# A Review of the Literature on the Experiences of Black, Minority and Internationally Recruited Nurses and Midwives in the UK Healthcare system

**Elizabeth West**
**Shoba Nayar**

University of Greenwich
Avery Hill Campus
Eltham, London
e.west@greenwich.ac.uk

October 2016

*This literature review was funded by the Nursing and Midwifery Council UK as part of a project titled: The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the NMC's Fitness to Practise Process. The findings and interpretation are those of the authors and do not necessarily reflect NMC policy.*

# Contents

# Executive Summary

Nurses and midwives constitute a significant proportion of the UK workforce and are vital providers and facilitators of health and wellbeing for the public. Playing such an important role, it is essential that all practitioners adhere to standards of care – both for their own protection and for the protection of their patients. It is no surprise, therefore, that at national level, across all professional services, there is an increasing focus on equality and fairness in regulatory procedures. Of concern however, is the evidence reporting an overrepresentation of Black and Ethnic Minority (BME) nurses and midwives in disciplinary procedures and reports to the regulator. While concerns about overrepresentation are not limited to the nursing and midwifery professions alone, the Nursing and Midwifery Council (NMC) have commissioned an investigation into Black and Minority Ethnic (BME) nurses and midwives progression through the 'Fitness to Practise' process in the UK. The aim of this literature review is to identify previous studies that might inform further analyses of NMC data and to provide contextual information that might increase our understanding of the issues.

A systematic search of the literature was conducted which resulted in 36 full text, peer reviewed articles, from the year 2000 and beyond, being included in this report. In addition, a search of the grey literature, in particular UK health and social care regulatory body reports provided a further 22 documents for inclusion.

This report is divided into two sections. The first section is contextual and reviews literature, both national and international, that provides insights into the experiences of BME and internationally recruited nurse (IRNs). The second section focuses specifically on the literature related to health and social care regulatory bodies within the UK, and the reporting of BME professionals in relation to fitness to practise. Key findings include:

- To date, no peer reviewed, published studies of BME nurses' and midwives' experiences of the fitness to practise process have been found – although studies were found for other professional groups.
- Four main concerns surrounding BME and IRNs fitness to practise include:
    1) communication difficulties;
    2) differences in cultural knowledge and practical skills;
    3) issues of injustice – discrimination and racism; and
    4) lack of workplace support.
- Evidence supports the proposition that BME staff are overrepresented in relation to fitness to practise referrals and are more likely to receive severe penalties. Factors related include place of qualification and area of practice. However, caution is advised in interpreting these findings due to fact that studies were often based on small samples.
- In some cases, regulatory bodies are not collecting data about ethnicity which precludes any quantitative analysis.

# Introduction

At the national level, across all professional services, there is an increasing focus on equality and fairness in regulatory procedures. The purpose of this literature review is to examine what is known about the progress and outcomes of Black and Minority Ethnic (BME) nurses and midwives progression through the 'Fitness to Practise' process in the UK as well as related international literature and reports on the activities of other regulators in this area.

Together, the nursing and midwifery professions constitute a significant proportion of the entire UK workforce. For decades, international recruitment of registered nurses has been a strategy used to alleviate the global workforce deficit (Tuttas, 2015). Following World War II, Britain experienced an acute labour shortage; yet the government of the time was committed to establishing the National Health Service (NHS). To ensure this commitment was fulfilled, the Department of Health actively recruited BME nurses from former British colonies including the West Indies, Africa, Singapore, Malaysia and the Philippines (Alexis & Vydelingum, 2004). Since then, international recruitment has been used to alleviate shortages in the health care workforce. In recent years, membership of the EU, which allows for the free movement of people, has led to a significant rise in the number of EU nurses working in the NHS. In early 2001-2, 7% of newly registering international nurses/midwives were from the EU; 8 years later, this figure had increased to 78% (Kings College London, 2014). Thus, today, the British nursing and midwifery workforce is comprised of UK born and trained nurses, as well as non-UK trained nurses and foreign born nurses. Indeed, the UK is considered one of the top five countries[1] employing the highest proportion of foreign born nurses within their respective workforce (Magnusdottir, 2005).

Despite the long history of a mixed ethnic workforce, research and evidence strongly suggest that BME staff in the NHS experience less favourable treatment, have a poorer experience of work life and fewer opportunities for development and career progression. This may have an impact on the efficient and effective running of the NHS and may adversely affect the quality of care received by all patients (Naqvi, Razaq, & Piper, 2016). In 2015, the NHS Workforce Race Equality Standard (WRES) was introduced to assist the NHS in tackling race discrimination and creating an environment of equality among all staff. A recent report published by the WRES, claimed that across all healthcare workers in 238 NHS trusts:

- higher percentages of BME (as opposed to White) healthcare workers report the experience of harassment, bullying or abuse from other staff members;
- BME staff are generally less likely than White staff to report the belief that the trust provides equal opportunities for career progression or promotion;
- BME staff are more likely to report they are experiencing discrimination at work from a manager, team leader or other colleague compared to White staff;
- Community provider trusts and mental health and learning disability trusts generally report a higher percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives of patients or the public when compared to White staff. (Naqvi et al., 2016, p. 11)

These findings are concerning in and of themselves but may also have implications for BME nurses and midwives in relation to disciplinary and regulatory processes.

To date, no peer reviewed, published studies of BME nurses' and midwives' experiences of the fitness to practise process have been found – although studies were found for other professional

[1] Ireland, the United States, Canada, and Australia, along with the UK comprise the top five.

groups. This reflects Archibong, Baxter, Darr, Walton, and Jogi's (2013) assertion that while there is a growing body of research and anecdotal evidence indicating that BME doctors are more likely to be referred for fitness to practise investigations, comparatively "less is known about the experiences of minority ethnic staff from other occupational groups within the NHS" (p. 6). Given the dearth of literature, specifically addressing the issue of BME nurses and midwives in relation to the fitness to practise process in the UK, the researchers have included, in the current literature review, studies and reports that cover BME, Internationally Recruited Nurses (IRN) and midwives' *working experiences* to explore possible contextual issues and contributory factors that may shape their fitness to practise experiences. Selected international research, to inform on the lessons to be learned from the experiences of minority ethnic health professionals in other countries, has also been included. In addition, this review sought to ascertain whether the regulators of other UK professions have or have not conducted research in similar areas, particularly in relation to the likelihood of BME registrants being reported, investigated and achieving less favourable outcomes than White registrants. The search included all of the health care professions regulated by the Professional Standards Authority (PSA), including medicine, dentistry and allied health professions in the UK. The literature review also included regulated professions outside of healthcare, such as solicitors.

It is intended that the literature review will be circulated within the Nursing and Midwifery Council (NMC), to improve the fitness to practise process; and, more broadly, among the nursing and midwifery professions to promote reflection and establish best practice protocols for supporting BME staff. The literature review will be useful to educational institutions that prepare nurses and midwives for work in the NHS and, incorporated into teaching materials, could sensitise new nurses and midwives to the problems experienced by BME and internationally recruited nurses/midwives. The literature review will be of interest to anyone in the NHS who is responsible for drawing up HR policies and anyone responsible for improving the environment in which nurses and midwives work. Additionally, the NMC can share the findings of the literature review with other health care regulators to help them identify any similar issues they might be experiencing and areas where they need to conduct more research.

# Methodology

In overview, the literature search conducted for this review comprised of two search strategies. The first strategy involved the identification of pertinent peer-reviewed articles; and the second strategy included the gathering of relevant 'grey' literature.

## Strategy one

Academic, peer-reviewed papers were identified using a selection of databases including Nursing Index; CINAHL; EBSCO; ERIC; Google Scholar; NHS Evidence; Nursing@OVID; Medline; Pubmed and Scopus. The search covers the years from 2000 to 2015. Full searches of these databases have taken place for UK and international peer-reviewed and published literature - and a literature search table has been generated relating to the literature search strategy findings (See Appendices – Table 1). In the initial search phase, article titles (and where necessary their abstracts) were read for relevance before a more rigorous assessment. Using this approach, in total 216 articles were identified as potentially relevant. Once duplications were removed, 45 articles with a potential for inclusion were identified. These remaining 45 articles were screened for quality and relevance using the appropriate Critical Appraisal Skills Programme (CASP) checklists (http://www.casp-uk.net/). From this screening, 9 articles were found to have no outcomes relevant to the research area; which left a remaining 36 UK and international peer-reviewed and published articles which have been included

in the literature review. These articles were further divided into four categories: 1) Main Articles; 2) Fitness to Practise; 3) International Literature; and 4) Background Articles. A table giving an overview of the 36 peer-reviewed articles identified to date can be found in Appendices – Table 2.

### Strategy two

The researchers identified a range of unpublished literature from a range of organisational websites including professional, statutory, independent and regulatory bodies (e.g. General Medical Council (GMC), General Dental Council (GDC), Health and Care Professions Council (HCPC), the Royal College of Nursing (RCN)). Concurrently, the NMC contacted the PSA which regulates eight other regulated professions to request they share any relevant internal publications and data relating to the experiences and outcomes of BME registrants and the fitness to practise processes. A total of 22 documents were identified in this way. This literature was also screened for eligibility, following which two were excluded. Tables overviewing the unpublished literature and excluded articles/literature, with rationale for exclusion, can be found in Appendices – Tables 3 and 4, respectively. An overview of the process for selecting the literature included in the current review can be found in the Appendices – Figure 1.

## Background

A number of researchers have explored the experiences of BME nurses and midwives practising in the UK and have identified a range of challenges and obstacles faced by overseas qualified nurses to professional practise in the UK. These mainly related to the work environment, including development opportunities, and racial discrimination. “Performance concerns are a key issue for those who regulate health professionals around the world” (Schafheutle, Seston, & Hassell, 2011, p. 8). Understanding the key areas of performance in which BME nursing and midwifery health professionals encounter difficulties is necessary in providing a context for potential entry to the fitness to practise process.

In seeking to better understand the experiences of BME nurses and midwives in relation to fitness to practise, this section is divided into two parts. The first part reviews the literature directly relating to the experiences of BME nursing and midwifery staff within the UK healthcare system. The second part of this, the background section, considers the literature pertaining to the experiences of ethnic minority health professionals internationally; revealing that the concerns related to BME nurses and midwives are not necessarily UK specific.

### Experiences of BME nursing/midwifery staff within the UK healthcare system

This review of the literature reveals that BME nurses and midwives employed within the UK healthcare system encounter both positive and challenging experiences in their daily practice. Although the positive experiences were not always the focus of the articles, it is important that they are recognised because strengths can be built upon and strategically utilised to support this group of health professionals and potentially reduce the number of fitness to practise enquiries they experience.

Two positive experiences that came through in the literature were exposure to a new culture (Alexis, Vydelingum & Robbins, 2007) and workplace support (Alexis, 2015). In a recent study, Alexis (2015) noted that overall internationally recruited nurses (IRNs) felt supported in their workplaces although this varied among ethnicities, with both Indian and Pakistani nurses feeling that they received more

support and African nurses receiving less support than any of their international counterparts in the working environment. Likewise, Winkelmann-Gleed and Seeley's (2005) survey of IRNs working in the NHS found that migrant nurses working in the London NHS, perceived the implementation of equal opportunities policies by their managers as highly effective, and felt supported by their supervisors and colleagues. Interestingly, Winkelmann-Gleed and Seeley's study found that the average age of IRNs was around 34 years. Thus, as mature professionals, as opposed to new graduates, it may be that these participants already had a level of resilience and coping skills that enabled them to access and utilise the support on offer.

While it is heartening to know that not all experiences are negative; nevertheless, serious issues do exist. Buchan (2003) undertook a study of five NHS and five private sector case studies from the London area as part of a Royal College of Nursing's commissioned report into the employment policy and practise implications of IRNs working in the UK. Buchan reported that across all case studies, the main challenges encountered by managers when employing IRNs were language, differences in clinical and technical skills, and racism in the workplace. A fourth challenge to emerge from the literature, to add to Buchan's list, is that of workplace support. Each of these themes will now be discussed.

It should be noted that the literature in this section primarily addresses the experiences of BME nurses, in particular those of IRNs. There was a dearth of peer-reviewed literature pertaining to the experiences of BME midwives; rather the literature tended to focus on the experience of midwives in general working with BME clients. Additionally, where appropriate, the experiences of ethnic minority health professionals across other disciplines, such as medicine, working in the UK have been included. As previously indicated, formal investigations into the overrepresentation of BME staff in disciplinary procedures at a national level have primarily focused on "doctors and dentists in hospital and community settings" (Archibong & Darr, 2010, p. 12). Therefore, an understanding of performance concerns for other health professionals may provide a deeper understanding of the issues presenting for nurses and midwives.

### Communication

The issue of communication, or language difficulties, was raised across a number of articles reporting on the experiences of BME nursing and midwifery health professionals. There were three dimensions associated with language that stood out in the literature: grammar, accents, and technical terminology.

Alexis and Vydelingum (2004) undertook a phenomenological study examining the lived experiences of 12 nurses who originated from the Philippines, South Africa, the Caribbean and sub-Saharan Africa and who had recently been recruited to work in the NHS in the south of England. Participants in this study described a feeling of "being thrown into a different world" (p. 16) as they communicated with patients and colleagues in English; which was not the first language spoken in their country of origin. As a result they experienced increased stress and sometimes embarrassment as colleagues corrected their grammar; as one participant in the study reported:

> 'When I do my sentences, my grammar. It is like they do check me right there and then, they don't wait for.... They say let's talk about how you should say it. I felt embarrassed and humiliated.' (Alexis & Vydelingum, p. 16)

Similarly, BME nurses, for whom English was a main language in their home country, also experienced difficulties in communication. Allan and Larsen (2003) conducted 11 focus groups with

67 IRNs in Leeds, Cardiff and London to explore their motivations and experiences of working in the UK. Although the report does not specifically identify the BME population, the authors noted that:

> A more severe and persistent language difficulty was the difficulty with which their UK colleagues and patients could understand and become familiarised with the IRNs' accents or dialects. This was a problem for IRNs who had English as a main language in their home country such as: India; Nigeria; Zimbabwe; or South Africa. (p. 70)

The issue of 'accent' was reinforced in a study by Matiti and Taylor (2005) who looked at the experiences of IRNs in large urban hospital trusts in the UK. In this article it was noted that the IRNs experienced language barriers both in regards to their own accent being understood and understanding the accent of their colleagues and patients.

