

A missed opportunity BMA response to the Race Report





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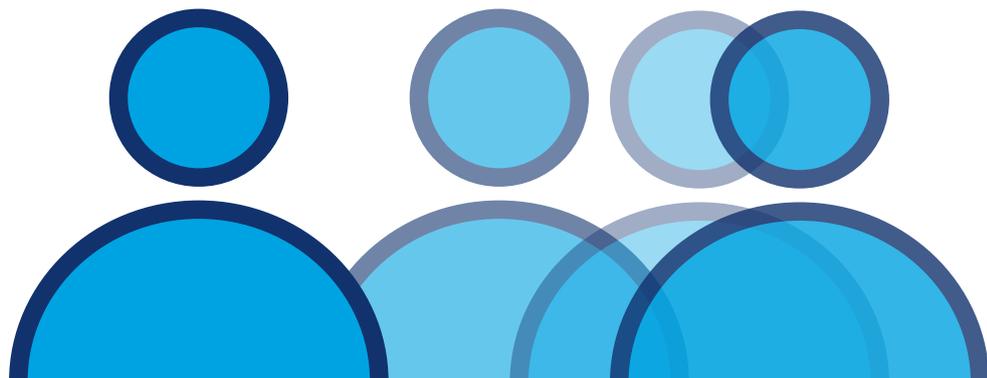
The much-anticipated Race Report from CRED (the Commission on Race and Ethnic Disparities) was published on 31 March 2021.

After due consideration, we firmly refute the overall findings in the Race Report. In particular, that they did not find evidence of structural race inequality as a major factor affecting the outcomes and life chances of many of our citizens.

The report did provide a wealth of information, with some important conclusions that should not be lost. This includes the need to disaggregate ethnic groups to better understand the nuance of differences in experiences and outcomes on the basis of race.

We have analysed the doctor-specific findings based on the understandings we've gained from our members' experiences, preceding research and our own [submission to the Commission's consultation for the report](#). Here we provide a critique of the elements of the report that relate to doctors and the inequalities in health that correlate to racial difference.

We also explore how the report defines racism and set out for the Government 21 recommendations to progress race equality in the healthcare sector.



Institutional/structural racism

The phrase 'institutional racism' first appeared in the Macpherson report in 1999, as a response to the inquiry into the Metropolitan Police investigation into the murder of Stephen Lawrence. Macpherson defined institutional racism as 'The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.'

Since the term 'institutional racism' was first coined, most would expect the UK to be on an upward trajectory towards racial awareness and equality, building on newly acquired knowledge for many about the complexity of racial inequality and how it intersects with other characteristics, such as gender, socio-economic status and culture. The concept and existence of institutionalised or structural racial inequality was most recently highlighted by *The Windrush Lessons Learned Review*. The review into the Windrush scandal (the actions taken by the Home Office that led to several individuals losing their jobs, homes and sense of British nationality) said that in the Home Office there was an 'institutional ignorance and thoughtlessness towards the issue of race and the history of the Windrush generation'¹.

The report agrees that the Macpherson definition has stood the test of time and presents a framework of how to distinguish between different forms of racial disparity and racism (see below). However, it fails to then make the link between its own definitions of structural, systemic and institutional racism, and the evidence it presents in the report. It has failed to include the evidence we presented in our submission, which offers clear examples of structural racism.

Definitions provided by the CRED Race Report

Explained racial disparities: this term should be used when there are persistent ethnic differential outcomes that can demonstrably be shown to be as a result of other factors such as geography, class or sex.

Unexplained racial disparities: persistent differential outcomes for ethnic groups with no conclusive evidence about the causes. This applies to situations where a disparate outcome is identified, but there is no evidence as to what is causing it.

Institutional racism: applicable to an institution that is racist, or discriminatory processes, policies, attitudes or behaviours in a single institution.

Systemic racism: this applies to interconnected organisations, or wider society, which exhibit racist or discriminatory processes, policies, attitudes or behaviours.

Structural racism: to describe a legacy of historic racist or discriminatory processes, policies, attitudes or behaviours that continue to shape organisations and societies today.

The existence of structural racism in the UK is internationally recognised. The UN's Special Rapporteur on Racism expressed [concerns about structural racism](#) in the UK in 2018 in relation to deaths in police custody.

