



The Royal College – Our Professional Home

An independent review on diversity and inclusion
for the Royal College of Surgeons of England

An exciting call for radical change

Introduction

‘The President of the Royal College of Surgeons of England (RCS England) Professor Neil Mortensen, asked me to lead this Review soon after he was elected to the Presidency. His decision was triggered by vocal expressions of dissatisfaction from a significant part of the surgical profession, largely women and people of colour. The most recent elections to leadership positions had produced a line-up of senior White men – all very distinguished – who seemingly came from very similar social backgrounds. It was felt that the College was not demonstrating itself to be a diverse and inclusive institution, reflecting the society in which we live or the changing profession of surgery. Any examination of the statistics show that the complaints are well founded. The reputation of the College is affected by such negative feelings, as disaffection can cause long-term loss of confidence in an organisation.

The homogeneous nature of the leadership was not a new occurrence. In its long and illustrious history, the College has had only one President of colour and one female President, and while both were singular leaders, they could not change the culture of the College. There has to be a collective will and real effort to create lasting change. Like so many esteemed British institutions, the College is a truly remarkable place but it has developed over multiple generations in ways that no longer work – maintaining organisational structures which are excluding and emanating an aura of the gentleman’s club.

There are of course the whispering voices of those who deny the need for reform and see the issue of diversity and inclusion as simply a fashionable trend. It is easy to be dismissive of some of the criticism included in the report as distorted perceptions. But perceptions – whether fair or unfair – can drive people away from an institution. Some of the experiences of discrimination of older surgeons may be outdated and change may have already rectified aspects of their experience, but it is what they remember and will be passed on to new generations unless a declaration of change is made.

What protectors of the status quo can also fail to see is that society has changed dramatically. Wider access to higher education has opened up opportunities for many who had previously been excluded. The young who came from working-class backgrounds were able to enter universities. And educational opportunities totally changed the status and aspirations of women across society. Half the students in UK medical schools now are female. A third of surgeons are women. Our society is multi-ethnic, greatly enriched by generations of immigration and the medical profession includes many surgeons from a great variety of different backgrounds: gay surgeons, straight surgeons, Black surgeons, White surgeons, surgeons with disabilities. The desire for diversity within the leadership of institutions is being felt across most fields – in the law and judiciary, in broadcasting, in Oxbridge colleges, in political parties,

in the diplomatic world and other parts of the civil service, on corporate boards, in sport and entertainment. All the parts of our social infrastructure are being challenged. And the challenge is simple. How can positions of authority and power be the dominion of any one group of people? Surely a healthy society opens opportunities to everyone, not just the traditional élites?

Rest assured, there is no institution in the land that would survive close scrutiny; every one of them would be dismayed at what would be exposed. The Royal College of Surgeons of England has courageously chosen to hold up a mirror to itself. It is those institutions who fail to undertake this reflection that face the biggest risks. It is those who are brave enough to do so that will reap the greatest rewards.

The mistake which organisations often make is to imagine that placing a few different faces in leading positions will bring resolution. Such cosmetic alterations never work. To create real change it is necessary to look further down the pipeline and identify the blockages that deter diverse groups from advancing to leadership roles. That is why this Review goes more deeply into the structures and pressures on surgeons than some might consider relevant. A superficial glance at voting structures does show some serious fault lines. However, voting reform alone will not provide the cure.

It is always a sign of good leadership when the person at the top takes the reins and looks for ways to address serious problems. Professor Mortensen has shown from the outset that he wants to take the College to a vibrant, new place. But the profession has to come in behind him.



Why do DIVERSITY, INCLUSION and a sense of BELONGING matter? For a start, it is better for patient outcomes. Those who enter the medical profession do so because they want to heal. It is a profession with the noblest of purposes; the care of others, the saving of human life, the development of high-level abilities so that treatment is successful and appropriate. The outcomes depend not just on individual skills but on professional teamwork. The General Medical Council produced a recent report called *Caring for Doctors; Caring for Patients*. It made the case clearly that doctors who are valued and treated respectfully, whose wellbeing is also a priority, will in turn provide a higher level of care for their patients.

DIVERSITY, INCLUSION and BELONGING also matter because it is now widely acknowledged that learning multiplies when it takes place in groups of people who are different. We learn from difference, not from homogeneity, and continuous learning is key to any profession.

Every field of endeavour must be directed towards the future not locked into the past.

Medicine is going through a period of transition. There are many technical developments in the field of surgery, radically altering the ways in which operations will be performed. The *Future of Surgery*, a recent publication by the College, paints an exciting vista of a new world where robotics, genetic engineering, remote surgery and expanded organ transplantation will gain ground. The pioneers in these fields are increasingly men and women from diverse, non-traditional backgrounds. Inventiveness finds sustenance when people come together from different experiences and work together in the spirit of mutual respect. Technical developments will have to be accompanied by cultural change if the College wants to make that great leap into the future successfully.

will reach them, through Twitter and Facebook or informal connections and emerging grassroots organisations that speak to ‘people like them’ such as Melanin Medics, GLADD, the Black Medical Society, BAPIO, Women in Surgery, Surgical Mums. Many younger surgeons are questioning why they should pay so much for annual subscription to an organisation, when there is a plethora of NHS and non-NHS organisations inside and outside the UK, that provide ideas, training and events on everything from public health to leadership to robotics and big data. People stay connected to the organisations that mean something to them, especially in turbulent times, when they are facing huge demands on their commitment as they have done during the COVID-19 pandemic.

DIVERSITY, INCLUSION and BELONGING are also fundamental to the viability of the College, going forward. It makes strategic as well as moral sense. Welcoming greater diversity into the Council and Committees and Examination structures – into the ecosystem of the College as a whole – is how the College will survive and thrive. The College has to recognise the growing competition that comes from other professional bodies, some of which may be more congenial to people from diverse groups, but there is also a challenge now from online social networks. Of course, they do not offer the golden route to the surgical Fellowship, but for longer-term engagement and exchanges of medical knowledge and professional friendships, social media is available at your fingertips. New generations of surgeons do not need to look to an institution for knowledge and ideas. Their attitude is that important developments

What distinguishes a profession?

There are many diverging ideas about what amounts to a profession, as distinct from a job or a set of tasks or a trade. As well as the long nature of the training, one of the factors is a commitment to something bigger than personal success, and a set of ethics and values directly linked to the role. This is where the College can play a vital part, as the space where ethical practices can be embedded. Training to become a surgeon means joining an honourable profession. It involves the development of standards, not just in surgical practice, but of behaviour.

The starting point is ‘First do no harm’. For a surgeon, the risk of harm is high but is reduced by constantly fine tuning technical skills and medical judgement by working closely with colleagues and having the humility to learn from each other. It means treating every patient individually according to their needs. That requires a serious engagement with the patient and securing the patient’s trust and informed consent to procedures.

Sometimes, it means resisting pressures to cut corners. It means upholding things that become unspoken between colleagues but are displayed in behaviours – the invisible made visible – respect, care, compassion, going the extra mile, valuing each other. Ethical standards include justice and fairness, which inevitably raise issues of non-discrimination.

Unfortunately, in pursuit of efficiency and value for money, the NHS is increasingly being run as if it were a business and some of the values essential to professionalism are being driven to the margins. Time is not made available for external activities such as participation in RCS England; extramural activities which sustain the profession and actually add to the success of a Hospital or Trust are insufficiently valued. Younger generations have completely different mindsets and expectations when it comes to values. Issues of identity, representation and voice are taken for granted. For them, the diversity and inclusion agenda is a touchstone. There is a greater willingness amongst younger generations to ‘do their own thing’ if established organisations do not stand up to their values-based scrutiny.

Being professional is about a convergence of technical ability and values; and being in a profession gives us an identity and sense of belonging. The College should be felt to be the PROFESSIONAL HOME of its membership but to achieve this it has to be for everyone, not just the select few. The message of identity and belonging has to be visible in the faces and personalities that lead the institution.

What is the College?

A prestigious building? An examining body? A select club? What would it take for the College to become the professional home for all surgeons and aspiring surgeons, whatever their background or community? What would it take for all surgeons and aspiring surgeons to think of the College as the place where they go for their networks, their content and learning, their development? And what would it take for all surgeons to wear the badge – or endorsement – of the College with pride? And not just because they did the work, passed the exams and played by the rules, but because the badge itself stands for a different image of surgeons and the profession – for progressiveness, compassion, a welcome and inclusion as well as expertise. This is, of course, a grand ambition but if the aspiration to be diverse and inclusive is to be achieved, the College has to think differently.

So what could or should the College look like? It goes without saying that the College’s leadership should become more diverse and in this Report we are making recommendations as to how this might happen. But to have a more diverse leadership, you need to become more attractive to more diverse groups of people, so that there is a rich, broad and deep pipeline into leadership positions.

The College is an amazing organisation. I have been invigorated by discovering the sheer volume of its activities and the extent of its work, especially its extensive research

fellowship and clinical trials programme. It offers interesting opportunities for a band of people to become engaged in its life – to be Regional Directors, Examiners, Assessors or Clinical Leads, for example. A chance to sit on the Board of Trustees or that of the Hunterian Museum. Imagine what a difference it would make to the image of the College if those opportunities were distributed in a representative way across the membership. But it would mean reaching out to members and prospective members differently – going to them and not expecting them to come to you.

The College is the central hub, holding together many different associations of specialist surgeons. These associations have different histories and different memberships, different training and different organisational structures. Their methods for electing or appointing their leadership and their representation on the College Council are varied. They are essential pillars of the surgical community and bring vital expertise to the different committees and to the collective decision making. There can be no change without the active engagement of the Specialist Associations and I hope that on the publication of this report they will examine their own processes of selection to ensure there is a rich, broad and deep pipeline into leadership roles.

It would mean getting a grip on the importance of people’s home lives, acknowledging that it is women who still often carry additional caring responsibilities for children and ageing parents, and it deters them from taking on College roles, organised around the early evening meeting. And when men take on a share in those caring responsibilities, the assumption too often is that they must have a wife somewhere who should shoulder the domestic burden. It means seeing that racism is a debilitating factor in the lives of so many colleagues of colour. It is recognising that colleagues from the LGBT+ community still suffer abusive comment or sexual innuendo from fellow professionals and instead of remaining silent, surgeons should start to call out unacceptable behaviour. It means consciously thinking about ways to make the College amenable for those with disabilities.

As a charitable body, the College is nervous about exercising any muscle in areas which might be seen as political, but the College should make creative use of its great convening power and potential to influence government on the right issues. Not in a party political way. But where has the voice of the College been during recent years as stress levels of medical staff and health service staff generally have climbed higher and higher in the face of increasing demands and inadequate staffing numbers? Especially in the period of the COVID-19 pandemic.

Where was its voice as many medics perceived themselves suffering real terms pay cuts over the last decade as costs of living have escalated? These things are clear from my conversations with members of the Association of Surgeons in Training (ASiT).

How is any of this the business of the College?

The College is the guardian of surgical professionalism and should have the wellbeing of its professionals as a major consideration. Surgeons are more than ‘service providers’ and it is important to recognise that language matters. Once caring professionals involved in life and death are seen in limiting ways, you are on the road to the de-professionalising of a great profession.

The figures on discrimination in the NHS remain shocking. Systems that do not respect and value the people who make them function become demoralised workplaces. While the College alone cannot fix that appalling situation what it can do is lead. It can take a leadership stance on the issue of discrimination and use its assets and resources to show the way.

