RACISM IN MEDICINE

Black and Asian doctors still face discrimination when applying for NHS jobs

“Y

ou have a very good CV, but there is something about you that you cannot change,” said the white consultant conducting the interview. He pointed to the applicant’s skin.

“Even though he is black, they all love him, and they don’t see him as different from us,” a referee wrote in response to the same doctor’s application for a consultant role. And at a consultant interview a panel member asked him, “Do you know this is a white area?”

These accounts show the discrimination experienced by a senior registrar who arrived in the British Isles in the 1980s and began looking for senior roles (box 1).

New data reveal the shocking extent of disadvantage many face in the recruitment process. Samara Linton reports

New figures show that black and Asian doctors and those of mixed ethnic backgrounds still experience discrimination when applying for jobs as NHS doctors in London in 2021.

The data, released under the Freedom of Information Act, show that white doctors applying for medical posts in London are six times more likely to be offered a job than black applicants. They also show that white doctors are four times more likely to be successful than Asian candidates or candidates from a mixed ethnic background.

These figures were uncovered through research carried out by Sheila Cunliffe, a senior human resources professional who works in workforce transformation in the NHS and wider public sector.

White doctors in London are six times more likely to be offered a job than black doctors

Box 1 | Asked why he kept such meticulous records, he responded, “For days like this”

L was a senior registrar when he first came to the British Isles in the 1980s. He worked as a registrar while he looked for a senior post. “I don’t know how many applications I wrote; I don’t know how many hospitals I visited,” he says. One white consultant told him, “You have a very good CV, but there is something about you that you cannot change,” pointing to L’s skin.

L eventually found a higher specialty training post and applied for a consultant role on completion of his training. One referee wrote, “Even though he is black, they all love him, and they don’t see him as different from us.”

At a consultant interview a panel member asked, “Do you know this is a white area?” L responded, “Yes, I do. And I don’t have any problems with that.”

“I probably went for four consultant interviews,” he says. “After one unsuccessful interview the consultant wrote to my consultant, saying, ‘Tell him to go back home, he will never get a job in the UK.’”

When L was finally offered a consultant job, he thrived in his role. Still, he faced more subtle forms of discrimination, such as being subject to unfounded complaints. For example, the hospital management accused him of missing clinics. He says, however, “I was able to show, through my records, that the clinics I missed were either public holidays or during a period of compassionate leave when one of my parents died.” When asked why he kept such meticulous records, he responded, “For days like this.”

Other forms of discrimination included not being credited for his work and being overlooked for leadership positions.

“The last straw was when a trainee—that I trained—was made chair of a committee I was on for years,” says L. While white colleagues sometimes acknowledged the discrimination he faced, they seldom took action to stop it or rectify the injustice.

“This kind of discrimination still happens, and it can grind you down,” he says. “But now we have more black doctors coming together—different networks and organisations. There’s enough space in this world for everybody to thrive and flourish.”

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No shortage of applicants

Cunliffe asked NHS acute trusts for a breakdown by ethnicity from 2020-21 of the numbers of applicants for medical jobs, shortlisted candidates, and candidates offered positions. She sent freedom of information requests to all 18 NHS acute trusts in London and has written up her findings in an online report. The data in this article are based on responses from 12 of the 18 trusts that shared full unredacted data with The BMJ (fig 1 and fig 2).

“The NHS is not making a significant shift in diversity and inclusion,” says Cunliffe. “NHSEI [NHS England and NHS Improvement] is not holding trusts accountable for delivering improvement in this area.”

She argues that action should be taken to improve the situation at trusts that show the widest ethnic inequalities in recruitment. “In my view, trusts with results like these need to be in a D&I [diversity and inclusion] version of special measures, with
urgent intervention from NHSEI. It is not from a shortage of applicants,” she continues, citing Kingston Hospital Trust: during 2020-21 the south London trust received applications from more than 400 black candidates.

The data she uncovered show that the trust offered positions to 90 applicants, including 50 of the 317 white applicants for medical positions during that period. In contrast, although 418 black candidates applied for medical positions and 65 were shortlisted, no black doctor was offered a position at the trust during that period. “I know that the human resources team at Kingston are highly committed to recruiting a diverse workforce, so one has to question what is going on within the business which has led to no black candidates being offered a position,” says Cunliffe.

A spokesperson from the trust told The BMJ, “Ensuring our staff are reflective of the communities we serve is a priority, and we acknowledge that we have much more to do to ensure equity of opportunity. We continue to work to improve our recruitment and selection processes and are currently training 26 diversity champions from across all professional groups and services to ensure that all our applicants are interviewed by panels that have enhanced skills in equality and diversity.”

Data from a number of other trusts also showed stark differences in the proportions of applicants from different ethnic backgrounds being offered medical jobs. At Barts Health NHS Trust, white applicants were 15 times more likely than black applicants to be offered a job. At St George’s University Hospitals NHS Foundation Trust, white applicants were 13 times more likely than black applicants, and 11 times more likely than Asian applicants, to be offered a job. And at Homerton University Hospital NHS Foundation Trust, white applicants were 13 times more likely than black applicants to be offered a job.