Additionally, the report refers to the language of race creating subjective definitions of racism, with examples of how the language is used in social media and perceptions of ethnic minorities of being 'othered'. The authors however do not explain how they define racism in this report. We suggest that a reminder of the legal definition of racism would be a useful start to any future conversations about disparities on the basis race in the UK – and that this would help create a baseline to understand the manifestation of structural racism. Legally the Equality Act 2010 defines four types of racial discrimination.

1. Being treated worse than another person in a similar situation because of your race (direct discrimination).
2. When an organisation has a particular policy or practice that puts people from a certain racial group at a disadvantage (indirect discrimination).
3. When someone is made to feel humiliated, offended or degraded in relation to their race (harassment).
4. Being treated badly because you have made a complaint of racism (victimisation).

In addition, in criminal law, race hate is a range of criminal behaviour where the perpetrator is motivated by hostility or demonstrates hostility towards a person's race.

Ethnic minority staff in the NHS (National Health Service)

The report states that the NHS is a '**success story with significant overrepresentation of ethnic minorities in high status professional roles**' it then goes on to say it is a 'less happy story' and lists disparities in staff experience correlated to ethnicity that affect staff experience, wellbeing and health outcomes and career progression. This is an example of how the report used one statistic, the number of ethnic minority people in the medical profession and used it to make a sweeping statement of success, with little acknowledgement of the significant disparities in experiences and outcomes for those people.

Any analysis of the status of racial inequality in healthcare in the UK must start with certain undeniable facts. The NHS started in 1948 in a post-war environment, and the UK has always recruited directly from the colonies and former colonies to fill short-staffed positions in the NHS. This makes the health service unique in comparison to other workforces, being significantly more racially diverse than the general UK population.

The report acknowledges this to some extent, celebrating the racial diversity of medicine as an achievement. However, the healthcare sector in the UK was born from the contribution of ethnic minority healthcare workers and the starting point of a racially diverse medical profession. At every point in the history of the healthcare sector ethnic minority healthcare workers' experiences were not fair or equal – and there is little evidence that there has been significant progress. People from ethnic minority backgrounds continue to be over-represented in lower pay grades and under-represented in higher grade roles. Staff surveys continue to show ethnic minority staff having a more negative experience and lower confidence in organisations providing equal opportunities (in 2020 16.7% of ethnic minority staff compared to 6.2% of white staff reported experiencing discrimination at work for a manager, team leader or other colleague¹). All of which provide evidence that the NHS is structurally racist.

Against this backdrop, we would expect the report to have moved beyond examining the question of whether institutional discrimination exists or not. Instead, it needed to acknowledge that the issue still exists, create the research base for addressing the root causes and provide a plan to create a post-racial society in the UK – a point the report itself said has not yet been reached.

Doctors in education, training and work

The report speaks of *'the onward march of minorities into positions of power and responsibility in medicine'*.

The negative experiences of many doctors from ethnic minority backgrounds in education, training and the workplace have been well documented, including in our submission to the Commission. For example, the BMA has been highlighting the issue of differential attainment² in medical education for many years. Our 2017 report³ showed that the biggest gaps in attainment during medical training are linked to race, both for British ethnic minorities and international medical graduates.

Race continues to play a significant factor in the progression of doctors. There continues to be a pass rate gap in all medical postgraduate exams, between UK-trained white doctors (76%), UK-trained ethnic minority doctors (63%) and IMG doctors (41%).⁴ There are also unequal opportunities to progress into more senior roles, with white CCT (certificate of completion of training) holders more likely to be shortlisted (98% versus 91% for ethnic minority groups) and more likely to be offered a first consultant post (29% of white doctors versus 12% of those from ethnic minority groups).⁵

There is currently no legal requirement for ethnicity pay gap reporting as there is for gender. However, several studies⁶ have shown there is a significant pay gap between doctors from an ethnic minority background compared with doctors from a white background. A 2018 report found a 4.9% pay gap with consultants⁷ and recently updated to specifically identify a 3.5% gap between black and white consultants, and 6% between mixed ethnicity and white consultants.⁸ This further demonstrates the need for more granular analysis of ethnicity data. The most recent NHS WRES (Workforce Race Equality Standard) report shows that only 10% of trust board seats are held by people from ethnic minority backgrounds,⁹ this is less than half the proportion of ethnic minority NHS staff (22%).¹⁰

