Career barriers in medicine: doctors' experiences

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BMA

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Editorial board

A publication from the BMA science and education department and the equal opportunities committee.

Equal opportunities committee

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Dr S Everington	elected co-chair, equal opportunities committee (from July 2004)

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Foreword

The BMA is committed to the elimination of unlawful discrimination and the removal of barriers to careers throughout the medical profession. In order to further explore these issues, the equal opportunities committee (EOC) decided that the remit of this publication should include doctors of minority ethnic groups, women doctors, disabled doctors, and gay, lesbian and bisexual doctors. These doctors are likely to experience career barriers and discrimination; this report aims to explore how they are affected and provide insight into how this kind of discrimination manifests itself. This report provides some key messages about medical career barriers and illustrates that these have broad consequences for the medical profession as a whole.

The BMA demands more action to tackle discrimination. However, this report does not aim to answer all the questions nor solve the problems identified. It does identify some of the key issues that need to be addressed and presents suggested approaches, upon which we would welcome further discussion.

The science and education secretariat carried out the research for this report. Through the accounts of individual experiences, it provides insight into some of the barriers that have been experienced by those who participated in the interviews. This report forms a fundamental component of the BMA's evolving equality and diversity strategy. This strategy has a strong focus on issues of race, but also includes emphases on other strands of equality such as disability, gender, age, sexual orientation, religion and belief.

The EOC has produced other reports and guidance on equality issues. For example, *Dealing with discrimination: a guide for BMA members,* and an internet resource for doctors with disabilities. The EOC is currently working on a number of other projects that address issues of equality and discrimination, such as the production of anti-discriminatory language guidelines and guidance on ethnicity monitoring. The BMA is also involved with other professional stakeholders to address many of the issues relating to equality and diversity within the medical profession.

This report is for doctors, healthcare professionals, medical workforce managers, educationalists and organisations that have strategic and operational responsibilities for the career progression of doctors.

Dr George Rae
Chair, equal opportunities committee
June 2004

'As co-chairs of the EOC we are committed to tackling the career barriers identified in this report. It is no longer acceptable in this day and age for doctors to be denied the opportunity to fulfil their potential because of discrimination and inequalities. We will be working with the members of the EOC and the staff of the BMA to challenge and change attitudes both within the medical profession and in the wider NHS which deny opportunities to doctors to fulfil their potential. For too long little has been done to ensure equality of opportunity for doctors in the NHS. This report sets out clearly the size of the problem and the effects it has on individual doctors' lives. The challenge now is to deliver real change over the next few years so that every doctor, regardless of skin colour, gender, disability or sexual orientation is able to play a crucial part in the NHS and deliver first class care to patients. Only in this way can doctors realise their full potential and ensure that the NHS achieves its goals.'
Dr Aneez Esmail and Dr Sam Everington – elected co-chairs equal opportunities committee

1 Introduction

BMA equal opportunities statement

The British Medical Association is committed to equality in the provision of its services to its members and stakeholders.

This ensures that all members, those applying for membership, and other service users will receive the highest possible standards of service from the BMA, irrespective of race, ethnicity, gender, sexual orientation, marital status, age, disability, chronic illness, religion or beliefs.

Our equal opportunities policy has been developed to ensure that BMA members and staff are fully aware of our commitment to provide equality of opportunity in all of our functions.

Furthermore, the BMA will monitor the implementation and application of its equal opportunities policy and ensure that it reflects and meets the requirements of the increasingly diverse membership which we seek to serve.

Tackling career barriers

This report contributes to the BMA's commitment to promote equality and diversity. It is clear that career barriers do exist for some doctors and that discrimination is a major contributing factor. As the regulator of the profession, the GMC outlines the duties of a doctor in *Good medical practice* (2001). It includes guidance on professional standards, patient care and working with colleagues. Medical practitioners are instructed to always treat their colleagues fairly. The aim of this research is to provide a voice for doctors who have experienced obstacles during their medical careers. By identifying some common themes of discrimination, recommendations and solutions can be enhanced. A further aim of this report is to consider how these individual experiences connect to the profession by reviewing some of the published research.

The report is based on qualitative primary research using interviews so that the stories and voices of those who have experienced barriers can be highlighted. It also reviews some of the published research to provide a more comprehensive analysis. The findings have raised some crucial concerns and issues, providing insight into some of the barriers that may affect the profession more broadly and need to be addressed. Suggestions are presented for the BMA as well as other key organisations such as the NHS, GMC, royal colleges and medical schools.

The BMA is committed to equality and diversity within medicine and healthcare. This includes the provision of support and guidance for BMA members who faced barriers to their career progression. Publications such as *Dealing with discrimination* (2003), *Racism in the medical profession* (2003), *Appraisal: a guide for medical practitioners* (2003) and *Exploring mentoring* (2004) are examples of BMA documents with a focus on support and guidance for doctors.

As the regulator of the profession, the GMC outlines the duties of a doctor in *Good medical practice* (2001). It includes guidance on professional standards, patient care and working with colleagues. Medical practitioners are instructed to always treat their colleagues fairly.

This report has highlighted many areas where change should occur. It should not be read as an independent document, but rather considered within a spectrum of medical experiences. The use of interview data to inform the suggested approaches is intended to provide more impetus for practical implementation.

2 Context

The wider context of the medical profession involves changing work patterns, the implementation of the European Working Time Directive, the expansion of the EU, changes to the NHS, and an increasing amount of legislation focused on discrimination. It is within these often-changing parameters that the individual experience of a doctor needs to be considered.

There are numerous initiatives aimed at removing some of the obstacles encountered by doctors throughout their careers. Royal colleges, medical schools, the NHS, health departments, primary care organisations (PCOs) and primary care trusts (PCTs) are among the organisations that have implemented programmes and initiatives. Examples include Positively Diverse, the NHS's zero tolerance zone campaign for bullying and harassment, the Department of Health's flexible careers and delayed retirement schemes and the Modernising Medical Careers initiative. Furthermore, the BMA and BMJ are leading a national initiative called Supporting Doctor's Career Choices, with the aim of improving career services for doctors.

In addition, the published literature includes a wealth of information in the form of studies, editorials and discussions. Many of these have been drawn upon to inform this report. It is an interesting area that is of concern to many stakeholders including patients, medical workforce planners, medical schools, the government and healthcare providers.

3 Methodology

Rationale

Primary research was undertaken to investigate the barriers that doctors may experience throughout their career progression. This qualitative approach took the form of semi-structured interviews and questionnaires. The interview is a flexible and adaptable tool to explore a topic. It has the potential of providing rich and highly illuminating material. Face-to-face interviews offer the possibility of modifying the line of enquiry, following up interesting responses and investigating underlying motives. Nevertheless, the flexibility of this approach does have well established limitations in terms of potential bias in both data gathering and interpretation.

Through personal stories, the interviews and questionnaires were designed to illustrate a range of perceptions, experiences and attitudes that exist within the medical profession. Qualitative methods typically produce detailed information about a small number of people and cases. This increases the understanding of the specifics of the situations studied, providing potential ideas and hypotheses to test in a wider context. Furthermore, qualitative methods, such as interviews, can contribute to depth, openness and detail of collected data.

Validity in qualitative methods hinge on the skills, competence and rigour of the researchers. In this case, seven researchers from the science and education department ('the research team') conducted interviews using the same interview schedule (appendix A). The structure of the interview was discussed among the research group and appropriate generic questions decided upon with the assistance of an expert. The generic questions were modified depending on the group being interviewed. This assured that all interviewers were using the same format for their questions.

The advantage of other research methods such as a quantitative approach is that it is possible to measure the reactions of a greater number of people to a limited set of questions, thus facilitating comparison and statistical aggregation of the data. In this study, qualitative research was deliberately chosen as the primary research method to contextualise the data complied. This approach enabled the report to present a more comprehensive analysis of the issues identified.

Finding willing respondents

It was decided that a minimum of 16 interviews would be sought, four from each group (minority ethnic groups, disabled doctors, women doctors, and gay, lesbian and bisexual doctors). Seventeen face-to-face interviews were conducted by the research team and eight subjects submitted their responses by email and post, (appendix B provides an overview of the interviews conducted).

The sample was not intended to be representative of the medical profession as a whole, but rather to offer an insight to highlight prominent themes and issues that affected the career progression of the doctors interviewed. It was a small-scale study, with self-selected participants and therefore, the findings should be interpreted as indicative.

Several umbrella organisations were contacted including the Gay and Lesbian Association of Dentists and Doctors (GLADD), Medical Women's Federation (MWF), Press for Change (PFC) and the BMJ careers matching schemes (for discrimination and chronic illness). Through these avenues, participants were invited to contact the BMA directly to express their interest and willingness to participate. These networks provided the research team with most of the volunteers for interview.

In order to collect written responses, participants completed a questionnaire (appendix C) which was adapted from the interview schedule (appendix A). It is acknowledged that there are differences to the ways in which people 'tell their stories' when the data is collected by questionnaires and by interviewing. However, it was decided that the collection of additional data would be beneficial to the study. As the sample was intended to be a snapshot and an illustration, this method provided an avenue to accommodate more insight from those who wished to contribute. Through interviews and questionnaires, a greater response rate was generated.

Doctors as respondents

Those interviewed for this study were self-selected volunteers. Given the scope and theme of the research, those who came forward were more likely to have experienced barriers. Respondents were asked to describe their experiences. For some, this related to the beginning of their career, or a specific period and may be some time ago. For others, the experiences described were more recent or current.

The participants did not represent a homogenous group and although there were often similar experiences described, they were told from an individual perspective. In addition to the categories identified for interview, the interviewees differed in other variables such as age, location and professional interests. For example, they ranged across various stages of their medical career from medical students to retirement. All face-to-face interviews were conducted in England, and written responses were collected from subjects across the UK.

Some interviewees acknowledged that they were in a position to be interviewed. They were willing or able to take a 'risk'. This perhaps meant that they had left

the medical profession, retired or had 'come out'.[i] It was difficult to capture the experiences of others who may have stories to tell, but may not be connected to any network that was contacted.

Transsexual and transgender (trans) doctors may have similar experiences to gay, lesbian and bisexual doctors in terms of stereotypes and assumptions. However, there are several key differences in particular many of the issues and concerns for the trans community are focused on gender identity and legality.[ii] Although there was an attempt made to interview trans doctors there were no available participants.

Confidentiality and accuracy

Permission to record interviews was sought prior to arranging them and again at the start of each interview. Ensuring that the voices of the contributors were retained throughout the process was a priority. Interviewees were sent copies of their transcripts for verification. Additionally, once a draft was completed, interviewees were sent copies to see how their comments had been contextualised. Identifying features were removed in order to protect anonymity. The process was conducted in accordance with the British Educational Research Association[1] guidelines.

Analysis of the data

The data convey a bleak message that many barriers are still prevalent within medicine today. The main concerns and themes throughout the report reiterate much of the existing research. The findings produce multiple layers for analysis, which provide an opportunity to inform recommendations and actively identify and encourage change within the medical profession.

The interviews generated an immense volume of relevant material. It is clear that many of the experiences described and obstacles faced by doctors are detrimental to their career progression. The researchers who had undertaken the primary research in the separate areas (disability, minority ethnic, women and gay, lesbian and bisexual) identified the themes common to that group. Once that exercise had been completed for the different groups, some themes that were common across the groups were extracted. (These are presented in section 8). Although there are signs of changes in attitude, this exercise has unequivocally proven that not enough is being done.

i 'Coming out' is about identifying as gay, lesbian, bisexual or transgender. It is usually a process which includes telling and disclosing this to other people.
ii The Gender Recognition Bill and organisations such as Press for Change (www.pfc.org.uk) assist in understanding some of the issues and concerns related to the trans community.

Structure of the report

Sections 4-7 explore the issues identified from the interview data in the context of other published research. There are separate sections for minority ethnic doctors and doctors with international medical qualifications, doctors with disabilities, women doctors and gay, lesbian and bisexual doctors. By linking the quantitative research to some of the qualitative research findings, it is possible to illustrate some of the initiatives that are already taking place and to recommend areas where more work needs to be done.

Section 8 illustrates some of the common themes and experiences extracted from the qualitative research. Many of these themes also appear throughout the published research. It is recognised that despite themes being displayed collectively, there are differences in the way that they impact on certain groups of doctors and individuals. It has been chosen to combine them in this way, because they illustrate common attitudes and experiences of the different groups interviewed.

4 Minority ethnic doctors and doctors with international qualifications

Key issues

- Racism towards minority ethnic doctors is still prevalent throughout the medical profession at all stages.
- A lack of information is a key barrier identified for doctors who come to the UK with international medical qualifications.
- Greater proportions of minority ethnic doctors are concentrated in staff and associate specialist grades. And more than 60 per cent of associate and staff grade hospital doctors (in England) have medical qualifications from outside the UK and EEA.
- Concerns in GP recruitment and retention are magnified because of the high proportion of minority ethnic doctors who work in primary care; the prediction that two thirds are likely to retire by 2007; and that many minority ethnic GPs practise in deprived areas.
- The number of GMC registrations is increasing at a greater rate from non-UK qualified than UK qualified doctors.

The concerns that confront minority ethnic doctors and doctors with international qualifications vary widely. The following section considers some of the issues that arise at the different career stages and grades. In addition, it separates some issues for minority ethnic UK trained doctors from those faced by doctors with international qualifications and also refugee doctors.

The minority ethnic doctors who were interviewed as part of this report all had international qualifications. Many of the experiences described, related to registering and integrating into the UK system. The responses were generally not positive. Much of the criticism was focused on the procedures and obstacles within the examination and registration processes.

Racism

'their career progression has been blocked because of their ethnic background'

There is much anecdotal evidence of racism in the NHS and that doctors from minority ethnic groups find it difficult to progress in their chosen specialty. Doctors from these groups report that they are not shortlisted for jobs for which they have sufficient qualifications and experience.[2] Doctors may be inhibited from complaining about discrimination because they fear victimisation afterwards.[2,3]

Perhaps the most frequently cited research into the operation of racism in the medical profession is that undertaken by Esmail and Everington.[4,5] The authors sent matched applications to 50 advertised senior house officer posts. Applications with an Asian name were significantly less likely to be shortlisted than identical applications with an English name. The authors recommended the use of standard and anonymised application forms together with strict enforcement and publication of the results of equal opportunities monitoring.

Esmail and Everington demonstrated that names could potentially jeopardise a career.[4] This type of prejudice is also experienced by doctors trained internationally and can manifest itself in different ways, for example in relation to language skills. Doctors who have international qualifications also face many similar challenges. However, there is also confusion and misinformation regarding qualifications, examinations and registration.[iii]

The problem of racism is also highlighted among graduates. The BMA's report, *Racism in the medical profession: the experience of UK graduates* (2003), found that racism is still prevalent within the medical profession and illustrated ways in which this was experienced by UK graduates. It found that the culture is maintained because of the following factors:

> 'In the population of UK graduates racism is manifest in access to training and careers, and in norms of acceptable behaviour. The system is sustained by the reluctance of trainees to complain and the widely held view within the profession that problems encountered by trainees from an ethnic minority are due to valid reasons such as "not understanding English culture".'
> Source: BMA (2003) *Racism in the medical profession: the experience of UK graduates.*

The interview data obtained for this research corroborate much of this existing research. Some excerpts from the interviewees describe racist attitudes and experiences.