A third aspect of communication that presented a difficulty was in relation to the culture of nursing language. Daniel, Chamberlain and Gordon (2001) sought to identify initial expectations and experiences of newly migrated Filipino nurses at a London hospital. Analysis of focus group interviews revealed that participants struggled to understand medical terminology, abbreviations, jargon, and names of drugs. This was particularly an issue if they had undertaken their nursing training in an American system. The challenge of being able to communicate using professional terminology/language can also be considered an aspect of difference in cultural knowledge and professional skills.

Different styles of communication was noted by regulators as a potential issue (Archibong & Darr, 2010). Staff for whom English was not their first language may express themselves in ways that could easily be interpreted negatively by colleagues, managers and patients and, if left unchecked, could have serious consequences. Linked to communication was the issue of differences in cultural behaviours and interactions with patients – which could be misunderstood and serve as grounds for taking disciplinary action.

### Differences in cultural knowledge and professional skills

As well as highlighting the issue of communication, Matiti and Taylor's (2005) study of IRNs' experiences in large urban hospital trusts in the UK revealed that the culture IRNs' brought with them, shaped their adaptation and practice processes in the host country. In particular, they noted that there were often vast differences in 'nursing cultures'. This finding was highlighted by Daniel et al. (2001) who noted the difference in nursing culture particularly in relation to specific tasks, such as medication administration and personal care assistance involving feeding and washing, as a result of not having assistance from family members, on which they would have been able to rely in their home country. Other areas of difference in nursing culture, as identified by the Filipino nurses, involved shift patterns and handing over responsibility the degree of specialisations, and lack of respect for the elderly (Daniel et al., 2001). These findings were reinforced in a later mixed methods study of 53 Filipino nurses in the UK (Withers & Snowball, 2003).

Participants in Alexis and Vydelingum's (2004) study also referred to nursing practise in the NHS as being different to what they were used to in their country of origin. One aspect in particular was highlighted in relation to organisation of care. In the UK, nurses work towards individualised and holistic nursing care, a practice that differs to that of a task-orientated schedule, which is what these participants were familiar with. Furthermore, the participants in this study felt that during their induction programmes they had not been prepared to deliver such care (Alexis & Vydelingum).

Differences in cultural knowledge and professional skills can lead to feelings of being devalued and deskilled (Matiti & Taylor, 2005; Taylor, 2005). Winkelmann-Gleed and Seeley (2005) have related

this to the fact that the average age of the IRN is around 34, meaning many of these nurses have practised for many years but are recruited at a lower level in the host country. Taylor (2005) recommended encouraging a climate of inclusion within nursing teams, and allowing overseas nurses to receive professional practise training as part of their adaptation programme.

Slowther, Lewando Hund, Purkis and Taylor (2012) and Slowther, Lewando Hund, Taylor and Purkis (2009) explored the experience of non-UK qualified doctors in working within the regulatory framework of the GMC document *Good Medical Practice*. Between 1 April 2006 and 31 March 2008, individual interviews and focus groups were conducted with participants attending training/induction programmes for non-UK-qualified doctors, and key informants involved in training and support for non-UK-qualified doctors. The findings from these studies revealed that the information and support provided to non-UK qualified doctors applying to register with the GMC, has little reference to the ethical and professional standards required of doctors working in the UK. Rather, understanding of the ethical, legal and cultural context of UK healthcare is assumed to occur once doctors are working in practise. Further, these authors found no information on the quality of induction programmes for BME doctors; and, if they are of the quality as that described above for BME nurses, then it is debateable how much information doctors actually receive. Indeed, Slowther et al. (2009, 2012) posited that non-UK qualified doctors experience a number of difficulties related to the fact that there were clear differences in the ethical and legal framework for practising medicine between the UK and their country of qualification. Recommendations from these studies included the provision of information and educational resources before registration, together with in-practise support to develop more effective practise in the UK.

In addition to the loss of status brought about by differences in professional skills, many overseas trained nurses have also reported experiences of discrimination (Winkelmann-Gleed & Seeley, 2005).

### Discrimination and racism

A recent literature review exploring the perceived racial and ethnic prejudice and discrimination experiences of minority and migrant nurses reported racist bullying in the UK (Tuttas, 2015). Of the 20 articles included in this review, findings reported from a UK study (Shields & Wheatley Price, 2002) revealed that, for non-White minority nurses, the factor that had the strongest impact on job satisfaction, was the degree of racial harassment endured from colleagues. Shields and Wheatley Price (2002) found in a UK study that almost 40% of non-White minority nurse participants, 48% of whom were Black African nurses, perceived they had been racially harassed by individual colleagues, in contrast to 4% of White minority nurses.

It was generally noted that across the literature there is agreement that most foreign nurses have a negative experience of working in the UK, and that central to this is the perception of having been bullied or on the receiving end of workplace racism. Likupe (2006) conducted a literature review to highlight the experiences of Black African nurses in the UK. She found 19 relevant articles primarily focussing on the experiences of IRNs and ethnic minority nurses in general. This article argued that while some African nurses had positive experiences of working in the NHS, equally, some encountered racism within the work setting and discrimination in pay and conditions of service. Alexis (2015) undertook a descriptive survey. Data were collected from 188 IRNs in 15 NHS hospitals using a questionnaire. Findings revealed that many IRNs perceived that they were discriminated against in the workplace. Interestingly, the data also showed that African nurses were more likely to perceive that they were discriminated against than nurses from India and Pakistan. As this was a survey, the study cannot explain why this might be the case.

Alexis and Vydelingum (2004) contended that discrimination in the form of racism was an everyday experience which, coupled with the lack of opportunities to develop appropriate skills to meet the needs of the department and patients, created an unpleasant feeling for their IRN participants. Participants in this study also reported experiencing bullying behaviour by their colleagues including being shouted at in front of other colleagues. The adverse influence of institutional racism on the daily working relationship between BME health professionals and their colleagues and nurses was also noted by Allan, Larsen, Bryan and Smith (2003). They described racism as an attitude that, when expressed covertly, could hinder BME workers' place in nursing hierarchies and their career progression. Indeed, follow-up research has confirmed these feelings of discrimination (and sometimes overt or covert racism) expressed by overseas trained nurses (Larsen, 2007) and the perceived difficulty in career progression (Henry, 2007).

Alexis et al. (2007) conducted focus groups with BME nurses, and participants expressed a clear feeling of discrimination and lack of equal opportunity, which at certain times amounted to abuse. However, they felt tolerating such behaviour was a necessity if they wished to stay in the country. Not having a clear understanding of how to go about reporting discrimination or the consequences of doing so was further highlighted in a report by Smith, Allan, Henry, Larsen and Mackintosh (2006). These researchers collated and summarised data from surveys on internationally recruited and BME nurses. A secondary analysis of survey data revealed that overseas-trained nurses were less likely to challenge what they perceived as instances of discrimination or unfair treatment through the official channels. Instead, they reported feeling powerless and unaware of their rights.

Concern about discrimination was also identified in a report produced by Smith, Allan, Henry, Larsen and Mackintosh (2006) as part of the Researching Equal Opportunities for Overseas-trained Nurses and Other Healthcare Professionals (REOH) study. This involved interviews with 93 overseas qualified healthcare professionals (mainly nurses, but also included midwives, doctors, physiotherapists and other professional groups). The interviewees felt that more complaints were brought against them than their White (and UK-trained) peers. They also felt that complaints against them were both perceived and treated differently, what the authors described as "*racialization of the mistakes and complaints procedures"*, manifested in three different forms:

1. Minor mistakes are committed by overseas-trained nurses and midwives tend to be over-reported whereas similar errors made by British nurses and midwives are more likely to go "un-noticed" (Smith et al., p. 78).
2. Mistakes made by BME staff are treated in a stricter manner than those made by White staff. Errors made by the latter are more likely to be resolved in a blame-free manner.
3. Clinical mistakes committed by BME staff are often attributed to *"inferior"* training.

Traditionally the literature on racism and on bullying has developed separately. Allan, Cowie, and Smith (2009) conducted an in-depth thematic analysis of three interviews purposively selected from a national study of overseas nurses (Smith et al., 2006). The cases were selected as they presented strong examples of workplace bullying. Findings in this paper suggested that racism can be understood by the concept of racist bullying, which includes: abusive power relationships, communication difficulties, emotional reactions to racist bullying and responses to bullying. These authors contend that current models for understanding cultural difference in nursing are inadequate. This may also, in part, explain the fourth issue to arise in relation to the difficulties experienced by BME nurses and midwives working in the UK – namely, lack of support.

## Workplace support

Two of the oldest studies included in this review reported on qualitative research of BME nurses working in the NHS in the south of England, conducted by Alexis and Vydelingum (2004, 2005). This research identified several difficulties faced by overseas qualified BME nurses including lack of perceived appreciation and feelings of inadequacy. Participants' encountered minimal support during their everyday working practises which, combined with their immersion in a different environment, caused increased anxiety and stress. However, of most interest to this review, participants also described unfairness in the distribution of nursing work; many felt that they were being given the most challenging cases. At the same time, they did not feel that there was an impartial senior member of staff with whom they could raise these concerns.

Allan (2010) has argued that there are barriers to effective and non-discriminatory practise when mentoring overseas nurses within the NHS and the care home sector. These include a lack of awareness about how cultural differences affect mentoring and learning for overseas nurses during their period of supervised practise prior to registration with the UK NMC. In a qualitative study involving interviews with 93 overseas nurses and 37 managers and mentors from six sites across the NHS, Allan argued that overseas nurses are discriminated against in their learning by poor mentoring practices. Equally, from these data, it appears that mentors are ill-equipped by existing mentor preparation programmes to mentor overseas-trained nurses from culturally diverse backgrounds. This finding is concerning given that five years earlier, Matiti and Taylor (2005) reported on the experiences of IRNs in large urban hospital trusts in the UK and stated that the quality of induction they received in the UK was often considered to be poor.

The need for appropriate mentoring, taking into account cultural practices is highlighted by the findings of a study by Smith et al. (2006), in which some efforts by domestic nurses to foster group inclusion had the potential to be misinterpreted by minority ethnic staff, and indeed to be seen as discriminatory. For example, when British nurses encouraged BME colleagues to participate in small talk about personal matters during break room conversations, or invited them to the pub after work, they did not recognise that these activities were not culturally acceptable to some ethnic minority group members. The staff's gestures were perceived as pressure to conform (Smith et al., 2006), and though designed to promote support and inclusion had the opposite effect by focusing attention on the differences between the two cultures.

Beyond effective induction programmes, there is a need for ongoing support. Locke, Scallan, Leach, and Rickenbach (2013) undertook a qualitative study to account for the means by which poor performance among doctors is identified by NHS organisations and how these processes may be strengthened in the light of revalidation and the requirement for doctors to demonstrate their fitness to practise. The study included a review of current practise and policy from 15 trusts in one deanery locality and 14 semi-structured interviews. As a dimension of support, identifying poor performance occurred at a team level, through supervision, appraisals, and local policy review; as well as an organisational level, through clinical audit and contract management. The authors concluded, however, there is little research to substantiate the success of complaints as a means of identifying poor performance. Rather more work needs to be done in evaluating current tools and developing stronger processes of support.

Humphrey et al. (2009) conducted a literature review and identified four domains where doctors who qualified outside the UK and/or BME doctors may encounter additional challenges or disadvantages. These domains included: medical education and the context of professional practise; the circumstances and opportunities of their working lives; the attitudes and behaviour of other

people; and their personal circumstances outside work. Certainly the 'context of professional practise' is similar to that raised above in the experiences of BME nurses and midwives.

## International experiences of ethnic minority healthcare professionals

The previous section aimed to elucidate the experiences of BME nurses and midwives working in the UK healthcare system in order to better understand the context for the overrepresentation of BME professionals in the fitness to practise process. However, the issue of overrepresentation is not confined to the UK. For example, in a quantitative study to determine the characteristics of disciplined physicians at-large and the risk of disciplinary action over time of those physicians registered with the Oklahoma Board of Medical Licensure and Supervision in the US, Khaliq, Dimassi, Huang, Narine, and Smego (2005) demonstrated that men and non-Whites were more frequently disciplined than women and White physicians.

BME nurses and midwives practising in the UK, encountered four primary challenges in their daily work. These difficulties related to: communication, differences in cultural knowledge and practical skills, discrimination and racism, and lack of workplace support. In reviewing the international literature pertaining to the experiences of ethnic minority healthcare professionals, similar trends were ascertained.

Qualitative studies of ethnic minority nurses working in the US, Iceland and Sweden all highlight communication, as well as different cultural knowledge and professional skills, as a challenge to working as an ethnic minority health care professional. Xu, Gutierrez and Kim (2008) employed a qualitative phenomenological methodology to explore the lived experiences of Chinese nurses working in the US healthcare environment, out of which the theme 'communication as the most daunting challenge' emerged. Issues as identified earlier regarding difficulty understanding accents and familiarisation with medical terminology were noted. However, this study of Chinese nurses in the US went further to identify communication issues as a risk to patient safety and quality of care. The authors contended that patient safety is potentially compromised through cultural adjustments linked with communication; for example, learning to challenge authority figures, such as physicians, to advocate for and protect patients. If communication problems do compromise patient safety, this may be one mechanism that could explain, at least in part, why nurses and midwives who trained overseas are more likely to be involved in disciplinary and regulatory processes.

Like Xu et al. (2008), Magnusdottir (2005) also used a phenomenological approach to unpack the lived experience of 11 registered foreign nurses, from seven countries, working at hospitals in Iceland. Of these 11 nurses, 7 were Western and 4 identified as non-Western. Analysis of the individual interviews produced five main themes: a) how the nurses met and tackled the multiple initial challenges; b) becoming outsiders and needing to be let in; c) the language barrier; d) the different work culture; and e) overcoming the challenge to win through. The overall theme was 'growing through experiencing strangeness and communication barriers'. This theme resonates with another theme from Xu et al.'s study which was titled 'different and even conflicting professional values and roles/expectations of the nurse between the United States and China' and 'cultural dissonance'. In addition to communication, this study found that patient safety was potentially further compromised through cultural adjustments such as learning to accept the notion of accountability along with the increased responsibilities and professional autonomy in American nursing.