As well as across the medical profession, distinct issues in specialties show continued systemic racism. GPs from ethnic minority backgrounds are more likely to work in single-handed practices and in deprived areas, and anecdotal feedback of the CQCs indicates greater sanctions against ethnic minority GP practices.¹¹ A recent report from the Royal College of Surgeons into the diversity of its own structures and the impact on doctors and patients, identified that an organisation that controls the education and training of surgeons must foster belonging and be inclusive at a strategic (structural) level to address racism at all levels.¹²

We also have long-standing concerns about racial abuse perpetrated by patients. In 2019, the Secretary of State for Health, Matt Hancock, sent [a letter](#) to all NHS staff stating that 'if a patient asks to be treated by a white doctor, the answer is "no". Your management must and will always back you up... staff of all backgrounds should rightfully expect to work in an NHS that exhibits a healthy, inclusive and compassionate culture.'. This was in response to a testimony of racial abuse by Dr Radhakrishna Shanbhag, BMA member, and NHS doctor for over 20 years. This example of racial abuse was not a new occurrence and our members from ethnic minority backgrounds continue to provide examples of abuse from patients and colleagues. The annual WRES reports detail such experiences in all trusts.

We know that from the onset of a career in medicine, ethnic minority medical students report bullying and harassment at four times the rate of their white peers. As a result, we felt compelled to produce a [racial harassment charter](#) for use in all medical schools.¹³ After qualifying, ethnic minority doctors continue to report bullying and harassment as a problem at their place of work at twice the rate of their colleagues¹⁴ and are twice as likely to be referred for fitness-to-practice processes by their employer.¹⁵ In addition, ethnic minority doctors are nearly twice as likely not to raise patient safety concerns because of fear of being blamed.¹⁶

Racial harassment is an additional burden and psychological injury that some people from ethnic minority backgrounds have to deal with. Individuals are the perpetrators of racial harassment, but organisations are legally required to maintain a safe working environment where doctors can work free from bias and discrimination. If an organisation fails to take action to protect their staff from the harm of racism, it is a clear example of institutional racism. This is an example of where racism is occurring at a structural level, when it is not addressed and assumed to be part of the job for the ethnic minority doctors and healthcare workers.

Racial health inequalities

The report states that ***'the overall picture suggests that racism and discrimination are not widespread in the health system, as is sometimes claimed'***. This is based on the interpretation of two patient satisfaction surveys.

We are troubled by this conclusion. The report fails to acknowledge what the evidence shows – that it is often structural inequalities that lead to people from ethnic minority backgrounds having poorer health outcomes. For example, the report references Sir Michael Marmot's 2010 landmark research on the social determinants of health, but not his 2020 update that acknowledged the link between structural racism and health, specifically that 'Intersections between socioeconomic status, ethnicity and racism intensify inequalities in health for ethnic groups'.¹⁷ Effective solutions to tackle health inequalities require an understanding of the complexity of racial inequality. To exclude the later more up-to-date report therefore seems inexplicable.

The health inequalities statistics related to race are stark. The report itself highlights that:

- maternal deaths are five times higher for Black mothers and two times higher for mothers from Asian ethnic groups than mothers from white ethnic backgrounds; and
- south Asian communities in Scotland have higher avoidable hospital admissions than white communities, with the highest rate in Pakistani men and women.¹⁸

It is disappointing that the report did not acknowledge the potential systemic causes behind persistent health inequalities like these. We do not dispute that there are several other factors at play that lead to negative disparities, such as socio-economic status, geography, and education, etc which often lead to particular disadvantage for some people from white ethnic groups. Recently we produced a report¹⁹ that explored the impact of COVID-19 on socially disadvantaged and vulnerable groups, highlighting the disproportionate impact of COVID-19 on the most deprived communities and health inequalities. The impact of poverty on health is an area in which the BMA has had a long-standing interest and have [worked on](#) prior to the COVID-19 pandemic. Most recently, [we commented](#) on the Northern Ireland Health Inequalities Annual Report 2021, that 'lays bare again how higher levels of deprivation leads to poorer health outcomes'. In addition, research shows that some ethnic minorities are more likely to be over-represented in certain socio-economic groups, but the report does not analyse why this may be the case. For example, 30% of Bangladeshi households are overcrowded compared to 2% of white.²⁰

There is a significant evidence base of research in the area of health disparities along racial lines, including in several independent and Government reports. Generally, these have reached the conclusion that these differences are attributable to some element of structural racism (as defined by the report). It is not clear what methodology has been used to reach the conclusions where the report states that structural racism is not a significant factor in the disparities in health based on race. The Government's own Race Disparity Audit, in summarising findings in relation to health inequalities by race, states that the context of a person's 'health pathway' is important, and dependent on 'behaviours and measures for the prevention of illness, their health conditions, location and access to health services, as well as the success of their treatment'.²¹ These elements, which could be interpreted as structural factors, are sighted in addition to the characteristic factors of socio-economics, demography and culture.