> 'Twice I was discriminated against "white" candidates. First was for a registrar job in a teaching hospital and then for senior registrar job in the 1990s.'

> 'Lots of ethnic minority doctors get stuck at LAT [Locum Appointment for Training], LAS [Locum Appointment for Service], trust grade, staff grade, associate specialists and locum consultants. Their career progression has been blocked because of their ethnic background.'

> 'I remember I went to an interview appointments committee and when I came home I had two phone calls from panel members saying that they don't want to be party to this appointment committee. They were quite racist, you should have heard the jokes … My consultant then … said … if they didn't give you a job, there's no point in trying to go there and just to get the next job.'

> 'It seems common for white consultants or their wives to be invited out socially by established consultants or their wives; but not the ethnic minority consultants.'

iii Constable J, Fish I & McKenna C (2002) A quick guide to working in the United Kingdom. *British Medical Journal* **325**: 153 provide a concise and beneficial resource for understanding examinations and registrations procedures.

Profile of medical workforce based on ethnicity

The following tables provide an overview of the available data on the medical workforce in terms of ethnicity.

Table 1: Profile of ethnicity of the medical workforce (hospital staff) for England and Scotland*
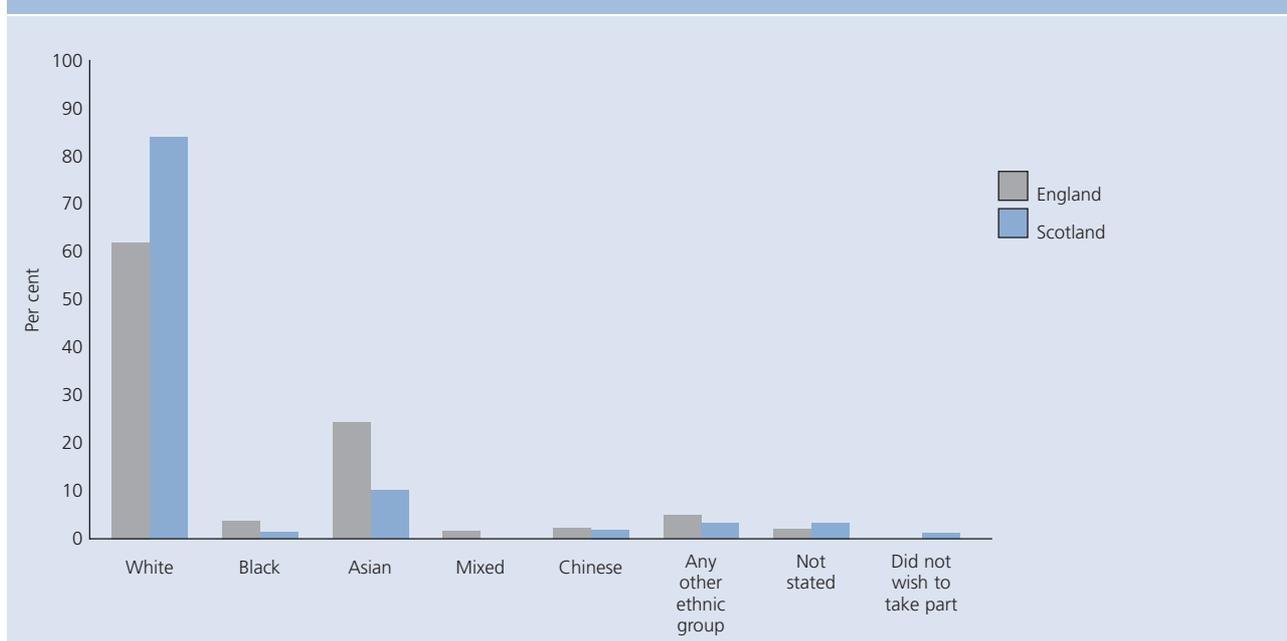
Sources: England: Department of Health (2003) *Medical and dental workforce census England.*

Scotland: ISD Workforce Statistics (2002) *G2 – hospital, community and public health medical and dental staff, by grade and ethnic origin.*

*Data collected in England and Scotland use different sub categories in the collection of each ethnic category. Data has been collated to present a more complete illustration.

Table 2: Comparison of the ethnic origin of the medical workforce by grade in England

	White (%)	Black or Black British (%)	Asian or Asian British (%)	Mixed (%)	Chinese (%)	Any other ethnic group (%)	Not stated (%)
Consultants	78.3	2.7	12.0	0.7	0.9	4.2	1.2
Associate specialists	41.6	5.0	36.9	1.0	0.7	13.3	1.5
Staff grade	35.5	7.6	41.1	1.0	0.7	11.4	2.1
Registrar group	58.6	3.6	27.5	1.6	2.4	5.2	1.1
Senior house office	47.0	5.1	34.5	2.1	2.4	5.2	3.7
House officer	56.6	2.8	23.9	1.9	2.6	3.5	8.7

Source: Department of Health (2003) *Medical and dental workforce census England.*

Tables 1 and 2 demonstrate that the distribution of minority ethnic doctors throughout career grades is disproportionate. For example, over three-quarters of consultants are 'white' and there is a high concentration of minority ethnic doctors within the associate specialists and staff grade.

Profile of medical workforce based on country of qualification

The GMC registration statistics illustrate that in 2003 over 18,000 doctors were registered in the UK. Nearly 14,000 were non-UK qualified whilst just over 4,700 were UK qualified.[6] Table 3 displays the number of GMC registrations for the last five years. It illustrates that the number of GMC registrations is increasing at a greater rate from non-UK qualified than UK qualified doctors.

Table 3: Number of GMC registrations from UK and non-UK qualified doctors			
	All registrations	Non-UK registrations	UK registrations
2003	18,656	13,926	4,730
2002	11,234	6,830	4,404
2001	9,422	5,143	4,279
2000	9,096	4,646	4,450
1999	8,792	4,492	4,300

Source: GMC Press Office (2004) *Registration statistics 1999-2003*.

From these figures, it is clear that doctors with international qualifications from outside the UK make up a significant proportion of the medical workforce. Table 4 displays some of these figures according to grade based on country of qualification.

Table 4: Country of qualification by grade – hospital medical staff (England)
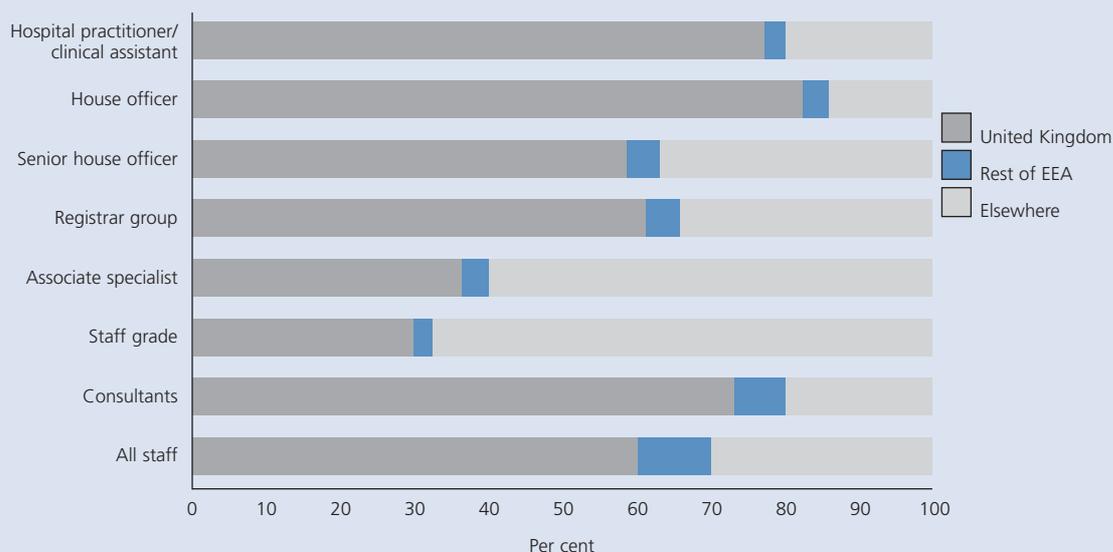
Source: Department of Health (2003) *Table 5: Hospital medical staff by country of qualification, gender and grade.*

Although this table is limited to hospital doctors in England, illustrative data can be extracted. It shows that a disproportionate number of doctors who qualified outside of the UK and EEA are associate specialist and staff grade doctors. This is similar to tables 1 and 2 which illustrate that a high concentration of ethnic minority doctors are in these grades.

In addition to the lack of training and career progress offered at those grades, doctors with international qualifications face other difficulties. For example, a study conducted for the GMC by Professor Allen found some discrepancies in the number of complaints and suspensions between doctors who are UK qualified and internationally qualified.[7] The report found that in 2001, 30 per cent of the complaints received by the GMC were about doctors with international qualifications; and that the proportion of internationally qualified doctors considered by the Preliminary Proceedings Committee (PPC) has remained constant at about 39 per cent; while the proportion of overseas doctors who had appeared before the Professional Conduct Committee (PCC) had increased to 58 per cent.[8] These figures are again disproportionate in relation to the medical workforce and pose some challenging questions.

The National Clinical Assessment Authority was set up in 2001 to provide a service to support the NHS in dealing with doctors and dentists whose performance gives cause for concern. They provide advice about the local

handling of cases, and where necessary carry out clinical performance assessments to clarify areas of concern and make recommendations on how difficulties may be resolved. Between 2001 and 2003 approximately 40 per cent of referrals from hospitals involved minority ethnic doctors and dentists.[9] This is again over-representative, compared to the hospital workforce (Table 2).

In 2004, the BMA published the results of a study of personal misconduct cases involving disciplinary action taken against BMA members between June 2001 and May 2003.[10] The results showed that 21 per cent of the consultants involved in disciplinary action were from ethnic minorities. This is greater than the percentage of ethnic minority consultants in the workforce. However, the proportion of overseas doctors involved in disciplinary action was similar to the percentage of overseas doctors in the medical workforce. Some of the underlying reasons behind the disciplinary action were also explored. These included interpersonal and communication problems, relationship problems with managers and employers, and work pressures.

Hospital doctors

As highlighted in tables 1-4, a greater proportion of minority ethnic doctors and doctors with international qualifications are concentrated in associate specialist and staff grades. At the present time, many doctors find that the staff and associate specialist grades provide no educational opportunities and no certainty of career progression. The evidence also indicates a general lack of continuing professional development (CPD) for staff and associate specialist grade doctors and shows that many take little study leave.[11] This could be due to a variety of reasons such as choice, limited resources or staff constraints. The lack of educational opportunities contributes to the difficulty of doctors in these grades to progress.

The BMA's response to the Department of Health's consultation document, *Choice & opportunity: modernising medical careers for non-consultant career grade doctors,* welcomed the recognition and willingness to confront some of the problems faced by staff and associate specialist doctors. The BMA supported the recommendations that doctors in these grades receive proper recognition, genuine opportunities for career progression and autonomy.[12]

Consultant status is not an end in itself. One way in which contributions made to the profession are acknowledged is through distinction awards.[13] Research into the allocation of distinction awards suggested that they were discriminatory against minority ethnic and women doctors. In England and Wales 'white' consultants had 1.37 (95% confidence interval 1.31 to 1.44) times as many awards as 'non-white' consultants and in Scotland 1.34 (95% confidence interval 1.08 to 1.66).[14] The research also found that the ratios increased with the increasing level of the award.[14] This research is not isolated and once again

exhibits an uneven distribution. In an attempt to ensure a fairer distribution of awards with greater openness and transparency, new clinical excellence award schemes have been introduced in England (2004) and Wales (2003). Northern Ireland implemented changes for the 2001-02 awards and have recently completed further consultation about them. In Scotland, discussions are ongoing about changes to the existing award scheme.

General practitioners

Minority ethnic doctors (overseas and UK trained) have been and continue to be vital to the primary care workforce, making invaluable contributions to the NHS.[15] Minority ethnic doctors often practise in deprived areas with large patient lists.[16] However, in spite of this important role, data on ethnicity is not collected for GPs in the UK. Country of birth has been used as a proxy, but is constrained as an explanatory variable.[16] Using family names as a proxy is an alternative method, but should be only used as an interim solution. It is estimated that one in six practising GPs in the NHS qualified in a South Asian medical school and that two thirds are likely to retire by 2007.[17]

Refugee Doctors

Refugee doctors are often grouped with minority ethnic doctors and doctors with medical qualifications from outside the UK. However, just as there are significant differences between and within those categories, there are differences in many of the primary concerns of refugee doctors.

The BMA has been coordinating an active campaign to assist refugee doctors. Its international committee has established a refugee database that has close to 1,000 entries. This resource enables refugee doctors to be more accurately targeted so that they can be updated on developments, projects and vacancies.

PLAB and other examinations

'there are many, many more like me who are well prepared and they can't practise'

The Professional Linguistics Assessment Board (PLAB) has been raised as a possibly discriminatory exam. Passing the PLAB examination is a requirement for practising medicine in the UK for doctors with qualifications from outside the EU. It is a difficult test of both language and clinical skills.[18] It has been suggested that a high proportion of British doctors would fail PLAB because of its clinical difficulty.[2] Doctors (with international qualifications) interviewed in this research commented on PLAB. It seemed to be one of the most significant barriers that this group of doctors experienced. PLAB is critiqued and discussed in a number of different ways.

The criticism of PLAB and other exams such as the International English Language Testing System (IELTS) is not related to the skills themselves, but rather the stagnant process, the cost involved and lack of information for those who are studying and taking the exam.

'You get trained doctors saying I am glad I don't have to take that [PLAB] because I don't think I would pass it. They have said that to me. If it was testing you on content that would be a different matter, but it's not.'

'I am a qualified doctor from a reputable medical school recognised by everybody including the GMC and I can't practise. I don't think that the GMC or the medical system should accept an individual into the system just like that. But I am saying that for me personally what could happen is I could be given an attachment at a hospital and I could be monitored and assessed over a period of time and a report sent to the GMC to say that I am safe to practise. I really don't see why this barrier is there … They are not really testing the true knowledge and potential of the individual in a setting like that. "You pass it and you are safe to practise", I think it's a misnomer … We are short of doctors and I can't work.'

'There are many, many more like me who are well prepared and they can't practise. I have studied in English all my life and I have been asked to do the English exam.'

'Obviously, I mean if you are a foreigner whose first language is not English you cannot converse well in English. And when it comes to the practical aspects of most of these exams, how fluent or how well you can express yourself in English actually tends to favour you. Because if you cannot express yourself well it may be a reflection of your confidence, not how well you know medicine.'

'And working, having a full-time job and studying for the PLAB is not easy, it is not a straight forward thing, you know. You just cannot do that, you have to sit and prepare properly. How am I going to do that when I am working fulltime? Should I give my job up to do it? So I find it very unfair, that I am not able to practise and I think that I have very good training. I have the motivation to do well in medicine and I have not been given the opportunity to do it.'