The College has a permanent staff of over 200 people. The change recommended in this Report applies to that part of the organisation too. As with the civil service and its relationship to Government, it is the staff which supports the delivery of Trustee and Council policy; it is often members of staff who identify surgeons who are suitable for roles on committees; it is staff members who can remind officers and Council members of their duty to deliver diversity. For this reason it is essential that staff receive appropriate training in the delivery of diversity and that in recruiting staff, diversity is part of the criteria.

I want to thank the impressive members of the Review Panel who shared their experiences and insights and gave so generously of their time. This Report is a product of their reflections as well as the product of the extensive evidence we received from so many others. In the course of the Review, I met many surgeons and supporters of the College, whose commitment and dedication was awe-inspiring. I was also greatly assisted by the College Chief Executive and the College staff. The Report was made possible by them all.

I want to pay a special tribute to the rare skills and brilliant work of Laura Harrison, who was my consultant, my confederate and right-hand woman in this Review. Her experience in strategic change, human resources and the ways of the world are unmatched. I was very lucky indeed.

The Royal College of Surgeons of England is a special institution and it is at a really exciting moment in its 200-year history. New building works will be completed in the near future, which will see the joining of a grand, historic structure to an exciting new space: the ancient merging with the modern, long-standing virtues with ground-breaking innovation. It is the perfect time to embark on a cultural shift, an opening of the doors and the creation of an ambience of welcome for all. It was a great privilege to be asked to lead this Review and I hope that you will take it to your hearts and make it one of your building blocks for the next stage in the College’s history. In the end, all organisations, institutions and colleges are about the people. With that piece sorted, anything is possible.

I would like to leave the final introductory words to two esteemed Panel colleagues and venerable surgeons, Averil Mansfield CBE, the first British woman to be appointed Professor of Surgery and founder of the College’s Women in Surgical Training Committee (now Women in Surgery) which celebrates its 30th anniversary this year; and Lord Ribeiro, President of the College from 2005 – 2008.

“Although retired I retain my interest in and concern for the up-and-coming trainee surgeons. I want to see those trainees supported no matter what their gender, ethnicity or background. When I speak to young surgeons I am encouraged by their altruism and by their enthusiasm and determination. I hope that we can ensure that no external influence deflects that engagement with their careers as a surgeon. I just want them to love it as much as I did and for the College to be their welcoming and supportive professional home”. – Professor Averil Mansfield

“As President of the Royal College of Surgeons of England between 2005 and 2008, I have been delighted to play a role in this important review. The College has so much to be proud of and I look forward to it taking the next steps recommended in this report, continuing to demonstrate professional leadership in a world that’s changing fast”. – Lord Ribeiro

It was a privilege to conduct this Independent Review.

Baroness Helena Kennedy QC



Who is this report for?

This report is for:

- The College – we aim to provoke and inspire the College towards a future blueprint and plan for an exciting and sustainable future;
- The qualified surgeon, trainee and aspiring surgeon – we aim to empower and to enable necessary and sometimes difficult conversations about mutual respect and ways of welcoming colleagues into your midst; and
- Health service professionals – we aim to foster discussion and engagement about the need for change.

A note on language

Words matter. Discussions about fairness, justice, advantage and disadvantage are sensitive. The words we use can inspire, irritate, alienate and trigger people in equal measure and for a wide range of reasons. Because words matter, we want to be explicit about how we have used language in this report:

We do not use the acronym 'BAME' (except in quotations where it has been used by others). BAME suggests a homogeneity of what is, of course, a diverse section of society and we consider it unhelpful to that diversity to imply otherwise.

- We describe people as what they are – not what they are not. And insofar as possible we use the language that they have used to self-identify. So, we write about Black surgeons and working-class White male surgeons and surgeons from the LGBT+ community. Some surgeons have described themselves as brown, and some as South Asian; where they have, we have. We do not describe people as non-male, non-White, non-Caucasian or non-middle class.
- We use the phrase 'anti-discriminatory', by which we mean an intention to remove barriers and construct enablers to access, participation and influence. Anti-discriminatory practice is activist and comes from a determination to develop a more equitable society. We find this more helpful than the language of 'equal opportunities' which seems to have lost meaning or developed a confused meaning over time.

- We use the language of trainer and trainee wherever we can, seeking to emphasise the responsibility of the trainer in the career of the trainee, regardless of the trainees' race, gender, sexual orientation, disability or other characteristics.
- We write in the first person. 'We' is the Panel of experts whose engagement and insight has been the foundation of this review and report.
- We write about the College ecosystem. During this review, we have looked into the depth and breadth of volunteer work that is carried out by surgeons (in the main, but including some lay people) on the College's behalf, as well as the work of the College's 200+ staff. Like an ecosystem, this workforce is complex and interconnected, and the opportunities for it to grow, be enriched by diversity and sustain itself are enormous – and these opportunities are the main focus of this report. However, also like an ecosystem, it is not immune to threat and in **Chapter 2** we talk further about the nature and attributes of this threat.
- We join the Associated Press and many other organisations in capitalising Black "in a racial ethnic or cultural sense, conveying an essential and shared sense of history, identity and community among people who identify as Black"¹

Reading this report

In **Chapter 1** we reflect on the core question of this review, the diversity of College professional leadership. In **Chapter 2**, we ask why this question matters; what is the importance of diversity to the College? In **Chapter 3**, we explain our approach to the review – our thinking and method. In Chapters 4 to 6 we comment on what we learnt from the Review and outline the conclusions that informed our recommendations; and in **Chapter 7** we outline our key recommendations, with details in **Appendix 2**.

We use quotations throughout the report to bring to life the matters discussed. All quotations, unless otherwise stated, are from invitees to Panel meetings or from interviews and focus groups run by the Review team. All have been made anonymous.

1. <https://apnews.com/article/9105661462>



In society at large people face discrimination based, not exclusively, on class, disability, ethnicity, gender, gender identity, religion or belief and sexual orientation.

The body of knowledge available to us during the writing of this report spoke primarily to ethnicity and gender. We recommend the College makes a significant investment in research and action relating to equity in a wide sense, specifically filling gaps in the evidence base on surgery and class, disability, gender identity and religion or belief and sexual orientation.

We note pending insights on disability and surgical examinations and hope these will be considered by the College.²

There is a limited amount of research on the relationship between class and medical school and surgical training showing those from lower socioeconomic backgrounds are least likely to become surgeons³ and highlighting cost as a barrier in pursuing a medical career.⁴

We recommend the College makes a significant investment in research and action relating to equity in a wide sense.

2. The Impact of Disability on Performance in a high-stakes postgraduate Surgical Examination, R Ellis, J Cleland, DSG Scrimgeour, AJ Lee, PA Brennan, publication pending

3. Relationship between sociodemographic factors and specialty destination of UK trainee doctors: a national cohort study B Kumwenda, J Cleland, G Prescott, K Walker and P Johnston <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC/6475150/>

4. <https://pmj.bmj.com/content/early/2021/01/07/postgradmedj-2020-139170.full>

Understanding the question

This review was asked to consider the question of the diversity of College professional leadership (The Question). We have considered and interpreted The Question as follows:

1.1 What do we mean by diversity?

Diversity has been a topic of discussion and debate in organisational life since the equality acts of the late 1960s and early 1970s. Some of the focus on diversity has been, and continues to be, a deliberate attempt to introduce fairness to the world of work. Some has been, and continues to be, more reactive – focused on defence against employment claims.

As the discussion has evolved, our understanding of the challenge has sharpened. We now talk about diversity, about inclusion and about belonging. To put this sharpened focus into College context, we look at it this way:

Diversity is about who's in the room – the degree of heterogeneity of characteristics in a Council meeting for example. It is fact-based and can be measured.

Inclusion is about inviting contribution – it's about seeking input and insight from a diverse group. It is behavioural and can be learnt.

Belonging is about creating for everybody a sense of welcome and being valued, not despite their diversity – and not solely because of it either. It's about making space for everyone and valuing the richness that comes from different perspectives and experiences. It is values-based and comes from individual belief systems.

In this report, we see the need to increase the diversity of the College ecosystem, but urge that this is not enough. Inclusive methods and habits need to be adopted and a culture of belonging – for the jobbing surgeon in the Wirral, for the trainee and the medical student, as well as for the London teaching hospital consultant – needs to be developed, nurtured and celebrated.

“If you want to be part of College life you have to get involved, become a tutor in your specialty, become a training director, those jobs go to White consultants, we'll be waiting 200 years for this to change unless we fundamentally make it clearer that there is a place for Black surgeons and women at the College. I would like to feel that the White male leaders of the College understand the problems that Black and female surgeons face, but I don't think that they do, how can they?”

A further important concept to unpick when we think about diversity is intersectionality. Intersectionality is much debated, but in the context of this report it matters insofar as it relates to reflecting on 'intersecting identities' which result in some being impacted by a layering of social justice problems. For example, the issues facing a White working-class man cannot be looked at through the same prism as a White middle-class privately-educated man, nor can the issues faced by a White woman from the LGBT+ community be looked at as being the same as those faced by a Black woman from the LGBT+ community.

1.2 What do we mean by College?

The College is more than a building or a club. It funds outstanding research, it sets standards, produces guidance, reams of content and awards the designations MRCS and FRCS. It convenes people and uses its voice to influence public policy and sentiment. But it could be so much more.

We think that there is a vacant role that can be filled by the College – to be the professional home for all surgeons and aspiring surgeons, as well as retired surgeons who still feel they have something to give. This professional home is sorely needed by the surgeons we met during this review, many of whom feel embattled, under-valued and, to a greater or lesser extent, lost or rootless within the medical system. But there is competition for this role – there are many digital and physical networks and organisations that are establishing credibility and relevance with both upcoming and established generations of surgeons. These are discussed further in **Chapter 2**.

In this report we urge the College to take on the challenge of becoming the professional home for all surgeons, regardless of background or circumstances, and to take on the role of community leader – fostering learning, being open to different voices and supporting members of the community through the ups and downs of their careers.

“When I saw what happened to David Sellu⁵ I thought ‘could that be me?’ ‘will I be next?’ I want to walk into theatre feeling that an institution has got my back, and will be there for me if the worst happens...”

“I don’t think of the College as my community – it’s not for people like me – I’m still in contact with friends from medical school and have a WhatsApp group – and I follow some of the higher profile female surgeons on twitter – that’s as close as I’ve got to a professional home”.

“I was at a low point in my life, the worst it’s been, getting divorced and under so much pressure... I felt I couldn’t show the flexibility that was expected of me in my rotations while I was managing childcare as a single parent and that I was failing on all fronts... I reached out to the College to see if there was any support or advice, I got nothing. I felt very alone”.

1.3 What do we mean by professional?

Professionalism has been much discussed in health. The Royal College of Physicians’ report Advancing Medical Professionalism described professionalism as:

“More than a lofty ideal; it encompasses who doctors are, how they work and what they value. It is writ large every day in the decisions doctors make, the way they treat their colleagues and patients, and the way they view themselves”.

Being a professional can be defined by being bound by a common body of knowledge, a commitment to something greater than your own self-interest, a shared identity and commitment to continuous learning and ethical practice. Diversity, inclusion and belonging weave through these attributes of being a professional such that exclusionary practice or a narrow embrace of only the elite or most successful runs counter to the very essence of what it means to be a professional. We think it is worth unpicking this further:

“I feel [as a Black surgeon] that I suffer a different level of scrutiny from other surgeons – and have access to much less support – and it can be very frightening”.