The impact of COVID-19

The report states that the narrative around race and health during the COVID-19 pandemic has been '**overly pessimistic**', that an increased risk of dying from COVID-19 is mainly due to an increased risk of exposure to infection. However, it fails to analyse how the correlation between increased occupational exposure and some ethnic groups could be due to structural inequality and significantly, there was no mention of the high proportion of ethnic minority doctors and healthcare workers who died from COVID.

We strongly disagree that the narrative about COVID and race is pessimistic and were alarmed by the report's failure to link exposure and structural inequalities.

Impact of COVID on the public

It is well known that a greater proportion of ethnic minority people work in insecure and public-facing roles exposing them to the virus, including in transport, hospitality, and retail. Furthermore it is often structural factors that lead ethnic minority people to work in these jobs. The latest data shows that, more than a year after COVID-19 reached the UK, [28% of intensive care beds](#) in England and Wales are occupied by ethnic minority patients. This is disproportionate to the 15% of the population from ethnic minority backgrounds and in direct contradiction to the conclusions of the Race Report.

The Government's own report into the impact of COVID-19 on ethnic minority people surmised that the 'risks associated with COVID-19 transmission, morbidity, and mortality can be exacerbated by the housing challenges faced by some members of BAME groups. The most recent research from the UK suggests that both ethnicity and income inequality are independently associated with COVID-19 mortality. Individuals from BAME groups are more likely to work in occupations with a higher risk of COVID-19 exposure'²², for example a third of taxi drivers and chauffeurs are Bangladeshi or Pakistani.²³ 'They are more likely to use public transportation to travel to their essential work. Historic racism and poorer experiences of healthcare or at work may mean that individuals in BAME groups are less likely to seek care when needed or as NHS staff are less likely to speak up when they have concerns about Personal Protective Equipment (PPE) or risk.'²⁴

Impact of COVID on doctors

85% of doctors who died from COVID-19 in the UK were from ethnic minority backgrounds. Our [surveys](#) of members during the pandemic found that doctors from ethnic minority backgrounds were more likely to feel pressured to work without adequate PPE, and were more afraid to speak out about safety concerns for fear of recrimination, or it affecting their careers. We have also received overwhelming feedback from our BMA BAME Forum of the hurt and frustration felt by some of our members that this report does not recognise their experiences, captured by Chair of the BMA Council in this BMJ opinion piece, [The lived experience of many ethnic minority doctors is not an equality success story](#).

The recommendations

We do not dispute that there are several other factors at play that lead to negative disparities such as socio-economic status, geography and education, etc. Recently we produced a report²⁵ that explored the impact of COVID-19 on socially disadvantaged and vulnerable groups, highlighting the disproportionate impact of COVID-19 on the most deprived communities and health inequalities. The impact of poverty on health is an area in which the BMA has had a long-standing interest and has [worked on](#) prior to the COVID-19 pandemic. Most recently, [we commented](#) on the Northern Ireland Health Inequalities Annual Report 2021, that 'lays bare again how higher levels of deprivation leads to poorer health outcomes'.

The report makes several valid conclusions that may have been lost in the overwhelming rejection of the politicised narrative underplaying the role of structural racism. A review of the recommendations that particularly relate to the BMA is set out below.

Recommendation 2:

Review the CQC's (Care Quality Commission's) inspection process. Review the CQC's approach to including disparities in the experiences, progression and disciplinary actions taken against ethnic minority staff in their inspections of healthcare providers.

It is important to note that concerns have been expressed by doctors that the CQC inspection process, in relation to general practice, appear to have resulted in disproportionate numbers of practices with ethnic minority doctors rated as "inadequate", the CQC needs to address structural factors causing these disparities. To achieve real equality outcomes for patients and those employed by healthcare providers, all CQC inspection processes must embed meaningful assessments of equality at all stages.

