a mistake made there is no context to it, the only thing that is visible to the white manager or the white senior person is the mistake and it's really white and black.* ***BAME doctor***

Despite the overwhelming awareness of intergroup dynamics influencing the likelihood of investigation, discipline and potentially referrals to the GMC, it was clear that some sites had

active strategies to reduce outgroup bias and increase inclusion of certain types of doctors. For example, concerning SAS doctors in one site:

> *I think the secret is the department really embracing them... Are they included in the meetings? Are they included in the developments? Are they taken notice of? So rather than just being given a rota and that's your rota, you've got to make sure that they get to the clinical practice meetings, they get to the business meetings, they're involved in the QI that's going on in the department, they're involved in training the trainees.It's about treating them as professionals, I think.* ***MD***

> *Symbolic things can be important. I had my appraisal done by an SAS doctor this year. Entirely capable of doing it and I hope it sent a message.* ***MD***

Overall, we make four recommendations for to address the challenge faced in which referrals from designated bodies to the GMC affect certain groups of doctors disproportionately. These four recommendations focus on:

1. Providing comprehensive support for doctors new to the UK or the NHS or whose role is likely to isolate them (including SAS doctors and locums)
2. Ensuring engaged and positive leadership more consistently across the NHS
3. Creating working environments that focus on learning and accountability rather than blame
4. Developing a programme of work to deliver, measure and evaluate the delivery of these recommendations.

Our recommendations are set out on page 6 of this report. Many of the recommendations build on examples of good practice we encountered during our fieldwork; this gives us confidence that, if implemented appropriately, these recommendations can have a wider positive impact across the NHS, reducing the disproportionality evidenced in the FtP process.

Box 3: What is evidence-based diversity & inclusion?

According to the Center for Evidence Based Management, evidence-based practice occurs when people management decisions are based on a combination of critical thinking and the best available evidence. Evidence may come from scientific research, but internal organisational information and professional experience also count as 'evidence'. Further, evidence-based practice necessitates the conscientious, explicit and judicious use of four sources of information to design effective initiatives to reduce disproportionality.

1. Scientific findings from the behavioural sciences and HR literature
2. HR, RO and MD and other practitioners' professional expertise
3. The values, concerns and experience of stakeholders such as locums, SAS doctors, IMGs
4. The organisation: Data or other information available from or collected by the Trust or board such as appraisal, Datix and employee survey data

Having collated this information, those considering or conducting a local investigation should:

1. Ask: A precise, specific and answerable question about the concern/opportunity and solution that will help identify relevant evidence
2. Acquire: Search for and obtain relevant evidence from each source
3. Appraise: Judge the quality of trustworthiness of each piece of evidence
4. Aggregate: Pull the evidence together to summarise and draw conclusions about the answer to the question
5. Apply: Apply the answer to the context (e.g. at Trust or site) to address the concern
6. Assess: Assess and evaluate the impact of the intervention

Where collated and analysed, and evidence of impact is distilled, such examples of effective practice should be prioritised for dissemination across other parts of the UK. This would build on the good soft intelligence gathering in place in many areas via the RO networks.

Resources:
Center for Evidence-Based Management https://www.cebma.org/
https://www.hrmagazine.co.uk/article-details/an-evidence-based-approach-to-diversity-and-

APPENDIX

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Ethnicity and place of Primary Medical Qualification

Definitions

Doctors who graduated in the European Economic Area, excluding the UK, are referred to as EEA graduates

Doctors who have graduated outside the EEA are referred to as International medical graduates (IMGs)

Half of all new doctors are non-UK graduates (EEA graduates or IMGs). EEA and IMG doctors continue to be a source of experienced and older doctors coming into the UK workforce. In 2018 half of new joiners were non-UK graduates, up from 44% in 2012. The increase in the relative proportion of non-UK graduates joining is primarily driven by an increase between 2017 and 2018 of IMGs joining the workforce for the first time. The number of EEA graduates joining has remained relatively stable (declining by just 1%) from 2016 to 2018, though we know that an increasing number of European nationals are now gaining their PMQ in the UK and practising medicine here

Table A1. Place of primary medical qualification (PMQ) of licensed doctors, from 2012 to 2018

	2012	2018
UK	63%	66%
EEA	10%	9%
IMG	27%	25%

Table A2. Ethnicity of licensed doctors, from 2012 to 2018

	2012	2018
White	52%	53%
BAME	29%	34%

Source: GMC. The state of medical education and practice in the UK 2018.