The third study to discuss the issue of communication as a challenge in the practise of ethnic minority nurses was conducted by Tavalli et al. (2014). This study is one of the few that describe families' experiences with minority ethnic health professionals in a multicultural society. Using an exploratory qualitative design, 14 parents with an ethnic Swedish background whose child was in hospital were interviewed regarding their perceptions and experiences of minority ethnic nurses' cultural competence. Findings were grouped into four main categories: influence of nurses' ethnicity; significance of cross-cultural communication; cross-cultural skills; and the importance of nursing education. The findings of this study were interesting in that overall, the nurses' ethnicity did not have much impact on parents' satisfaction with their child's care. Rather, the nurses' language skills and their adaptation to and awareness of Swedish culture were of primary importance. The participants in this study emphasised that cultural competence is more about nurses' cultural awareness and cultural sensitivity and their ability to have a successful cultural encounter – all of which is ensured by having comprehensive communication and language skills. The main conclusion to be drawn from these articles is that language and culture are inseparable entities; and they do not always make for a safe playing field.

There is a global nursing shortage and the international migration of nursing professionals means that socio-culturally the nursing workplace is becoming increasingly diverse. Mapedzahama, Rudge, West, and Perron (2012) examined how skilled African migrant nurses working in Australia forge social and professional identities within their transnational, cross-cultural existence. Using a qualitative critical approach, 14 black African migrant nurses were interviewed about their experiences of practising in Australian healthcare settings. The findings of this study exposed how racism is played out in seemingly 'normal' functioning of everyday interactions in a White dominated workplace which privileges the ideals of a 'non-racist' profession while systematically avoiding confronting racism when it occurs. Xu et al. (2008) also found themes of marginalisation, inequality and discrimination throughout the nine in-depth interviews with Chinese nurses working in the US healthcare environment.

Finally, Tolbert Coombs and King (2005) designed a quantitative study using postal surveys to determine first of all, the types of discrimination that exist for the practising physician and second, which groups of physicians are most likely to experience the various forms of discrimination. The sample included racial/ethnic minority and international medical graduates amongst physicians in Massachusetts. A total of 168 (40.9%) survey respondents classified themselves as a racial or ethnic minority; and 63% of all respondents had experienced some form of discrimination. In particular, just under half of all respondents (48.1%) noted racial discrimination to be a very or somewhat significant extent in their current work setting. It should be noted that there is potential response bias in that those more likely to have experienced discrimination were probably more likely to respond to the survey. However, the findings of this study and those reviewed throughout this section do suggest that internationally, minority ethnic nurses and other health professionals experience many of the same issues as their counterparts working in the UK healthcare system.

## Summary

This section has reviewed the national literature pertaining to the experiences of BME nurse and midwives, and other health professionals, working in the UK healthcare system; as well as relevant international literature concerning issues for ethnic minority health professionals working in other parts of the world. There are common themes arising from this literature, including issues to do with communication, differences in cultural knowledge and practical skills, issues of injustice related to

discrimination and racism, and lack of workplace support. An important study that examines these issues from a different perspective was conducted by Archibong et al. (2013) with representatives from NMC, the GMC, the GDC, the HPC, the General Optical Council, the General Orthopaedic Council, the Royal Pharmaceutical Society of Great Britain, and the Pharmaceutical Society of Northern Ireland. They used mixed methods to assess the extent of involvement of BME staff in disciplinary procedures within the NHS. Their findings suggested that a "custom and practise culture exists within the NHS that was seen as perpetuating unwritten workplace norms and was instrumental in reproducing inequalities" (p. 6). Understanding the challenges that arise through practise culture and customs, provide important background information that might go some way to explaining why BME health professionals are overrepresented in fitness to practise enquiries and disciplinary procedures.

## Fitness to Practise

The NHS is the largest employer of BME staff in the UK (NELFT, 2015) and, in 2013, individuals of BME background comprised 14% of the NHS workforce (Archibong et al., 2013). In light of the growing empirical and anecdotal evidence indicating that health professionals with a BME background are overrepresented in disciplinary procedures (Carter, 2000; Royal College of Midwives, 2013), there is an urgent need to address this issue for the benefit of staff members and ultimately, patient care. The accumulating evidence dates back as far as 1990 when it was revealed that BME nurses were overrepresented among those reported for investigation of alleged professional misconduct (Archibong et al., 2013). A recent report into BME midwives and disciplinary proceedings revealed that the problem has not gone away. This paper reported on the five year trend (2011-2015) based on data gained from Freedom of Information requests and revealed that during this period:

- BME midwives (66.4%), of the total number of midwives referred for fitness to practise) were disproportionately more likely to face disciplinary proceedings;
- A higher proportion of BME midwives (19.6%) than White midwives (6.3%) were suspended while facing disciplinary proceedings;
- A higher proportion of BME midwives (n=37) than White midwives (n=1) were dismissed during disciplinary proceedings.
  (Royal College of Midwives, 2016, p. 1)

Archibong et al. (2013) previously argued that there is a need to collect detailed ethnicity information linked to the information provided by members on registration, as part of fitness to practise procedures, so as to better ascertain whether ethnic groups were disproportionately represented. Prior to the introduction of a new electronic recording system in 2005, the GMC did not routinely collect data pertaining to ethnicity but in 2007-2008 it "undertook a major exercise to improve the quality and coverage of its ethnicity data" (Humphrey et al., 2009, p. 19) due to growing concerns over possible discrimination and racism based on anecdotal reports that non-UK qualified doctors appeared to be at higher risk both of being referred to the GMC and subsequently receiving a high impact decision, which would include being struck off the register. Unfortunately, collection of ethnicity data is a weakness across all regulatory bodies. The literature reviewed in this section pertains to what is currently known about fitness to practise processes and outcomes for BME health professionals working in the UK. Briefly included are also the experiences of non-health UK regulators.

## Process

In this section, literature relating to the fitness to practise pathways for dentistry and medicine are considered; and doctors' perceptions of the GMC's fitness to practise process are discussed.

While inadequacies in the collection of ethnicity data is recognised as an issue associated with the fitness to practise process, Singh, Mizrahi, and Korb (2009) noted that in addition, issues arise because of the lack of an exact definition of what is, and what constitutes, serious professional misconduct within The Dentists Act 1984. The absence of a working definition means that for the UK General Dental Council, "serious professional misconduct" is determined by the Professional Conduct Committee, which may be susceptible to personal bias and subjective opinions.

Generally the process for moving through a fitness to practise enquiry is similar across regulatory bodies, with no significant differences among the regulators; however, there is a degree of subjectivity in the process. The UK General Dental Council and the General Osteopathic Council both have a three stage process for dealing with the complaints procedure (General Osteopathic Council, 2016; Singh et al., 2009). In stage 1, all complaints are subject to a caseworker examination. If the complaint is upheld it moves to stage 2, the Investigating Committee who consider the allegation and determine what route of action to take. If an enquiry is warranted, the case moves to stage 3, the Professional Conduct Committee decides on the penalty to be imposed or refers on to either the Professional Performance Committee or the Health Committee. This process is similar to that of the GMC. Since 2004 the GMC fitness to practise procedures start with a triage process to decide whether or not to proceed with the case. The second stage requires a full investigation and the stage is adjudication, which consists of a formal hearing by a fitness to practise panel made up of medical and non- medical lay members with five possible outcomes from no further action through to erasing a doctor from the medical register (Chamberlain, 2011).

In 2014, the GMC commissioned research into doctors' perceptions of the GMC. The researchers conducted a mixed methods study – qualitative focus groups and a quantitative survey of a randomly sampled group of doctors – to explore views and perceptions across four key areas, one of which was fitness to practise (Bridges, Ahmed, Fuller, & Wardle, 2014). The ethnicity split was fairly even with 49% White respondents and 45% BME respondents. The data in relation to fitness to practise revealed some key differences in perception amongst participants. With regards to investigating concerns, the majority of BME (66%) and non-UK qualified doctors (69%) thought the GMC should deal with all concerns, regardless of who raises them. In response to the same question only 52% of White doctors and 51% of UK qualified doctors expressed the same opinion. In response to which particular groups were more likely to be treated unfairly during an investigation, 60% of BME doctors thought some groups were more likely to be treated unfairly – namely non-UK qualified and BME doctors; 70% of White doctors felt that no particular group would be treated unfairly. In relation to fitness to practise – outcomes of investigations, 29% of BME versus 7% of White doctors thought that a complaint would be more likely to be upheld about them. With respect to harsher sanctions being applied if a complaint was upheld, 95% of White doctors did not think this would be the case; yet only 69% of BME doctors felt the same way (Bridges et al., 2014).

Overall, just over a quarter of doctors (28%) thought that the fitness to practise proceedings were more fair now than they were five years ago (Bridges et al., 2014). More recent research has revealed that BME doctors exhibit more confidence than White doctors in GMC's regulation (78% compared to 72%), with over a quarter stating that they were very confident (IFF Research, 2015). All doctors were also asked how confident they were in the fairness of fitness to practise investigation outcomes (for all groups of doctors). UK qualified doctors were more likely to lack

confidence, compared to doctors who qualified elsewhere; however overall confidence did not significantly differ by ethnicity (IFF Research, 2015).

Finally deBere et al. (2014) presented findings from an in-depth qualitative review of GMC decision-making within the fitness to practise procedures which aimed to identify instances of bias or discriminatory practice. The data utilised in this study were fitness to practise case files and the GMC's fitness to practise guidance and criteria documents. The researchers found no evidence of bias or discriminatory practices, either in the GMC's guidance and criteria documentation for decision-makers, or the sampled case files. In the instances where documentation made specific reference to doctor characteristics, for example their cultural background, these references were either in the context of discussing factors which could genuinely impact upon a doctor's fitness to practise or on ensuring that doctors are not disadvantaged within the fitness to practise system. The decisions reached in the reviewed case files were found to be in line with the guidance and criteria set out for decision-makers.

Overall, the literature reveals that for the medical and dental professions, there is clear process for moving through a fitness to practise enquiry, although there is a degree of subjectivity, for example around what is and what is not defined as serious professional misconduct. That said, for the GMC, there have been no identifiable instances of bias or discriminatory practice; although BME doctors do have greater concerns regarding the fairness of fitness to practise outcomes (deBere et al., 2014).

## Outcomes for BME health professionals

In 2009, Archibong and Darr (2010) assessed the extent of involvement of BME staff working in NHS trusts in disciplinary proceedings within the organisation. Using a range of methods, including a web audit of 398 NHS trusts and focus group interviews, they found that BME staff in the NHS were twice as likely to be involved in a disciplinary hearing as their White counterparts. This difference was significant in acute, primary care, mental health and learning disability and care trusts, but not the ambulance trust that was included in the audit. Factors thought to explain this phenomenon included inconsistencies in management practices and behaviours and an organisational culture within the NHS that did not easily accommodate difference. The findings of this research are, however, limited by the very high proportion of missing data, where only one fifth of the trusts included in the audit had published data that could be included in the analysis. In total there are 12 health and social care regulatory bodies in the UK. In the next section, the outcomes for midwives, doctors, dentists, pharmacists and optometrists in relation to BME staff and fitness to practise outcomes are considered.

### Midwives

As previously indicated, the trends for BME overrepresentation in midwifery disciplinary action has recently been highlighted. It is only recently that accurate data has started to be collected for this profession, beginning in 2011 when the Royal College of Midwives (2012) submitted a Freedom of Information request to each of the 24 trusts in London that offer maternity services, to obtain the number of midwives subject to disciplinary proceedings, broken down by ethnic group. The initial data supplied by the trusts indicated that BME midwives were more likely to be subject to disciplinary procedures than their White counterparts. Indeed, 60.2% of the midwives who were subject to disciplinary proceedings were Black/Black British however only 32.0% of midwives in London were Black/Black British. They were also more likely to receive higher impact decisions (dismissal and suspension) and less likely to have no further action taken. There were 10 midwives

who were dismissed during the time period; every midwife who was dismissed was Black/Black British; 15.4% of the Black/Black British midwives who were subject to disciplinary during the time period were dismissed. Although these findings need to be interpreted with caution given the small sample size of the study, an ongoing analysis of Freedom of Information requests (2012-2015) indicates that the problem is not diminishing.

### Doctors

In recent years the number of fitness to practise enquiries received by the GMC has increased considerably (Archer et al., 2014). The majority of complaints (over two thirds) are from the general public, but there has been a gradual increase in complaints from other sources, including other doctors and those acting in a public capacity (Chamberlain, 2011; GMC, 2015). Between 2010 and 2014, concerns raised by people acting in a public capacity, as well as employers and police, were more likely to be about BME doctors and non-UK graduates, where the latter are more likely to be than UK graduates (GMC, 2015). This finding reinforces an earlier report by the NHS National Clinical Assessment Service (NCAS, 2011) into the profile of doctors, which observed that non-UK qualified doctors (elsewhere in the EEA and outside the EEA) were more likely to be referred to the GMC than UK-qualified doctors. However, this report also noted that there was no difference in referral rate between non-White UK qualified doctors and their White counterparts.

These findings raise the question as to whether the country of medical qualification is associated with the fitness to practise process and outcomes. Humphrey, Hickman and Gulliford (2011) examined over 7,000 enquiries made to the GMC's fitness to practise committee over the period from 1st of April 2006 until 31st of March 2008. After controlling for a number of possible confounding variables that included other characteristics of the doctors and enquiries, they found that ethnicity of registrants could not be included as an independent (predictor) variable in the analysis due to the large proportion of missing data. The main finding of this study was that non-UK qualified doctors were significantly more likely to receive "higher impact" decisions at each stage of the process; this difference persisted even after adjusting for sex, years since primary medical qualification, medical specialty, source of inquiry, type of inquiry and content of allegations (Humphrey et al., 2011). This finding is supported in an earlier study by Allen (2000) and a recent GMC (2015) report.