Generally there seems to be a sense of frustration. For example, other research has discovered 'doctors who have passed the PLAB test and have not found a job for months; candidates with the membership staggering from one locum post to another; and doctors moving into psychiatry or other shortage specialties simply to earn a living. There is a glaring disparity between the number in pursuit of higher training and the number of posts available.'[19]

The criticism relates to previous PLAB experiences. The GMC is leading a review on PLAB and registration in the UK. The review explores many of the experiences

described here. There is additional guidance available on the GMC's (and NHS careers) website.

Lack of information/misleading information

'I was misguided in lots of ways'

In addition to the criticism lodged towards PLAB and other exams, there seemed to be a sense of confusion and lack of information that was prevalent from the respondents who had trained internationally.

'[I applied to] a lot of jobs that I shouldn't even have tried to apply for. I did not know what the difference was between a staff grade SHO and a SHO in training. I did not know a lot of things really.'

'When I first came here I was misguided in lots of ways. I wasn't provided with appropriate information ... The information that I got back (from the GMC) was quite clear that my degree was recognised and I would be able to practise here. There was nothing in those documents suggesting that between the recognition of my qualification and starting to work, that there was an adjustment of taking the PLAB … so it was a shock when I went to the GMC and they said you have to take the PLAB.'

Some of the doctors interviewed described their first experiences of working in the UK. One respondent highlighted the benefits of doing clinical attachments.

'They were very keen for me to have a job, but they simply couldn't give me a job because UK graduates needed all the jobs. It went on like that and they were sad and I was sad. There was an excellent consultant who supported me, but couldn't help. And yes it was quite hard. Eventually, three months later, I got my first job. And that's it, from then onwards life was very easy, really easy. From then onwards I had jobs after jobs.'

'Then after two weeks I was with one consultant physician, a very nice man. He said that I didn't need a one month clinical attachment – I was fine. He gave me a reference and told me to start applying, but that I might have to apply to every job … and that I will need to take any job going … [It was] very good advice ….'

Interview structures and shortlisting

'somebody else who knows what to say'

There has been much written about interview structures and processes. Recruitment techniques and processes are key areas where changes are often considered. Changes to interview structures and shortlisting need to be contextualised in the broader framework of job structures.

One participant applied for 'in excess of a hundred if not two [jobs].'

Cultural differences, especially related to interview preparation was another aspect where information seemed lacking. For example, one of the interviewees highlighted the differences in how to answer an interview question about making mistakes.

' "Have you ever made a mistake and learned anything from that?" This doctor said, "no I have never made a mistake", and so gets one mark out of five. Then somebody else who knows what to say and how [to say it] gets five marks for that question.'

'I remember one of my very good friends phoned me, we were registrars together. After the interview selection committee for registrars and she was distraught. She phoned me at home to say "today we interviewed 58 people and we appointed 24 white people and only four ethnic minorities and about 23 minorities didn't get the jobs. I am quite upset about it, but the truth is some of them interviewed so badly they were not in the running. If you were going to do something to help people you need to get them improving their interview skills because I have marked them honestly." The marks were genuinely not good for some people, and she gave an example of a very good doctor with very good references. She said this is the question and this is the answer. But this person can answer this question much better … I think training everybody who is going to be on interview committees on issues related to ethnicity, equal opportunities and really to reflect themselves. I think the chairman should remind them [the committee] in the interviews that they have been trained and that there is an expectation to behave and to be aware and that there should be no discrimination. Any biases that they may have should be left at home.'

'I am for protecting the profession in a sense that people must be safe, but protection doesn't mean that you should put any kind of barrier around and prevent anyone else from getting in. That's how I feel, I feel that I am not in the system. I am outside although I am fully trained.'

Cost

Cost was identified as a critical barrier in the experiences of doctors who have international qualifications in registering for exams and preparation courses.

'how can I even afford to pay for these courses'

'The only problem was the expense. Both the English exam and the PLAB exam cost a lot. Otherwise, in terms of content, they were alright … The barrier at that stage is not ethnicity but the financial costs.'

'There were courses ranging from £300 to £1,000 … But how can I even afford to pay for these courses which everybody was telling me were most crucial. Without taking at least a couple of those courses – there is no way

you can even get close enough to passing the exam … The first one I got, I was lucky, the next one would have been difficult. So, that stopped me from … carrying on.'

Key messages from the respondents: minority ethnic doctors and doctors with international qualifications

- The findings illustrate the prevalence of racist attitudes and experiences.
- Much of the criticism towards exams such as PLAB and IELTS is related to the stagnant process and lack of information for those who were studying and taking the exam.
- Recruitment techniques (application forms, short-listing and interviews) are often seen as barriers for minority ethnic doctors and doctors with international qualifications.
- Cost is also considered to be a barrier – especially related to registration and exams.

5 Doctors with disabilities

Key issues:
- Doctors with disabilities or chronic illness are often stigmatised.
- There are few data collected or collated for doctors with disabilities.
- Doctors with disabilities may not be willing to identify themselves, for it may potentially undermine career progression.
- Based on UCAS data, the number of applicants and acceptances to medical school is similar whether a student indicates they have a disability or not.
- The Disability Discrimination Act (DDA) has been extended to enhance the legislative framework and includes the requirement for organisations to make 'reasonable adjustments'.
- The data generated from the interviewees unequivocally compels organisations including the BMA to have a stronger focus on the concerns of doctors with disabilities.

Doctors who have a chronic illness or disability often face many difficulties. Inflexible working patterns, poor contingency cover, and colleagues who are 'sympathetic until it affects them' often add guilt to an already difficult situation and leave doctors wondering whether they can continue working in a position that makes little allowances for specific health needs.

The Disability Rights Commission (DRC) estimates that there are 8.6 million people in Britain with a disability.[20] Further research highlights that nearly one in five people of working age in private households are disabled (3.3 million women and 3.6 million women); employment rates vary according to the type of impairment and that there are regional differences in rates of disability (16% in London; 23% in Wales; 25% in the north east of England).[21] Table 5 below illustrates that disability rates differ with age and ethnicity.

Table 5: Disability – Great Britain for age and ethnicity

(thousands and per cent)	16-24	25-34	35-49	50-59/64	All aged 16-59/64
All disabled	659	975	2,337	2,890	6,860
(% of total population)	10%	12%	18%	33%	19%
White	606	882	2,093	2,745	6,326
	11%	13%	18%	33%	19%
Mixed	–	–	20	–	36
			30%		16%
Asian and Asian	28	53	127	90	298
British	7%	10%	26%	45%	19%
Black and Black	13	22	56	28	119
British	8%	11%	17%	35%	15%
Chinese	–	–	–	–	11
					7%
Other ethnic groups	–	10	37	17	67
		7%	27%	35%	17%

Source: Disability Rights Commission (2004) *Disability briefing – January 2004.*

These data are informative in highlighting the type of data that can be collected. It also provides insight into understanding the complexity of how disability can impact differently when related to different variables such as age and ethnicity.

There are few data (quantitative or qualitative) on doctors with disabilities. Statistics are not kept on the number of disabled doctors in the medical workforce.

Defining disability

Perhaps there are few data because of confusion in defining disability. The DRC defines disability for the purpose of implementing the DDA. Although the definition does not provide much detail, given the legislative framework on disability, it is a relevant starting point.

A person is disabled if they have:
- a mental or physical impairment
- this has an adverse effect on the ability to carry out normal day-to-day activities
- the adverse effect is substantial
- the adverse effect is long term (meaning it has lasted for 12 months, or is likely to last for more than 12 months or for life).

Source: Based on Disability Rights Commission (2004) *Definition of disability.*

Other definitions include recognition of the disabling environment: for example, moving from the 'medical model of disability' to the 'social model of disability'. Broadly, the medical model of disability identifies the disabled person as the problem. People with disabilities are expected to adapt to their surrounding environment. If they are not able to, then basic needs are met at home or in specific institutions.[22] The social model of disability aims to be more inclusive. It highlights the disabling environment and that people with disabilities are disadvantaged (individually and collectively) based on constructions of institutional discrimination.[22]

The BMA's disabled doctors working party defined disability as:

'The end result of either physical, mental or sensory impairments (and people can be healthy with such impairments) or long term ill health (which can limit functional ability). Either case may result in a loss or limitation of opportunities.'

Source: British Medical Association (1997) *Meeting the needs of doctors with disabilities.*

Collection of data

Another reason for the lack of data could be that doctors with disabilities may not be willing to identify themselves for it may undermine their careers as doctors. Additionally, many potential doctors may have been turned away from the profession and, as a result, it is difficult to capture their views. Increasingly, guidance is being produced providing organisations with methods and examples of good practice to ensure that they do not discriminate against people with disabilities and to suggest ways of providing an enabling environment. This is particularly timely, as from October 2004, the DDA is being extended. From that date, service providers have to consider making 'reasonable adjustments' to their physical environment.[iv]

Medical schools and disability

UCAS collate statistics on medical school applicants and acceptances. Table 6 compares these figures with the number of applicants and acceptances of all courses, (a fuller table of these statistics appears in appendix D). These numbers are indicative. The accompanying UCAS explanatory notes highlight that these figures may not be representative as potential students may not give accurate information. With this information, table 6 illustrates that the percentage of students who apply to and are accepted to study medicine with and without indicating disability is similar. The numbers, however, differ substantially. Compared to the overall statistics for all courses, table 6 shows that the rate of

iv The DRC explain that a 'reasonable adjustment' can include making adjustments to premises (for example installing ramps or an induction loop); reallocating work within a team; finding suitable alternative work for someone who has become disabled; being flexible, for example allowing someone to have different core working hours and to be away from the office for rehabilitation, assessment or treatment; providing training; using modified equipment; making instructions and manuals more accessible; or using a reader or interpreter.

being accepted to medicine (in general) is lower than the overall rate of acceptance to higher education.

Medicine	2000	2001	2002	2003
With disability (applicants)	218	263	323	462
With disability (acceptances)	112	140	168	212
% of acceptances	51%	53%	52%	46%
With no disability (applicants)	10,597	10,565	12,368	15,428
With no disability (acceptances)	5,602	6,100	6,791	7,455
% of acceptances	53%	58%	55%	48%
All courses	2000	2001	2002	2003
With disability (applicants)	15,508	19,151	19,588	20,371
With disability (acceptances)	12,159	15,298	15,795	16,355
% of acceptances	78%	80%	81%	80%
With no disability (applicants)	373,583	380,494	382,266	389,597
With no disability (acceptances)	296,559	310,174	315,930	317,587
% of acceptances	79%	82%	83%	82%

Table 6: Comparison between applicants and acceptances for medicine compared to all courses.

Source: UCAS (2004) *Statistics compiled from UCAS website.*

'it was a very foolish thing to say because if I had wanted to take them to the cleaners I could have.'

Discrimination based on disability

The data exposed through the interviews illustrate many of the obstacles encountered by doctors with disabilities. Cost of finding and purchasing specialist equipment was also mentioned. The interviews identified feelings of isolation and stigma experienced by doctors with disabilities. They also described cases of direct discrimination.

'I had a very good CV and was short-listed for lots of jobs so I attended many interviews … I always arranged to visit early and meet at least one of the consultants on the interview committee beforehand. This was specifically … so we could talk directly about my [disability] … My referees specifically told me that, in their references, they had said that … they had been working with me for months and had not found my disability to interfere significantly with patients or with staff … I kept being turned down at interview and on two occasions was asked to wait after the other candidates had left and was told I had been turned down because of my [disability]. Once, the consultant who spoke to me told me

that I should not be applying for clinical jobs at all and advised me to change career …'

'I went for a job … and they turned me down … he said that I had not been appointed because of my [disability] … it was a very foolish thing to say because if I had wanted to take them to the cleaners I could have.'

Supportive and enabling?

Medicine is often described as not being supportive or enabling, especially to those who do not conform to the normative perceived standard. Some respondents described a lack of support, others mentioned stigma associated with a specific trait or characteristic. It was of particular relevance to doctors with disabilities.

'if you have a weakness you keep it hidden'

'It is difficult to talk about your weaknesses … We are expected to conform to a certain standard and I think if you have a weakness you keep it hidden, you don't want to talk about it.'

'[You] would expect tolerance from doctors, but this is the worst group when dealing with their own … most people don't want to know … medicine has a "survival of the fittest" style.'

'I think that there's still an attitude that is around in medicine and I think it's quite a shock to people sometimes to find that they [doctors] are vulnerable …'

'Having the badge of a physical illness is actually terribly reassuring … When I see some of the flexible trainees with mental illness, I think I've got a real physical illness, you know and one does feel a bit more relaxed because you know that it is very difficult for the bosses to get at you … they can't, you know, mumble at you.'

Not much has changed

In 1997, the BMA's working party outlined that the main problems and issues concerning doctors with disabilities could be categorised into:
- general attitudes towards disability (adverse or hostile)
- employment structures and procedures
- lack of resources and facilities in education and employment.[23]

The recommendations suggested by the working party were divided into areas of information, careers advice, occupational health services, skills assessment, access and facilities and changing attitudes. Some of these recommendations have been carried out, others have been reiterated in section 8, the way forward. The data generated from the interviewees unequivocally compels organisations, including the BMA, to have a stronger focus on the concerns of doctors with disabilities.

The BMA plays an important role in supporting and campaigning for equal opportunities in all areas, including disability. The *Doctors with disabilities* web resource is intended as a sign-posting service. It provides contact details and links to organisations and information sources that may be helpful to doctors and medical students with disabilities. Many of the sites listed include links to more specialised information.

> ## Key messages from the respondents: doctors with disabilities
> - Direct discrimination based on disability occurs in medicine.
> - Some of the implications (for doctors with disabilities) are feelings of isolation; stigma towards people with disabilities; cost associated with equipment; lack of understanding; and lack of flexibility.
> - Medicine is often described as not being supportive or enabling, especially to those who do not conform to the normative perceived standard. This is particularly resonant for doctors with disabilities.
> - Although there have been some changes, many of the key concerns for doctors with disabilities have not been challenged.

6 Medical women

Key issues

- The distribution of men and women over career grades is disproportionate and the number of women at senior career grade is smaller. Seventy-six per cent of consultants (in England) are currently men. They would have graduated at a time when medical schools were male-dominated.
- Women now make up 60 per cent of the intake at medical school.
- Flexible working needs to be offered as a positive option for women and men. Schemes need to provide genuine training and progression opportunities. The disaggregation of data can help in identifying ways in which such schemes can be further developed.

Gender and the medical workforce

The following tables provide a representative profile of the UK medical workforce based on gender. They are beneficial in understanding the qualitative data and provide a more comprehensive overview.