1.3a The body of knowledge

We are long past the days when knowledge was owned by one group or another, or could be found only behind high physical or even digital, walls. It has been suggested that until 1900 the sum of human knowledge doubled broadly every century⁶. It is now said to double at least every year. The porous boundaries around knowledge, and the ways that we now work with that knowledge, have profound impacts on the role of professional bodies. They have to be more extrovert and to focus on inclusivity to ensure that new knowledge is widely spread and accepted within the profession. It also requires a willingness to explore emergent practice or ideas that may not fit within the straitjackets of specialties or conventional career paths, and a willingness not to try and force these into existing norms. Again, it’s about inclusivity and belonging.

“I don’t consider myself as a urologist, I consider myself a cancer specialist – there are new areas of expertise – robotics, data science, Artificial Intelligence, education – which cut across the traditional specialisms – is there a home for these in the College?”

1.3b Shared identity

We anticipate dismay when some of the findings from this review are shared. The findings do not cast surgeons or the College in a progressive, modern or particularly attractive light. We have heard of ‘jokes’ being made about rape and sexual assault and about the ‘N word’ being used by surgeons. We heard that a gay woman surgeon was told not to mention her sexuality if she wanted her career to progress and of a trainee who was told by her consultant that as he was of Pakistani origin he couldn’t stand up for her, or for what was right, as he was terrified for the impact on his career. We heard people who were upset and bewildered by sidebar

5. <https://www.theguardian.com/global/2019/jun/16/they-look-for-a-scapegoat-a-surgeons-battle-to-clear-his-name-dr-david-sellu>

6. Critical path, Buckminster Fuller (Fuller 1981)

inappropriate conversations in and around College meetings and of women being instructed by other women on what to wear and how to behave to be accepted in that environment. We heard about medical students who took acting classes and elocution lessons to be accepted, from a surgeon of Middle Eastern heritage who was introduced to his team as 'the departmental terrorist' and from a trainee who desperately tried to hide her pregnancy so as not to prejudice her chances of a good rotation. We heard of two women of colour being continually called each others' names, reference to South Asians as having a 'corner shop mentality', of a consultant turning someone down for a job because 'I don't want a gay in the department', of people who came to give evidence to the Panel being told by their colleagues 'you're brave...' and the grinding impact on women, LGBT+ surgeons, disabled people and people of colour of everyday micro-aggressions.

The many surgeons who told these stories had little confidence that the College knows, cares or is invested in a different future, although many expressed enthusiasm for this Review. This lack of faith in the College's commitment to diversity is echoed in the findings of our member survey: the most commonly referred to barrier to achieving a senior role in College life was the 'old boys' network'.

Despite all the above, we remain convinced that very few surgeons want surgery to have an antediluvian identity, or for the College to be viewed as an 'old boys' club'. We think that surgeons as a whole deserve a better identity, but they must not be let down by the worst of the group whilst others stand by. One of the most striking things about the evidence we've heard is that people on the receiving end of unacceptable behaviour seem to be asking themselves continually what *they could have done differently*. This is a well-documented response of those who experience discrimination in any field. There seems to be very little expectation of – and minimal evidence of the practice of – *ally-ship*, for example, where a White male upper middle-class surgeon calls out poor behaviour and takes responsibility to follow through and address it. It has appeared, at times, *that it is presumed to be the role of women, LGBT+ people, disabled people and people of colour to champion the diversity agenda themselves, by themselves*.

"It's very hard to address things without seeming accusatory – if I as a Black male medical student say 'this isn't right' it's as though I don't quite have the right to say it... People are scared..."

Another common response to discussions of exclusion is for those who enjoy privilege to assume that fault lies with the 'other' rather than examine the possibility of fault lying with the institution. 'They' just don't come forward. 'They' are too concerned with their own practice and 'they' do not engage with the bigger picture.

Only through the most powerful within the system addressing the behaviour of the worst will the overall identity of surgery be pulled up. There is a possibility of a reignited professional identity, one that is progressive, exciting, trusted and highly valued. But that kind of legitimacy and value will only come through a willingness to change and that will mean sacrifice on the part of some, to make way for others, in pursuit of a stronger and more morally legitimate future.

"A lack of professional behaviours and leadership are regularly reoccurring problems identified within the RCS invited review process, an independent peer review process for managing surgical performance. In the RCS 2019 Invited Review report, 76% of cases identified teamwork as an area that needed vast improvement. Over half of the reviews (54%) suggested a need for improvement in multidisciplinary team working, individual surgical behaviours and leadership and management".⁷

"It's not that the current officers aren't good enough to be President or Vice-President, it's that they don't seem to understand the role of privilege in their having got there... Many of us are 'good enough,' maybe even better, but we are only considered when there isn't a White man available for the job..."

7. <https://invitedreviews.rcseng.ac.uk/>



“I want to be a surgeon, and I’m female, that’s not the same as wanting to be a ‘female surgeon’ is it?”

1.3c Continuous learning

We have heard surgery described as a ‘craft-based profession’ and surgical training as an ‘apprenticeship’. The College’s Future of Surgery report makes it clear just how important continuous learning is to any surgical career. And yet learning is not aided by homogeneity – we learn from difference and the ‘new’. Nor is learning helped by exclusion or allowing structural inequalities to overwhelm learning environments – opportunities must not be shut off to those who don’t jump forward first in theatre, or who lack the confidence to make their presence known to consultants because they are unsure of whether they ‘belong’.

“In one of my first times in theatre the trainee said to me ‘how cute, you want to be a female surgeon’... I felt really patronised...”

“Learning and training in surgery – it’s a two-person job, minimum. You can’t do it yourself from a textbook. But so many training and development opportunities are closed to me [as an SAS surgeon]. Just because I’m not a Trainee doesn’t mean I shouldn’t be training, but so few people are willing to help me. How is that good for patients?”

Further, we have some insight into the kind of learning opportunities that the College should be focusing on. In our survey, we found that just over half of respondents wanted the College to provide more training programmes and education focused on ‘soft skills’ (defined as leadership, management, wellbeing, work culture).

1.3d Ethical practice

We make good judgements when we value everybody. It is unlikely that a surgeon who devalues, unconsciously or consciously, certain patient groups, for example first-generation immigrant patients or poor White working-class patients, holds all their colleagues, including those from these backgrounds, in equal esteem. And yet we know that there are significant inequalities in access to – and treatment within – healthcare settings. We know that not everybody is treated equally. This is a moral challenge for surgeons and for the College. Only by bringing discussion and study of health inequalities to the heart of College life will the College have the moral and societal legitimacy needed to champion and uphold professional values.

“One of my experiences as a trainee captures the essence of the problem. In clinic, the consultant and I saw two babies presenting with the same problem. The first baby came in with his Turkish mum, we examined the baby and put him on the waiting list of 3 – 4 months for a routine procedure. The second, White, baby came in with both parents... The baby had an identical diagnosis to the first baby, but in this case the consultant took out his diary and said he’d perform the procedure himself the following week...”

When we discuss racism we think of the most obvious cases of people saying or doing things that are clearly wrong, but I think the vast majority of the damage is being done in these very subtle ways. The consultant in this case was gentle when he examined both babies, was polite to both parents, but he didn’t seem to value both in the same way”.

1.4 What do we mean by leadership?

Through the process of this Review we have been probing what is meant by College professional leadership. What sort of leadership does the College want or need? The answers we've heard point in different directions:

- **Managerial leadership** – to be the focal point for ensuring that the activities and behaviour of the College ecosystem are the right ones, and are delivered effectively.
- **Technical/surgical leadership** – this has been described as we need to know 'that the man [sic] is good with his hands, he needs to know what he is doing'.
- **Inspirational leadership** – to inspire, innovate, bring to life the future of surgery, draw the outside world in and engender enthusiasm for the future.

- **Political leadership** – to be the voice of the profession to policy-makers and society.

“Aren't we all 'good with our hands' – that's all surgeons isn't it? Except the exceptional few who the system deals with... We shouldn't confuse political and managerial competence with clinical excellence.”

“What is important to be President – surgical expertise at the cutting edge, managerial skills or political skills – are we primarily an education body or a lobbying organisation? And can you lobby effectively if you're long out of practice or away from the coal face?”

We conclude that the leadership needed should be contextualised by the findings of this Review, and needs to answer the question '**leadership towards what?**' So, we have developed a Vision for the College:

To be an inclusive, diverse, professional organisation committed to fairness, and anti-discrimination, supporting and promoting the highest professional/surgical standards and the best outcomes for patients in a spirit of respect and compassion – for patients and for each other.

Leadership therefore, for us, and using the language of the Center for Creative Leadership, is about creating direction (i.e. accepting the Vision above), alignment and commitment to the Vision.

It is worth noting the emphasis on leadership, as opposed to individual leaders, and the recognition that inclusivity or togetherness are integral to the leadership definition above. Further, it is worth noting that encouragingly, 36% of our survey respondents expressed that they would be interested in playing some kind of leadership role at the College in the future.

In the next chapter, we consider the context in which this leadership is required.

“Leadership is a social process that enables individuals to work together to achieve results that they could never achieve working as individuals.

Leadership emerges from:

Direction: *Agreement on what the collective is trying to achieve together.*

Alignment: *Effective coordination and integration of the different aspects of the work so that it fits together in service of the shared direction.*

Commitment: *People who are making the success of the collective (not just their individual success) a personal priority”.*

Center for Creative Leadership

What do we mean by micro-aggressions?

A micro-aggression is a behaviour or action – whether accidentally or purposefully – that subtly undermines someone's identity by playing into the stereotypes or historic biases about social groups. While not born out of malicious intent, it can have a serious consequence or impact on the people it is directed towards.

Examples that were highlighted to us in this review included:

- The far greater propensity to call women surgeons by their first names in situations where their male counterparts would be given their title.
- Failure to make it clear to a patient that a woman surgeon or a person from an ethnic minority in scrubs is indeed a surgeon.
- Locker room talk of a sexually explicit nature in theatre.
- "I don't know how many times I have heard the expression 'that's a bit gay' at work".
- Addressing correspondence 'Dear Sirs' – as though all surgeons are men.
- Asking a Black surgeon when they would be returning to their country.
- Calling a female surgeon a 'pretty girl with an empty head' in theatre.



Why the question should matter to the College

In simple terms the College helps people to get into the profession, it helps them to get on in the profession, and it works to have pride in, and commitment to, the College so that its qualifications keep value and societal legitimacy.

The sustainability of the College's operation of this model needs to be looked at through both a moral and a strategic lens.

2.1 Looking through the moral lens

The GMC's submission to this Review outlines:

"The evidence is clear – doctors are better supported and patients are safer when there is inclusive, compassionate leadership creating positive cultures. This was made clear in independent research we published in 2019:

- 'Caring for doctors, caring for patients': How to transform UK healthcare environments to support doctors and medical students to care for patients, by Dame Denise Coia and Professor Michael West. This identifies the need for autonomy, belonging and control for doctors in their workplaces.
- 'Fair to refer? Reducing disproportionality in fitness to practise concerns reported to the GMC', Dr Doyin Atewologun and Roger Kline. This identifies factors leading to disproportionate referrals for certain groups and provides recommendations to address them.
- 'How doctors in senior leadership roles establish and maintain a positive patient-centred culture', by Dr Suzanne Shale. This identifies doctors' pathways into leadership, and the type of support and training needed at crucial points.