In an earlier study, Humphrey et al. (2009) conducted a secondary analysis of data held by the GMC about doctors going through the fitness to practise process. After adjustment, enquiries involving UK-qualified doctors showed no association between ethnicity and outcome at any of the three decision points- triage, investigative, adjudication. However, there were differences by place of qualification and ethnicity regarding the categorisation and content of enquiries (complaint, referral, criminal conviction, determination, other); with both non-UK qualification and BME status being associated with 'higher risk' enquiry characteristics.

Place of qualification does appear to be a factor that has the potential to increase the likelihood of a BME practitioner risking a fitness to practise enquiry. Campbell et al. (2011) sought to investigate potential sources of systematic bias arising in the assessment of doctors' professionalism. These researchers used cross-sectional questionnaire survey data from 11 clinical practices in England and Wales involving 1,065 doctors from various clinical specialties and settings, 17,031 of their colleagues, and 30,333 of their patients which they analysed using linear regression. After adjusting for characteristics of the doctor and the patient sample, patient feedback was less favourable when the doctor had obtained their primary medical degree from any non-European country. Doctors who obtained their primary medical degree from countries outside the UK and South Asia scored lower

on feedback from colleagues as well. However, in fully adjusted models, the doctor's ethnic group was not an independent predictor of patient or colleague feedback. Thus, the more important predictor of less favourable patient feedback was related to the doctor's place of qualification as opposed to ethnicity. The researchers do suggest caution in interpreting these findings; however, the research does point to the notion that sources of complaint are perhaps influenced by the perceptions people hold regarding birth place and education.

In addition to place of qualification, performance of international medical graduates (IMGs) on the professional and linguistic assessments board (PLAB) exam may also be related to the likelihood of referral and higher risk outcomes in relation to fitness to practise. Tiffin, Illing, Webster and McLachlan (2013) compared results of the PLAB exam between IMGs and Foundation Year 1s who have completed training in the UK. They found that IMGs were more likely than UK graduates to be referred or censured in relation to fitness to practise; the probability of which could be predicted by multiple attempts at both PLAB part 1 and part 2; PLAB part 1 scores at first attempt and at pass; and PLAB part 2 score at first sitting.

### Dentists

In the NCAS (2011) report, the authors noted that a higher percentage of referrals for fitness to practise enquiries were for White dentists who qualified elsewhere in the EU. Singh et al. (2009) investigated fitness to practise in the dental profession in an analysis of 209 cases that were brought to the Professional Conduct Committee of the UK General Dental Council between January 2003 and December 2007. Just over one fifth of cases (n=44; 21.1%) of registrants held foreign degrees that were not readily recognised in terms of UK qualifications. Similar to the findings reported for studies of medical doctors, this study observed that dentists qualified in certain countries were more likely to appear before a committee than UK-trained dentists (Singh et al., 2009). However, the authors recommend caution in drawing conclusions from these findings, as the number of registrants from different countries was only available at one time point in the study (December 2007), whereas the total number of charges was spread over five years.

### Pharmacists

Pharmacists from BME backgrounds represent a significant proportion of the UK pharmacy profession; yet unlike the evidence surrounding BME doctors and discrimination in employment and regulatory practices, little is known about the experiences of BME pharmacists. Seston, Fegan, Pharm, Hassell, and Schafheutle (2015) undertook a systematic literature review to identify published evidence on the disproportionate treatment in employment and regulatory practices of BME pharmacists in the UK. The search strategy identified 11 items; 6 peer-reviewed articles, 2 published reports, 2 conference papers and one PhD thesis. Findings revealed that BME pharmacists were overrepresented in disciplinary processes but there was no evidence of disproportionate treatment in the outcomes of inquiries. However, given the small number of studies, the authors advocated for further research.

In September 2010, the newly created General Pharmaceutical Council replaced the Royal Pharmaceutical Society as regulator of pharmacy professionals and premises in Great Britain. Using data from the Royal Pharmaceutical Society of Great Britain's Disciplinary Committee, Phipps, Noyce, Walshe, Parker, and Ashcroft (2011) compared 117 referred pharmacists, with 580 pharmacists who had not been subjected to disciplinary action but that matched the disciplined pharmacists on a set of demographic factors (gender, country of residence, year of registration). Statistical analysis revealed that 'working in a community pharmacy' was the only statistically significant characteristic to increase the likelihood of a pharmacist being referred to the disciplinary committee. Although

there was some indication that the pharmacist's qualification and ethnicity might be relevant, they were not statistically significant in this study. As with Seston et al. (2015) above, these researchers acknowledge the limitations of their study and recommend further research with a larger dataset (Phipps et al., 2011).

Working in a community pharmacy, as well as having trained overseas, appear to be two factors influencing fitness to practise enquiries for the pharmacy profession. Schafheutle, Seston and Hassell (2011) conducted a systematic literature review of factors found to be relevant to pharmacists' performance in national and international studies. They found some evidence to suggest that pharmacists of ethnic minority origin were more likely to experience performance problems and in the UK be called before a disciplinary committee. Other characteristics underpinning performance problems included being male, working in community pharmacy and, as with doctors and dentists, having trained overseas.

In an earlier study, Tullett et al. (2003) used a method of name recognition to assign ethnic origin to 344 pharmacists whose misdemeanours were reported in the *Pharmaceutical Journal.* Pharmacy is a particularly interesting profession in this context because it attracts a higher percentage of ethnic minority applicants than is found in the general population. From their analysis of the cases, they concluded that there had been a greater proportion of misdemeanours committed by ethnic minority pharmacists, which may be related to the fact that a high proportion of them work in community pharmacies. On the whole, ethnic minority pharmacists committed more professional than personal misdemeanours (e.g. failure to keep adequate written records versus fraud); which the authors speculate could be due to strongly held religious beliefs, attitudes to alcohol and strength of family codes of conduct.

### Optometrists

The General Optical Council is the regulator for the optical professions in the UK. There was minimal information available regarding the outcomes for BME optometrists in relation to the fitness to practise process. A report disseminated by the General Optical Council (2015) indicated that they have a "reasonably ethnically diverse workforce" (p. 5). While this statement is somewhat vague, the Council does acknowledge that they have not been in a position to collect sufficient information on the diverse characteristics of the optical profession; although there are plans to collect this data in future. The report does note, however, that there may be a slight under-representation of BME members when compared to the UK population. In regards to fitness to practise, data on ethnicity ceased to be collected in 2011-12.

## Outcomes for non-health UK regulators

As part of the review of literature, a search of the published and grey literature on the regulation of non-health professionals was conducted. The Solicitors Regulation Authority (SRA) commissioned research (2010) to explore whether there was a disproportionate number of cases brought against BME solicitors and what registrant-factors were possibly confounding this relationship. The research observed that when all solicitors are examined as one group, there was no association between ethnicity and the number of external cases referred to the organisation. But when solicitors who had qualified in the preceding 10 years where examined separately, they found that a disproportionate number of cases were brought against BME solicitors. This was not, however, a direct association, but rather one that was influenced by a number of solicitor and practise-related characteristics, including:

- Number of years since admission: Those who have been admitted recently to the profession are more likely to have cases brought against them, and BME solicitors are more likely to be in this category;
- Size of firm: Solicitors working in smaller firms are more likely to have cases brought against them, and BME solicitors are over-represented in smaller firms (SRA, 2008);
- BME-owned firms: BME solicitors are more likely to be employed in BME-owned firms. This type of firm is more likely to have cases brought against its employees from external sources.

In addition to exploring disproportionality in the initial referral, the researchers also explored whether the outcome of the SRA processes reduced, maintained or exacerbated the disproportionality observed at the initial stage. The study observed that this depended on the type of case and the referral source. For example, referrals made through the Legal Complaints Service for conduct cases are more likely to not be upheld by the SRA. Alternatively where BME solicitors have multiple cases raised against them, this is likely to exacerbate disproportionality. This research highlights the complexity of understanding the relationship between BME status and representation in professional conduct hearings, and the number of factors that might influence this relationship.

In an earlier independent review by the SRA (2008) regarding the disproportionate regulatory outcomes for BME solicitors, it was noted that the level of prejudice and bias which exists among personnel in this and other similar organisations is not to be under-estimated:

> No one admits to the existence of such prejudice in the SRA and there is not the evidence to suggest that its application is widespread. Nevertheless, in those areas of decision-making where subjectivity and discretion prevail there is evidence of some stereotyping being applied and this needs to be tackled urgently. (p. 6).

## Summary

This section has reviewed the available peer-reviewed and non-peer reviewed literature related to the fitness to practise process amongst selected regulatory authorities in the UK. The pathway through a fitness to practise enquiry is generally standard across regulatory bodies; although there is potential for the process to be subject to potential bias (though this was not substantiated for the GMC). The evidence supports the proposition that BME staff are overrepresented in relation to fitness to practise referrals and are more likely to receive more severe penalties. Factors contributing to this effect include the place where qualification has been obtained, as well as the particular area of practice. However, much of the literature reviewed advises caution in interpreting the results due to small sample size. Additionally, obtaining an accurate picture of the outcomes for BME healthcare professionals who undergo a fitness to practise process is hampered by the fact that some regulatory bodies are not collecting ethnicity related data.

Given the dearth of information directly relating to the progression of BME nurses and midwives through the fitness to practise process, this literature review sought to shed light on potential reasons for the overrepresentation of BME nurses and midwives in disciplinary procedures. Literature addressing the experiences of BME and IRNs within the work setting, as well as literature related to health and social care regulatory bodies within the UK reveal a number of challenges facing BME healthcare professionals. Further research is required to better understand these challenges, and provide support for BME staff within the UK healthcare sector.

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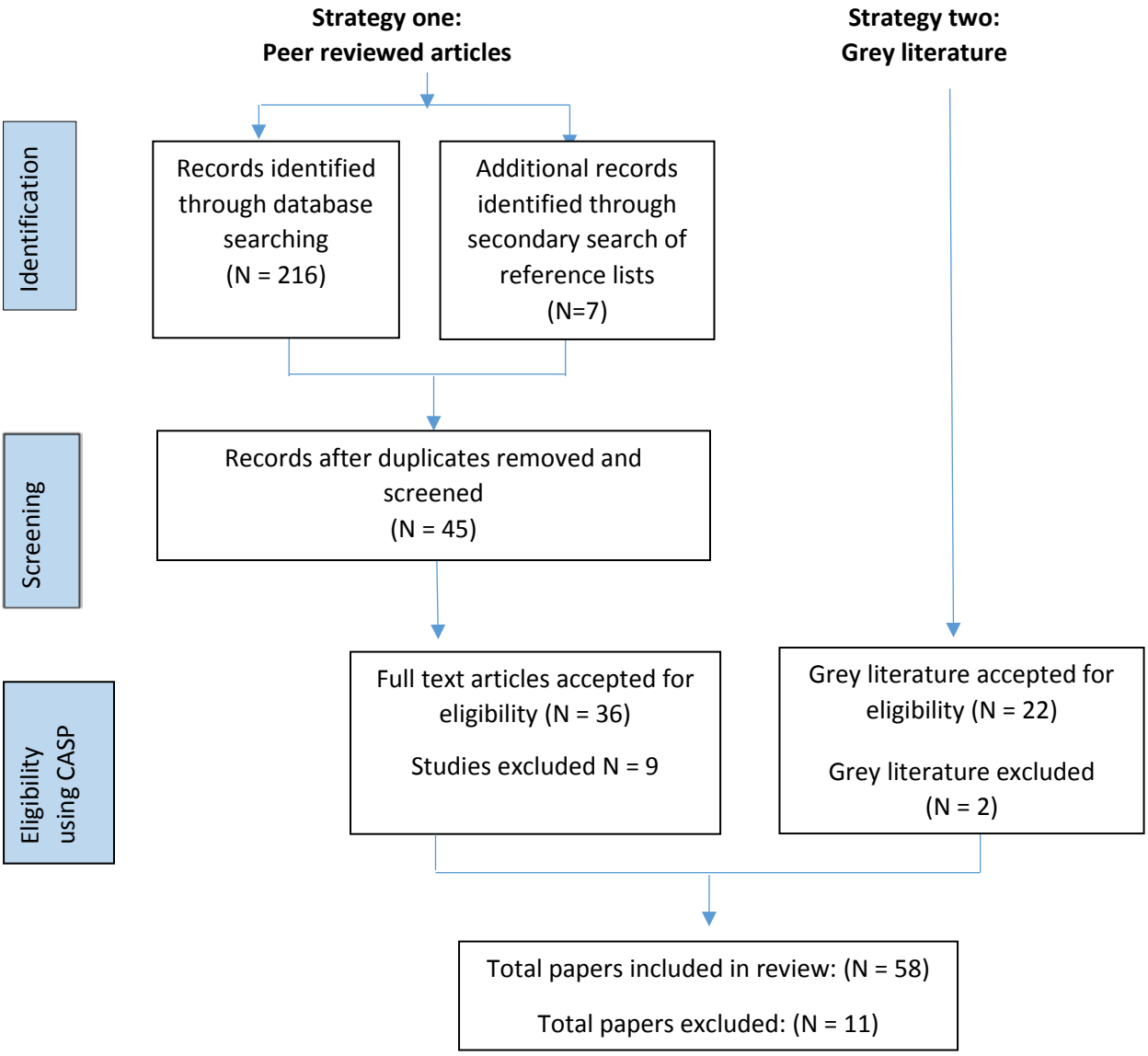
# Appendices