Figure 7a: Gender profile of UK medical workforce using representative data from 2000-03 – general practitioners
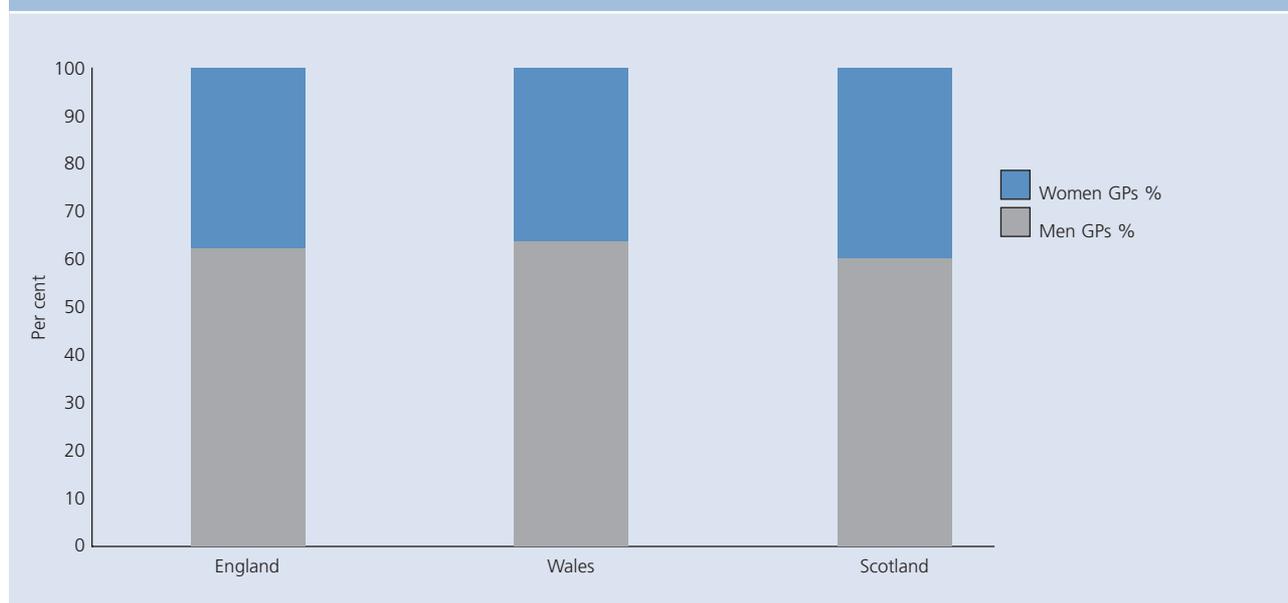
Sources: (England and Wales) Department of Health (2003) *Table 1A: All practitioners GMS and PMS (excluding retainers): analysis by sex.*
(Scotland) ISD Workforce Statistics (2003) *C2 – general medical practitioners; by sex and contract status – all unrestricted principles.*

Figure 7b: Gender profile of UK medical workforce using representative data from 2000-03 – hospital workforce
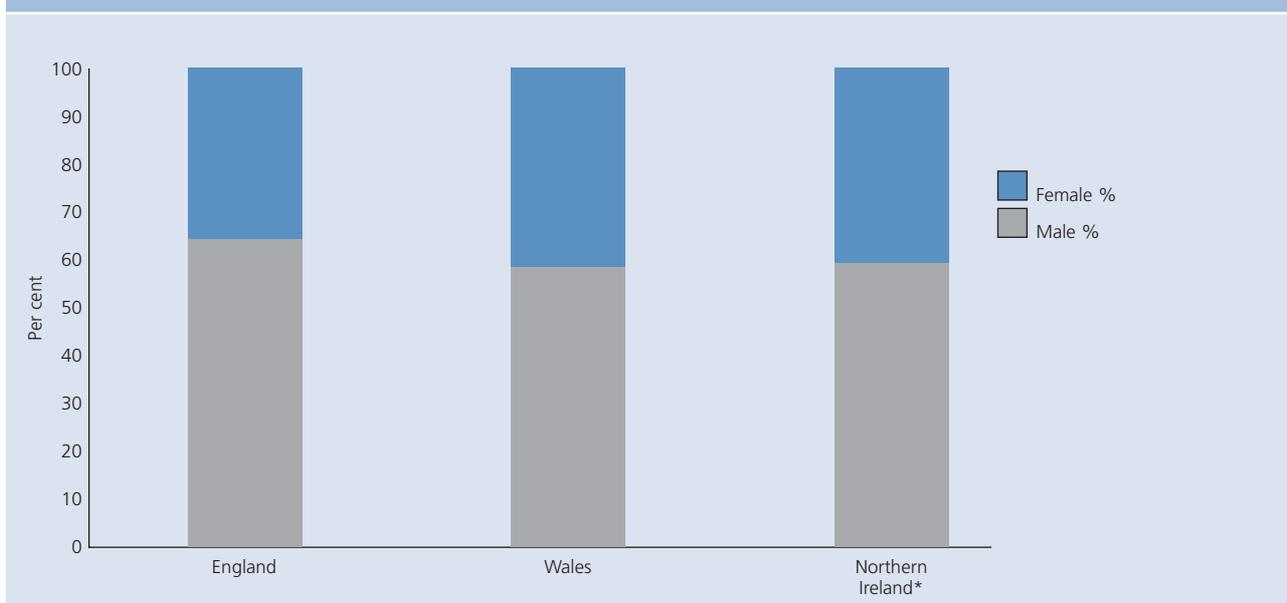
* includes dental staff as well as all medical staff

Sources: (England) Department of Health (2003) *Table 4: Hospital medical staff by nature of contract, gender and grade.*
    (Scotland) ISD Workforce Statistics (2002) *B7 – all medical and dental staff employed in NHS Scotland by type and service, grade, contract type and gender.*
    (Northern Ireland) NI HPSS Workforce Census (2002) *The health and personal social services workforce.*

Table 8: Gender profile of the medical workforce by grade (England)

	Men %	Women %
Consultants	76	24
Associate specialists	63	37
Staff grade	63	37
Registrar group	61	39
Senior house office	56	44
House officer	47	53

Source: Department of Health (2003) *Table 4: Hospital medical staff by nature of contract, gender and grade.*

Figures 7a, 7b and table 8 profile the medical workforce in terms of gender. They show that currently there are more men than women doctors. Table 9 describes the current pattern of medical school entrance. Increasingly it highlights a pattern that more women than men are applying and accepting places at medical school. The BMA's *Demography of medical schools: a discussion paper* further investigates these trends.

Table 9: Gender profile of medical school applications and acceptances

		1996	1997	1998	1999	2000	2001	2002	2003
Female	Percentage of applications (female)	50.5	52.0	52.3	54.1	56.4	58.0	58.8	58.8
	Percentage of acceptances (female)	54.4	54.2	55.5	56.4	57.9	59.0	60.9	61.5
Male	Percentage of applications (male)	49.5	48.0	47.7	55.9	43.6	42.0	41.2	41.2
	Percentage of acceptances (male)	45.6	45.8	44.5	43.6	42.1	41.0	39.1	38.5

Source: UCAS (2004) *Statistics compiled from UCAS website.*

Figures 7a and 7b and tables 8 and 9 illustrate the gender differences that exist within medicine. They show the number of women at each career grade decreasing. More women than men now enter medical school (table 9) and women make up a greater percentage of the house officer workforce than men. Women occupy 45 per cent of senior house officer posts, just over a third of associate specialists, staff grade and registrar groups, and 24 per cent of the consultant workforce. As current consultants graduated at a time when medical schools were male-dominated, it will be interesting to see how these patterns change to reflect medical school numbers in relation to gender over the next decade.

Many of the options and solutions offered for more gender parity include the increasing need for flexible training for women and men to allow doctors to balance their career ambitions with home responsibilities, lifestyle choices and/or childcare. However, this seems to form only part of a potential solution. If a more gender-balanced workforce is the aim, there will need to be a more dramatic evaluation of the structure of the medical profession, medical training and the way doctors work. Flexible training and work is an insufficient solution on its own. Other factors need to be addressed, such as work culture and stereotypes. Work practices that accommodate a variety of needs and requirements could address a wider scope of concerns and issues for women and men.

Medical specialties and the gender profile

A report published by the working party of the Federation of Royal Colleges of Physicians (RCP) identifies part of the problem that women face and suggests potential solutions in greater detail. Table 10 demonstrates the further disparity between men and women consultants according to specialty whereby there is a proportionate under-representation of women. In over half the specialties, less than 21 per cent are women.

Table 10: Consultant workforce by specialty and gender – all general medical specialties, United Kingdom

Specialty	Male consultants (%)	Female consultants (%)	Total number of consultants
Cardiology	93	7	737
Clinical pharmacology & therapeutics	92	8	74
Gastroenterology	91	9	693
Neurology	89	11	404
Renal medicine	89	11	312
Respiratory medicine	88	12	619
Infection & tropical medicine	88	12	116
General medicine	87	13	80
Intensive care	87	13	38
Endocrinology & diabetes	86	14	597
Clinical neurophysiology	86	14	81
Paediatric cardiology	84	16	64
Immunology	82	18	60
Medical oncology	81	19	171
Metabolic medicine	79	21	19
Geriatric medicine	77	23	1,037
Rheumatology	77	23	479
Rehabilitation medicine	77	23	133
Nuclear medicine	75	25	60
Haematology	69	31	626
Genito-urinary medicine (& HIV/AIDS)	67	33	287
Allergy	65	35	20
Dermatology	61	39	457
Audiological medicine	56	44	34
Clinical genetics	46	54	127
Palliative medicine	41	59	257
All medicine group specialties	79	21	100
Totals	6,022	1,560	7,582

Source: Royal College of Physicians (2002) *Specialty breakdown of consultant physicians.*

The recommendations proposed within the RCP report provide a variety of frameworks for practical implementation. For example, the report argues that part-time consultant positions were a temporary solution and do not necessarily provide the scope and flexibility required throughout a career. Furthermore, it suggested that training requirements should be based on competency rather than length of time served.[24] The report highlighted the benefit of forward and strategic planning to provide flexible training opportunities for the workforce and ensure that education development is available to those who do not work full time. It further suggested

that academic departments should establish part-time posts with research opportunities. These changes would demonstrate a commitment to varied work patterns within the profession and a departure from previous patterns of employment and attitudes.

Table 11 considers the consultant workforce by age and gender. It contributes to a more comprehensive understanding of where policies could to be directed. For example, it can be observed that the percentage of male consultants increases from 65.2 per cent when they are 34 or younger until the 60-64 age bracket where 92.5 per cent of consultants are men. The opposite is true for female consultants where the number steadily decreases from a maximum of 34.8 per cent at age 34 and younger to 10.5 per cent at age 65 and above. In previous decades, employment rates for women were lower, which could contribute to some of the findings especially in the older age brackets. However, this type of disaggregated data contributes towards a broader understanding of the patterns and changes in the medical workforce. It also poses questions of how the medical workforce will respond to the changing composition of medical students in relation to gender.

Table 11: Consultant workforce by age and gender – all medical specialties England, Wales, Northern Ireland and Scotland			
Age	Men (%)	Women (%)	Total
34 and younger	65.2	34.8	135
35-39	69.9	30.1	1,273
40-44	75.3	24.7	1,678
45-49	78.1	21.9	1,533
50-54	84.3	15.7	1,418
55-59	88.6	11.4	1,046
60-64	92.5	7.5	429
65 and above	89.5	10.5	67
Unknown	100	0.0	3
Total	79.4	20.6	7,582

Source: Royal College of Physicians (2002) *Consultant workforce by age and gender, all medical specialties.*

A further example is a report produced by the Department of Health about general practitioner recruitment and retention. Table 12 presents the results (by sex) from a survey conducted identifying the most common reasons why GPs leave a practice. The analysis demonstrates that the differences in gender can be partly explained by the age distribution within GP practices. This finding and explanation seems to have some similarities to the data presented previously by the RCP (table 11). The breakdown of data assists in devising and determining more relevant solutions.

Table 12: Most frequent reasons given for a GP leaving a practice, split by sex

	Leaving GP		
	Women (%)	Men (%)	Total
Family reasons	74	16	62
Emigrated	45	55	11
Taken non-medical post	42	58	12
Partnership problems	41	59	22
Taken NHS post outside General Practice	38	62	26
Taken GP post elsewhere	34	66	83
Ill health	25	75	53
Other	25	75	28
Retired on age grounds	22	78	170
Death	14	86	22
Total	34	66	489

Source: Department of Health (2000) *General practitioner recruitment, retention and vacancy survey 2000 for England and Wales.*

'completely opposed to women in medicine'

Sexism

Data generated from the interviews further highlighted some of the obstacles directed at women throughout the medical profession. The main concerns focused on sexist attitudes towards women and a lack of flexibility within the structure of the profession.

'The fact is there are a lot of women doctors who have been very badly treated around and that is why there is a crisis.'

'I had to work for one who I knew was completely opposed to women in medicine. He had been heard telling women medical students that he thought that they shouldn't be in medicine, they should be at home having children.'

'I had to have a form signed. Now this form is quite important – I forgot what it is called, but every six months at that time, probably still, during your training you had to have approval from the consultants that you had completed that period adequately … So I went along to the meeting … there was one consultant – the particular consultant I was working for who did undoubtedly have a problem with me, as some of the others had. Anyway, he sat down and we went through the first bit of it and it was all routine. Then he came to something about my co-operation. And he said, "sorry, I just don't feel that I can sign you off for this section because I don't feel you have been cooperative." And I said, "what do you mean", baffled. You know, I

thought I had gone the extra mile … I thought I was doing more than was required. He said, no, no you refused to do this list – this day case unit list. And I was just shocked, but I said, "you know it's somebody else's list, it's every second week, I said, it didn't suit me for childcare reasons, what do you mean I am not being cooperative?" And he said, "well fine, I don't feel I can sign the form." You know and that is a very serious thing, not to sign, not to give approval for my six months training with him, very serious indeed and I actually, for the first time then, I burst into tears – I couldn't believe it.'

'If men gave birth I think the medical profession would be structured somewhat differently!'

'I didn't want to take it further. I also rang up the Equal Opportunities Commission and talked to them about this, the bullying and they said they thought I had a case but they said that there was a huge emotional cost of going to an industrial tribunal to seek, whatever it is called, "constructive dismissal." And I weighed it up and I thought I probably would have a good case, but I also thought I had wasted three years of my life being terribly unhappy. I was actually very happy at home. I had three children, you know, we were very happy – they were delighted to have me around and I thought well, I'm not going to spend two years going to lawyers – living through all this over and over again, for what? For an apology, or something? I mean, you know, there could be no possible compensation. I didn't particularly want any money, even if, had that been on offer. I knew I was in the right, I knew I had been badly treated, I didn't need a court to tell me that.'

Key messages from the respondents: medical women
- Sexist attitudes are still prevalent within the medical profession.
- The structure within medicine and particularly in some specialties is not conducive to work-life balance.

7 Lesbian, gay and bisexual doctors

Key issues:
- The Employment Equality (sexual orientation) Regulations were enacted in December 2003 which make it unlawful to discriminate based on sexual orientation.
- There are few data collected and collated based on sexual orientation.
- The medical education agenda needs to be updated to not represent and define 'homosexuality' in contrast to a normative standard of 'heterosexuality' as this perpetually reinforces negative stereotypes.

The literature presents a depressing picture for lesbian, gay and bisexual doctors. There is a wide range of literature related to the decision to 'come out' and about becoming and being a doctor. However, there are very few resources that negotiate the impact concurrently.[25] The decision to 'come out' is a common struggle for many lesbian, gay and bisexual doctors.[25] It is not one moment or an event, but usually a continuous process. Some people are comfortable talking about their sexuality whereas others may not be. There are many issues to consider, for example, whether one should 'come out', how patients may respond, progression through a career, (and for the research team) how to capture the views of those people who have turned away from the profession as a result of their experiences.