This recommendation chimes with what we have publicly called for in our [Caring, Supportive and Collaborative report](#):

- 'A supportive culture where doctors work in an environment that supports their wellbeing, promotes learning and encourages the development of systems to improve safety and quality of care – and where diversity is celebrated and there is equal opportunity and reward'
- 'Regulators of NHS organisations must take robust and proactive steps to ensure workplaces are fully inclusive and free from a culture of bullying, undermining and harassment'
- 'The Government should radically improve the way the NHS supports doctors of all backgrounds by making inclusivity a core competency for NHS leaders, something they are expected to demonstrate and be held accountable for'

Our view is that in addition to asking the review team to work closely with *'the disciplinary bodies of the medical professionals to ensure that the views of these bodies feed into this work'* it should work with the representatives of the medical profession itself.

Recommendation 10:

Improve understanding of the ethnicity pay gap in NHS England.

We support this recommendation. Our submission to the Commission urged further research into the ethnicity pay gap in the NHS.

Recommendation 11:

Establish an Office for Health Disparities.

If an Office for Health Disparities is established, the close relationship between systematic racism and socio-economic status must be recognised. We welcome this long overdue focus on health inequalities as part of the wider conversation about race in the UK. We would encourage some clarification of the relationship between the recently established Race and Health Observatory and any new office to avoid duplication and wasted resources.

Recommendation 12:

Prevent harm, reduce crime and divert young people away from the criminal justice system: develop an evidence-based pilot that diverts offences of low-level Class B drug possession into public health services.

As set out in our submission to the report, we support a 'health in all policies approach'. This must be accompanied by sufficient funding for public health services. Public health medicine has suffered significant reductions in funding over the years – a £850m drop in real-terms funding between 2015/16 and 2019/20. The principal issue undermining local public health delivery in England has been severe cuts to the local public health grant, which have occurred since 2015/16. In the Government's own estimate, every £1 spent on public health prevention returns £14 in related benefits, meaning that such cuts are a false economy.

We have called for a reversal of these damaging cuts and for a robust public health approach to be at the heart of local decision-making, with a funding increase of £1bn to return the public health grant to 2015/16 levels. This must be accompanied by additional investment year on year, increasing to £4.5bn by 2023/24.

Recommendation 20:

Making of modern Britain: teaching an inclusive curriculum.

We support this recommendation. Our submission to the Commission highlighted our agreement with the Baroness Lawrence review that societal prejudices are learned from an early age. We asserted that efforts to diversify the national curriculum would help with this, as well as ensuring that future generations of medical students will begin their medical training with a better understanding of the diversity and history of the UK's population, eg dermatology training on how skin conditions present on darker skin tones.²⁶

Recommendations 23 and 24:

Use data in a responsible and informed way and disaggregate the term 'BAME'.

We support this recommendation. It is right to conclude that assessments of racial discrimination based on a collective ethnic minority group may not be effective addressing barriers for individual groups. 'Recognition of the differences between groups requires a new and more granular approach to data and how it is collected and used'²⁷ is something that we have called for since the start of the pandemic. More complete and broken-down ethnicity data will enable us to understand where race is a key factor in differences. It will also enable a greater interrogation of the intersection between gender, race, colour, ethnicity and faith – for example, the differences of the impact of colour-based racism, antisemitism, islamophobia and cultural discrimination against white ethnic minorities, such as gypsies and travellers.

Next steps

We are broadly supportive of the recommendations made in the report, but not the narrative that surrounds it. For effective change, there must be a baseline that reflects reality. Therefore, the Government will have to address the gaps in the evidence and the fundamental issues that were not addressed, such as institutional, structural and systemic racism.

It is essential that we realise this is not just another report on race, it was intended to be the Race Report. The organisations, communities, and individuals waiting for its findings were expecting an analysis of where race does play a factor in differentials, not the undisputed fact that there are many factors that play a role in differentials. For example, the role of social determinants. In our written submission, we asked for some exploration of the link between race and deprivation (with half of people from black ethnicity households living in poverty, compared to one in five white background households²⁸). We are still hopeful that the Government will conduct some analysis on this.