Supporting more inclusive and diverse leadership is a priority for the GMC and we look forward to working with RCS England and others to achieve this".

Further, the GMC submission highlights:

Demographic data

- The surgery specialty has a slightly lower proportion of international medical graduates (IMGs) than the average (21.3% compared to 27.5% of all licensed doctors).
- In surgery, over a third of all trainees are female (34.8%) and the proportion of consultants who are female increased from 9% in 2012 to 14% in 2020. This compares against the broader population of trainees where just over half are female (56.6%) and the proportion of consultants who are female increased from 31% in 2013 to 37% in 2020.
- The programmes in 2020 with the highest proportion of female doctors in training are paediatric (53.0%) and plastic surgery (39.1%). The lowest proportions are seen in oral and maxillo-facial surgery (20.0%) and trauma and orthopaedic surgery (18.2%).



**JUST OVER
a third**
of all surgical trainees are
female (34.8%) versus just
over half (56.6%) in the
broader trainee population



21.3%
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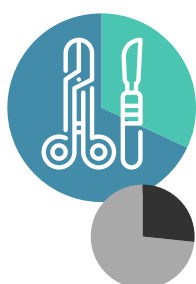


GMC referrals for surgery

- The data highlights that Black and minority ethnic (BME) surgeons appear to be referred to the GMC more frequently than their White colleagues (from 2012–2018 21.8% of BME surgeons were referred to the GMC, compared to 17.1% of White surgeons). This is a worse ratio than for overall doctors (11.8% of BME doctors, 10.7% of White doctors referred). However, this is a complex picture and other demographic variables also need to be considered. For example, male surgeons are more complained about than female surgeons (over the same date range, 19% of males and 9% of females were referred), and a higher proportion of White surgeons are female than BME surgeons (7% of BME surgeons are female, and 15% of White surgeons are). Similar interlinked relationships exist between age and place of qualification so it is problematic to assume the entire difference in these rates of being referred to the GMC is due to ethnicity alone, and further work is required to understand the scale of disparity.

SAS and LE Survey

- The GMC's 2019 survey of SAS and locally-employed doctors showed a higher proportion of doctors in surgical specialties reported bullying, undermining and harassment (32.0%) than the average across all specialties (26.7%). Of those who reported bullying, two thirds (65.8%) reported the behaviour coming from a consultant – and the most common behaviours described were 'Belittling and humiliation' (59.1%), 'Rudeness and incivility' (59.1%) and 'Threatening or insulting comments or behaviour' (38.6%).

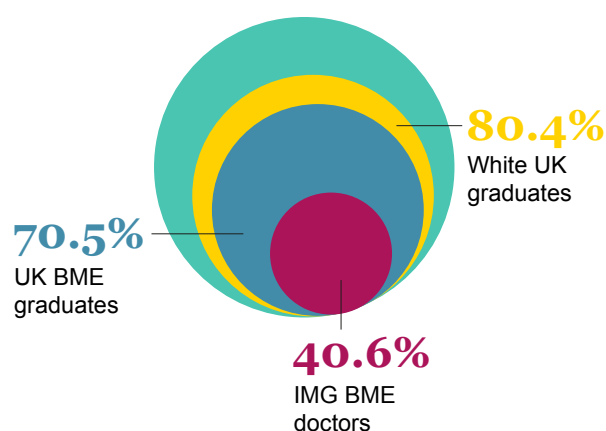


32%
of doctors in surgical specialties reported bullying, undermining and harassment versus 26.7% average across all specialties

Trainee data

- 2019 national training survey results suggest that trainees in surgery have higher than average risk of burnout (with 52% being in the high or moderate risk categories), and that BME doctors in surgical training experienced a higher rate of bullying than White trainees (10.2% vs 6.0%).
- White UK F2 applicants are more likely to be deemed appointable to core surgical training than BME applicants (80.4% of White UK graduates were appointable between 2012 and 2019, compared to 70.5% of UK BME graduates, and IMG BME doctors were the least likely with 40.6% deemed appointable).

Applicants deemed appointable to core surgical training:



Countless studies have shown that there is a problem and there is a moral imperative to stop diagnosing and start treating. This report makes recommendations as to how to do this.

2.2 Looking through the strategic lens

The College operates its business in a highly disrupted space. This is true of many commercial enterprises. It was once the only reliable and viable source for specialist information, networking and content. And that is how it has survived financially. Now there is content everywhere, much of it not behind paywalls, and people can find, online, their own communities to engage with. It is very common for the younger generation to think 'if it's important, it will find me' – they don't go looking for content on a website or in a library; the assumption is 'if it matters, someone in my network will share it'.

"I think one of the reasons I love the College is that I went there, to the physical building, to study for my [qualification], that's where my loyalty started. But people don't really do that any more".

Not only is there a generational shift in terms of how knowledge or content is managed and used, there is also a generational shift in expectations when it comes to diversity, inclusion and belonging. Many teenagers in the UK entering medical school now have grown up with identity politics; including exploration of class, disability, gender, race, sexuality and identity and challenging attitudes to individual and collective responsibility. It is hard to conceive how this generation will have the patience for a slow, evolutionary approach to change in institutions like the College. It is, in a sense, too easy to start your own organisation, find your own networks or go it alone.

“The College booklet ‘Avoiding unconscious bias’... highlights ‘traditional surgical behaviours’ and these are rightly unacceptable to students and foundation doctors. Those young professionals have very different expectations to those which senior surgeons had. The pre-eminence of surgery as a career choice has evaporated and a change is needed if it is to be attractive.” - ASGBI submission to Review

Looking ahead, we have considered the College's Future of Surgery report and the need to build diversity, inclusion and belonging within the College ecosystem. It is highlighted by the statement from the report's executive summary that:

“The multi-disciplinary and multi-professional surgical care team will become increasingly important in developing and delivering care of the highest quality. They will be able to provide more aspects of care and take over some aspects of surgical care currently delivered by surgeons”.

There is an opportunity for the College to be a key influence over the practice and behaviour of this multi-disciplinary team of the future, but in order to realise that opportunity the College will need to think differently about whom it welcomes into its embrace, and how it does so.

In looking through the strategic lens, we have asked ‘what can the College uniquely do?’ Of course, the answer is it can award the designations MRCS and FRCS. It is tempting to think that this unique positioning is enough for sustainability, but it is not. We highlight two threats that draw together the moral and the strategic case for change:

1. The designations are badges that have meaning because of the ‘brand’ that underpins them. If that badge is allowed to tarnish, to cease to have moral or social legitimacy, to represent the endorsement of an ‘old boys’ network’ rather than a vibrant, progressive and diverse community, then the value of the designations will decrease accordingly. This devaluing may already be happening. “Why do I bother renewing my membership?” seems to be a reasonably common question amongst members and in our survey we found that whilst similar proportions of respondents agree (33%) and disagree (36%) that the College ‘represents people like them’, over two in five say the College does not do enough to foster an inclusive environment (42%).
2. The College is not the only surgical College, there are four in the UK and Ireland. We have heard countless times that “if you’re a person of colour go... [elsewhere] to do your exams, they’re friendlier, more welcoming, they don’t behave as though they want you to fail.” Now, we acknowledge, this is anecdote. But we have to accept that perception drives behaviour. And so, there is a real risk of a talent drain which we would suggest the RCS England can ill afford.

2.3 Conclusion

The Question matters because there is an existential threat to the College. The College operates within a competitive environment of four surgical colleges, all of whom have a similar proposition. It competes with them for members, for volunteer effort and for space in policy and media terms. The College operates within the context of one of the industries most disrupted by technology (it makes money through content). New generations rely on their social networks and for ‘content to find them’. They don’t rely on an institution as a place to go and look for it. They can convene without the College. Very few people need their networks brokering any more. What’s more, surgery is changing, fast. A diverse and inclusive College that fosters belonging will be able to keep pace with the changes taking place and being predicted in the College’s Future of Surgery report. A static or stuck institution will not.

Diversity and valuing everyone is the fundamental response to these external threats to College legitimacy and sustainability and will enable the adaptation and innovation that is sorely needed by the College, by its members, by surgical care teams and patients.

Our approach

3.1 Panel and method

This report is the result of deliberations of a Panel of experts (see **Appendix 2**), chosen for their diversity, as well as breadth and depth of experience, over the course of October and November 2020. The Panel met seven times and heard from 22 witnesses. In addition, the Review team conducted focus groups and interviews involving a further 75 surgeons and medical students, studied an assessment conducted by the College library of the existing evidence base related to diversity, inclusion, surgical careers and patient outcomes and conducted a survey of College members' thoughts on The Question (which received over 1,400 responses). The College also issued an open call for evidence, responses to which were sent to the Review team and sought institutional submissions (see **Appendix 3**).

All Panel meetings, interviews and focus groups were conducted under the Chatham House rule, consequently all quotations have been made anonymous.

We noted during the Review that whilst there is a strong body of evidence relating to diversity, inclusion, surgical careers and patient outcomes, very little of this evidence base speaks to the experiences of LGBT+ surgeons. This gap is of concern, particularly as the evidence⁸ we did see reported, amongst other things, that

“Over 70% of LGBT+ medics had endured one or more types of experience short of harassment or abuse in the last two years related to their sexual orientation. These ranged from feeling unable to talk about their private life at one end of the spectrum to homophobic name-calling at the other”.



In this study, only a quarter of the 800 respondents who felt they had suffered harassment/abuse reported it to someone senior.

Similarly, we found next to no evidence on the issues of surgery and disability, yet those with disabilities in the NHS report the highest levels of discrimination of any group.⁹ A medical student drew our attention to her not being able to find anything on the College website which spoke to the issues of disabilities and surgical careers. Likewise, we (the Review team) were not able to find anything on this topic.