In December 2003, the Employment Equality (sexual orientation) Regulations were enacted. The regulations apply across Great Britain (England, Scotland and Wales). Separate, but similar, legislation was introduced for Northern Ireland. The aim of this legislation is to 'outlaw discrimination in employment and vocational training on grounds of sexual orientation.'[26] The legislation is applicable to all aspects of employment and vocational training such as recruitment, terms and conditions, pay, promotion, transfers and dismissals. Guidelines have been developed by several organisations to facilitate the implementation of these new regulations.[v]

Stereotypes are common and can often be misleading. Like other doctors, lesbian, gay and bisexual doctors vary in looks, personality, opinions and ambitions. Education throughout a doctor's career should reiterate that people are different. Some medical schools in the UK have developed communications courses and have revised the methods that they use to educate about sexuality. Sexuality is often inappropriately taught and discussed in the context of HIV or psychiatry. Developing communication skills is one method that demonstrates a positive step

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[v] Some examples are: Advisory, Conciliation and Arbitration Service (2003) *Guidance, sexual orientation and the workplace; putting the Employment Equality (Sexual Orientation) Regulations 2003 into practice.* UK: ACAS. www.acas.org.uk; and Gay and Lesbian Association of Doctors and Dentists (2003) *Improving working lives: dignity at work for lesbians and gay men in the NHS.* www.gladd.org.uk

towards challenging stereotypes. Communication skills including learning how to be receptive and responsive are increasingly included as part of medical education. Other suggestions of components that could benefit medical students include learning how to present oneself as non-judgemental for feelings about sexuality, privacy and vulnerability.[27] Additionally, many experts believe that lesbian, gay and bisexuality should be integrated into the curriculum rather than be defined as the 'other' or in contrast to heterosexuality. Challenging the medical education agenda can be beneficial in helping to address these questions.

There are few data collected on lesbian, gay and bisexual doctors. This research demonstrated that attitudes towards sexual orientation can be confrontational. Sensitivity is paramount when discussing and implementing methods for the collection, collation and dissemination of data.

Common perceptions: the impact of HIV and AIDS

It is difficult to determine the impact of HIV and AIDS. For example, one study that compared attitudes of 'gay' and 'non-gay' doctors found that 'the non-gay group were aware of prejudice in the profession against gay doctors, but mainly considered that the advent of AIDS had made it worse, whereas the gay doctors believed that attitudes had always been so negative that AIDS had made only a minimal difference.'[28] A further study highlights the complexity further. It suggests that 'the rise of AIDS drew fresh attention to gay men and gave homosexual and bisexual concerns a new visibility. Some homophobic views were probably softened through empathy, while others hardened amid increasing vitriol directed at the gay community.'[29] Education and awareness are critical in the process of breaking down stereotypes and promoting diversity throughout the lesbian, gay and bisexual population.

Homophobia

Homophobia is often cited as one of the main barriers facing lesbian, gay and bisexual doctors. Homophobia can manifest itself in a number of different forms. Homophobia is often based on notions that heterosexual relationships are the only 'normal' and 'valid' partnerships.[30] The degree to which a homophobic attitude prevails varies widely for lesbian, gay and bisexual doctors. Isolation and loneliness are often described.[31]

'made jokes about homosexuals in front of me'

The respondents expressed many of the concerns described above. The following excerpts reveal several instances where homophobia exists.

'My senior partner in the practice was very homophobic. Made jokes about homosexuals in front of me, and made disparaging comments about gay patients. I contacted a gay organisation to offer my services, and details were

sent to him as senior partner. He told the other partners that it would adversely affect the reputation of the practice, but did not confront me. I had to bring the subject up with him, and reluctantly agreed to withdraw my name from the organisation's database.'

'And certainly when I moved here it wasn't recognised that I had a partner and that had to be taken into consideration as I was offered single accommodation.'

'They sent round a news sheet inviting you to their annual golf bash and lots of opportunities to talk about medical remuneration as if it is the only thing that people care about, and the odd soft touch towards nominal wider education. A local official … high up in the local BMA who is a GP, had written a sort of local newsy, chatty introductory article to this bulletin and it said something like "why doesn't this government get on with sorting this, that or the other out, instead of wasting their time with trivial issues like banning fox hunting and pro gay legislation", something like that … So I phoned the most senior person on the local committee and said, "what exactly are your complaint procedures, because I am a gay man I find that deeply offensive, I am not interested in the personal views of this fuddy duddy, and I would like also to know how I would take my complaint forward to BMA national because I am sure they wouldn't be comfortable with supporting these views". Well, it took two or three tries but basically I got a grovelling phone call from the GP concerned, light-hearted you know, the usual rubbish. I was absolutely gob smacked …'

Some of the respondents spoke more about prevailing societal attitudes, particularly in relation to gender roles and sexuality.

'Well I think it goes back to the whole notion of how gender is approached really. We're very socialised to look at male and female and if you deviate from that then it's pathologised in a way. So I think that does flavour how one looks at, or one medically trained looks at, that.'

'I am sure there are lots of people out there who are still homophobic, and it is not necessarily malicious, but I am very much of the opinion that the only way to heal this sort of nonsense is for people to be more open. It is a process – as more people "come out." We have a lot to thank Graham Norton for! If someone sees this great big Irish poof on the television every night and laughs it is difficult to think mean thoughts.'

Fear of discrimination

In addition to the comments and actual experiences described throughout this report thus far, there also seems to be a fear of discrimination. Fear of discrimination can be as important as actual discrimination. It was most often referred to (but not exclusively) in relation to sexual orientation.

'they don't have the freedom to be open about their sexuality'

'If I look at my friends that are gay doctors they don't have the freedom to be open about their sexuality in the same way, partially because their perception of the risk of being open about their sexuality is so great that they perceive it as going to stop their career progression or they are going to experience discrimination in the workplace or people aren't going to communicate with them, that they would rather stay closeted at work than come out ...'

'If people do disclose their sexuality then they feel that discrimination may be inevitable anyway – so that encourages you to follow the vicious cycle of keeping quiet when at the same time there may well be people in the work place who would be fine about it and want to help eradicate discrimination. It can feel too frightening to take the risk though – particularly if you have had previous bad experiences. So I suppose what I am saying is whether to run the risk of "outing" yourself in the workplace or on a monitoring form is complex and varies from person to person depending on other aspects of their lives and the perception of safety.'

'If somebody makes a derogatory comment like describing someone as a dyke or a poof, I won't challenge it because I don't want to draw attention to myself, but if someone makes a racial comment then I do challenge them on it. No such comments should be allowed, be it homophobic or racist.'

'I think we are very bad at supporting our own … We have very senior people who we know to be gay or lesbian, but they have kind of gone back in the closet once they have reached a certain level and they no longer support other younger lesbian or gay doctors because they see it potentially as a threat either because it will "out them" or because it … will undermine them in some way.'

Safe space

For some respondents, especially lesbian and gay doctors, part of their decision making process was based on where they would feel comfortable.

'I have naturally been attracted to somewhere I feel safer'

'Becoming a radiologist was a decision very much driven by my sexuality… I was very definitely looking for a safer space in which to be a doctor and a gay man.'

'I have kind of almost given up the fight and come to the most gay friendly place in the whole of the UK … I have naturally been attracted to somewhere I feel safer …'

Key messages from the respondents: lesbian, gay and bisexual doctors
- Homophobic experiences exist throughout the medical profession.
- Fear of discrimination is referred to by lesbian, gay and bisexual respondents as prevalent in their work environment.
- Some doctors spoke of choosing a particular specialty where they felt safer about others' perceptions of their sexuality.

8 Experiences

The following section provides an analysis of some of the experiences of barriers described by the respondents. While the previous sections have illustrated specific issues and concerns arising from the qualitative and existing research, the following section contextualises some of the experiences described by respondents more broadly. The experiences are from all the groups interviewed.

Attitudes and stereotypes within the medical profession

Many of the barriers considered in this report are also prevalent throughout different professions and industry – to different extents and with different emphases. Some of the respondents expressed concern about how the views of society pervade their profession and career progression.

'it is still a very conservative profession'

Attitudes, perceptions and stereotypes were some of the most significant barriers discussed by the respondents. They were often described as obstacles and in contrast to a normative standard. Interviewees expressed negative experiences and attitudes, which impacted on the medical profession. Some interviewees felt that attitudes within society had changed over time.

'I think now people are beginning to perhaps acknowledge that there may be other people existing within medicine who are not married GPs with 2.2 children etc… But I think it is still a very conservative profession.'

'Doctors are beginning to be seen as fallible human beings … And equally doctors realise that perhaps they haven't got all the answers and that they may need sometimes to ask for help themselves. So I think that's a healthy change … It is becoming more balanced.'

'I am an openly gay man … The world has changed and also I am 15-16 years on from that point of decision making. I have never overtly experienced homophobia.'

'You have to have completed the equal opps training day and I went on that in the 90s sometime and it was utterly bizarre. It was basically a training day saying "we know you are going to be biased and prejudiced because that is the kind of people you are, so the very least you can do is not get caught with your trousers down by saying wildly inappropriate things." It was basically how to get away without embarrassing the establishment. There was no real effort to promote equality … It was very much a training in how not to embarrass the establishment by saying the wrong things in an interview process…'

Additionally, respondents seemed to imply that certain characteristics were stigmatised when one was different or deviated from a norm.

'Career choice doesn't always go smoothly if [you are] perceived as different in some way.'

'Oh I bring my [same-sex] partner along ... But this is the kind of attitude that you get, very subtle. Everybody's very nice about actually being very nasty and inconsiderate.'

> ### Key messages from the respondents: attitudes and stereotypes
> - Attitudes, perceptions and stereotypes of society and the profession are identified as presenting significant barriers.
> - Attitudes are slowly changing within the profession, but are not reflected across the workforce as a whole.
> - Negative attitudes are experienced in contrast to a perceived normative standard.

Discrimination

'this is a small specialty and you need a job'

The interviews highlighted instances and anecdotes of direct and indirect discrimination, bullying, harassment and victimisation. Many of the stories are extensions of the attitudes and perceptions already described. They do not portray the profession in a positive light. A finding from our research was that discrimination in some variation was evident throughout all the categories of respondents participating in the interviews. They are important to include because they are often unnoticed. Whether or not these findings are widely representative, may or may not be important – what is clear, however, is that for the people we spoke to, discrimination and a discriminatory environment were a reality.

Although there is a legislative framework within the UK to outlaw discrimination, instances of discriminatory behaviour still exist. There is a spectrum of discriminatory behaviour, prejudice and attitudes within medicine. Discrimination and fear of discrimination are often experienced within a threatening environment.

'[The post graduate dean] said to me "are you sure you want to say these things because this is a small specialty and you need a job" … So I realised that I could say no more. I withdrew my complaint … I was put into a kind of deep freeze. I had no idea what was going on. Nobody spoke to me.'

Other examples of respondents' experiences of discrimination are in sections 4-8.

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Key messages from the respondents: discrimination

- There is an expanding legislative framework within the UK to outlaw discrimination.
- There is a spectrum of discriminatory behaviour, prejudice and attitudes identified within medicine.
- Incidents of discrimination are often unnoticed and unchallenged.
- For the doctors interviewed, discrimination and a discriminatory environment were the realities of their everyday lives.
- Doctors could not always rely on those in authority for support. Their advice was sometimes to 'not rock the boat'.
- Fear of discrimination affects people and can be as significant a barrier as actual discrimination.

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Lack of flexibility

The attitudes and perceptions towards flexibility are significant in the way that they manifest themselves. Drawing on this theme, the respondents highlighted other ways that the structure and attitudes within medicine act as obstacles. Structural barriers such as pressure to conform, reluctance to change, lack of flexibility and adapting to non-traditional career paths were all mentioned.

'flexible training is not highly regarded'

'I think in order to do well in specialties for example, surgery, obstetrics and gynaecology, and so on, you have to have been progressing systematically from your primary training onwards …'

'I kept looking around for a way back into adult haematology and eventually I did get part-time jobs in haematology and then I cobbled up the odd session here and there … I think the difficulty was that I started to realise that I'd qualified at a time of change and while I had been working part-time and trying to keep my head above water, the goal posts had moved. Haematology was changing from being a laboratory specialty to a very high intense clinical specialty for which I wasn't qualified …'

'I hadn't done full-time work on call for about five years and I left in about six weeks and I just completely fell apart physically. My body couldn't cope with it, I just crashed.'

'I think medicine is quite reductionist really … There are pockets of conservatives, where people have to get on the career line and not do anything wrong. Do your research posts, do your SHO post as quickly as possible, get your exams. But there are elements – pockets where people are able to tolerate difference, and that means different career paths with different interests ...'

Flexibility is seen as a key aspect. Even when flexible working was available, for example flexible training schemes, negative attitudes towards these options sometimes presented barriers. Previous research conducted by the BMA highlighted similar attitudes and a reluctance and stigma associated with flexibility; 'I went part-time and this was despised "half-time, half-baked, half hearted".'[23] For the most part, the participants in this research repeated this sentiment.

> 'Often meetings changed without consultation which affected my school run.'

> 'I think flexible training is not highly regarded nor part-time working. I think there is a bit of stigmatisation for it, which is a pity.'

> 'The title of my job was flexible trainee – and on one occasion the consultant accused me of not being sufficiently flexible, but the point is of course that the flexibility was for my benefit, not for his benefit, but he didn't see it that way. He thought I should be more flexible for his benefit ….'

In 2003, the BMA-led working party on flexible training published a report supporting flexible training and outlining the short-term and long-term benefits for doctors and the health service more broadly.[32] The recommendations focused on access and appointment processes, funding, departments of health, colleges, deanery, trainer, childcare, flexible training data and workforce planning. By outlining these areas as key, the report provides added momentum to genuinely offer more flexibility to more doctors.

Key messages from the respondents: lack of flexibility
- Lack of flexibility within the working environment and career structures has negative consequences for all the groups who participated in the interviews.
- Flexibility is one of the key ways that barriers to career progression can be overcome.
- Negative attitudes towards flexible options pose a new set of barriers for those attempting to follow such career paths.
- Not adhering to a standard of full-time and continuous employment can be stigmatised and is often defined negatively as 'not full time' or 'non-standard'.

Cost

'working as a flexible trainee is crap money'

In addition to the financial barriers already discussed in relation to exam costs and specialist equipment for doctors with disabilities, other cost implications were raised. Childcare costs as well as flexible working were mentioned as having cost implications.

'There are barriers in money, because working as a flexible trainee is crap money and that is really very frustrating.'

'Being informed that places at the workplace crèche are prioritised for nurses, as doctors earn more and can afford alternatives.'

> Key messages from the respondents: cost
> - Cost was identified as a barrier particularly in the context of exams and registration for overseas doctors, equipment for doctors with disabilities and childcare.

Career choices and constraints

There are many reasons and criteria upon which decisions are made about where to specialise within medicine. The discussion is often framed in terms of interests and skills. However, our respondents also often discussed this in the context of choices and constraints. Within the decision-making process, it is difficult to determine the influential factors and their causes. However, issues such as perceptions, stereotypes, working hours and the 'culture' of different specialties and grades can all have varying degrees of influence.