When considering the next steps for implementing and evaluating the recommendations from the report, there should be some awareness of how to effectively implement and evaluate progress on racial equality. Britain's equality and human rights body the EHRC (Equality and Human Rights Commission), produced the evidence-based *Is Britain Fairer?* reports²⁹ on inequalities. They include recommendations that this Race Report could have reviewed in terms of effective implementation. *Is Britain Fairer?* presents a clear methodology and measurement framework, which are missing from the Race Report. The report recommends extending the remit of the EHRC, which could build on better reporting and measurement of inequality as was begun in the *Is Britain Fairer?* reports.

In light of the issues we have raised, we believe the report's recommendations do not go far enough.

What is really needed:

- Acceptance that structural racism exists
- Explicit determination to tackle structural racism
- Cultural transformation across all levels of the healthcare sector

We ask the Government to consider the additional recommendations below to aid effective implementation with support from the medical profession.

Immediately

1. Any future analysis or reports about race disparities to include a clear definition of racism.
2. To ensure transparency in how the Commission reached its conclusions, as well as to aid further research, we ask that a summary of all the evidence presented to the commission should also be available for public view to show how the Commission reached its conclusions.
3. Immediate evaluation of the impact of the work to increase vaccine take-up by different ethnic minority groups and engaging with those who continue to have low take-up to understand their concerns.
4. All recommendations agreed for implementation must have a monitoring framework with timelines for evaluation.

Ongoing – healthcare sector

6. Provide a direction that all Government, arm's length bodies and bodies commissioned to deliver public functions look at the intersection between race and social determinants when making decisions that impact the public.
7. Performance objectives of leaders and organisations in the healthcare sector to include measurable equality, diversity and inclusion objectives.
8. Increase accountability of employers of healthcare professionals who do not address workplace cultures where bullying and harassment on the basis of race is evident.
9. A requirement that all healthcare bodies implement a just culture model by reviewing their policies and processes to identify and address system failings and pressures that contribute to individual doctors being put through unnecessary procedures (often exacerbated by racial discrimination and stereotypes).
10. Invest in freedom to speak up guardians and training in healthcare education, training and workplace organisations as a key method to raise concerns about racial discrimination in formal processes.
11. The review of the CQCs inspection process to include consultation with representatives from the medical profession.
12. Mandatory race training for decision-makers in all healthcare bodies. The training to be quality assured and evaluated for content and effectiveness.

Ongoing – the medical profession

13. A requirement for medical schools to implement an explicit race equality policy (in line with our Medical Schools Charter) and publish their monitoring and evaluation of the extent to which medical curricula includes varied learning material based on the UK population's diversity
14. A requirement that all organisations who recruit doctors (and healthcare workers) who have been trained outside of the UK, provide comprehensive induction, mentoring and ongoing support for those healthcare workers.
15. Where differentials that appear to be linked to race have been identified (via FOIs, research or reports) e.g. differential attainment in the medical profession or disproportionate referrals into fitness to practice processes – those organisations must publish a detailed explanation of a) the work they are doing to understand the causes of the differentials b) the action they are taking to eliminate discrimination. For example, the GMC and MPTS to assess their processes and address any inequities of their investigations and outcomes for ethnic minority doctors.
16. All organisations to be required to publish summaries of the equality impact assessments they have undertaken for policies that are related to processes that have been evidenced to show differentials in outcome by race for medical students and doctors.
17. Organisations with public functions to be required to evaluate the programmes, training and interventions that are aiming to progress race equality to ensure effectiveness.

Ongoing – health inequalities

18. Implement models of proportionate universalism to put proportionately more resources towards tackling the causes of worse health outcomes linked to ethnicity.
19. All public health messaging and policy must be culturally sensitive and adapted to target ethnic groups that have been identified as having lower take-up of services or worse health outcomes e.g. Gypsy, Roma and Travellers, vaccine take-up and maternal mortality for Black and Asian women.
20. Standardised race/ethnicity monitoring categories with best practice guidance for public bodies and the public about the purpose and use of the data.
21. Commission an extensive analysis of the link between race and deprivation, including a consideration of the historical and geographical context.
22. We support a “health in all policies approach” where tackling racial health inequalities is sustained and meaningful. This must be accompanied by sufficient funding for public health services. Increase funding to £1bn to return the public health grant to 2015/16 levels with additional investment year on year to £4.5bn by 2023/24.