Even at trusts with numerically smaller inequalities, stark differences remain between success rates among white doctors and those of other ethnic backgrounds. Data from London North West University Healthcare NHS Trust showed that white doctors were three times as likely as black doctors and twice as likely as Asian doctors to be offered a job. And figures from Epsom and St Helier University Hospitals NHS Trust showed that white doctors were three times as likely as Asian and black doctors to be hired.

Equality standards

Cunliffe, who has also analysed ethnic inequalities in other areas of NHS recruitment, argues that the findings she has uncovered are just one indicator of the barriers faced by applicants from ethnic minorities.

“The racism some of these results point to will be replicated in the day-to-day lived experience of staff working within the trust,” she says. “NHSEI needs to look at data in a more detailed way and, where needed, set out to trusts its clear expectations and targets for improvement. This would require an investment in the resources needed and a shift in their strategic approach to date. It shouldn’t take a freelance consultant undertaking a piece of pro bono research to shine a spotlight on the issue.”

Cunliffe’s data follow the publication of figures from the Medical Workforce Race Equality Standard (MWRES) showing that discrimination against doctors from ethnic minorities begins early and continues throughout their careers. MWRES was launched in September 2020 as a supplement to the Workforce Race Equality Standard (WRES), focusing on
data included figures only from the staff in the NHS.

ethnic inequalities among medical things have become.”


Box 2 | The London Workforce Race Strategy

The London Workforce Race Strategy highlights 15 key recommendations for tackling race inequality, based on data and evidence from WRES and the experiences of staff. They highlight areas where commitment and focus could make a significant difference and bring lasting improvement.

The strategy calls for organisations to commit to de-biasing recruitment and selection processes, to advocate for the review of internal secondment processes, and to increase the accessibility and visibility of new roles. The new London De-Bias Recruitment and Selection Toolkit, developed by the regional team, was launched in July 2021.

The launch of the Heads of Resourcing Network also brings together recruitment leads to share best practice and to help ensure consistency of standards and approach throughout London.

In addition, the strategy recommends that the Care Quality Commission should have conversations with commissioners before an organisation achieves a “good” or “outstanding” rating, to discuss how it is performing against the WRES indicators.

The commission also suggests that NHS London should review how organisations use agencies, including striking off executive search agencies or headhunters if they’re not meeting contractual targets that are representative of a trust’s ambitions around the ethnic minority workforce agenda.

Digging deeper

Cunliffe’s findings have led to a call for official data to reflect the whole recruitment process, from application, shortlisting, and to the job offer.

Aneez Esmail, professor of general practice at the University of Manchester and coauthor of a landmark 1993 paper that found that ethnic minority doctors were less successful than white doctors in securing specialty training posts, says, “When establishing the WRES, we understood that this doesn’t tell the whole story. But it is the data trusts almost always collect.”

He explains that focusing the WRES on shortlisted candidates circumvents arguments about the quality of the applicants—they were good enough to be shortlisted, so why were they not good enough to be appointed?

Rao believes that “the colleges are key to change for each specialty.” She also urges the senior consultants overseeing new appointments to reflect on why particular appointments were made and, if ethnic minorities were not appointed, why that may be. “Could it be interview practice? How are they performing against the essential and desirable requirements of a post, compared with white candidates? There will likely emerge a mix of issues, but those reasons need to be addressed and urgently corrected,” she says. “We need to achieve equity on this.”

She notes that the Royal College of Physicians is now doing a “deeper dive” into the reasons behind these inequalities, and she hopes that others will follow.

Accountability and de-biasing recruitment

Roger Kline is former codirector of the WRES and author of an influential 2014 report, The “Snowy White Peaks” of the NHS. He says, “It is great that Sheila has done this work, but why has no one else done it before? The challenge now for NHS London is to understand why this is the case and to address it.”

Responding to Cunliffe’s findings, a spokesperson for the NHS in London said, “The NHS in London is built on the skill and dedication of its diverse workforce and is committed to ensuring fair and equal opportunities for all. And, after listening to the experiences of NHS staff, work is under way to improve recruitment and selection processes, as well as the accessibility and visibility of new roles.”

The trust points to the London Workforce Race Strategy 2020, which highlights recommendations for tackling racial inequalities, including calls for organisations to commit to de-biasing their recruitment and selection processes (box 2).

Kline says, “The way that organisations have gone about their recruitment and career progression has been greatly influenced by all sorts of biases, stereotypes, and assumptions. What the evidence shows is that we need to stop focusing time on de-biasing individuals and instead de-bias the processes—and, linked to this, establish accountability.”

He argues that data driven accountability, not training, is essential to eradicating inequalities in recruitment—for example, by embedding key performance indicators and adopting “comply or explain” processes. “And, once you appoint people,” he says, “you have to create an inclusive environment for them to work in.”