The notion of a 'glass ceiling' often enters the debate. It refers to an often invisible obstacle that limits progression and advancement throughout a career. For example, many doctors from minority ethnic groups turn to general practice. It has been suggested that this is because racism prevents them from progressing in hospital medicine.[3] Even when the notion of the 'glass ceiling' was only alluded to by our respondents, it was clear that the obstacles they faced presented significant barriers within their own career progression.

'Culture' of specialties

The culture of different specialties was mentioned throughout the interviews, mostly from women, gay and lesbian respondents. It seemed to be critical in the decision-making processes. Some of the following comments highlight this.

'there are some deeply illiberal mindsets'

'I can talk for gay men from my own personal perspective, but I know obviously lots of other people … Well there is a kind of barrier – although I enjoyed my surgical posts and house jobs – I wouldn't necessarily choose those. There's a kind of laddish culture and that doesn't have to be gender specific. I think women in surgery can also be quite … they take on that kind of characteristic to be quite laddish. So you're excluded in a certain respect, I suppose on that level, but also that's kind of mixed up with personality types.'

'When I started medical school I said I wanted to do paediatrics and people said "you can't because you are a gay man".'

'Obviously my career path would have been different … many colleagues, particularly many surgeons, seem stuck in a 1950s time warp in terms of social values. There are some deeply illiberal mindsets.'

'And certainly you know in terms of psychiatry it has got a very, well it has got a very difficult history with sexuality and gender really, so I think it's peculiar that you do find a lot of lesbian and gay, bisexual and trans doctors in psychiatry.'

'I don't think I would want to go into obs and gynae … people assume me to be a straight female so for me to go in is almost under false pretences. Patients put trust in you and yes, you are there to do your job, but the patients may (if they knew) have a different opinion. I wouldn't choose to put myself into that situation, I would feel awkward doing so.'

'And when I was working for a very eminent neurologist he said to me, if he had his time again he would do ophthalmology … and he also said that it was a very good specialty for a woman. I have had many years to reflect upon his words … It was a very good specialty for a woman if you were prepared to be a clinical assistant. I did not understand this then. I assumed it was a good specialty for a woman as a consultant. So, certainly some misunderstanding there.'

'The gulf between my experience as the mother of three children trying to be a surgeon part time, and the powerful men who were full time, high status, extremely wealthy, was so great they could never, never see my position. They could never, never understand my situation, and only a woman could.'

Personal priorities

'I think it's about personal choice'

It is often difficult to analyse influential reasons affecting career choice. Priorities may also change throughout a doctor's life and career. What may be construed as a barrier for one doctor may not be for another – it often depends on individual circumstances and perspectives.

'I suppose the sort of choices you start having to make is when I got my specialist exams and I decided to start a family. Again I was encouraged, I was encouraged to take up a part-time job and I think I had a very enlightened consultant who was head of department at the time because he said "you must have a job to come back to after you've had your baby otherwise you'll never do it" and I think he was probably right …'

'So you know in terms of if you're looking at barriers to career progression I think it's about personal choice and the barriers are only there if you make choices in that way and make choices to spend more time with your family. It

is not just women who do that, men do it too and I do know men who've chosen not to go for high intensity specialties because they thought it would take them away from their family too much. So I think it is about personal choices really and I've never regretted the choices that I made.'

Self-selection

Some of the respondents selected themselves into or out of certain areas of medicine. Choices were sometimes based on the perceptions of likely constraints. Some respondents described this process as a barrier while for others it was a positive choice.

'I don't know how many people choose not to go into medicine based on … the perceived reactions they believe they will get from other students, from staff, from patients, whomever, which is sad because you could be losing many people who would be very good doctors. Because they self-select themselves and take themselves out of what is otherwise a worthwhile and fulfilling career.'

'I saw it as a specialty that would be reasonably conducive to family life because … it was laboratory based and it had more contained working hours. I mean there was on-call, but it was to a predictable rota … the working day was more contained and you could fairly reliably know that you would be able to cope with having to leave at a certain time to pick children up and that sort of thing. So I did see it in that sense as something that was conducive to family life. But, as I said, haematology changed rather dramatically and that was no longer the case really.'

'I guess it's more what my personality type was and of course part of my personality type encompasses my sexuality and my class, my family origin and various other things so it's actually quite difficult to tease out different factors.'

'Traditionally gay men, I am not so sure about women, have tended to gravitate towards larger cities were there are networks and social facilities particularly for gay people.'

'I say no no, I am doing exactly what I want – but am I? I am now working in one of the most stressful areas for general practice in the country. It is fascinating and rewarding, but stressful working in this area – I wonder is it because it is the only area in the country where it is safe to be a lesbian GP and be honest about it … without fear of being attacked or humiliated or gossiped about.'

'I saw it as a specialty that would be reasonably conducive to family life'

'I gave up the fight'

Leaving the profession

The repondents represent a cross section from the profession in terms of age, location, specialty and career grade. The BMA recently published a report titled *Why do doctors leave the profession?* The study found that the main reasons why doctors left the profession were: that they were not valued; that they were not supported; and because of the unacceptable work-life balance.[33] This was also true of this research.

Some of the respondents had already left the profession. From among this group, there were individuals whose decision to leave was a consequence of the barriers that they had experienced. Some respondents commented that it was their position outside of the profession that enabled them to tell their story.

One respondent described the process of leaving the profession and decision to be interviewed.

'I have encountered extreme obstacles in my career progression to the point where I frankly didn't really want to speak to you. My memories are very painful and very unpleasant, however, I suppose, for the good of the cause I felt it an obligation to do so. But I am sure there will be women, in fact I know at least one, who I am sure will not respond to this call, because she still would be unable to describe her experience. And so you will not be getting a full sample. There are women whose experience is so painful they will not be willing to even discuss it.'

'After I had complained to the dean and I realised I was helpless … I drove up to the hospital and I just realised that I couldn't go in. So I turned around and I drove home and I went to my GP and I got a sick note and I didn't go back. And that was it really. Six to eight weeks passed during which time I began to feel more myself, and I realised how unhappy I had been because I began to feel the way I normally feel.'

'After a couple of months there, I thought "what can I do? I have to finish my training. To finish my training I have to go back to the teaching

hospital …" I had three small children, I couldn't commute to London. So I thought, well there is no point in carrying on because I am not prepared to go back into the same environment, so I resigned. And I left medicine.'

'This is something that has completely destroyed my career. It has had very serious implications for my mental health for some time and it was completely unnecessary, because I was totally British trained, a good quarter of a million pounds of tax payers' money went to my training and it has not been used. I am here at home. I have been home for some years. The NHS is crying out for surgeons, they are desperate.'

Other respondents described the process in terms of losing a battle or facing obstacles that could not be defeated.

'Well I have met quite a lot of good people in medicine in the UK. People who are at the cutting edge of medicine and they are excited about it. They are very hurt as well that (these are people who are friends of mine some of them are consultants) and they are very hurt that I am not able to practise medicine because they know that I would love to.'

'I think if I am honest it was a combination of pressures in the work and the [disability] … and I gave up the fight.'

'After the first part, then I would have to sit down, study for the PLAB, clear both parts and then apply for support and continue with my training to be eligible for MRCP part II examination. It would have taken a very long time, I was short of cash, and it wasn't financially possible for me. The other option would have been to go back, continue my training and then prepare for the PLAB … So that would have been a big financial burden on me and my family. And obviously being a very junior doctor, I would not have been able to save that much, to prepare for the PLAB and take some courses and just come over here for the examination and then stay afterwards or go back and forth. So all those factors just contributed to my decision to change my career.'

While for others, leaving the profession was described as a positive gain.

'And I found that a lot of my patients would seek me out for the talking treatment. They sort of recognised that I was the doctor who wouldn't necessarily make them have the nasty treatment. I would discuss it with them and give them their own choices within the recommended treatments available. And from that I moved more into thinking "I'm not really being a medical doctor any more, I'm being a counsellor" and that took me into a career change. And so I decided eventually to retire from medicine altogether and become a counsellor instead. So again in a

sense what you might perceive as a barrier, as I was not happy with the work I was doing, turned into a … positive and I thought "well what am I going to do" and looking at what I'm good at … So I'm working at the age of 60. I'm working half-time with a range of counselling jobs. I've still got several part-time jobs and you know, completely different specialty from where I started out and I'm very happy.'

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Key messages from the respondents: leaving the profession

- Barriers to career progression can play an important part in any decision to leave the profession.
- In extreme circumstances this can have an impact on physical and mental health.
- The decision is not one taken lightly and often came at the end of a long and difficult process.
- Leaving the profession can be perceived in terms of loss and as a positive impetus for change.

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Support structures and role models

The subject of support provoked a wide range of positive and negative comments. The following reflects the mixed spectrum of support. It also includes different perspectives and approaches from formal and informal support.

'My impression of the medical profession is that they know no more about [the disability] than the general public and that attitudes to me are just as variable.'

The value of good support

'I met a lot of nice people who ... encouraged and supported me'

Support was received both formally and informally. There seemed to be a sense that a supportive environment or person genuinely made a difference and provided the opportunity for people to overcome barriers and in some cases, continue to practise medicine. Support seemed to be valuable and beneficial.

'I have been very fortunate. Ninety per cent of what I got I wanted to achieve and met a lot of nice people on the way, who encouraged and supported me (most of whom were 'white').'

'I basically discussed this with her [the flexible training advisor] and she said you can become a flexible trainee … I think they fast-tracked me … So I then went through my SHO training scheme. If I hadn't had the flexible training I would not have survived, I would have left medicine ... probably in another area of the country this wouldn't have happened. It is very 'postcode'… Once I was able to go part time and I could control my diary, rather than the diary controlling me, I was fine.'

'I keep in touch with my occupational health physician … we have an understanding so I phone him up when I need him … He knows I know enough about the situation and that I'll call him if I am in a crisis and they are pretty good at sort of getting you through and getting people off your back.'

'I have received excellent support and guidance from my postgraduate dean, my psychiatrist, CPN and counsellors.'

'I have attended GLADD events for a couple of years now, which has been refreshing. It was just really nice to go into an environment where people aren't going to judge you based on answers you give regarding your relationships so you don't have to lie, which unfortunately I do quite a lot to maintain privacy.'

'I was encouraged. And as a woman I was encouraged by my colleagues and peers so I felt that I was making normal progress and doing what I wanted to do.'

'Towards the end of my clinical years, just around the time when we were due to take finals, I became quite severely depressed. I was under a lot of pressure around the exams, everything seemed to pile in on me and issues around my sexuality and who I was and who I wanted to be. Fortunately I sought treatment, but it got so bad that I ended up attempting suicide and almost succeeding, but I was rescued by one fellow student in a fairly spectacular way. I owe him and my close friends at that time a great deal – in fact the rest of my life. I went into hospital and somehow that was a turning point. It seemed to me I think that I had to be me, I had to be authentically me, and all this sort of pretence was just doing me a severe disservice really.'

Mixed experiences of support

Other respondents described more mixed experiences in terms of wanting, needing and receiving support.

'I cannot say that I have been supported. I had an operation and was off for four weeks and I went back … I wasn't functioning 100 per cent … so it was all quite stressful … There were colleagues, who didn't like that I was off, although the consultant was very good. He was excellent.'

'When I was in South Africa essentially I never felt that I experienced any obstacles and it was no problem for me to be fully open about myself, my life, and my supervisors and bosses have always been supportive. I think in this country people tend to respect one's privacy, but it seems that with one's managers, it is not an issue that is addressed or talked about openly … People aren't very frank about issues of discrimination and even racism. One of the difficulties I've been experiencing in this country is actually racism.

'it is also proving really difficult even getting suitable [equipment]'

Much more than frank homophobia, but in terms of career progression I don't think, I can't think of any frank examples. It's difficult to say.'

'The knowledge that I am not obliged to reveal health information directly to employers (shielded by occupational health) and being told my illness was not a barrier to continued employment in the NHS was a revelation (which was only revealed to me years into my experience). It is such a pity I was not aware of OHS much earlier in my career.'

'The financial help available is limited. If I had not been in work, or if I were self-employed, I could have applied for full funding for all the equipment I needed. Because I am employed, my employer is expected to pay the first few hundred pounds and then 20 per cent of the rest … (that) will cost £6,000. My employers are the GPs I work for. This is a great deal of money for them to find and I do not feel it right to ask them for it. We work in a very deprived area, we have a profound shortage of GPs, the service they provide is excellent so they are very short of money… I think this is an unfair system … It is also proving really difficult even getting suitable [equipment] … I do wonder whether all NHS staff should be given priority on waiting lists and should be seen by more senior, experienced healthcare professionals. We have a shortage of many professionals and a demoralised workforce. Should we not be doing all we can to keep us in good health?'

'People with a disability have spent their lives working with the disability and minimising its impact and they are not really terribly keen to advertise it … I don't want to be seen as a disabled person … my whole energy is going into demonstrating that I can do the job and the disability is irrelevant.'

'I felt helpless'

Lack of support

The respondent group provided numerous examples where they had experienced a lack of support. This may impact on other areas of concern, for example, it may exacerbate issues such as feelings of isolation and weakness, thereby compounding problems for the individual.

'I have found it really difficult getting information about stethoscopes and other aids … Yet surely there are many professionals with hearing loss.'

'What would have helped me when I returned … would have been a much clearer acceptance of responsibility to assist me. I asked for adapted telephone, I had to nag and nag and I felt very humiliated constantly reminding people … I hated having to constantly harp on about it … [The additional equipment required] only cost about £25 … Instead of the lead consultant simply saying OK such and such a person will be responsible for doing that … Every time a patient

came in I had to go and seek somebody out and ask if they would do it, which they always did, but it would have been much easier for me if it was simply laid down that somebody did it … It was kind of like rubbing salt in the wound a bit.'

'Anyway, it was the last straw, I left and I went into work for two or three days feeling very angry and very determined to hold up my end, because I felt it was completely wrong and completely unfair. I also went to the postgraduate dean, I went to the personnel officer, in fact, that very evening I went home and I wrote down a full account of the whole thing, because it was so outrageous and so illegal and I, then I talked over the next few days to these other people and I felt helpless.'

'And then came the event that precipitated my departure from medicine … I was very isolated in the department. I felt very unwanted, I felt positively bullied.'

Role models, support networks and organisations

Role models, support networks and organisations were mentioned on several occasions. They were able to provide positive assistance and were valued by those who identified with, or engaged with them.

'it would help to talk'

'It kind of gives you a more positive sense of self to see that there are doctors that are 50 or 60 that are happy, in long-standing, caring [same-sex] relationships and that have managed to succeed in their careers … It's just nice to have a conversation with people where you can see a future for yourself in medicine.'

'I wanted to meet somebody else who has had the same problem … I think if you had an illness it would help to talk.'

Respondents seemed to appreciate support networks. Sometimes they just valued knowing that they were there even if they did not use them personally.

'I think this is one of the reasons why one would join something like GLADD. It's basically to develop networks and get to meet peers you know in the same area while at the same time supporting the goals of your organisation, but I think for me certainly coming from somewhere else, I needed to find some way of linking up with people.'