3.2 What have we done?

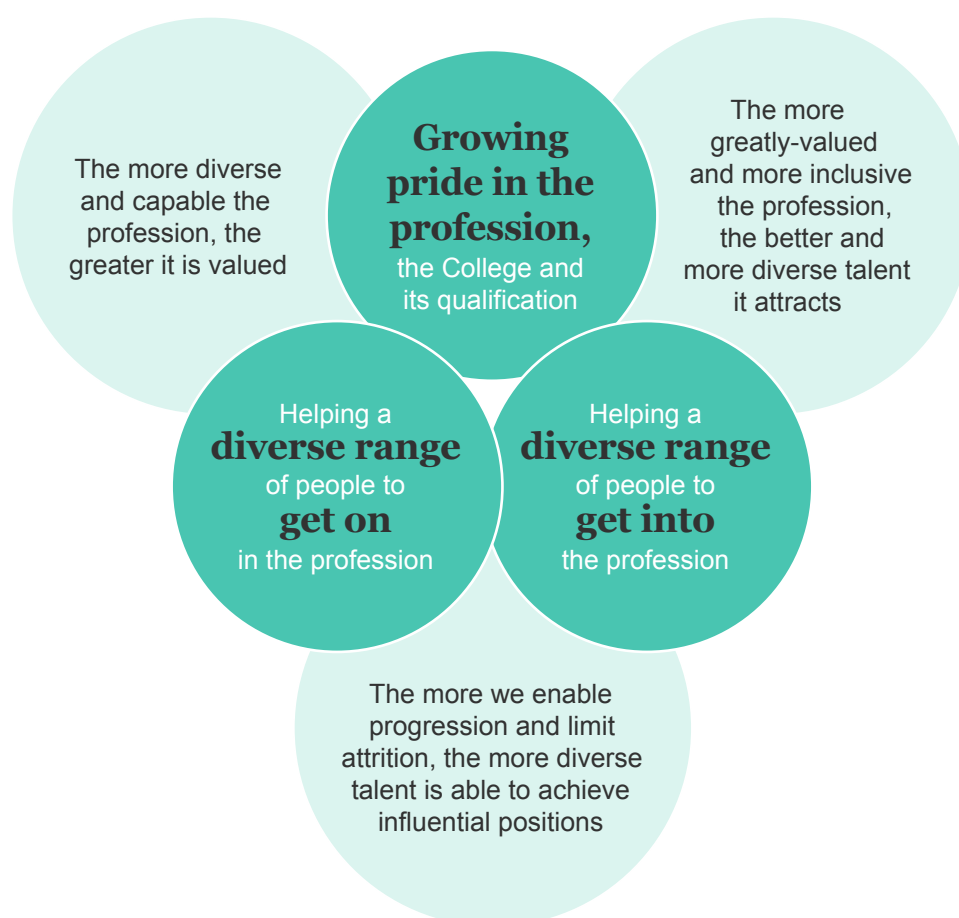
We have looked widely at the pipeline that feeds the electoral pool that ultimately presents for the officer roles at the College. We have looked at the medical school environment, and what might or might not be impacting students' interest in surgical careers; we have looked at early years in the profession and the perspectives of established surgeons. We have analysed the series of societal, educational and career events that propel people forward towards engagement with the College, or repel them from the same.

We have recognised that the College is not omnipotent. The College ecosystem itself works in an even more complex ecosystem of health education bodies and NHS Trusts. We have endeavoured to think about recommendations through the lens of what the College itself can directly impact and where it might use its voice of influence to make a difference.

8. https://www.bma.org.uk/media/1094/bma_experience-of-lgb-doctors-and-medical-students-in-nhs-oct-2019.pdf

9. <https://www.kingsfund.org.uk/publications/making-difference-diversity-inclusion-nhs>

In developing findings and recommendations, to try and cut through the complexity of the College ecosystem and operations, we have used the simple three-part framework below:



3.3 What we have not done?

We have not got tied up in questions such as “is the College a racist institution?”, “is the College a sexist institution?”, “is it hostile or unwelcoming to LGBT+ people, working-class people and disabled people?”. We have taken the question at face value and as an intention to change for the better. We absolutely support that intention – for both the moral and strategic reasons outlined in **Chapter 2**.

Rather, we have asked “what is the College doing to ensure that its strategy, policies and processes are anti-discriminatory?”. The answer is “not enough”. And in Chapters 4 to 7 we share findings and make recommendations as to how to create a meaningful shift towards better practice, use of influence and power.

“The biggest barrier is hesitation, fear, paralysis; we know enough now, we have to act”.

3.4 Vision, objectives and recommendations

We describe in **Chapter 1** the Vision for the College to become an inclusive, diverse, professional organisation committed to fairness, and anti-discrimination, supporting and promoting the highest professional/surgical standards and the best outcomes for patients in a spirit of respect and compassion – for patients and for each other.

Of course a Vision is one thing, how will we know this is being achieved?. The objective therefore that underpins this Vision is that;

Within two presidential terms, the staff and surgeons who undertake College roles will reflect the diversity of the wider-qualified medical workforce.

We have built our recommendations around achievement of this objective.

3.5 Framing of recommendations

We have made recommendations according to the framework below:

1. Symbolic change – the purpose of these recommendations is to provide opportunities for College leadership to show commitment to change, ‘put a stake in the ground’ and energise the staff and professional surgeons on whose shoulders much of the work will fall.
2. Institutionalising good practice – the purpose of these recommendations is to give guidance on the College’s becoming a progressive organisation that can state with conviction that its policies and practices are anti-discriminatory and working towards the Vision outlined above.
3. Building on strengths – these recommendations relate to green shoots which with some cultivation and strategic focus could make a real difference to achievement of the Vision. Some of this is work being done within the College and some is work that is done within other environments that the College has an opportunity to amplify, advocate for or adopt.

3.6 A note on ecosystem culture

There are themes that will recur throughout the recommendations that relate to the culture of the College ecosystem. Of course, it is important to consider what recommendations will be taken forward, we note these points on culture as they relate to how recommendations are taken forward.

1. *Big world not small:* Time and time again we have heard that “surgery is a small world”. We would argue that it is not small, unless you are in the small world that is the centre of the College ecosystem. The College has over 28,000 members and the potential for quite extraordinary diversity. And yet, on the data we were provided by the College, the Board of Trustees has only one woman trustee (out of 13 positions); the Court of Examiners is 11.14% female; Regional Specialty Professional Advisers (RSPAs) are 8.26% female and the most senior 16 roles (grade 6 to CEO) on the College staff are all held by White employees. Available data on the ethnicity of the College is poor so it is hard to draw meaningful conclusions, but we point to *BAME under-representation in surgery leadership in the UK and Ireland in 2020: an uncomfortable truth*¹⁰ which provides an external perspective on the ethnic diversity at College leadership level.

The College ecosystem needs to internalise the idea that surgery is a big world, full of potential advocates for the College and for surgery and that relying on the ‘usual suspects’ is not helping the College in the long term.

“I am invited to speak in the US, Europe and Australia – I go abroad for my networks and professional development and reputation building – it’s a more welcoming environment than the UK if you don’t fit the ‘old White man’ mould”.

2. *Belonging vs assessment:* Surgeons are clever people. They pass exams and continue to take exams and accrue designations and post nominals throughout their careers. There is no doubt that being assessed, and assessing others, is an integral and necessary part of surgical life. However, we suggest that this culture of assessment has crept too far into the College’s ways of working and risks crowding out the opportunity for a culture of belonging to take hold. There is too narrow an understanding of the skills, abilities and attributes needed in a modern organisation. Examples of where this could play out are in awarding roles or funds (e.g. the Lady Estelle Wolfson Emerging Leaders Fellowship) and in examinations (e.g. MRCS): everyone who has applied, e.g. for the Emerging Leaders programme, is expressing an interest in College life and should be valued as such – whether they are successful or not – and everyone who is sitting an exam could be in theatre the next day so they are important to the College – and their professionalism is important to society – whether they pass the exam that day or not. The ecosystem needs to recognise that all of these assessments are also opportunities to build a sense of belonging in the College and treat people accordingly, for example with feedback and suggestions for development, and always with kindness and compassion.

“I applied for the Estelle Wolfson programme twice and was unsuccessful twice. I wasn’t given any feedback as to why I was unsuccessful or what I could do differently to be selected. Of course that made me question whether the College values me, particularly when at a WinS meeting, it was reported that a candidate’s application was so poor, they were given not only feedback but personal coaching... Despite that the subsequent application was still poor but she was given an interview for her persistence. This highlighted a lack of transparency and favouritism. Everyone should have the same opportunity. The college is missing an opportunity to engage members as those applying are those interested in making a contribution”.

10. BAME underrepresentation in surgery leadership in the UK and Ireland in 2020: an uncomfortable truth JP Joseph, AO Joseph, NVG Jayanthi, B Pereira, J Gahir, <https://publishing.rcseng.ac.uk/doi/full/10.1308/rcsbull.2020.166>

3. *Digital first:* One of the barriers to participation in College life is the London location. In our survey, travel and time commitment were seen as the second-biggest barriers to achieving a College leadership role. The 'old boys' network' coming out on top. COVID-19 has meant that Council and other College meetings have taken place over Teams. Virtual meetings from hereon in will radically change the landscape of meetings and will be key to achieving the Vision.
4. *Cohorts not individuals:* The College identifies as an education organisation. The unit of education, or development is the cohort. It is not the individual. We learn in cohorts (at medical school for example) and we like to stay connected with these cohorts (as the WinS network so powerfully demonstrates). The College's culture and business model seems very skewed towards individual, atomised relationships. It seems to discount the opportunity to cultivate, influence or develop cohorts, particularly diverse cohorts, or does so as the exception rather than the rule. We think that this should change, and the College should use its convening power to bring cohorts together, so make recommendations accordingly.
5. *Editorial clarity:* From reading College outputs it is not clear that diversity, inclusion and belonging play an important – or even minor – role in College ideas about what makes a good surgeon, a good leader or mentor. There is some patchy diversity content on the website but in no way could it be argued that it is a consistent theme or relentless drumbeat. This needs to change. A surgeon, a leader, a mentor, a team – all of the College content on these themes needs to reinforce a consistent message about the importance to patients, surgeons and the surgical team of creating a culture of belonging. We would suggest only in exceptional circumstances, and it is hard to imagine what these would be, should course design, content writing and editorial decision-making, not include a diversity element. The College needs to make it clear what it stands for. During the period of the Review the College published a letter from a retired surgeon which appeared to question the existence or legitimacy of stress within the profession¹¹ and, a few weeks earlier, a letter from a surgeon who carried on working through a miscarriage because she felt she had no choice.¹² The reader had no idea where the College stood on either of these points, which seems at best a lost opportunity.

Finally, we know that there may be times when it seems that this Review has strayed outside its lane or suffered from 'scope creep'. The breadth of this report is deliberate and comes from a deep understanding of the interdependency between diversity, inclusion and a culture of belonging on the one hand, and the organisation's strategy, effectiveness, ability to innovate and adapt on the other. Understanding that interconnection is vital to the long-term sustainability of the College in a rapidly-changing world.



11. <https://publishing.rcseng.ac.uk/doi/full/10.1308/rcsbull.2020.199>

12. <https://publishing.rcseng.ac.uk/doi/full/10.1308/rcsbull.2020.200>

Defending and growing the value of the College and its qualifications

4.1 What we learnt

4.1a Review origins

This Review was commissioned at what felt like a critical societal moment. In the world outside, the public had been shocked by witnessing the killing of George Floyd. In many quarters, boundaries were being transcended in showing support to the Black Lives Matter (BLM) movement. Corporations and large Firms were coming out in solidarity with BLM and stating intentions to do better on racial justice. At the same time, we were also learning about the different impacts of COVID-19 on diverse communities and the appalling statistics on deaths of Black and South Asian heritage doctors and healthcare workers.¹³ Simultaneously, the College Council held its elections, and the successful candidates were four White men.

“It was like watching an awful movie, when the [video conference] election went through its voting rounds you could see the diversity drop away and you just thought ‘oh, here we go again’”.

The College was on the receiving end of unfavourable social media attention as a result of this election outcome and, laudably, announced this Review.

“I feel so proud of my College for taking this on. We’ve known forever that there’s problem and lots of the Royal Colleges are the same, although many think surgery is the worst... but this is our opportunity to show real leadership”.

We believe that the Vision we have outlined, if achieved, will have an extraordinary impact on pride in, and engagement with, the College. And that there will be a corresponding ‘halo’ effect around the College’s qualifications and designations. But as we outlined in **Chapter 2**, we also believe that a failure to act will have a correspondingly damaging impact on pride, engagement and a tarnishing of the badge, the designation, that is at the heart of the College’s *raison d’être*.