We are committed to tackling racism in all forms, interpersonal and structural. We will continue to listen to the lived experiences of our members and advocate for race equality in the NHS and in the UK more widely. This year we will continue to build the extensive evidence base presented in this report, by launching research to look at solutions to the ethnicity pay gap in medicine and to build empathy by amplifying the often unheard experiences of doctors from diverse ethnic backgrounds through our BAME Doctors Forum. We will continue to share our evidence and recommendations for action with Government at every opportunity.

Conclusion

In summary, the report was a missed opportunity. Considering the wealth of evidence and expertise provided to the Commission, it had the opportunity to build on the findings from previous reports and address the underlying causes of racial inequality that led to the black lives matters protests in 2020. Instead, the report’s dismissal of evidence of those underlying structural factors may regress rather than progress racial inequality. Without a true understanding of cause, any proposed actions will be ineffective. We are at a pivotal moment in time, with a real opportunity to move the dial and stop the cycle of research, reports and recommendations with little follow-up and evaluation of the implementation of those recommendations.

It is not our role to question why this single-story narrative of race inequality in the UK healthcare sector has been written. It is our role to represent the voices of the doctors, their colleagues and patients who expected far more from this report. The pandemic continues to exacerbate and highlight existing inequalities in healthcare. The experiences of some doctors from ethnic minority backgrounds who have been the backbone of the NHS for as long as it has existed have not been reflected in the narrative of this report.

Racial diversity is a historical fact of our UK healthcare model, which we acknowledge is positive. However, the structural factors that cause unlawful disparities between racial groups, should not and cannot be ignored if we are to make progress. It is only by having a more in-depth understanding of structural racism in our society – something which this report fails to do – that we can begin to challenge these deep inequalities and build a fairer future.

Endnotes

- 1 [NHS Staff Survey](#) (2020)
- 2 GMC [Data and research on differential attainment](#). Differential attainment is defined by the GMC as 'systematic differences in outcomes when grouping cohorts by protected characteristics and socio-economic background'.
- 3 BMA (2017) [Differential attainment – making medical training fair for all](#)
- 4 GMC (2019) [GMC Education data reporting tool](#)
- 5 RCP (2020); [2019 survey of medical certificate of completion of training \(CCT\) holders' career progression](#)
- 6 Kline, R (2014) [The 'snowy white peaks' of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England](#).
- 7 BMJ (2018) [Ethnic pay gap among NHS doctors](#)
- 8 Nuffield Trust (2021) [The ethnicity pay gap in the English NHS](#)
- 9 NHS England (2021) [Workforce Race Equality Standard Data Report 2020](#)
- 10 NHS Digital (2021) [NHS Workforce](#)
- 11 Pulse (2021) [How systemic racism affects general practice](#)
- 12 RCS (2021) [The Royal College – Our professional home: an independent review on diversity and inclusion for the Royal College of Surgeons of England](#)
- 13 BMA (2020) [A charter for medical schools to prevent and address racial harassment](#)
- 14 BMA (2018) [Caring, Supportive, Collaborative All-member survey](#)
- 15 GMC (2019) [Fair to Refer](#)
- 16 BMA (2018) [Caring, Supportive, Collaborative All-member survey](#)
- 17 Marmot (2020); [Health Equity in England – The Marmot Review 10 Years On](#)
- 18 Race Report; Pages 218-219
- 19 BMA (2021) [Mitigating the impact of Covid-19 on health inequalities](#)
- 20 The Institute for Fiscal Studies (2020); [Are some ethnic groups more vulnerable to Covid-19 than others?](#)
- 21 Cabinet Office (2018); [Race Disparity Audit: Summary Findings from the Ethnicity Facts and Figures website](#)
- 22 PHE 2020; [Beyond the data: Understanding the Impact of Covid-19 on BAME Communities](#)
- 23 Office for National Statistics (2020); [Why have Black and South Asian people been hit hardest by Covid-19?](#)
- 24 PHE 2020; [Beyond the data: Understanding the Impact of Covid-19 on BAME Communities](#)
- 25 BMA (2021) [Mitigating the impact of Covid-19 on health inequalities](#)
- 26 BMJ (2020);369:m2578
- 27 Race Report; page 34
- 28 Social Metrics Commission (2020) [Measuring Poverty 2020](#)
- 29 Equality and Human Rights Commission (2015 and 2018) [Is Britain Fairer? The state of equality and human rights 2018](#)