Figure 1: Identified, included and excluded peer-reviewed and published papers



## Table 1: Search terms and outcomes

| Index Term | Synonyms | Related Terms |
|---|---|---|
| 1. Regulat* | 1a) NMC – Nursing Midwifery Council<br>1b) GMC – General Medical Council<br>1c) GDC – General Dental Council<br>1d) HCPC – Health (and) Care Professions | 1e) Fitness to Practise<br>1f) Complain*<br>1g) Professional Standards |
| 2. Nurs* | 2a) Midwi* | |
| 3. Medic* | 3a) Doctor*<br>3b) Surge*<br>3c) Pharmacist | |
| 4. Dent* | | |
| 5. Ethnic* | 5a) Country of Origin<br>5b) Country of Qualification<br>5c) Black and Minority Ethnic | 5d) Qualifying country |
| 6. Teacher | 6a. Social worker | |

| Database | Search terms used | No. of papers | Total Papers |
|---|---|---|---|
| Google Scholar | 1a and 5a | 5 | 14,800 |
| Google Scholar | 1a and 5b | 5 | 12,000 |
| Google Scholar | 1a and 5c | 6 | 5840 |
| Google Scholar | 1a and 5d | 5 | 8210 |
| Google Scholar | 1b and 5a | 0 | 20,000 |
| Google Scholar | 1b and 5b | 4 | 17,400 |
| Google Scholar | 1b and 5c | 4 | 1060 |
| Google Scholar | 1b and 5d | 2 | 15,800 |
| Google Scholar | 1c and 5a | 2 | 16,000 |
| Google Scholar | 1c and 5b | 3 | 10,500 |
| Google Scholar | 1c and 5c | 3 | 15,700 |
| Google Scholar | 1c and 5d | 2 | 10,900 |
| Google Scholar | 1d and 5a | 6 | 16,100 |
| Google Scholar | 1d and 5b | 6 | 15,900 |
| Google Scholar | 1d and 5c | 4 | 16,700 |
| Google Scholar | 1d and 5d | 5 | 15,600 |

| | | | |
|---|---|---|---|
| Google Scholar | 1e and  1a and 5 | 4 | 2520 |
| Google Scholar | 1e and 1b and 5 | 4 | 16,100 |
| Google Scholar | 1e and 1c and 5 | 4 | 6690 |
| Google Scholar | 1e and 1d and 5 | 9 | 15,800 |
| Google Scholar | 1f and 1a and 5 | 5 | 6,950 |
| Google Scholar | 1f and 1a and 1e | 5 | 2760 |
| Google Scholar | 1f and 1b and 5 | 2 | 17,000 |
| Google Scholar | 1f and 1c and 5 | 3 | 9,200 |
| Google Scholar | 1f and 1d and 5 | 4 | 9,200 |
| Google Scholar | 1g and 1a and 5 | 5 | 13,600 |
| Google Scholar | 1g and 1b and 5 | 3 | 16,800 |
| Google Scholar | 1g and 1c and 5 | 1 | 16,000 |
| Google Scholar | 1g and 1d and 5 | 0 | 17,800 |
| Google Scholar | 2 and 5a | 0 | 15,500 |
| Google Scholar | 2 and 5b | 3 | 17,200 |
| Google Scholar | 2 and 5c | 5 | 16,200 |
| Google Scholar | 2 and 5d | 1 | 7,470 |
| Google Scholar | 2a and 5a | 2 | 15,800 |
| Google Scholar | 2a and 5b | 2 | 15,500 |
| Google Scholar | 2a and 5c | 2 | 11,700 |
| Google Scholar | 2a and 5d | 0 | 8650 |
| EBSCOhost | 1a and 5 | 0 | 27 |
| EBSCOhost | 1a and 5a | 0 | 1 |
| EBSCOhost | 1a and 5b | 1 | 3 |
| EBSCOhost | 1a and 5c | 0 | 1 |
| EBSCOhost | 1a and 5d | 0 | 0 |
| EBSCOhost | 1b and 5 | 2 | 22 |
| EBSCOhost | 1b  and 5a | 0 | 51 |
| EBSCOhost | 1b and 5b | 1 | 4 |
| EBSCOhost | 1b and 5c | 0 | 7 |
| EBSCOhost | 1b and 5d | 0 | 0 |
| EBSCOhost | 1c and 5 | 0 | 5 |
| EBSCOhost | 1c and 5a | 1 | 1 |
| EBSCOhost | 1c and 5b | 0 | 1 |
| EBSCOhost | 1c and 5c | 0 | 5 |
| EBSCOhost | 1c and 5d | 0 | 0 |
| EBSCOhost | 1d and 5 | 3 | 1068 |
| EBSCOhost | 1d and 5a | 0 | 28 |
| EBSCOhost | 1d and 5b | 1 | 4 |
| EBSCOhost | 1d and 5c | 0 | 51 |
| EBSCOhost | 1d and 5d | 0 | 0 |
| EBSCOhost | 1e and  1a and 5 | 0 | 5 |
| EBSCOhost | 1e and 1b and 5 | 0 | 3 |
| EBSCOhost | 1e and 1c and 5 | 0 | 0 |
| EBSCOhost | 1e and 1d and 5 | 0 | 0 |
| EBSCOhost | 1f and 1a and 5 | 0 | 0 |
| EBSCOhost | 1f and 1a and 1e | 0 | 0 |
| EBSCOhost | 1f and 1b and 5 | 0 | 0 |
| EBSCOhost | 1f and 1c and 5 | 0 | 0 |
| EBSCOhost | 1f and 1d and 5 | 0 | 0 |
| EBSCOhost | 1g and 1a and 5 | 0 | 3 |
| EBSCOhost | 1g and 1b and 5 | 0 | 3 |
| EBSCOhost | 1g and 1c and 5 | 0 | 0 |
| EBSCOhost | 1g and 1d and 5 | 0 | 0 |

| | | | |
|---|---|---|---|
| EBSCOhost | 2 and 5 | 1 | 3,906 |
| EBSCOhost | 2 and 5a | 1 | 166 |
| EBSCOhost | 2 and 5b | 0 | 46 |
| EBSCOhost | 2 and 5c | 2 | 468 |
| EBSCOhost | 2 and 5d | 0 | 0 |
| EBSCOhost | 2a and 5 | 0 | 273 |
| EBSCOhost | 2a and 5a | 0 | 9 |
| EBSCOhost | 2a and 5b | 0 | 4 |
| EBSCOhost | 2a and 5c | 0 | 20 |
| EBSCOhost | 2a and 5d | 0 | 0 |
| EBSCOhost | 4 and 5 | 0 | 313 |
| EBSCOhost | 4 and 5a | 0 | 9 |
| EBSCOhost | 4 and 5b | 0 | 4 |
| EBSCOHost | 4 and 5c | 0 | 6 |
| EBSCOHost | 4 and 5d | 0 | 0 |
| EBSCOHost | 3c and 5 | 1 | 40 |
| PubMed | 1a and 5 | 0 | 11 |
| PubMed | 1a and 5a | 0 | 0 |
| PubMed | 1a and 5b | 1 | 2 |
| PubMed | 1a and 5c | 0 | 3 |
| PubMed | 1a and 5d | 0 | 0 |
| PubMed | 1b and 5a | 0 | 5 |
| PubMed | 1b and 5b | 2 | 3 |
| PubMed | 1b and 5c | 0 | 9 |
| PubMed | 1b and 5d | 0 | 0 |
| PubMed | 1c and 5 | 0 | 4 |
| PubMed | 1c and 5a | 1 | 2 |
| PubMed | 1c and 5b | 1 | 1 |
| PubMed | 1c and 5c | 0 | 0 |
| PubMed | 1c and 5d | 0 | 0 |
| PubMed | 1d and 5 | 1 | 44 |
| PubMed | 1d and 5a | 1 | 4 |
| PubMed | 1d and 5b | 3 | 5 |
| PubMed | 1d and 5c | 1 | 3 |
| PubMed | 1d and 5d | 0 | 0 |
| PubMed | 1e and 1a and 5 | 0 | 0 |
| PubMed | 1e and 1b and 5 | 0 | 1 |
| PubMed | 1e and 1c and 5 | 0 | 0 |
| PubMed | 1e and 1d and 5 | 0 | 0 |
| PubMed | 1f and 1a and 5 | 0 | 0 |
| PubMed | 1f and 1a and 1e | 0 | 0 |
| PubMed | 1f and 1b and 5 | 0 | 0 |
| PubMed | 1f and 1c and 5 | 0 | 0 |
| PubMed | 1f and 1d and 5 | 0 | 0 |
| PubMed | 1g and 1a and 5 | 0 | 1 |
| PubMed | 1g and 1b and 5 | 2 | 4 |
| PubMed | 1g and 1c and 5 | 0 | 0 |
| PubMed | 1g and 1d and 5 | 0 | 83 |
| PubMed | 2 and 5 | 4 | 1640 |
| PubMed | 2 and 5a | 0 | 66 |
| PubMed | 2 and 5b | 0 | 12 |
| PubMed | 2 and 5c | 2 | 157 |
| PubMed | 2 and 5d | 0 | 2 |
| PubMed | 2a and 5 | 0 | 296 |

| | | | |
|---|---|---|---|
| PubMed | 2a and 5a | 0 | 15 |
| PubMed | 2a and 5b | 1 | 3 |
| PubMed | 2a and 5c | 0 | 25 |
| PubMed | 2a and 5d | 0 | 0 |
| PubMed | 3 and 1e | 0 | 0 |
| PubMed | 3a and 1e | 1 | 194 |
| PubMed | 3b and 1e | 0 | 28 |
| PubMed | 3a and 1e and 5 | 0 | 2 |
| PubMed | 3b and 1e and 5 | 0 | 0 |
| PubMed | 3a and 1e and 5c | 0 | 0 |
| PubMed | 3b and 1e and 5c | 0 | 0 |
| PubMed | 3a and 1g and 5c | 0 | 0 |
| PubMed | 3b and 1g and 5c | 0 | 0 |
| PubMed | 4 and 5 | 0 | 20 |
| PubMed | 4 and 5a | 0 | 8 |
| PubMed | 4 and 5b | 1 | 4 |
| PubMed | 4 and 5c | 0 | 18 |
| PubMed | 4 and 5d | 0 | 0 |
| Scopus | 1a and 5 | 0 | 3 |
| Scopus | 1a and 5a | 0 | 1 |
| Scopus | 1a and 5b | 0 | 0 |
| Scopus | 1a and 5c | 0 | 0 |
| Scopus | 1a and 5d | 0 | 0 |
| Scopus | 1b and 5a | 1 | 9 |
| Scopus | 1b and 5b | 0 | 1 |
| Scopus | 1b and 5c | 2 | 3 |
| Scopus | 1b and 5d | 0 | 0 |
| Scopus | 1c and 5 | 0 | 0 |
| Scopus | 1c and 5a | 1 | 1 |
| Scopus | 1c and 5b | 1 | 1 |
| Scopus | 1c and 5c | 0 | 0 |
| Scopus | 1c and 5d | 0 | 0 |
| Scopus | 1d and 5 | 0 | 7 |
| Scopus | 1d and 5a | 0 | 1 |
| Scopus | 1d and 5b | 1 | 2 |
| Scopus | 1d and 5c | 0 | 1 |
| Scopus | 1d and 5d | 0 | 0 |
| Scopus | 1e and 1a and 5 | 0 | 0 |
| Scopus | 1e and 1b and 5 | 0 | 1 |
| Scopus | 1e and 1c and 5 | 0 | 0 |
| Scopus | 1e and 1d and 5 | 0 | 0 |
| Scopus | 1f and 1a and 5 | 0 | 0 |
| Scopus | 1f and 1b and 5 | 0 | 0 |
| Scopus | 1f and 1c and 5 | 0 | 0 |
| Scopus | 1f and 1d and 5 | 0 | 0 |
| Scopus | 1g and 1a and 5 | 0 | 0 |
| Scopus | 1g and 1b and 5 | 1 | 2 |
| Scopus | 1g and 1c and 5 | 0 | 0 |
| Scopus | 1g and 1d and 5 | 0 | 2 |
| Scopus | 2 and 5 | 4 | 793 |
| Scopus | 2 and 5a | 1 | 63 |
| Scopus | 2 and 5b | 0 | 75 |
| Scopus | 2 and 5c | 3 | 45 |
| Scopus | 2 and 5d | 0 | 7 |

| | | | |
|---|---|---|---|
| Scopus | 2a and 5 | 0 | 160 |
| Scopus | 2a and 5a | 0 | 12 |
| Scopus | 2a and 5b | 0 | 9 |
| Scopus | 2a and 5c | 0 | 12 |
| Scopus | 2a and 5d | 0 | 0 |
| Scopus | 3 and 1e | 0 | 1 |
| Scopus | 3a and 1e and 5 | 1 | 3 |
| Scopus | 3b and 1e | 0 | 28 |
| Scopus | 3a and 1e and 5c | 0 | 0 |
| Scopus | 3b and 1e and 5c | 0 | 0 |
| Scopus | 3a and 1g and 5c | 0 | 0 |
| Scopus | 3b and 1g and 5c | 0 | 7 |
| Scopus | 4 and 5a | 0 | 8 |
| Scopus | 4 and 5b | 0 | 11 |
| Scopus | 4 and 5c | 1 | 3 |
| Scopus | 4 and 5d | 0 | 1 |
| ERIC | 1a and 5a | 2 | 48 |
| ERIC | 1a and 5b | 1 | 58 |
| ERIC | 1a and 5c | 0 | 6 |
| ERIC | 1a and 5d | 1 | 32 |
| ERIC | 1b and 5a | 1 | 15 |
| ERIC | 1b and 5b | 1 | 15 |
| ERIC | 1b and 5c | 1 | 15 |
| ERIC | 1b and 5d | 10 | 15 |
| ERIC | 1c and 5a | 0 | 1 |
| ERIC | 1c and 5b | 0 | 1 |
| ERIC | 1c and 5c | 0 | 1 |
| ERIC | 1c and 5d | 0 | 1 |
| ERIC | 1d and 5a | 0 | 0 |
| ERIC | 1d and 5b | 0 | 0 |
| ERIC | 1d and 5c | 0 | 0 |
| ERIC | 1d and 5d | 0 | 0 |
| ERIC | 1e and 1a and 5 | 0 | 0 |
| ERIC | 1e and 1b and 5 | 0 | 0 |
| ERIC | 1e and 1c and 5 | 0 | 0 |
| ERIC | 1e and 1d and 5 | 0 | 0 |
| ERIC | 1f and 1a and 5 | 0 | 2 |
| ERIC | 1f and 1a and 1e | 0 | 0 |
| ERIC | 1f and 1b and 5 | 0 | 0 |
| ERIC | 1f and 1c and 5 | 0 | 0 |
| ERIC | 1f and 1d and 5 | 0 | 0 |
| ERIC | 1g and 1a and 5 | 0 | 4 |
| ERIC | 1g and 1b and 5 | 0 | 37 |
| ERIC | 1g and 1c and 5 | 0 | 16 |
| ERIC | 1g and 1d and 5 | 0 | 8 |
| ERIC | 2 and 5a | 0 | 0 |
| ERIC | 2 and 5b | 0 | 0 |
| ERIC | 2 and 5c | 0 | 0 |
| ERIC | 2 and 5d | 0 | 0 |
| ERIC | 2 and 5 | 0 | 29 |
| ERIC | 2a and 5 | 0 | 1 |
| ERIC | 6 and 5c | 3 | 17 |
| ERIC | 6a and 5c | 0 | 1 |