4.1b Perceptions of the College

It is easy to think that the face of the College is the Council, or the officers, but for many, it is the website or the examiner or the faculty member that they meet. College staff have said to us, in relation to lack of diversity and fairness, “that’s just perception, we’re not really like that...” but the College must accept that it is perception that drives peoples’ behaviour, towards or away from the College. The College has to take on the challenge of changing perceptions, as well as changing some of the very concerning realities (e.g. the lack of diversity in the College ecosystem as described below in **Chapter 5**).

As we mention in **Chapter 1**, our survey found that the ‘old boys’ network’ is perceived to be the biggest barrier to achieving leadership roles in the College. We thought it worth digging a little deeper into the survey responses of those who perceived this barrier to see what the College could do to address the perception.

13. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

From our survey: of those who considered the 'old boys' network' to be the main barrier to achieving leadership roles and who aspire to a leadership role:

- The majority are dissatisfied with their current level of influence within the College (65%), while only 6% are satisfied.
- 3 in 10 would like to become a Council member (29%).
- Nearly half said lack of opportunities (47%) and lack of training/guidance on what is required (47%) are barriers to their achieving a senior leadership role. For example, one respondent mentioned a "lack of encouragement and transparency in the election process".
- Nearly 2 in 5 say racial discrimination (37%) and lack of role model in a senior leadership role (37%) are barriers. For example, one respondent said, "I have not seen a Black man or woman on the Council, no role models to make me think this is achievable".
- 3 in 5 do not believe the College represents people like them (60%), while only 9% believe it does.
- Half disagree that people like them are important to the College (50%, while 30% feel they are important).
- Only 6% believe the College uses its influence, resources and assets effectively to combat discrimination (while 63% disagree).
- Three quarters believe the College does not do enough to foster an inclusive environment (74%).
- Over half or more rate the College as weak on 'soft skills' training (53%), opportunities for secondments to different roles or organisations (65%), networking opportunities (60%), developing attitudes and behaviours of the surgical community (57%), opportunities to be mentored by senior surgeons (68%), diversity and inclusion training (63%) and research into surgical careers, diversity and inclusion (56%). Broadening representation at the College is seen as the weakest area, with nearly three quarters rating it as weak (73%).
- 3 in 10 rate the College as strong on advocacy to government on wider issues affecting surgeons (30%).
- The top 3 areas that they would like the College to demonstrate more of are broadening representation (71%), training focused on 'soft skills' (59%), and developing the attitudes and behaviours of the surgical community (57%).



4.1c Council as College leaders

The image of the Council cannot be separated from perceptions of the College.

“We now have a College led by 4 White men ... from the same background trying to represent the community of the RCS. This is not 1920 but 2020. The wider society and the world of surgery is enriched by multiculturalism and ethnicity and also empowering women with a strong and powerful voice... I urge [the College] to take some radical steps to realign the College otherwise the new building would merely represent a missed opportunity.”

We understand that there have been various attempts to reform, or to consider reforming, Council.

“The topic [Council size and make up – specialties] got too hot to discuss... but we’re more settled as a group now and it could be re-opened.”

“We couldn’t even get the Specialty Associations to agree to a particular selection method.”

“Council seems to have forgotten that there was meant to be a follow-up review to the introduction of the Specialty Associations – and to look at reducing Council numbers.”

“There is a huge spectrum in terms of how the speciality associations appoint their Council member – from ballot of all their members to deals made in smoke-filled rooms...”

Disincentives to engage with Council also seem to be the lack of efficiency in its operations, the plethora of Committees and sub-Committees, the poor accountability (e.g. for Committees to produce annual or quarterly objectives, to report back on performance, for the Council to hold each other to account for progress or lack thereof) and an absence or low level of ‘reporting back’ to Council when members represent College in other forums. These disincentives are real concerns when relying on

volunteer effort – which – as discussed in **Chapter 3** – is a scarce resource, under threat from competing pressures (workloads, family life, research, increasing expectations from NHS trusts, other Colleges, SSAs and so on).

Our concern is that Council risks being staffed largely by a self-selecting group who have the resources to work within this system and have little incentive to change it, but in not changing, risk excluding diversity.

We think that only by a radical shake-up, and deliberate injection of diversity into Council can any of the above start to be addressed. The Council needs Specialty Association representatives, but it also needs younger surgeons and surgeons with a wide range of background and experiences. It is vitally important that the Council discourse represents surgery as it is now, and what it may become, in order that Council’s hard work is of maximum relevance to the profession. We know that the College’s election processes are currently under review¹⁴ and the issues that we think need to be considered are:

- Widening the franchise for election of the President by presenting the membership with a ‘slate’ or shortlist of Council member candidates, elected by Council members.
- Setting the aspiration that there will be at least one woman Vice-President from hereon in.
- Balancing a widening of the franchise for Officer roles with the need for continuity and institutional knowledge and memory; we suggest that one of the Vice-President roles is voted for by the membership, and one by Council.
- Ensuring Specialty Associations are mindful of this report in their representation on Council.
- Regional representation on Council (including for international ‘regions’).
- Creating a closer relationship between the Future Surgeons Forum and the Council, ensuring that opportunities are taken to listen to the voices of medical students and ensure that the College has a progressive and informed voice on issues of medical school education.
- The mandate for elected and invited roles; we think it needs to be clearer whether Council members are representing ‘themselves’ or a specific community within surgery – and if the latter – what standards are expected by the Council to ensure that, that representation happens. If a Specialty Association Chair is speaking for their specialty, for example, the College should consider laying out the expectation that their input comes from data and evidence from that community, not from ‘gut feel’ or experience – that may be out of date or subject to any number of biases.

- The Commitment that is expected from Council members and Officers should be made clear, and articulated as much in terms of values and behaviours as activity. Our findings suggest that there will be a more meaningful shift in member engagement with the College by focusing on bringing values and principles to the fore, than in more busy activity to produce content for a very crowded ‘market’.

4.1d College staff and operations

Another very visible facet of the College is its staff, or paid workforce. The College’s ethnic diversity is low, with all sixteen of the most senior roles being occupied by White personnel. However, the leadership is gender balanced, with eight of these sixteen roles being occupied by women. On the gender pay gap, in February 2020 the College states on their website: “As of 5 April 2018... Our mean pay gap is 13.2% (National Average 17.4%)”.

The College’s vision, strategy and action plan for diversity – either in its staff or in the College ecosystem – is next to non-existent. The College has struggled to get a programme of work off the ground to develop a long-term strategic plan, vision or values. An internet search for RCS England values takes you to a page which states the “mission and values” as follows:

“The Royal College of Surgeons of England is committed to enabling surgeons to achieve and maintain the highest standards of surgical practice and patient care.”

Which does little to inspire, engage or tell the story of what the College really stands for (and what it will take a stand against).

Also on the College website is a section called “Equality and diversity” [sic] which states:

The Royal College of Surgeons of England is committed to complying with relevant equality legislation, the Equality Act 2010, codes of practice and best practice guidance.

Read our policy

In December 2020, the link to the policy does not work; the compliance statement (“we do this because it is a legal requirement”), rather than a values-based statement (“we do this because it is the right thing to do”); and the misspelling of diversity do little to inspire confidence that this has been an area of any concern or focus in preceding years.

Using different search criteria, we were able to find a 2004 document on the College’s website entitled “Equality and Diversity policy”¹⁵ which states, amongst other things, that:

- 2.1. *All people have rights under anti-discrimination legislation. They also have responsibilities to act without discrimination to others. All staff, affiliates, members, fellows and council members are required to conform to the College’s equality and diversity policies.*¹⁴
- 2.2. *Responsibility for equality and diversity issues are allocated as follows:*
 - *overall responsibility rests with the president and vice-presidents of Council;*
 - *each representative of the College is responsible for equality and diversity issues in his or her area.*

Of course, we cannot show causation between the lack of diversity in College officers, Council or staff and lack of strategic focus on diversity, but we suggest that the College accepts that the problems you solve and the solutions you develop depend upon the questions you ask. And it doesn’t appear that there has been anyone around with the power and influence to ask (or have answered), what we would suggest are, in this context, the right questions.

4.2 Conclusions

The College is a venerable institution that has achieved much. However it is unattractive to many. The perception of the ‘old boys’ network’ gets in the way of progress and must be changed. The College needs to shake up the composition and constitution of its Council and must recognise that it has a long journey to go on with its internal strategy, staffing and operations.

15. file:///Users/xxx/equality%20and%20diversity%20(2).pdf

Getting into the profession

5.1 What we learnt

5.1a Pre-medical school

For some of the surgeons and aspiring surgeons we heard from, the desire to be a surgeon started as early as the GCSE study period at school (ages 14 – 16). We heard of fantastic career advice from teachers and family, who, for example, had connected a love of science with a desire to ‘do something practical’ or ‘do something with [my] hands’. Dispiritingly, we also heard from medical students whose schools had attempted to dissuade them from thinking of surgical careers with comments such as “have you thought about pharmacy or biochemistry?” These students attributed this lack of teachers’ confidence or conviction that surgery could be for them as being due to their ethnicity, social background and teachers not being able to make the leap of imagination that someone who ‘looked like them’ could become a surgeon.

We heard positive and encouraging stories from students about widening participation programmes at medical schools, but none flagged visibility of the College in these programmes.

5.1b At medical school

We heard anecdotally that interest in surgical careers tends to drop off as medical school progresses.

The students we heard from were universally conscious of their backgrounds and the associated advantage or disadvantage. We heard from those who came from families of doctors and seemed aware of how this helped them – they felt they had the language and the understanding to be able to interpret soft signals, to look around corners and make sense of the world they’d entered.

“My uncles are all surgeons... it definitely helps... I grew up hearing about things that other students might not know about... And I can go to them for help when I need it”.

Those from less ‘traditional’ and/or less socially and economically privileged backgrounds described the early experience of medical school as very difficult.

“I was one of only two males from a state school background in my year at med school.”

“It was the first time I met people from outside my immediate community”.

“I felt like I had to change my accent – I felt judged all the time – and I had to work so much harder – or I thought I did – just to prove I wasn’t ‘some kind of a thug’ when I showed up in theatre”.

“Some of my friends went for acting or elocution lessons the summer before they started. They felt they had to. I became really conscious of how I walk and how I speak”.

The visibility, accessibility and narratives of role models and mentors was highlighted again and again:

“One of the people who said the ‘N word’ is a very senior boss, I can never do anything about that because I want a good job”.

“When I [a fourth year medical student] speak to Black surgeons they emphasise how hard it is... I’ve never heard a Black surgeon say anything different. It worries me because I think I know how hard you have to work to be a surgeon without having to work even harder because I’m Black”.

“People have said to me ‘the death of George Floyd was terrible, but did you hear what he’d done?’ – you’re under pressure to do a job but then you have these other things that are eating away at you and making you angry and upset. BLM is less high tension now but people like to debate it as an academic thing rather something that really affects people, for example they say, ‘but playing devil’s advocate maybe they should have killed him [George Floyd]”.

The feeling of having to change yourself to fit in – albeit something that to some degree may be felt by older adolescents regardless of social background – is concerning when we know that the representativeness of front-line hospital staff in relation to their communities predicts patient experiences of civility and care quality (and even hospital financial performance).¹⁶ As one medical student with a ‘regional’ accent and coming from a working-class background put it “I know it’s good for patients if I’m me but it might be less good for my career if I’m me.”

“I am sticking at it because I am stubborn and surgery is what I want to do, but I can’t exactly say I am encouraged [as a Black female medical student]”.