'I was extremely, extremely happy to have left the hospital, and at that time to have left medicine, I have to say. But, I still felt a great, acute sense of injustice because I have always been the high flier. I wasn't the incompetent surgeon. I wasn't somebody pushed beyond their capacity. I

was somebody who had been broken down, who had been good. I remember thinking during this time ... What has happened that I now seem to be so bad. Is it because I have children? That can't have affected my brain, my skills, you know, I couldn't understand it. Anyway, so I brooded over this, and I contacted the Medical Women's Federation and I talked to a lot of people about my situation, just because I was trying to understand it.'

'The only solution in my book is to be true to yourself which I feel includes sharing who you are with yourself and with other people. In saying this I want to pay tribute to a number of people, one therapist in particular, who has helped and worked with me over many years. One of the sadnesses is that we still meet doctors who try and live a double life. They hide their sexuality in professional terms and I suspect from their families too. My heart goes out to them. I feel we can't expect people to genuinely love us unless we tell them "this is who I really am." Otherwise we are dealing with irreconcilables which cause stress and disharmony and I believe inhibit personal growth.'

Confidence and self-awareness

'you have to do something about it'

Other respondents described mechanisms that were more about increased self-confidence and self-awareness. These qualities seemed to provide an additional means of support which could give the individual strength to overcome their difficulties.

'If you hit an obstacle you have to do something about it. You have to either sit back and do nothing or you bring some energy to it and decide you're going to have a go.'

'So I'm coming out more and more because it helps me feel more relaxed and people's attitudes may change in a non-confrontational way. They may automatically reassess their views about gay people.'

Key messages from the respondents: support
- A supportive environment or person seemed to make a genuine difference and benefit the doctor.
- Some respondents described a lack of support within the profession, which exacerbated feelings such as isolation.
- Role models and support networks were generally appreciated by respondents.

9 The role of the BMA

Interaction with the BMA

Some interviewees were asked about their interaction with the BMA and how they perceive it as a professional association. The results highlight more areas where the BMA can be more responsive to the needs of its members.[vi] Although not always positive, the interviewees seemed pleased that the BMA is actively seeking the views of doctors to inform a report.

'I think things are improving, but the BMA still has a long way to go. I am really impressed with recent events. But the BMA has to do a lot to convince its members and should communicate much better with the grassroots and ethnic minority doctors.'

'I know I could go there if there was a problem and especially if there was legal issues, I know who to call.'

'There is the BMA helpline; that's very good.'

'At that time, I contacted the BMA who were not desperately helpful. They basically said it was an educational matter and we don't do educational matters. Basically their line was, "it's not an employment matter. This is a matter about the deanery and the royal colleges and we don't get involved in that. We don't have a responsibility for doctors in training." That was kind of what they were saying. And they said, "basically until you get anything in writing, there is nothing we can do." And I am like well they have never put anything in writing and that is part of the problem.'

'There are no women on this committee [EOC] and as far as I am concerned, that immediately colours my feeling about what I will say even in this interview because I do not feel that I will get a sympathetic hearing from men as I would from women. And I think if this committee is to have any validity, and if its conclusions are to be trusted by women, there must be a woman on it … Simply advertising for women is not enough. If there isn't a woman who volunteers, a woman must be sought – a medical woman. And I know there are plenty of women in medical politics such as the women in the Medical Women's Federation. One of them must be found and invited to join the committee, and pleaded with to join the committee, or it will not have strength.'

> ### Key messages from the respondents: the BMA
> - There is still more that the BMA can do for its members especially at grass-roots level.
> - That the committee structure should reflect membership more broadly.

[vi] In addition to the publications and initiatives of the BMA, the BMA's *Directory of membership services* and *Student directory of membership services* are updated annually with information on services provided by the BMA for its members.

10 The way forward

The issues raised in this report are challenging. The respondents, in their own words, have told us that not enough is being done. This is confirmed by evidence in the literature showing that for these groups of doctors, discrimination and barriers to career progression are the reality of their everyday lives.

This report, on its own, cannot answer all the questions or solve the problems identified. What it can do, however, is bring these issues into stark focus by adding the voices of those individuals who have experienced these problems.

This report clearly shows that these are issues for everybody – not just for those who are affected by career barriers and a negative working environment. We are all responsible for creating that environment and it is only through our own collective and individual actions that the environment can change. Attitudes need to be altered to implement change.

The legal framework is changing rapidly and this may offer people more protection from many of the problems raised here. However, legal action itself must be seen as a last resort. Many of our respondents indicated that they did not wish to take that course of action and that decision must be respected. This reluctance is due, in part, to the fact that such discrimination is carried out within a culture where it is difficult to stand up and state that something is unacceptable.

The BMA, through its equal opportunities committee, will continue to explore these issues and has set in place a comprehensive programme of work for the forthcoming session. The following highlights that both short term and long term goals need to be set. Many of the same problems are repeated. Reiterating unfulfilled recommendations may not necessarily be the most effective method of influencing change, because the focus of where the problem exists may have changed.

Within the following section, the BMA identifies some of the key issues that need to be addressed and presents suggested approaches, whilst at the same time, remaining open to further discussion. The equality strategy being developed by the BMA will be able to identify time scales and responsibilities. Through this organisational approach, priorities and actions can be implemented in a more structured way to facilitate change.

Overcoming medical career barriers
There must be zero tolerance of discrimination
Suggestions:
- *The BMA will continue to work with the health departments to develop a comprehensive 'zero tolerance' strategy for the NHS that includes all forms of discrimination experienced by doctors.*

This should be based on the work of the NHS zero tolerance initiative on bullying and harassment of NHS staff.

- *The BMA will lobby the government to provide more funding to enable all Trusts and NHS organisations to sign up to initiatives such as Positively Diverse.*
  Positively Diverse is a successful programme developed in the NHS to encourage equality and diversity in the workplace.

Education and training in equality and diversity is a key tool in challenging attitudes and changing behaviour
Suggestions:
- *Guidelines for education and training in diversity and equality matters should be developed by the BMA in conjunction with the Council of Heads of Medical Schools, General Medical Council, royal colleges, regional postgraduate deans, advisors in general practice and undergraduate deans.*
  Medical education has a critical role in challenging stereotypes and the BMA believes that medical schools should ensure incorporation of education into diversity and equality issues into the undergraduate curricula as well as postgraduate training programmes. Such education should be stimulating and encourage individuals to challenge their own attitudes and stereotypes.

- *Trusts should run training sessions on diversity and equality as part of their induction programmes for newly appointed doctors.*
  Such training would help to increase awareness of equality and diversity issues and provide doctors with contact details of individuals and organisations who can advise them, or with whom they can safely discuss such issues, if they feel that they are being treated unfairly.

Doctors need good quality careers guidance and support
Suggestions:
- *Stakeholders from universities, deaneries, royal colleges, as well as clinical tutors should continue to work together with the BMJ/BMA in a national initiative "Supporting Doctor's Career Choices".*
  There is an urgent need for doctors and medical students to receive support in their career choices. This initiative targets specialised groups such as female, disabled, and ethnic minority doctors while also addressing the needs of the wider community. It provides guidance on career options, recognised and alternative career paths, as well as retraining options.

- *The BMA, should continue to provide expert guidance and support to members in dealing with issues of discrimination.*
  This should be done particularly through the work of regional services, the equal opportunities committee and 24-hour telephone counselling service.

Under-represented groups should be supported into leadership and management roles

Suggestion:

• *The BMA supports the work of the NHS Leadership Centre to promote leadership development across the NHS.*
The Breaking Through programme aims to support the progression of black and minority ethnic staff into senior leadership roles. It provides one example of how organisations can work towards a more balanced workforce. Programmes and schemes should be extended to include other under-represented groups such as women, doctors with disabilities, and gay, lesbian and bisexual doctors.

Best practice in equality and diversity should be shared

Suggestion:

• *The BMA should report examples of best practice in the area of equality and diversity in relation to the medical profession.*
The BMA can publicise and enhance positive examples through their website and publications such as BMA News.

More work needs to be done to examine and highlight the underlying issues that present barriers to career progression

Suggestions:

• *More research needs to be undertaken into the experiences of doctors and career barriers that exist within the medical profession.*
This report contributes to the expanding literature illustrating that barriers to career progression are not isolated issues for a minority of doctors, but are more widespread and common. More research will continue to pressure the medical profession and stakeholders to be more actively responsive to barriers.

• *BMA news, BMJ and Student BMJ should publish case histories on a regular basis*
This is a further way that the medical media can increase awareness and recognition of the problems and issues faced by these groups.

Minority ethnic doctors and doctors with international qualifications

The recruitment process (including job applications and interviews) is a problem area for discrimination

Suggestions:

• *Trusts should ensure that members of interview panels and selection committees receive equal opportunities awareness training.*

• *Deaneries and Trusts should provide guidance on filling in application forms and information about interview procedures.*

This could include examples of likely questions or points for discussion so that interviewees can be adequately prepared.

- *Equal opportunities monitoring should be carried out by Trusts in relation to applications for job vacancies.*
  In the first instance, Trusts should monitor gender, ethnicity and disability. Consideration should be given to developing ways to monitor sensitive data such as religion, sexual orientation and age. Any bias or perceived discrimination should be investigated and appropriate actions taken.

- *Trusts should consider the use of anonymised application forms for job vacancies.*
  This is one option by which some of the bias that might arise on the basis of non-English names might be removed. This approach would also help to focus the assessment of the candidate on their medical skills and relevant experience.

Disciplinary systems must be fair and constructive
Suggestions:
- *The BMA will encourage the GMC and the NCAA in their quantitative analysis of data on disciplinary cases.*
  In addition, a report should be prepared which includes qualitatively focused examination of the underlying reasons why minority ethnic and overseas doctors are more likely to be disciplined or suspended. This information would help highlight any issues within the disciplinary system and to target future initiatives and support to specific problem areas experienced by this group of doctors.

- *The BMA should repeat (on a regular basis) the 2004 survey of cases referred to regional services which investigated the underlying causes of doctors' disciplinary problems.*
  This would help to determine how the patterns of disciplinary problems are changing and to identify emerging themes that need to be addressed.

Staff and associate specialist grades must have opportunities for career development
Suggestion:
- *The BMA should continue to work with the Department of Health to support the implementation and further development of the recommendations contained in "Choice & opportunity: modernising medical careers for non-consultant career grades"* (NCCGs, also known as staff and associate specialist grades – SAS). These recommendations include:
  - enabling all SAS doctors to have opportunities for career progression
  - developing a fair system of competency based assessment to enable SAS doctors to enter career grade posts

- developing a system of competencies through which SAS doctors with formally recognised skills can work independently at the appropriate level
- providing the resources and infrastructures for continuing professional development of SAS doctors.

Clinical excellence awards must be open, fair and non-discriminatory

Suggestions:

- *Trusts should ensure that there is openness and transparency within the clinical excellence awards system.*

- *Trusts should monitor clinical excellence awards in terms of ethnicity, gender, disability and sexual orientation.*
  The results of this monitoring should be collated, analysed and published by the Advisory Committee on Clinical Excellence Awards.

Ethnicity data is needed for general practitioners

Suggestion:

- *Primary care organisations should collect ethnicity monitoring data for general practitioners.*
  This data should be collated and analysed centrally by the health departments in order to provide a clearer picture of the composition of the GP workforce.

Requirements and implications of PLAB and other examinations need to be reviewed

Suggestions:

- *The BMA welcomes the review of the PLAB examination being carried out by the GMC.*
  This should consider the relevance and suitability of the test as a means of assessing a doctor's ability. In addition, the costs should not be prohibitive.

- *The GMC, with support from the BMA, should examine the arrangement whereby doctors qualifying outside the UK or EU are currently required to take the International English Language Testing System (IELTS) examination regardless of nationality.*
  Action needs to be taken to avoid any unnecessary examination burden for those individuals who, for example, have English as their first language, or received their main education in English.

Employment information is needed for doctors who have trained internationally

Suggestions:

- *A single official website for internationally trained doctors should provide clear and updated information about employment prospects in the UK.*

There is much confusion about registration procedures, and employment processes and opportunities in the UK for doctors with international qualifications. It would be beneficial if one site provided information and up to date links to relevant organisations. For example, the National Advice Centre for postgraduate Medical Education (NACPME), maintained by the British Council (www.britishcouncil.org) is currently updating its website. This website should be the central information point with relevant and accurate information for doctors coming to work in the UK. The BMA will continue to monitor the provision of information on the web, and make appropriate recommendations.

- *The GMC should consider developing a central database of overseas doctors who are registered and seeking employment, particular overseas doctors who have passed the PLAB test.*
  This could allow monitoring of the types of appointments obtained by this group, the number of applications made and the length of time spent on the register. The data could also be valuable to target initiatives aimed at helping this group of doctors into employment.

Support organisations and networks play a valuable role in ameliorating difficulties facing minority ethnic doctors
Suggestion:
- *The BMA should work with the Department of Health to encourage and facilitate networking amongst minority ethnic doctors so that they can meet one another to give mutual support, share experience and advice.*

Doctors with disabilities
More information is needed about doctors with disabilities
Suggestions:
- *Health Departments should collect and publish anonymised data on the number of health care professionals (by profession and grade) with disabilities in the UK.*

- *More research is required into whether and how disabled doctors' needs are being met in employment and medical education.*

Doctors with disabilities need more information about the options and support available
Suggestions:
- *The BMA should continue to review and update the "Doctors with disabilities" web resource.*
  This is a sign-posting service to provide contact details and web links to information sources for disabled doctors and medical student members.

This service provides information about aids, facilities, equipment and financial help, and includes a link to the BMJ Career Focus Chronic Illness Matching Scheme which is a resource through which disabled doctors and medical students can get in touch with one another.

- *Medical schools should provide clear admissions information about the facilities, course content, as well as physical access, that is available for disabled or chronically ill individuals wishing to study medicine.*

- *The definition of disability used for monitoring within the health sector, including by UCAS for entry to medical school should be reviewed.*
  This revised definition should encompass a broader understanding of disabilities in the context of a disabling environment. It should not only be focused on those disabilities requiring special needs or extra support.

Comprehensive occupational health services should be available for all doctors

Suggestion:
- *There should be a fully comprehensive NHS occupational health service for all doctors, including general practitioners.*
  Occupational health practitioners and specialists who are experienced in dealing with the needs of people with disabilities should be available to provide advice for doctors and students. Occupational health practitioners should work in partnership with disability organisations to give advice and support.

Assessment criteria should consider desirability in relation to skills, abilities and specific job description

Suggestion:
- *The GMC should work with the BMA and medical schools to develop guidelines on skills assessment for doctors with disabilities.*
  This should include consideration of the knowledge, skills, attitudes and behaviour that are required to follow different medical career paths, the suitable training required to equip individuals to follow these careers, as well as innovative approaches to demonstrate the ways in which students with a wide range of disabilities or health conditions can achieve the required standards.

Doctors and medical students with disabilities need improved access and facilities

Suggestions:
- *Trusts, medical schools and primary care organisations must take action to ensure that they meet their legal obligations under the Disability Discrimination Act.*
  In October 2004, the DDA is being extended to apply to service providers, who will be required to make reasonable adjustments to facilities for disabled medical

students and doctors. Furthermore, it will be unlawful for an employer to discriminate against a disabled person in recruitment, promotion, dismissal or redundancy.

