Diversity in Health and Social Care 2008;5:235–6

Guest editorial

A profession of equals

Professor Sir Graeme Catto
President, General Medical Council

The GMC, as a regulator, expects a great deal from individual doctors when it comes to diversity issues. Patients may not want to talk openly and honestly with their doctor if they feel they are being judged on the basis of their religion, culture, values or political beliefs. Our core guidance, *Good Medical Practice* (General Medical Council, 2006), makes it clear that doctors must treat their colleagues and patients with respect regardless of their personal circumstances or background, life choices or beliefs. As respected figures in society, doctors also have an opportunity to encourage tolerance of people from different backgrounds. Every member of the profession is in a position to promote equality.

The UK healthcare system has long relied on doctors coming from abroad to work and settle in the UK. If it had not been for this influx of doctors, the NHS would not have seen so many achievements in its 60-year history. Unfortunately, we know that doctors who graduate overseas (international medical graduates) are over-represented throughout all stages of our disciplinary procedures. This is not simply an aberration within the GMC's system – last year, an audit by King's College London investigated our procedures and found the GMC's handling of cases to be 'transparent, consistent and appropriate' – it is a sector-wide concern. We need to investigate further before we can understand conclusively why this is the case.

We believe that it is our duty to understand this issue and, if necessary, to take action or encourage others to take action to mitigate any discrimination. There are legal imperatives behind our approach (Race Relations Amendment Act 2000), but there is also a strong moral imperative: doctors have the right to expect fairness and consistency, regardless of their ethnic or cultural background.

The issue of ethnicity in relation to the over-representation of international medical graduates in our procedures is difficult for us to assess because, until recently, we have held very little information about the ethnicity of doctors on our register. We can only assume that the 249 000 doctors on the GMC's register are from a range of ethnic backgrounds. What we know for sure is that the majority of these doctors gained their primary medical qualification from a UK medical school and that the rest (37%) graduated outside of the UK. A degree certificate alone does not indicate the nationality or the ethnicity of these doctors. I graduated from Aberdeen but, for example, I could have trained in Germany. It would not make me German, ethnically speaking. Currently, no single organisation holds accurate ethnicity data about all doctors practising in the UK. We are working to change this, and this year we began our first comprehensive exercise to collect ethnicity data, with results expected later this year.

The GMC is undertaking a significant body of long-term research in collaboration with several organisations, including the Economic and Social Research Council (ESRC), to address concerns about the experience of international medical graduates. Part of the programme will investigate the experiences of UK, EU and non-EU medical graduates making the transition to the UK workplace, how non-UK qualified doctors and doctors from a variety of cultural backgrounds understand the ethics of medical practice in the UK, and how systems of medical regulation differ around the globe.

There is no 'magic bullet', but we believe that building up a profile of doctors on our register through the ethnicity census information, combined with results from the ESRC research programme, will enable the GMC to start to develop an evidence base to inform policy making and further ensure that our procedures are fair, objective and transparent.

At the GMC we strive to ensure that equality and diversity are embedded into all aspects of our work. We have an Equality and Diversity Scheme which demonstrates the steps that we take to achieve this. This year we have worked with medical schools around the UK to publish guidance offering them practical advice on making adjustments to improve the accessibility of medical education for disabled students. This might include installing hearing loop systems for those with hearing impairments, or the linking of microscopes to CCTV screens for students with visual impairments. Our work with Stonewall has helped to combat concerns that some doctors are not responding properly to the health needs of lesbian, gay and bisexual (LGB) people. We produced an information

leaflet which has been widely distributed across the LGB community to inform people of their rights as patients. It explains how to complain if LGB patients feel they have been discriminated against by their doctor.

There is a good deal still to learn about the diversity of doctors on our register. Medicine is a caring profession and as such it encourages people from all backgrounds to work together to improve the health of our patients. Being cared for by doctors and nurses from many different cultures means that patients are more likely to be understood fully as people, each with a unique combination of beliefs, concerns and needs. This is why it's a good thing that society can't choose its doctors and doctors can't choose their patients.

REFERENCES

General Medical Council (2006) *Good Medical Practice*. London: GMC.

Race Relations Amendment Act 2000. Available at: www.opsi.gov.uk/acts/acts2000/ukpga_20000034_en_1

ADDRESS FOR CORRESPONDENCE

Professor Sir Graeme Catto, President, GMC, 350 Euston Road, London NW1 3JN, UK. Tel: +44 (0)207 189 5016; email: opce@gmc-uk.org