Table 2: Peer-reviewed articles

| # | Author (year) | Citation | Summary |
|---|---|---|---|
| 1 | Alexis, O. (2015) | Internationally recruited nurses' experiences in England: A survey approach. *Nursing Outlook, 63*(3), 238-244. http://dx.doi.org/10.1016/j.outlook.2014.10.005 | Determined internationally registered nurses' perception of discrimination, support, and their adjustment to a new environment in the NHS in England. Quantitative: 188 internationally recruited nurses answered a questionnaire across 15 National Health Service hospitals in England. Generally, internationally recruited nurses from Africa perceived discrimination to be evident in the workplace and the support they received was limited. |
| 2 | Alexis, O., & Vydelingum, V. (2004) | The lived experiences of overseas black and minority ethnic nurses in the NHS in the south of England. *Diversity in Health and Social Care, 1*(1), 13–20. | Phenomenological study examined the lived experiences of 12 nurses who originated from the Philippines, South Africa, the Caribbean and sub-Saharan Africa and who had recently been recruited to work in the NHS in the south of England. Data revealed eight themes: differences in nursing practice, adjustment to a new environment, differences in communication, absence of support, discrimination, lack of equal opportunity, bullying and separateness. Overall the findings showed that the nurses were marginalised and felt excluded. |
| 3 | Alexis, O., & Vydelingum, V. (2005) | The experiences of overseas black and minority ethnic registered nurses in an English hospital. *Journal of Research in Nursing, 10*(4), 459-472. | Explored the experiences of overseas BME nurses working in the NHS in the south of England. Qualitative: Phenomenological method, semi-structured interviews. Eight themes were revealed: feeling underappreciated, feeling inadequate, feeling unwelcome, lack of opportunities for skill development and training, unfairness in nursing practice, performance review, support from overseas black and minority ethnic colleagues and proving self. |
| 4 | Alexis, O., Vydelingum, V., & Robbins, I. (2007) | Engaging with a new reality: Experiences of overseas minority ethnic nurses in the NHS. *Journal of Clinical Nursing, 16*, 2221-2228. | Examined the experiences of overseas BME nurses in the NHS in the south of England. Qualitative phenomenological study using focus groups. Mixed response: negative and positive. Negative response included reports of abuse, discrimination and inequality. |

| | | | |
|---|---|---|---|
| 5 | Allan, H. (2010) | Mentoring overseas nurses: Barriers to effective and non-discriminatory mentoring practices. *Nursing Ethics, 17*(5), 603-613. doi: 10.1177/0969733010368747 | Investigated barriers to effective and non-discriminatory practice when mentoring overseas nurses within the NHS and the care home sector. Qualitative: Interviews with nurses from overseas backgrounds. Data suggested that overseas nurses experience discrimination through poor mentoring practices that has a negative effect on their learning. |
| 6 | Allan H., Cowie, H., & Smith, P. (2009) | Overseas nurses' experiences of discrimination: A case of racist bullying? *Journal of Nursing Management, 17*, 898-906. | Investigation of racist bullying and discriminatory practices operating in the workplace. Qualitative: semi-structured, audio-recorded interviews and thematically re-analysed. The national study suggested that racism is entrenched in health workplaces. |
| 7 | Allan, H, Larsen, J. A., Bryan, K., & Smith, P. A. (2003) | The social reproduction of institutional racism: Internationally recruited nurses' experiences of the British health services. *Diversity in Health and Social Care, 1*, 117–125. | Paper contributes to understanding how immigrant workers from Black and other minority ethnic backgrounds experience working in British health services and provide empirically grounded accounts of individual and institutional racism. Qualitative study: 11 focus groups involving a total of 67 internationally recruited nurses. Participants described discrimination and racism as central to their experiences as IRNs working in the UK. This study demonstrates the ways in which racism and institutional racism work in healthcare practice from the perspective of IRNs and how they cope with these negative experiences. |
| 8 | Archibong, U., Baxter, C. E., Darr, A., Walton, S., & Jogi, M. (2013) | Disciplinary and fitness-to-practice data, policies, and practices in the NHS trusts and health professional bodies in the UK. *Journal of Psychological Issues in Organizational Culture, 4*(3), 6-25. doi: 10.1002/jpoc021117 | Assessed the extent of involvement of BME staff in disciplinary procedures within the NHS. Quantitative and qualitative methods used. (1) Web audit (2) examination of disciplinary policies (3) exploration of the experiences of BME staff (4) a comparative literature review. Findings suggested a custom and practice culture exists within the NHS that was seen as perpetuating unwritten workplace norms and was instrumental in reproducing inequalities. |
| 9 | Campbell, J. L., Roberts, M., Wright, C., Hill, J., Greco, M., Taylor, M., & Richards, S. (2011) | Factors associated with variability in the assessment of UK doctors' professionalism: analysis of survey results. *British Medical Journal, 343*:d6212. doi: 10.1136/bmj.d6212 | Investigated potential sources of systematic bias arising in the assessment of doctors' professionalism. Quantitative: questionnaire survey data. The doctor's age, sex, and ethnic group were not independent predictors of patient or colleague feedback. |

| | | | |
|---|---|---|---|
| 10 | Carter, J. (2000) | New public management and equal opportunities in NHS. *Critical Social Policy, 20,* 61-83. | There is a tension between the discourse of new public management and the discourse of equality of opportunity within the NHS. The confinement of ethnic minority nursing staff to the least desirable specialities and grades has largely been unaltered by the introduction of equality policies and in fact has led to increased feelings of scepticism on their part. Of particular significance is the over-representation of ethnic minority nursing staff in disciplinary procedures which reinforces ethnocentric assumptions about minorities among mainly white managers within the NHS. |
| 11 | Chamberlain, J. M. (2011) | The hearing of fitness to practice cases by the General Medical Council: Current trends and future research agendas. *Health, Risk & Society, 13*(6), 561/575. doi: 10.1080/13698575.2011.613984 | Described quantitative data pertaining to the GMC's management of the process by which fitness to practice complaints against doctors are dealt with from initial receipt through to subsequent investigative and adjudication stages. Statistical analysis of trends in complaint data in relation to a doctor's gender, race and ethnicity. The data show that there has been an increase in rehabilitative and/or punitive action against doctors. |
| 12 | Daniel, P., Chamberlain, A., & Gordon, F. (2001) | Expectations and experiences of newly recruited Filipino nurses. *British Journal of Nursing, 10*(4), 258–265. | Sought to identify initial expectations and experiences of newly migrated Filipino nurses at a London hospital. Focus group interviews were conducted with two groups of nurses shortly after their arrival. Differences emerged between the nurses' expectations of the nursing role and their actual experience on the wards. Adjusting to the new system of health care proved stressful but was helped by the provision of support services. Factors that may promote successful adaptation and retention included equal opportunities with respect to training and promotion and the use of culturally sensitive orientation programmes. |
| 13 | Henry, L. (2007) | Institutionalized disadvantage: Older Ghanaian nurses' and midwives' reflections on career progression and stagnation in the NHS. *Journal of Clinical Nursing, 16*(12), 2196-203. doi: 10.1111/j.1365-2702.2007.02094.x | Explored the perceptions of career progression in the NHS of a group of midwives and nurses trained in Ghana and working in the UK. Qualitative: semi-structured interviews with nurses, midwives and managers. Ghanaian nurses and midwives experience difficulty in progressing into senior positions because of cultural differences and gaps in knowledge. These problems can become institutionalised and entrenched by practices on the ward. |

| | | | |
|---|---|---|---|
| 14 | Humphrey, C., Hickman, S., & Gulliford, M. (2011) | Place of medical qualification and outcome of UK General Medical Council "fitness to practice" process: Cohort study. *British Medical Journal,* 340:d1817. doi:10.1136/bmj.d1817 | Assessed whether country of qualification is associated with "higher impact" decisions at different stages of the GMC's "fitness to practise" process. Retrospective cohort study. Inquiries to the GMC concerning doctors qualified outside the UK are more likely to be associated with higher impact decisions at each stage of the fitness to practice process. |
| 15 | Khaliq, A. A., Dimassi, H., Huang, C-Y., Narine, L., & Smego, R. A. (2005) | Disciplinary action against physicians: Who is likely to get disciplined? *The American Journal of Medicine, 118,* 773-777. doi:10.1016/j.amjmed.2005.01.051 | Sought to determine the characteristics of disciplined physicians at-large and the risk of disciplinary action over time; and to report the type and frequency of complaints and the nature of disciplinary actions against allopathic physicians in Oklahoma. Quantitative analysis of publicly available data on physicians licensed by the Oklahoma Board of Medical Licensure and Supervision. Men, non-Whites, non-board-certified physicians, and those in family medicine, psychiatry, general practice, obstetrics-gynaecology and emergency medicine were found to be at greater risk of being disciplined than other medical specialty groups. |
| 16 | Larsen, J. (2007) | Embodiment of discrimination and overseas nurses' career progression. *Journal of Clinical Nursing, 16*, 2187-2195. | Examined how discriminatory attitudes and practices are experienced by overseas nurses and how the discrimination may affect their career progression and well-being. Qualitative: Phenomenological in-depth analysis of one-to-one interviews. Overseas nurses claim that their UK colleagues, managers and patients express discriminatory, racist and xenophobic attitudes. |
| 17 | Likupe, G. (2006) | Experiences of African nurses in the UK National Health Service: A literature review. *Issues in Clinical Nursing, 15,* 1213–1220. doi: 10.1111/j.1365-2702.2006.01380.x | Aimed to highlight the experiences of black African nurses in the UK. Literature search revealed most foreign nurses have a negative experience of working in the UK. Nurses face discrimination in pay and conditions of service and most are exploited by managers. |
| 18 | Locke, R., Scallan, S., Leach, C., & Rickenbach, M. (2013) | Identifying poor performance among doctors in NHS organizations. *Journal of Evaluation in Clinical Practice*, 19, 882–888. doi:10.1111/j.1365-2753.2012.01868.x | Aimed to account for the means by which poor performance among career doctors is identified by the NHS and the requirement for doctors to demonstrate their fitness to practice. Literature review and qualitative interviews. Tools are, in the main, reactive – with an individual focus. There is more work to be done in evaluating current tools and developing stronger processes. |
| 19 | Magnusdottir, H. | Overcoming strangeness and communication barriers: | Aimed to generate an understanding of the "lived experience" of |

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| | (2005) | A phenomenological study of becoming a foreign nurse. *International Nursing Review, 52*, 263–269. | foreign nurses working in Iceland. Qualitative study: interviews with 11 registered nurses from 7 countries. The findings and their international context suggest the importance of language for personal and professional well-being and how language and culture are inseparable entities. |
| 20 | Mapedzahama, V., Rudge, T., West, S., & Perron, A. (2012) | Black nurse in white space? Rethinking the in/visibility of race within the Australian nursing workplace. *Nursing Inquiry, 19*(2), 153–164. doi: 10.1111/j.1440-1800.2011.00556.x | Analysed data from a critical qualitative study with 14 skilled black African migrant nurses, which document their experiences of nurse-to-nurse racism and racial prejudice in Australian nursing workplaces. Brings to the fore silenced discussions of nurse-to-nurse racism in Australia and exposes the subtle, mundane nature of contemporary racism. |
| 21 | Matiti, M. R., & Taylor, D. (2005) | The cultural lived experience of internationally recruited nurses: A phenomenological study. *Diversity in Health & Social Care*, *2*(1), 7-15. | Investigated the cultural experiences of internationally recruited nurses in the UK within the Trent region. Qualitative: semi-structured interviews, a phenomenological approach. The data suggested that the IRNs felt deskilled and devalued. |
| 22 | Phipps, D. L., Noyce, P. R., Walshe, K., Parker, D., & Ashcroft, D. M. (2011) | Pharmacists subjected to disciplinary action: Characteristics and risk factors. *International Journal of Pharmacy Practice*, 19, 367–373. doi: 10.1111/j.2042-7174.2011.00119.x | Explored whether there are any characteristics of pharmacists that predict their likelihood of being subjected to disciplinary action. 11 pharmacists, referred to the Disciplinary Committee, were matched with a quota sample of 580 pharmacists who had not been subjected to disciplinary action but that matched the disciplined pharmacists on a set of demographic factors (gender, country of residence, year of registration). Frequency analysis and regression analysis were used to compare the two groups of pharmacists in terms of sector of work, ethnicity, age and country of training. Only one characteristic – working in a community pharmacy – was statistically significant. This study provides initial evidence of pharmacist characteristics that are associated with an increased risk of being disciplined, based upon the data currently available. |
| 23 | Schafheutle, E. I., | Factors influencing pharmacist performance: A review | Explored factors affecting pharmacists' performance. The review |