It is generally recognised that to make it to medical school is an achievement. It was reported in 2019 that the applicant pool for 2020 entry was record-breakingly large.¹⁷ What is abundantly clear is that to make it to medical school from what is often referred to as a ‘non-traditional background’ is an extraordinary achievement. To make it through medical school and to retain a commitment to surgery is even more extraordinary.

Some students described very positive experiences of theatre in medical school. Others struggled, and didn’t feel that they were given the guidance that they needed to know ‘how to behave’. The College’s ‘Learning in Operating Theatres’ may not have penetrated the system in the way that it could have done.

We heard some positive examples of training starting to be put in place in medical school on health inequalities and combating discrimination but this seems long overdue. Students described how it didn’t feel like long ago that “[the medical profession] believed that Black patients have higher pain tolerance, thicker skin, need less recovery time after injuries – we still need to discuss these things... for example have more education to help people understand that pain can be expressed in different ways in different cultures”. There is a clear opportunity for the College to be more vocal on the need for anti-discriminatory training in medical schools and its relationship to patient treatment and outcomes. Relevant resources include the AMEE Guide Teaching Diversity to Medical Undergraduates,¹⁸ the BMA’s ‘Charter for Medical Schools to Prevent and Address Racial Harassment’,¹⁹ and ‘Mind The Gap’ (guidance on clinical signs on black and brown skin, founded by Malone Mukwende, a St George’s medical student)²⁰.

16. King, E. B., Dawson, J. F., West, M. A., Gilrane, V. L., Peddie, C. I., & Bastin, L. (2011). Why organizational and community diversity matter: Representativeness and the emergence of incivility and organizational performance. *Academy of Management Journal*, 54(6), 1103-1118.

17. <https://www.bbc.co.uk/news/education-50318703>

18. <https://pubmed.ncbi.nlm.nih.gov/26642916/>

19. <https://www.bma.org.uk/media/2030/bma-med-school-charter-implementation.pdf>

20. <https://www.blackandbrownskin.co.uk/mindthegap>

5.1c Careers outreach

Careers outreach from the College appears patchy and to rely on volunteers, particularly through significant efforts on the part of WinS members, yet this is the point where engagement with the College could build lifelong loyalty and commitment. Where there are events supported by individual College volunteers, e.g. Becoming a Doctor²¹ for school children, the events are not highly visible across College digital channels, so the opportunity is missed to remind the wider membership of the importance of their responsibilities to foster future generations. The College literature on careers in surgery is not particularly enticing and does not seem to have a clear audience in mind. It could be argued that the target audiences should be the same audiences that are targeted by widening participation programmes; that the priority audience should not be those who are likely to go to medical school anyway, but those that aren't.

There is a clear opportunity for the College to build loyalty with medical school students that carries into future careers. In our survey, the age 18 – 24 cohort was the most enthusiastic of all age cohorts in its attitude to the College, although there is a 'red flag' over the degree to which the College fosters an inclusive environment.

Survey extract: People aged 18–24 are the most likely age group to agree that the College represents people like them (60%), that people like them are important to the College (70%), and that they are satisfied with their level of influence (50%). However, they are also the most likely to believe the College does not do enough to foster an inclusive environment (50%).



60%
of 18–24 year olds agree
that the College represents
them but believe it does not
do enough to foster an
inclusive environment

5.2 Conclusion

Careers outreach to diverse communities is not staffed or planned for as a strategic priority in the College, but we suggest that it should be. It is the opportunity to 'get in early' with aspiring surgeons from diverse backgrounds and for existing surgeons to learn and gain better connection – or maintain connections – with the future pipeline. This opportunity begins at school and goes through medical school and into foundation years.



21. <https://www.becomingadr.org/>

Accepting the unacceptable to advance in the profession

6.1 What we learnt

6.1a Attrition of women

It's clear something happens to women in surgery. More than 50%²² of medical school entrants are women. In surgery, over a third of all trainees are female (34.8%) and the proportion of consultants who are female is 14% in 2020²³. This compares against the broader population of trainees where just over half are female (56.6%) and the proportion of consultants who are female increased from 31% in 2013 to 37% in 2020.²⁴

The College runs Women in Surgery which has been spoken of highly by many of the women we spoke to for this Review, but it appears to be tangential to, rather than core to, the strategy and operations of the College. The Chair of Women in Surgery is not a Council role. Despite the strength of the network and the events delivered, there is a risk that ‘women’s issues’ (i.e. the issues of 50% of the population) are marginalised and seen to be the concern of this group or network alone. It is worth asking whether the de facto Men in Surgery network is the majority of the College ecosystem, with Women in Surgery being run on the sidelines as a minority pursuit.

The other key initiative to support women in surgery is the Lady Estelle Wolfson Emerging Leaders’ programme, which was developed five years’ ago with a view to developing women into leadership roles. Whilst a number of the women from the programme have taken up leadership roles in their Trusts or their specialisms, the success rate for Council is disappointing. We think the programme is ripe for a refresh. The pipeline of applicants could be bolstered, the selection criteria made clearer and greater transparency introduced into the process. It is worth questioning whether it is right ‘to fix women’ for the Council environment. Maybe the Council environment should be made more friendly to women, as an independent evaluation of the programme suggested.²⁵

“It seems both Masonic and colonial”.

“Overall I was left... with an impression of long tedious meetings in an organisation which was very hierarchical and stuffy... Clare Marx was a breath of fresh air but the rest was stifling and off-putting”.

The same feedback study²⁶ cited that:

“More than a third (36%) [of the women surveyed] considered that a concern that female surgeons are not valued by the RCS serves as a barrier to female surgeons applying for College leadership roles. Comments made by a couple of respondents suggest that perceptions of the RCS as a ‘boys’ club’ persist for some and can serve as a barrier. As one fellow said ‘Positions rely on votes and being clubbable’.”

Time and location are also frequently cited as a barrier:

“Juggling hospital leadership positions with other career development – examining... No leave outside SPAs being given for external work means repaying clinical time, family commitments and the travel to London”.

There is of course a vicious cycle here. The less time someone has to commit to College life, the less chance one has to raise one’s profile and therefore to be successful in elections or appointments to College roles.

22. <https://www.bmj.com/bmj/section-pdf/959692?path=/bmj/360/8138/Careers.full.pdf>

23. GMC submission to this Review

24. GMC submission to this Review

25. Independent Evaluation RCS England Lady Estelle Wolfson Emerging Leaders’ Programme June 2020

26. Independent Evaluation RCS England Lady Estelle Wolfson Emerging Leaders’ Programme June 2020

“Juggling multiple roles and managing the family is the single biggest barrier that I encounter”.

The recent independent evaluation²⁷ of the Lady Estelle Wolfson programme states:

“This evaluation provides evidence that fellows of the programme are made more aware of leadership opportunities at the RCS and, for 80%, it has sparked their interest in getting involved with the College. This should have long-term gains, even if in the short term it leads to only limited numbers of fellows applying for leadership positions. Of the forty fellows this survey heard from, nine (23%) had applied for a leadership role at the RCS.

Given some of the comments made around the time commitment entailed in taking up leadership positions, consideration should be given to arrangements for job sharing and part-time working in leadership roles. The RCS may also wish to give thought to the career stage at which female surgeons are most likely to apply for leadership roles, in light of comments made by SAS surgeons regarding the paucity of opportunities for these surgeons and also the number of trainees who have participated, including one ST4.

Some comments made by fellows regarding perceived barriers for female surgeons to leadership roles at the College highlight that there is still some way to go: lack of confidence to apply for these positions and insufficient awareness of the leadership opportunities at the RCS are two challenges that the leadership programme is well-placed to address and in which it is demonstrating impact.

It is evident that the leadership programme is extremely well received by participants and its impact extends well beyond encouraging female surgeons to apply for leadership positions at the RCS. Most of the fellows who joined the programme already occupied a leadership role and went on to apply for other roles. The value of the programme in terms of increasing self-confidence was emphasised time and time again.”

Although the College has a Less than Full Time (LTFT) advisor, LTFT does not seem to have a high profile at the College. The Royal College of Physicians has a LTFT network and Health Education England’s (HEE) submission to this Review refers to:

“A planned expansion of our Less Than Full Time (LTFT) Category 3 offer, which will also provide trainees in any specialty with the opportunity to apply to train LTFT, without having to provide a specific reason. This has significant potential to benefit those trainees who do not wish to share disability or other personal circumstances to HEE”.

In one focus group of surgeons starting families, a surgeon in their network who worked LTFT was described as *“the mythical LTFT surgeon”*, indicating how rarely the option is available or considered feasible.

Our survey also sheds some light on women’s perceptions of the College:

Men are more likely than women to feel the College represents people like them (37% and 24% respectively). Males are also more likely than females to believe the College uses its influence, resources and assets effectively to combat discrimination (31% and 16% respectively), that people like them are important to the College (48% and 36% respectively), and to disagree that the College does not do enough to foster an inclusive environment (27% and 13% respectively).



The last years of training coincide for many women – and men – with starting families, taking on further debt (for mortgages), and, in the case of many, beginning to take on more caring responsibilities for aging relations. For some it is a time of immense, overwhelming pressure. One of the major societal changes for recent generations has been the renegotiation of personal relationships; many more women have jobs and careers and many men now share parenting and other domestic responsibilities.

“There are new dads in my network who have taken on research posts just to be able to spend more time with their babies. I think less and less people will be prepared to put up with what it takes to see training through, particularly if both of the couple are medics”.

“It used to be that you could be in theatre and then go out for a drink or to a meeting and go home knowing that everything was taken care of [by your wife]. I know it’s not like that for many surgeons now”.

“I struggled to work part-time as a male trainee with childcare issues. The Deanery may have pretended to be supportive, but all consultants in this trust were very difficult.”

But as a group of female ENT trainees stated:

“We suggest that increased understanding and flexibility of the profession towards trainees with extra-work responsibilities will be ‘paid back with interest’ in terms of full-time retention, and those who do not have children (yet or ever) will also eventually find themselves in circumstances to also benefit from this increased flexibility. In addition, it is increasingly common for medical students and junior doctors of both genders to take work-life balance into account when planning their specialty choice – if we want the best end product (and more women), we need to attract them to start with (or at least, not put them off)”.

We did not identify a significant influence of the BMA’s work on *Enhancing Junior Doctors’ Lives*²⁸ or HEE’s associated work²⁹ on the College’s strategy and discourse around surgical education and surgical culture and we consider that this may be a missed opportunity. The College could be using its voice and influence to assert to Trusts and Deaneries not just the importance of supporting parents in keeping their careers going through challenging times, but more widely about the importance of both trainers and trainees engaging in College life – enriching and advancing the profession for the benefit of current and future generations of patients.

6.1b It’s not only about straight, White women

There is no College equivalent of Women in Surgery for people of colour, LGBT+ surgeons or surgeons with disabilities. Further, looking at the issue of attrition through an intersectional lens, it is clear that surgery is a very difficult place for Black women, more so for Black women from the LGBT+ community. A gay Black woman surgeon who was interviewed for the Review did not feel safe giving evidence to the Panel and conveyed a real loneliness from her time as a trainee and spoke passionately about the need for mentors and role models from diverse backgrounds and communities.

Black and Asian men and women can suffer a double jeopardy in discrimination terms – not only from colleagues within hospitals and healthcare settings but also from patients. It is very clear that more work needs to be done at College level to amplify, reinforce or codify in standards the various NHS Trust and NHS bodies’ work on ally-ship and bystander training.