The proportion of BAME doctors on the medical register rose from 29% to 35% between 2012 and 2018, whilst the proportion of EEA doctors and IMG doctors fell slightly in the same period.

Over one third of doctors working in the UK obtained their primary medical qualification outside the UK. Of the licensed doctors with overseas medical qualifications, 15% of them are GPs (GMC 2018). The number of IMG doctors who are specialists in the UK medical workforce has been steadily increasing.

Participants and data collection

Table A3. Participant demographics for all stage 2 data collection (Total N= 262; 221 + 41).

	White		BME	
	Male	Female	Male	Female
Total	83	78	72	29
Secondary care	73	68	59	21
Primary care	10	10	13	8

Table A4. Participant roles across secondary and primary care.

Role	No. of participants
Consultants, SAS Doctors and Locums	120
HR Directors and HR professionals	18
Clinical Directors / Clinical Leads	35
Responsible/ Professional Standards Officers	14
Chief Medical Officers/ Medical Directors	20
Chief of Staff/ Service Staff	10
CEO/ Executives	4
General Practitioners	41

Table A5. Data collection methodology for secondary and primary care

	No. of focus groups conducted	No. of interviews conducted
Secondary care	26	44
Primary care	23	18
Mixed	2	0

Academic Literature Search Terms

Search number	Search Terms and Filters	Gross Results	Excluded	Exclusion Rationale	Net Results (included)
S1	"systems" "Frameworks"	4	3	1-DUP 2 -IRR	1
S2	Included “Hospitals”, “public health”, “physicians”, “decision making” "medicine"	19	19	1 - DUP 18 -IRR	0
S3	“Medicine”, “United Kingdom”, “Great Britain”, “physicians”, “medical regulation”, “ethics”, “humans”	48	45	10-DUP – 34 – IRR 1-OL	3
S4	“Medicine”, “public health”, physicians, “clinical competence”, “appraisal”, Trust, “National Health Service”, “clinical regulation”	48	47	5-DUP 35-IRR 7-OL	1
S5	“The General Medical Council”	4	3	3-DUP	1
S6	“physicians”, “professional misconduct” “medicine” “medical ethics”, “standard of care”	13	12	3-DUP 9-IRR	1

Exclusion Criteria Key
IRR- Irrelevant
DUP – Duplicate (appeared on previous search label)
OL -Other language (not English)

Indicative semi structured interview protocol

We explored the following themes in interviews and focus groups:

- Safety culture: In contrast to what went wrong, to what degree is safety and learning emphasised in reviewing potential FtP incidents?
- What explicit governance/regulations/procedures/guidelines/policies are referred to (e.g. Practitioner Performance Advice (formally NCAS)?
- How do people go about sharing feedback about concerns especially at the point of an incident?
- What is the threshold for internal decision making prior to escalation to external processes?
- What 'us vs them' fault lines seem to recur, between which groups?

In addition, we used a version of the critical incident technique (Flanagan, 1954) with certain stakeholders, such as ROs, and in subsequent meeting with regional and employer liaison officers and HR, BMA officers. Questions were refined as the interviews progressed to accommodate early learnings:

Think of an occasion in which you had a **positive (or negative)** experience relating to deciding (or 'thinking about') whether an issue relating to a BAME/white (pick one) (locum) doctor should be referred to the GMC

1. What happened (brief information on context and key players, including ethnicity/age)
2. How did you/others feel?
3. What did you/others do?
4. What knowledge/skills influenced these feelings and behaviours?
5. What did/will you/others do differently as a result of these events?

In addition, as necessary we probed the following areas:

1. How the 'initial' discussion/ preliminary investigation played out and evidence galvanised for this discussion and how quickly/ how responsive to it.
2. What additional post-initial discussion options were offered?
3. What happens when there is contradictory information?
4. To what extent is there focus on wider contexts and team too (not just individual or pairs)?
5. What happens in instances of successful remediation?
6. Whether there is evidence of separation of investigation from decision-making.
7. Any recurring themes regarding development such as induction, training, appraisal.
8. What aspects, if any, of the support from Practitioner Performance Advice (formally NCAS) could be improved to assist with each step from incident to potential referral?
9. What aspects of the work of the GMC could be improved to assist with each step from incident to potential referral?
10. What measures might be in place to trigger proactive intervention to minimise incidents that might lead to potential referral?
11. How do people see the role of HR in handling each step from incident to potential referral?
12. What specific challenges do individuals find with locum/SAS/ other category of doctors that might be improved to minimise the risk of referrals