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| | Seson, E. M., & Hassell, K. (2011) | of the peer-reviewed literature. *Health Policy, 102*, 178-19. doi: 10.1016/j.healthpol.2011.06.004 | found that there was some evidence to suggest that pharmacists with certain characteristics (e.g. being male, being of ethnic minority origin, working in community pharmacy and having trained overseas) were more likely to experience performance problems. |
| 24 | Seston, E. M., Fegan, T., Pharm. M., Hassell, K., & Schafheutle, E. I. (2015) | Black and minority ethnic pharmacists' treatment in the UK: A systematic review. *Research in Social and Administrative Pharmacy, 11*, 749–768. http://dx.doi.org/10.1016/j.sapharm.2014.12.006 | Identified published evidence on the disproportionate treatment in employment and regulatory practices of BME pharmacists in the UK. Only a small number of studies have been published in this area, and the evidence of disproportionate treatment of BME pharmacists is equivocal. |
| 25 | Shields, M., & Wheatley Price, S. (2002) | Racial harassment, job satisfaction and intentions to quit: Evidence from the British nursing profession. *Economica*, *69*, 295-326. | Investigated the determinants of perceived racial harassment at the workplace, and its impact on job satisfaction and quitting behaviour among ethnic minority nurses, using data from a unique large-scale survey of British NHS nurses. Nearly 40% of ethnic minority nurses report experiencing racial harassment from work colleagues, while more than 64% report suffering racial harassment from patients. Such racial harassment is found to lead to a significant reduction in job satisfaction, which, in turn, increases nurses' intentions to quit their job. |
| 26 | Singh, P. Mizrahi, E., & Korb, S. (2009) | A five-year review of cases appearing before the General Dental Council's Professional Conduct Committee. *British Dental Journal, 206*, 217-223. | Reviewed 209 cases brought before the Professional Conduct Committee of the GDC over a five-year period regarding the conduct of members of the dental profession: factors such as ethnicity/gender are assessed. Provides information on the geographic distribution of registrants as well as their country of origin and year of qualification. 58.9% graduated in the UK and the rest graduated in 15 overseas countries. |
| 27 | Slowther. A., Lewando Hund, G. A., Purkis, J., & Taylor, R. (2012) | Experiences of non-UK-qualified doctors working within the UK regulatory framework: A qualitative study. *Journal of the Royal Society of Medicine, 105*, 157–165. doi. 10.1258/jrsm.2011.110256 | Assessed the experiences of non-UK-qualified doctors working within the UK regulatory framework. Qualitative Study: interviews and focus groups. Non-UK-qualified doctors experience a number of difficulties related to practising within a different ethical and professional regulatory framework. |
| 28 | Tavallali, A. G., Kabir, | Ethnic Swedish parents' experiences of minority ethnic | Explored how parents with ethnic Swedish backgrounds experience |

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| | Z. N., & Jirwe, M. (2014) | nurses' cultural competence in Swedish paediatric care. *Scandinavian Journal of Caring Science, 28*, 255–263. doi: 10.1111/scs.12051 | minority ethnic nurses' cultural competence and the care the nurses provide in a Swedish paediatric care context. Qualitative study 14 semi-structured interviews to identify parents' perceptions and experiences of minority ethnic nurses' cultural competence. Nurses' ethnicity did not have much impact on parents' satisfaction with their child's care. The parents attached importance to nurses' language skills and to their adaptation and awareness of Swedish culture. They also attached weight to nurses' professional knowledge and personal attributes. The role of nursing education to increase nurses' cultural awareness was highlighted. |
| 29 | Taylor, B. (2005) | The experiences of overseas nurses working in the NHS: Results of a qualitative study. *Diversity in Health and Social Care 2*(1), 17-27. | Examined the experiences of nurses who have trained overseas and travelled to work in the NHS. Exploratory qualitative study. Findings showed that the nurses recruited from overseas experienced loss of status and became de-skilled. |
| 30 | Tiffin, P. A., Illing, J., Webster, L., & McLachlan, J. C. (2013) | The validity of the professional and linguistic assessments board (PLAB) exam: Research report. *A report for the General Medical Council*. Durham, UK: Centre for Medical Education Research. | Study aimed t*o evaluate to what extent the knowledge and skills of PLAB International Medical Graduates (IMGs) could be considered equivalent to those doctors who had completed their Foundation Year 1 of their training in the UK and whether the likelihoods of referral or censure in relation to fitness to practice were equivalent between PLAB IMGs and FY1s.* Even after controlling for the effects of the available potential confounding factors, PLAB IMGs who passed the PLAB system demonstrate, on average, poorer performance on ARCP compared to UK graduates. Raising the pass mark for the IELTS or PLAB may reduce the magnitude of this difference but is unlikely to eradicate it completely. In addition, changing the structure or scoring for PLAB may have some effect on fitness to practise referral rates for PLAB IMGs though is much less likely to impact on the proportions receiving censure from the GMC. |

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| 31 | Tolbert Coombs, A. A., & King, R. K. (2005) | Workplace discrimination: Experiences of practicing physicians. *Journal of the National Medical Association, 97*(4), 467-477. | Study aimed to: (1) describe the types of discrimination that exist for the practising physician and (2) determine which groups of physicians are more likely to experience the various forms of discrimination. Surveys were mailed to 1930 practising physicians in Massachusetts asking if they had encountered discrimination, how significant the discrimination was against a specific group, frequency of personal discrimination, and the type of discrimination. Physicians practising in academic, research, and private practice sectors experience discrimination based on gender, ethnic/racial, and IMG status. |
| 32 | Tuttas, C. (2015) | Perceived racial and ethnic prejudice and discrimination experiences of minority migrant nurses: A literature review. *Journal of Transcultural Nursing, 26*(5) 514-520. doi: 10.1177/1043659614526757 | Explored the state of knowledge related to minority migrant nurses' (MMNs) experiences of perceived prejudice and discrimination in health care work settings including (a) the extent to which MMNs experience perceived racial and ethnic prejudice and discrimination, (b) the types of perceived prejudice and discrimination identified among MMNs, and (c) theory-based implications of perceived prejudice and discrimination among MMNs. The literature suggests that perceptions of discrimination can be mitigated when the host country invests in measures to facilitate social networks and support for migrant nurses. |
| 33 | Tullett, J., Rutter, P., & Brown, D. (2003) | A longitudinal study of United Kingdom pharmacists' misdemeanours trials, tribulations and trends. *Pharmacy World and Science, 25,* 43-51. | Longitudinal study to define trends and identify areas where remedial or preventative support could be focused. Case analysis of reports of individuals' misdemeanours published in the British Pharmaceutical Journal over a 12-year period (Sept '88-Oct 2000). 344 cases, involving a wide range of personal (162) and professional (590) misdemeanours were found. The most common professional misdemeanour was failure to keep adequate written records. The most common personal misdemeanour was fraud. The most common reason cited for committing any misdemeanour was financial gain. The odds of involvement ratio for ethnic minority versus Caucasian pharmacists was 3.8 (CI: 3.06-4.72). The nature of misdemeanours changed little over the period of the study; indicating the spectrum of misdemeanours likely to be |

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| | | | encountered by a regulating board in the immediate to medium-term future. |
| 34 | Winklemann-Gleed, A., & Seeley, J. (2005) | Strangers in a British world? Integration of international nurses. *British Journal of Nursing, 14*(17), 899-906. doi: 10.12968/bjon.2005.14.18.19880 | Investigated the prejudice/discrimination and experience of foreign nurses working in London. Mixed-methods: survey, semi-structured interviews. Work-related identities among international migrants are complex; a group of employees which poses a challenge to management. |
| 35 | Withers, J., & Snowball, J. (2003) | Adapting to a new culture: A study of the expectations and experiences of Filipino nurses in the Oxford Radcliffe Hospitals NHS trust. *Nursing Times Research, 8*(4), 278-290. | Explored the match between expectations and experiences of nurses from the Philippines. Mixed methods: 45 questionnaires and 8 interviews. Many of their experiences were good but some participants experienced perceived racial discrimination from patients and colleagues. |
| 36 | Xu, Y., Gutierrez, A., & Kim, S. H. (2008) | Adaptation and transformation through (un)learning. Lived experiences of immigrant Chinese nurses in US healthcare environment. *Advances in Nursing Science, 31*(2), E33–E47 | Qualitative study examined the lived experiences of Chinese nurses working in the US. In-depth interviews with 9 self-identified Chinese nurses. Five primary themes emerged: (a) communication as the most daunting challenge; (b) different and even conflicting professional values and roles/expectations of the nurse between the US and China; (c) marginalization, inequality, and discrimination; (d) transformation through clinging to hope, (un)learning, and resilience; and (e) cultural dissonance. |

## Table 3: Non-Peer Reviewed Literature

| # | Author (year) | Citation | Summary |
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| 1 | Allan, H., & Larsen, J. A. (2003) | *"We need respect": Experiences of internationally recruited nurses in the UK*. London, UK: Royal College of Nursing. | Study explored the motivations and experiences of IRNs in order to understand what experiences they undergo. Sixty-seven IRNs participated in 11 focus groups run on three sites: Leeds, Cardiff and London. IRNs had frequent experiences of discrimination. In some cases this appeared as crude racism and, in other cases, white IRNs explained how they, also, felt discriminated against because they were foreign. |
| 2 | Allen, I. (2000) | *The handling of complaints by the GMC: A study of decision making and outcomes*. London, UK: Policy Studies Institute. | Report found no evidence of discrimination or racial bias in the handling of complaints against doctors by the GMC. However, there are still questions about the extent to which the disciplinary procedures of the GMC are consistent, transparent and fair to all doctors and all patients. Report is based on a two-year wide-ranging investigation and notes the many changes and improvements in process made by the GMC since earlier research by PSI published in 1996. Main recommendations highlight the need for a commonly understood working definition of 'serious professional misconduct'; efficiency and speed in dealing with complaints which pose a risk to the public; clear protocols defining the types of cases which come within the jurisdiction of the GMC; a formal record of the reasons for all decisions; racial awareness training for all staff and committee members; discussions with public bodies on the reasons why they are relatively more likely to complain to the GMC about overseas qualified doctors. |
| 3 | Archer, J., de Bere, S. R., Bryce, M., Nunn, S., Lynn, N., Coombes, L., & Roberts, M. (2014) | *Understanding the rise of fitness to practise complaints from members of the public*. London, UK: Camera with Plymouth University. | Analysis to support the GMC's efforts to manage fitness to practise complaints, both in terms of its own decision-making processes and communication activities, and with regard to its interactions with other key stakeholders. Mixed-methods: quantitative and qualitative methodologies. Analysis of the GMC's statistical data established that the rise in complaints from members of the public has been largely consistent at regional and national levels throughout the UK, suggesting that the increase has been driven by wider social trends rather than localised factors. |
| 4 | Archibong, U., & Darr, | *The involvement of Black and Minority Ethnic* | Study was undertaken between June 2008 and November 2009 to |

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| | A. (2010) | *Staff in NHS disciplinary proceedings*. University of Bradford. ISBN 99781851432646. | assess the extent of involvement of BME staff in disciplinary procedures within the NHS and to identify good management practice in this area. Involved 4 phases: 1) web audit of 398 NHS trusts to compare the disciplinary rates of BME staff with their white counterparts; 2) examined disciplinary policies and practices of NHS trusts through workshops with 11 human resources managers and 9 representatives of health professions regulatory bodies; 3) analysed the experiences and views of 91 staff at five BME staff network events and related forums; 4) literature review to compare the experience of BME staff involvement in disciplinaries within the NHS with those working in other public sector organisations. The extent of BME staff involvement within NHS disciplinaries resonates with their experience in other public sector organisations, most notably within the police service and local government. Reasons for the disproportional representation of BME staff in these sectors appear to be similar to those identified in the NHS and relate to a tendency amongst managers to formalise the disciplinary process too quickly, the presence of discriminatory attitudes, lack of clarity concerning disciplinary policies and a failure to train staff appropriately. |
| 5 | Bridges, S., Ahmed, H., Fuller, E., & Wardle, H. (2014) | *Fairness and the GMC: Doctors' views.* London, UK: NatCen Social Research. | Explored doctors' view of GMC. Employed focus groups and a large-scale survey. Responses were analysed to determine if views differed depending on ethnicity.<br>Levels of overall confidence in the GMC varied by ethnicity and place of qualification. BME doctors had greater confidence in the GMC than White doctors and non-UK qualified doctors had greater confidence than UK qualified doctors. The majority of BME doctors and non-UK qualified doctors thought some groups of doctors may be more likely than others to be treated unfairly in these processes. Where doctors felt that some groups may be at risk of receiving unfair treatment, three groups were most commonly identified: non-UK qualified, BME and older doctors. |
| 6 | Buchan J. (2003) | *Here to Stay? International Nurses in the United Kingdom*. London, UK: Royal College of Nursing. | The Royal College of Nursing commissioned this report into the employment policy and practice implications of the rapid growth in the |

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| | | http://www.rcn.org.uk/publications/pdf/heretostay-irns.pdf. Accessed August 4, 2007 | number of internationally recruited nurses (IRNs) working in the UK. Five NHS and five private sector case studies were conducted. These found that IRNs made up between 4-65% of the total qualified nursing workforce in the ten organisations. All actively recruited IRNs in the case study organisations worked full time. The highest employment levels of international nurses were in the independent sector. Managers in all the case studies reported that the main challenges they faced when employing IRNs were language, differences in clinical and technical skills, racism in the workplace, and the reaction of patients. |
| 7 | de Bere, S. R., Bryce, M., Archer, J., Lynn, N., Nunn, S., & Roberts, M. (2014) | *Review of the decision-making in the General Medical Council's fitness to practise procedures.* London, UK: Camera with Plymouth University. | Presents findings from an in-depth qualitative review of GMC decision-making within the fitness to practise procedures which aimed to identify instances of bias or discriminatory practice, and more generally to assess the quality of GMC decisions and decision-making processes. The review raised several issues as having relevance for the disproportionate representation of BME doctors in the fitness to practise procedures. Factors are divided into two categories: those about the doctor, their work role/work place; and those which were about the decision-making processes within the fitness to practise system. |
| 8 | de Vries, H., Sanderson, P., Janta, B., Rabinovich, L., Archontakis, F., Ismail, S., Klauter, L., Marjanovic, S., Patruni, B., Puri, S., & Tiessen, J. (2009) | *International comparison of ten medical regulatory systems: Egypt, Germany, Greece, India, Italy, Nigeria, Pakistan, Poland, South Africa and Spain.* Santa Monica, CA: RAND Corporation. | GMC commissioned research to investigate the similarities and differences of the systems of medical regulation in place in a number of countries where many doctors working in the UK obtained their primary medical qualification. Desk-based internet research complimented by key informant interviews. Recommended assistance to non UK-qualified medical graduates be provided to help them adapt to and understand the UK patient-centred approach to medical practice. |
| 9 | General Medical Council. (2015) | Complaints about doctors. In *The state of medical education and practice in the UK 2015* (pp. 58-83). London, UK: Author. Retrieved | Book chapter. Sets out the types of complaint received by the GMC and how these complaints are resolved. Over the five years from 2010–14, complaints about doctors to the GMC increased by 54%. However, |