- *There should be financial assistance for Trusts and general practices employing doctors with disabilities when special equipment, aids and structural alterations are required.*

- *Medical schools should foster greater awareness of, and provision for, disability issues during medical training.*
  Medical students may become disabled during their undergraduate training. They should be provided with rehabilitation and support to continue with their training in line with the treatment that doctors would receive.

There needs to be a change in attitudes and behaviour which positively values people with all levels of ability
Suggestions:
- *Guidelines for education and training in disability matters should be developed by the BMA in conjunction with the medical royal colleges, regional postgraduate deans, advisors in general practice and undergraduate deans.*
  Training should acknowledge the important multi-dimensional contributions of different healthcare professionals and include the social model of disability.

- *Doctors should be made aware of how their environment can or may be disabling to their colleagues.*
  This should be promoted through disability awareness/equality training within the undergraduate curriculum and in post-graduate programmes.

- *All employers and general practitioners should ensure that policies and procedures for equal opportunities include disability in all employment matters, including recruitment and selection, training, promotion and career development.*
  They should seek to attain the Two Ticks Symbol – Positive About Disabled People, which is given by Jobcentre Plus, to employers who have agreed to meet five commitments regarding the recruitment, employment, retention and career development of disabled people.

Medical women
Flexible working needs to be valued as a positive career option by everyone in the profession
Suggestions:
- *There is a need to change the culture and attitudes within the profession which view flexible and part-time working as being less committed and inflexible.*
  This would benefit not only women, but all members of the profession for

whom this style of working would be suitable. A change in culture would also aid the concept of a continuum of training, with no marked dichotomy between full-time and flexible training.

- *The BMA should continue to support the Department of Health, Improving Working Lives (IWL) initiative.*
  The IWL initiative commits the NHS to delivering a range of flexible working practices. This should include ensuring fairness and equality of access, increasing awareness of flexible working, as well as supporting and encouraging the uptake of the flexible careers scheme in both hospital and general practice settings. The IWL initiative should also identify role models/advisors within individual trusts, deaneries and colleges who can promote the benefits of flexible working and training more widely within their area.

- *The IWL good practice database should be promoted and used by Trusts to help them identify options for flexible working practices and to share experience of good practice across the NHS.*
  This should include the provision of adequate information about cost implications.

Affordable and accessible childcare should be widely available
Suggestion:
- *With the support of the NHS childcare strategy, Trusts should provide good quality, affordable and accessible childcare facilities for those working in the medical profession.*
  Trusts need to recognise and provide funding provision for the additional cost of child care during out-of-hours periods. Childcare co-ordinators are to be welcomed, as a valuable source of advice, however more coverage is needed across the country.

Lesbian, gay and bisexual doctors
Legislation needs to be understood and implemented in relation to sexual orientation
Suggestions:
- *The BMA should produce guidance on sexual orientation to address some of the issues and concerns for doctors as employers and employees, in the light of new Employment Equality (sexual orientation) Regulations.*
  The guidance should help to raise awareness within the health sector more generally as well as providing information and resources, potential strategies, patient interaction, educational strategies and recommendations.

- *Trusts and primary care organisations should ensure that they are fully aware of the legislative requirements and should implement existing guidance.*
  Some examples are work produced by ACAS, GLADD, and Stonewall-NHS Scotland.

Data would assist in identifying where problems exist and should be collected in a sensitive manner

Suggestion:

- *More data need to be collected on lesbian, gay and bisexual doctors.*
  The health departments should consider how such information could be gathered for the medical workforce, in addition to other statistical information currently collected. However, great care and sensitivity will be needed in the collection, collation and dissemination of this data.

Support should be more widely available and confidentiality should be ensured

Suggestion:

- *Trusts and deaneries should identify a key individual who can act as a first line of support and confidential advice to doctors.*
  These individuals should be identified and provide confidential advice to doctors who raise concerns about issues of discrimination in relation to sexual orientation. The role of these individuals needs to be supported by the Trust so that there are procedures in place which address concerns and allegations of discrimination.

Medical schools should regularly review curricula

Suggestions:

- *Medical schools should review the way in which sexual orientation is presented within the medical curriculum.*
  In particular, teaching about 'homosexuality' should be integrated into the curriculum rather than defined in contrast to a normative standard of 'heterosexuality' as this perpetually reinforces negative stereotypes. In addition sexuality should not be exclusively taught and discussed in the context of HIV, genitourinary medicine or psychiatry.

- *Medical schools should consider issues of sexual orientation within their admissions policies and within their anti-bullying and harassment procedures.*

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Appendix A – Interview schedule

Guidelines and shaping questions for the barriers to career progression project equal opportunities committee
November 2003

Remember: this is just a guide, you need not ask every question or even ANY question on this list. The hope is that the conversation will be a free-flowing one in which you will not have to speak too much, and during which the interviewee will lead the discussions.

Potential themes which may arise and which you may want to explore:
- support and sources of help
- discrimination
- changes experienced over time, eg attitudes, facilities
- time as a student/qualified doctor, present experiences.

Welcome
- Thank you for agreeing to speak with me.
- Are you comfortable with me recording our conversation? If not….
- All the content of our discussion will be anonymised.
- In this interview we will be talking about people from minority groups. We are interested in, for example, women/doctors with disabilities/ethnic minority doctors/gay doctors

The interview
What made you interested in medicine/becoming a doctor?

How did you hear about this project and what made you decide to be a part of this study?

Where do you currently work?

Which medial school did you go to?

Where are you currently in your medical training? When did you qualify?

What was the process that led to your current job? (This question is very large in scope, but could bring out some interesting comments in its vagueness)

(If the interviewee is a junior doctor) What specialty do you hope to chose?

What factors influenced your decision to choose your specialty?

Were there specialties that you specifically chose not to pursue? Why?

Have you ever been made to feel uncomfortable in the workplace? In what way? And who by?

What are your perceptions of problems in the medical community for people in minority groups? (women/doctors with disabilities/ethnic minority doctors/gay doctors?)

Have you heard about other doctors who have experienced barriers to career progression or other similar difficulties?

Do you think things need to change? In what way? How would you like things to change?

Do you have any examples of good practice/positive experiences?

Tell me about your experiences. (For example, as a female doctor/doctor with a disability/ gay, lesbian, or transgender doctor, doctor from an ethnic minority).

What is your perception of the problems in career progression faced by members of minority groups (for example, disabled doctors).

Have you ever contacted the BMA on a matter relating to equal opportunities?

Closing
- Once we have produced a transcript of this discussion, I will share a copy of the draft final report and ask for comments and, of course, guarantee anonymity.
- Thank you for speaking with me.

Appendix B – Overview of the interviews conducted

The following table presents the number of doctors interviewed in the required 'categories'		
	Face-to-Face interview	Response sent by post / email
Minority ethnic doctors	4	2
Doctors with disabilities	4	3
Women doctors	3	1
Gay, lesbian and bisexual doctors	7	1
Total	18	7

Appendix C – Questionnaire for email/post

Thank you for agreeing to participate in the British Medical Association's Barriers to career progression project. The questions provided here are a guide. Please feel free to answer those questions that you feel are relevant to you. You do not need to answer all the questions listed.

Background information
The British Medical Association is currently working on a project titled Barriers to career progression exploring some of the barriers that doctors experience throughout their careers. The aim is to provide a voice and relevant context to often marginalised groups of doctors. The project is based on qualitative interviews so that the stories of those who have experienced barriers throughout their medical careers can be highlighted. At the suggestion of our equal opportunities committee, the report will focus on doctors of ethnic minorities, women doctors, disabled doctors, and gay, lesbian, bisexual and trans doctors.

Questions
What made you interested in medicine / becoming a doctor?

Where do you currently work?

What medical training have you undertaken?

What factor/s influenced your decision to choose your current job / specialty?

Describe your experience in the medical profession. What (if any) kind of barriers have you experienced?

Have you ever been made to feel uncomfortable in the workplace? In what way?

Have you heard about other medical professionals who may have experienced barriers to career progression or other similar difficulties?

Have you ever contacted the British Medical Association on a matter relating to equal opportunities?

Any further comments you wish to add.

Additional information

Once all the interviews have been conducted we will circulate a draft with your comments for consideration. You can then decide whether you would like your comments attributed to you or if you would prefer to remain anonymous. Please do not hesitate to contact me should you require further information or clarification; by email or phone.

Appendix D – UCAS data on application and acceptance to medicine and all courses

Applicants to higher education by disability 2000 –2003

Disability	2000 no	2000 (%)	2001 no	2001 (%)	2002 no	2002 (%)	2003** no	2003** (%)
No disability	373,583	96.01	380,494	95.21	382,266	95.13	389,597	95.03
Dyslexia*	7,110	1.83	9,336	2.34	10,044	2.50	—	
Learning difficulty							10,930	2.67
Blind / partially sighted	456	0.12	598	0.15	602	0.15	641	0.16
Deaf / hard of hearing	793	0.20	868	0.22	875	0.22	900	0.22
Wheelchair / mobility difficulties	441	0.11	477	0.12	580	0.14	659	0.16
Need personal care support	19	0.00	19	0.00	41	0.01	—	
Autistic disorder							165	0.04
Mental health difficulties	472	0.12	622	0.16	553	0.14	663	0.16
Unseen diabetes, epilepsy, asthma	2,939	0.76	3,304	0.83	2,776	0.69	2,817	0.69
2+ disabilities / special needs	560	0.14	647	0.16	638	0.16	702	0.17
Other disabilities / special needs	2,718	0.70	3,280	0.82	3,479	0.87	2,894	0.71
Total	389,091	100	399,645	100	401,854	100	409,968	100

Source: UCAS (2004) *Statistics compiled from UCAS website.*

Accepted applicants to higher education by disability 2000 –2003

Disability	2000 no	2000 (%)	2001 no	2001 (%)	2002 no	2002 (%)	2003** no	2003** (%)
No disability	296,559	96.06	310,174	95.30	315,930	95.24	317,587	95.10
Dyslexia*	5,681	1.84	7,570	2.33	8,153	2.46		
Learning difficulty							8,866	2.65
Blind / partially sighted	370	0.12	467	0.14	501	0.15	507	0.15
Deaf / hard of hearing	621	0.20	696	0.21	709	0.21	715	0.21
Wheelchair / mobility difficulties	348	0.11	371	0.11	458	0.14	536	0.16
Need personal care support	15	0.00	15	0.00	31	0.01	—	
Autistic disorder							139	0.04
Mental health difficulties	314	0.10	444	0.14	380	0.11	495	0.15
Unseen diabetes, epilepsy, asthma	2,307	0.75	2,648	0.81	2,238	0.67	2,226	0.67
2+ disabilities / special needs	422	0.14	504	0.15	482	0.15	542	0.16
Other disabilities / special needs	2,081	0.67	2,583	0.79	2,843	0.86	2,329	0.70
Total	308,718	100	325,472	100	331,725	100	333,942	100

Source: UCAS (2004) *Statistics compiled from UCAS website.*

Applicants to pre-clinical medicine, by disability 2000–03

Disability	2000		2001		2002		2003**	
	no	(%)	no	(%)	no	(%)	no	(%)
No disability	10,597	97.98	10,565	97.57	12,368	97.45	15,428	97.09
Dyslexia*	69	0.64	83	0.77	145	1.14	198	1.25
Blind / partially sighted	4	0.04	8	0.07	7	0.06	11	0.07
Deaf / hard of hearing	11	0.10	11	0.10	15	0.12	23	0.14
Wheelchair / mobility difficulties	6	0.06	3	0.03	8	0.06	12	0.08
Need personal care support	3	0.03	0	0.00	3	0.02	N/A	N/A
Mental health difficulties	4	0.04	3	0.03	5	0.04	11	0.07
Unseen diabetes, epilepsy, asthma	78	0.72	90	0.83	67	0.53	113	0.71
2+ disabilities / special needs	3	0.03	2	0.02	4	0.03	16	0.10
Other disabilities / special needs	40	0.37	63	0.58	69	0.54	78	0.49
Total	**10,815**	**100**	**10,828**	**100**	**12,691**	**100**	**15,890**	**100**

Source: UCAS (2004) *Data supplied by statistical enquiries team.*

Accepted applicants to pre-clinical medicine, by disability, 2000-03

Disability	2000		2001		2002		2003**	
	no	(%)	no	(%)	no	(%)	no	(%)
No disability	5,602	98.04	6,100	97.76	6,791	97.59	7,455	97.23
Dyslexia*	37	0.65	51	0.82	79	1.14	101	1.32
Blind / partially sighted	3	0.05	2	0.03	1	0.01	4	0.05
Deaf / hard of hearing	9	0.16	5	0.08	6	0.09	9	0.12
Wheelchair / mobility difficulties	4	0.07	0	0	3	0.04	7	0.09
Need personal care support	0	0.00	0	0.00	1	0.01	N/A	N/A
Mental health difficulties	1	0.02	2	0.03	1	0.01	6	0.08
Unseen diabetes, epilepsy, asthma	39	0.68	46	0.74	39	0.56	48	0.63
2+ disabilities / special needs	2	0.04	2	0.03	1	0.01	5	0.07
Other disabilities / special needs	17	0.30	32	0.51	37	0.53	32	0.42
Total	**5,714**	**100**	**6,240**	**100**	**6,959**	**100**	**7,667**	**100**

Source: UCAS (2004) *Data supplied by statistical enquiries team.*

* In 2003, the wording on the application form changed from 'You have dyslexia' to 'You have a specific learning difficulty (for example, dyslexia)'.

** In 2003, the 'Need personal care support' category was not an option on the application form; an additional category of 'You have Autistic Spectrum Disorder / Asperger Syndrome' was introduced, but no medical applicants/accepted applicants indicated that they had this disability

We have reservations regarding the robustness of this data. In the past it has been suggested to us that students:

• may be unwilling to declare a disability at the time of application, preferring to 'go it alone' without 'special' consideration or declare it once they have enrolled or when difficulties arise.

• at the time of application may have not been assessed or aware that they have a disability (eg dyslexia)

• may have acquired a 'disability' between applying and attending HE.

Department of science and education publications

- The demography of medical schools: a discussion paper (2004)
- Exploring mentoring (2004) (in press)
- The impact of flying on passenger health: a guide for healthcare professionals (2004)
- Genetically modified foods and health: a second interim statement (2004)
- Medical education A to Z (2004)
- Diabetes mellitus: an update for healthcare professionals (2004)
- Smoking and reproductive life: the impact on smoking, reproductive and child health (2004)
- Dealing with discrimination: guidelines for BMA members (2003, revised 2004)
- Doctors with disabilities (2003)
- Getting involved in BMA committees (2003)
- Adolescent health (2003)
- Appraisal: a guide for medical practitioners (2003)
- Sign-posting medical careers for doctors (2003)
- Childhood immunisation: a guide for healthcare professionals (2003)
- Health & ageing: an internet resource (2003)
- Housing and health: building for the future (2003)
- Sunbeds: an internet resource (2003)
- Communication skills education for doctors: a discussion paper (2003)
- Towards smoke-free public places (2002)
- Asylum seekers: meeting their healthcare needs (2002)
- Drugs in sport, the pressure to perform (2002)
- Driving under the influence of drugs: an internet resource (2002)
- Sexually transmitted infections (2002)

Copies of these and other reports can be obtained from:

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