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| | | from http://www.gmc-uk.org/SOMEP_2015.pdf_63501874.pdf | there has been a slowdown from 2012–13, which continued in 2014. It is not possible to tell whether this is the end of a rapid increase in complaints or if the five-year trend of increasing complaints will continue in the long term. |
| 10 | General Optical Council. (2015) | *Equality and diversity monitoring report.* Retrieved from https://webcache.googleusercontent.com/search?q=cache:hh6-Lfq-BQYJ:https://www.optical.org/download.cfm%3Fdocid%3DFAF0E2BB-AB1A-4081-BC7DEB0FBCD0E686+&cd=2&hl=en&ct=clnk&gl=uk | Provides information on equality, diversity and inclusion at the GOC, employee profile, council and committee member profile, member recruitment, registrants and registrants subject to a fitness to practise complaint. |
| 11 | General Osteopathic Council. (2016) | *Fitness to practise report 2014-15.* London, UK. Retrieved from http://www.osteopathy.org.uk/news-and-resources/document-library/fitness-to-practise/fitness-to-practise-annual-report-2014-15/ | Provides information on the GOCs fitness to practise process and enquiries for 2014-15. |
| 12 | Humphrey, C. et al., (2009) | *Clarifying the factors associated with progression of cases in the GMC's fitness to practise procedures*. Full research report, ESRC End of Award Report, RES-153-25-0101. Swindon, UK: ESCR. | To test the hypothesis that doctors qualified outside the UK and/or doctors from (BME) backgrounds are more likely to receive 'high impact' decisions at various stages in the fitness to practise process; and to evaluate the alternative hypothesis that 'high impact' decisions are associated with other demographic or professional factors or characteristics of the complaints received that are independently associated with place of qualification or ethnic status. Secondary analysis of anonymised data from 7526 enquiries/complaints about individual doctors received by the GMC between 1.4.06-31.3.08. Findings support the hypothesis that doctors qualified outside the UK are more likely to receive 'high impact' decisions at various stages in the fitness to practise process. |
| 13 | IFF Research. (2015) | *GMC Perceptions Study: NatCen comparisons and further analysis.* Retrieved from http://www.gmc-uk.org/NatCen_comparisons_and_further_analys | The IFF survey replicates some questions from the 2013 NatCen survey which focused on fairness of the GMC and its processes. Confidence in the GMC's regulation varied across both surveys by ethnicity and |

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| | | is_GMC_IFF_Confidential_V03.00.pdf_60396286.pdf | gender. BME doctors exhibiting more confidence than white doctors; 78% of BME doctors were confident in GMC's regulation (compared to 72% of white doctors), with over a quarter stating that they were very confident (26% vs. 16% of white doctors). This mirrors the pattern seen in the NatCen report, albeit with a lower proportion of both BME and white doctors citing confidence in the IFF survey (78% of white doctors in the NatCen report had confidence vs. 87% of BME doctors) |
| 14 | National Clinical Assessment Service. (2011) | *Concerns about professional practice and associations with age, gender, place of qualification and ethnicity – 2009/10 data*. London, UK: NHS. | The main concern for NCAS is to test that its processes are not discriminating between practitioners from different ethnic backgrounds. Paper largely deals with monitoring of ethnicity, updating earlier published statistics with data for 2009/10. Place of qualification analyses distinguishes practitioners from other parts of the European Economic Area from other practitioners qualifying outside the UK. The report shows statistics for doctors and dentists but not pharmacists. Non-White doctors qualifying outside the UK are more likely to be referred, but higher rates of referral are not found amongst UK qualified non-White doctors, taking all grades together. |
| 15 | Naqvi, H., Razaq, S. A., & Piper, J. (2016) | *NHS workforce race equality standard 2015 data analysis report for NHS trusts.* Publication Gateway Reference Number: 05062. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2014/10/WRES-Data-Analysis-Report.pdf | Less favourable treatment of BME staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients. That is exactly why the NHS Workforce Race Equality Standard (WRES) was introduced in 2015. Report presented the 2015 WRES baseline data for the four WRES Indicators that align to the NHS Staff Survey. It presents analyses against the four indicators by NHS trust type. The report is intended to prompt discussion and inquiry within each organisation and encourage good practice. Hence the primary aim of the report is not to make explicit comparisons between organisations with regard to performance. Following the return of the 2016 WRES data, inter and intra-organisational comparisons and benchmarking will be undertaken and reported. |
| 16 | Slowther. A., Lewando Hund, G., Taylor, R., & Purkis, J. (2009) | Non UK qualified doctors and good medical practice: The experience of working within a different professional framework. Retrieved from | GMC commissioned research exploring the experiences of International Medical Graduates, including graduates from the European Economic Area, in adjusting to working within the GMC's professional and ethical |

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| | | http://www.gmc-1uk.org/Executive_Summary_2_09_AS.pdf_25402925.pdf | regulatory framework. Mixed-methods; survey and interviews with doctors, interviews with individuals involved in training and support for non-UK qualified doctors and desk-based internet research. Number of difficulties identified as experienced by Non UK qualified doctors in their transition to practice within the UK ethical and professional regulatory framework. |
| 17 | Smith, P., Allan, H., Henry, L., Larsen, J., & Mackintosh, M. (2006) | Valuing and recognising the talents of a diverse healthcare workforce. Report from the REOH Study: Researching equal opportunities for overseas-trained nurses and other healthcare professionals. Guildford. Retrieved from http://www.covwarkpt.nhs.uk/aboutus/equality-and-diversity/Documents/Valuing%20and%20Recognising%20Talents.pdf | Collated and summarised data from surveys on internationally recruited and BME nurses. Secondary analysis of survey data. Comparative results of two previous surveys reveals some statistics around pay and grading; working hours, professional development, careers in an equal opportunity context, professional development, ethnicity and working well, and ethnicity and feeling valued. |
| 18 | Solicitors Regulation Authority. (2008) | Independent review into disproportionate regulatory outcomes for Black and minority ethnic solicitors. Retrieved from https://www.sra.org.uk/ouseley/ | Report considers how BME solicitors are treated by the Solicitors' Regulation Authority (SRA). Follows an extensive independent review of the work of the SRA, its approaches to equality and diversity in the profession, in its workforce, as a regulatory body, in all its activities and its responses to BME solicitors' complaints and concerns about differential treatment and disproportionality. In spite of launching a number of initiatives, the SRA acknowledges that progress has been lacking in a number of areas. Report identifies a number of areas of disproportionality affecting BME solicitors who are more subject to forensic investigations than white solicitors and, as a consequence, are disadvantaged considerably through the non-disclosure of information about allegations made about them. |
| 19 | Solicitors Regulation Authority. (2010) | *Commissioned research into issues of disproportionality.* Retrieved from http://www.sra.org.uk/sra/equality- | Commissioned report into the disproportionality of regulatory actions taken against BME solicitors. Factors associated with solicitors having a case raised against them are whether the solicitor was a trainee at the |

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| | | diversity/reports/research-disproportionality.page | time the case was raised; a shorter number of years practising, and over time having a large number of practising certificates. Findings suggest that solicitors are more likely to have cases raised against them at the start of their career and after they have been practising for a long period of time. BME solicitors have a disproportionate number of cases raised against them from external sources for Initial assessments, Conduct cases raised by the LCS, and Regulatory cases. |
| 20 | The Royal College of Midwives. (2012) | *Freedom of information request: Midwives and Disciplinary Proceedings in London*. London, UK: The Royal College of Midwives. Retrieved from http://www,byrsubgtunes,bet.Hiyrbaks.2012/11/12/i/d/l/RCM-report.pdf | The FOI Request showed a disproportionate number of black/black British midwives were subjected to disciplinary hearings and a disproportionate number were subjected to a more punitive outcome from the disciplinary proceedings. Key findings were: 60.2% of the midwives who were subject to disciplinary proceedings were black/black British however only 32.0% of midwives in London were black/black British. Ten midwives were dismissed during the time period; every midwife who was dismissed was black/black British; 15.4% of the black/black British midwives who were subject to disciplinary during the time period were dismissed. However, the numbers from the FOI request only show one side of the story and it is likely that the causes for the numbers are complex. |
| 21 | The Royal College of Midwives. (2016) | *BME midwives, disciplinary proceedings and the workplace race equality standard.* Equality and Diversity Publication. Retrieved from https://www.rcm.org.uk/sites/default/files/Equality%20and%20Diversity%20Publication%20-%20BME%20Midwives%20and%20Race%20Equality%20Standard%20A5%2028pp_Spread.pdf | Compares findings for 2012-15 FOI with the original information from 2011. Follow-up report reveals significant issues with BME midwives and disciplinary proceedings in the NHS. Key findings included: Over the five years BME midwives are disproportionately more likely to face disciplinary proceedings; a higher proportion of BME midwives have been suspended while facing disciplinary proceedings; there was no trend or overall difference in the comparison of BME midwives to white midwives who had no further action taken, received a first written warning or received a final written warning as an outcome of their disciplinary proceedings; a higher proportion of BME midwives have been dismissed during disciplinary proceedings. |
| 22 | Tiffin, P. A., Illing, J., Webster, L., & McLachlan, J. C. (2013) | The validity of the professional and linguistic assessments board (PLAB) exam: Research report. *A report for the General Medical Council*. | To ensure that the PLAB test continues to be an objective, fair, non-discriminatory and fit for purpose method of assessing the knowledge and skills of International Medical Graduates (IMGs) applying for |

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| | | Durham, UK: Centre for Medical Education Research. | registration with the GMC. Evidence suggests that the knowledge and skills of IMGs who had passed the PLAB test were not equivalent to those of UK graduates. PLAB IMGs were more likely than UK graduates to have a fitness to practice complaint made about them and for that complaint to result in action by the GMC. |

Table 4: Excluded articles

| # | Author (year) | Citation | Reason for Exclusion |
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| 1 | Xue, Y. (2015) | Racial and ethnic minority nurses' job satisfaction in the U.S. *International Journal of Nursing Studies, 52,* 280-287. http://dx.doi.org/10.1016/j.ijnurstu.2014.10.007 | No discussion of fitness to practise issues; too far removed from context of current study. |
| 2 | Woolf, K., Cave, J., Greenhalgh, T., & Dacre, J. (2008) | Ethnic stereotypes and the underachievement of UK medical students from ethnic minorities: Qualitative study. *BMJ, 337*:a1220 | Focus on students, not pertinent to the group being investigated in current study. |
| 3 | Wilkins, C., & Lall, R. (2011) | 'You've got to be tough and I'm trying': Black and minority ethnic student teachers' experiences of initial teacher education. *Race Ethnicity and Education, 14*(3), 365-386. doi: 10.1080/13613324.2010.543390 | Focus on education, not pertinent to the group being investigated in current study. |
| 4 | Sabri, B., St. Vil, N. M., Campbell, J. C., Fitzgerald, S., Kub, J., & Agnew, J. (2015) | Racial and ethnic differences in factors related to work place violence victimization. *Western Journal of Nursing Research*, *37*(2), 180-196. doi:10.1177/0193945914527177 | No discussion of fitness to practise issues; too far removed from context of current study. |
| 5 | Roberts, M. J., Campbell, J. L., Richards, S. H., & Wright, C. (2013) | Self-other agreement in multisource feedback: The influence of doctor and rater group characteristics. *Journal of Continuing Education in the Health Professions, 33*(1), 14-23. | No discussion of fitness to practise issues; too far removed from context of current study. |
| 6 | Pope, M. F. (2010) | *Faculty bullying: An exploration of leadership strategies to reduce relational violence in nursing schools*. Dissertation Presented in Partial Fulfilment of the Requirements for the Degree<br>Doctor of Educational Leadership<br>University OF Phoenix. | Focus on the education setting, not the health setting; not pertinent to the group or context being investigated in current study. |
| 7 | Leyerzapf, H., Abma, T. A., | Standing out and moving up: performance | Study conducted in Netherlands. No discussion of fitness to practise |

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| | Steenwijk, R. R., Croiset, G., & Verdonk, P. (2015) | appraisal of cultural minority physicians. *Advances in Health Science Education, 20*, 995-1010. doi: 10.1007/s10459-014-9577-6 | issues; too far removed from context of current study. |
| 8 | Esmail, A., & Roberts, C. (2013) | Academic performance of ethnic minority candidates and discrimination in the MRCGP examinations between 2010 and 2012: Analysis of data. *BMJ, 347*:f5662. doi: 10.1136/bmj.f5662 | Focus on doctors and students, not pertinent to the group being investigated in current study. |
| 9 | Cuban, S. (2010) | 'It is hard to stay in England': itineraries, routes, and dead ends: An (im)mobility study of nurses who became carers. *Compare: A Journal of Comparative and International Education,* 40(2). 185-198. doi: 10.1080/03057920903546047 | Focus on career change which was not as a result of fitness to practise issues. |
| 10 | Coleman, M., & Campbell-Stephens, R. (2010) | Perceptions of career progress: The experience of Black and Minority Ethnic school leaders. *School Leadership & Management, 30*(1), 35-49. doi: 10.1080/13632430903509741 | Focus on education, not pertinent to the group being investigated in current study. |
| 11 | Esmail, A., & Abel, P. (2009) | *Measuring organizational attitudes to workplace discrimination, prejudice and diversity: an exploratory study to assess these factors in public bodies which refer cases to the General Medical Council.* A report to the ESRC: Project RES-153-25-0103 | Literature review to identify instruments which could be used to assess organizational attitudes to discrimination, prejudice and diversity in the UK context and specifically in the NHS. |