28. <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/enhancing-junior-doctors-working->

29. <https://www.hee.nhs.uk/our-work/doctors-training/enhancing-working-lives>

“As a Black man, a consultant, it’s shocking when a Black patient says I want to see a White surgeon, but it does happen... what can you say?”

“I can’t count the number of times I’ve been mistaken for a nurse”.

Stand-out findings from our survey on race and ethnicity were:

People from a Black ethnic background are more likely to disagree that the College is representative of people like them (66%) compared to those from other ethnic backgrounds. White respondents are more likely to feel satisfied with their current level of influence within the College (23%), to believe that people like them are important to the College (50%) and that the College is effectively combating discrimination (32%) compared to people from other ethnic groups.



2 in 3
from a **Black ethnic background** feel the **College is not representative** of people like them

We also learnt in the Review about the difficulties of ‘coming out’ for LGBT+ trainees, who may have to go through the difficulty of this experience every few months as they progress through their rotations and we heard of examples of both blatant and subtle discriminations when they did so. We heard reports of people being ‘outed’ painfully, in ways that had considerable emotional consequences.

6.1c Career Milestones: College examinations

The MRCS and FRCS are significant career milestones. We have looked at these examinations through three lenses:

- i. Experience of examinations.
- ii. Differential attainment.
- iii. The Court of Examiners.

6.1ci Experience of examinations

Of most concern in this area were the stories that we heard that seem to be well-embedded within the profession’s discourse that the English College is not the place to do exams if you are a surgeon of colour or an international medical graduate (**see also Chapter 2**). It did not appear that College staff or leadership had a high level of awareness of this narrative. This lack of awareness provides a sharp example of the need to increase diversity within the system, so that the College does not sleepwalk towards risks that are highly visible to some (under-represented groups), but perhaps not others (current incumbents).

6.1cii Differential attainment

The College provided us with a paper from 2017/18 on differential attainment with data from 2013–17.³⁰ The paper defines differential attainment as “the difference in levels of educational achievement that occur between demographic groups undertaking the same assessment.” The paper acknowledges differential attainment to be evident across all examinations and highlights examiner recruitment and a mandatory online training course as the key tactics to close attainment gaps.

The online training material which we reviewed includes the statement that “*the Surgical Royal Colleges... are working to eliminate the differences within the MRCS. This will involve the concerted effort of all those involved in the examination which is part of the reason for this course.*” The material also states that “*...there is differential attainment across these groups [gender, age, ethnicity, specialties]. The reasons for these are complex. More data and research will be necessary to fully understand them. However, in this context it is important that the Surgical Royal Colleges are doing as much as possible to ensure that their processes are fair and robust.*”

We were not provided with any more current data on differential attainment (post-2017), nor with any information that suggested that the *further data and research into this complex issue* referred to above is a strategic priority for the College. The data on the diversity of the Court of Examiners (see below) is discouraging.

Examinations are a key touch point for surgeons. They are an opportunity for assessment, but also for the College to show itself at its best, at its most welcoming and developmental. We did not witness strategic clarity on this point, nor did we gather that the statements of intent made in the online examiner training were being borne out in terms of investment in, and commitment to, greater understanding and commitment to eliminating differentials.

30. Differential Attainment, Royal College of Surgeons of England (internal paper)

6.1ciii The Court of Examiners

Attaining a position on the Court of Examiners is seen as an important step towards Council and potentially College leadership. The Court of Examiners is the 'visible' face of the College to many at a critical point in surgeons' careers, and it has significant power over those peoples' careers. The diversity of this group, then, could be argued to be one of the most important of any College group. It is therefore quite shocking to see the low gender diversity within the Court of Examiners; 11% are female and 30% are from minority ethnic backgrounds. We consider that significant work needs to be done to bring a greater gender balance to the Court.

6.1d Progressing to leadership

As we learnt from one Black consultant surgeon, it is perfectly possible to progress and have a successful career in surgery without engaging with the College.

"You're right, I have been very successful... but I haven't really got involved in College life. If you hit your head hard enough against a wall you might break through I suppose – but at the beginning of your career you're trying to establish yourself and it's harder as a Black man anyway – then you try for a couple of College roles and you're unsuccessful – and the same people are successful over and over again and you just realise that you're better off not getting into the politics side of medicine... Maybe I should have pushed harder but there's a wall there".

But this Review is focused on College leadership so this section focuses on the pathway through to that.

The pathway through to College leadership seems to be movement through the ecosystem, culminating in either being elected to Council, being appointed to Council (as the head of Surgical Specialty Association (SSA)), or not. There are no written rules for this movement through the ecosystem, ultimately it is a question of having profile so that when it comes to Council elections your name and face are known. To reach the ultimate leadership roles of President or Vice-President, you need to be elected by the Council (by those in elected SSA roles). There is no reason to think that structural or societal inequalities are overcome by the College's electoral system, as is evidenced by the data from the College on the diversity of successful and unsuccessful candidates.

We have considered the issue of progression to College leadership from three perspectives:

- i. Elections to Council and leadership.
- ii. Developing profile in the College ecosystem.
- iii. Belonging and the 'mental load'.

6.1di Elections to Council and leadership

The College provided us with data on two years of elections to Council, split by gender and ethnicity. It also provided five years of data on gender and elections to Officer roles and five years of data on gender of the Trustee Board. Data on ethnicity and elections for Officer roles and the Board of Trustees was not available at the time of writing (see **Tables 1** and **2, Appendix 1**).

Approximately one quarter of Council roles are held by Specialty association representatives. Currently these do not add to the diversity of the Council, if anything they skew Council further from being representative, as the significant majority of these roles are held by White men (see **Tables 3** and **4, Appendix 1**).

From this limited data set, one thing is clear. The issue of low diversity or lack of representation in Council and Officer roles is not on a path to resolving itself over time. **If anything, the trajectory is in the wrong direction.**

6.1dii Developing profile in the College ecosystem

We found that the diversity of the various volunteer roles in the College ecosystem is low. In other words the pipeline towards the electoral pool is low in diversity, in some areas quite shockingly so (see **Tables 5** and **6, Appendix 1**).

What is clear from the College is that other than in some limited examples there is no strategy for fairness, diversity or inclusion in the selection or appointment of these roles. We heard a great deal of "I was invited to..." "I was asked to..." a culture of shoulder tapping, of a small not a big world (see **Chapter 3**). There is also no central pulling together or monitoring of data, so there is no impetus or governance around improvement. Developing a diverse (and therefore representative and sustainable) ecosystem does not appear to have been a priority. What isn't measured is unlikely to matter.

Translating this lack of diversity into 'real life' has two significant, and for someone who is structurally disadvantaged, quite frightening, implications:

1. Power, over peoples' careers (e.g. whether they pass or fail exams, whether they receive a research grant or don't, the experience that they have in training), is concentrated in the hands of a narrow section of society who are likely to have walked in very different shoes down very different paths than those less privileged.
2. The chances of increasing diversity in the Council, and therefore the pipeline through to leadership roles, are infinitesimally low, until this issue is addressed.

6.1diii Belonging and the ‘mental load’

It is one thing to recognise that election mechanisms are inadequate or that recruitment methods need to change. It is another to develop the empathy and understanding required to make welcoming the environments you wish to recruit more diverse people into. An absence of welcome, or of a sense of belonging, for women, disabled, LGBT+ surgeons and surgeons of colour came through time and time again in this Review.

We must not underestimate the impact of the issues raised in the GMC’s Fair to Refer³¹ report and high profile cases such as David Sellu’s on people of colour in surgery; nor the impact of ongoing micro-aggressions and the degree to which they can grind people down. Surgery is a tough job, it requires stamina, resilience and self-belief. You have to be confident to do it well. We think the College needs a heightened awareness of just how much additional work is involved in being in a space where you may not feel welcome.

“It’s very subtle, it’s the way you’re ignored completely – you go to a meeting and you’re the only Black person there – and even colleagues from your own hospital don’t seem to have time for you when their White colleagues are around. You’re left asking ‘shall I force my way into the conversation?’ but you leave it because you don’t feel welcome and you’re just ignored”.

“And yes there are things that I experience that I know White male consultants don’t – but I can’t react – it’s very easy to label a Black man as aggressive, arrogant or defensive, you constantly watch over your shoulder and accept slights that you know are wrong”.

“The [working] culture is a huge part of what will influence my career choices – it’s that, that makes me wonder if surgery is for me...”.

“[In a discussion forum] one SHO shared that they feel under pressure to perform and be as good or better than others – and a White male SHO shared that he feels he is automatically accepted when he arrives on a new ward. Then an older consultant came in and said emphatically and loudly ‘not one of you has experienced racism, there is no racism in this trust’ which made [all the people of colour] in the room feel de-valued and undermined”.

“There is a constant internal stress and battle of being in spaces where no one else looks like you and you keep it under control but every now and again the emotions surface. And this is our daily lives”.

“When I see people like me it makes me more comfortable – it makes all the other difficult things about pursuing a career in surgery seem more manageable...”.

31. <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/fair-to-refer>

The quotes above should not be read as victim narratives. We did not meet contributors to this Review who were looking for sympathy. What they were looking for was knowledge, insight and empathy. And, admirably, many contributors brought these issues directly back to patient care:

“At work when you hear a racist comment you may have a patient on the table – you don’t want any discord in the group because that would have result in poor patient care so you don’t say anything... but if it was a more complex case my upset could have resulted in poor patient care because I would have found it hard to concentrate”.

We also heard about the hypervigilance that many surgeons of colour feel that they are subject to. Once again, there is a double jeopardy; the surgeon of colour feels greater scrutiny, so is more careful, takes more time, then is criticised for not moving at pace, getting through their lists and for not getting involved in less core activities – including, of course, College life. We heard from a medical student who described her deep discomfort about the way trainees spoke about one of their colleagues, because she was (in the mind of the medical student) very conscientious and concerned not to make mistakes, but had a ‘weakness’ (in the minds of her colleagues) for which she was mocked, behind her back (but in front of medical students).

6.1e SAS surgeons and international medical graduates

We cannot complete a section on ‘getting on in the profession’ without a focus on international medical graduates (IMGs) and Specialty and Associate Specialist (SAS) surgeons. The issues and difficulties are well rehearsed³² and we understand that joint action between the four surgical Colleges is planned to start to address these issues. The College currently seems to make minimal specific or tailored provision for its c1,800 SAS members, yet the NHS long-term plan³³ makes clear that international recruitment is set to rise.

“When you come to this country [as an IMG] the system is bewildering”.

“We can learn the UK culture, we want to, that’s not the main role of the College – we need help understanding and navigating the system – and we need professional development. And we need the College to stand up for us. Just because we’re not Trainees doesn’t mean we don’t need training”.

“The SAS community are not having their basic work needs met – they lack opportunities for voice and influence, to have control over their schedules and activity; they fear blame and perceive injustice, they lack supportive colleagues and a sense of belonging”.

“When Overseas doctors join the NHS they get very poor induction into the new milieu”.

“The RCS feels behind the curve in utilising the talents of its non-consultant grade population – specifically the SAS group. There is an SAS group and SAS representation at council, but these feel separate from rather than integrated into the work of the College”.



“IMG surgeons are the most fearful, the most bullied, it has to stop. They are so keen to participate, to be part of education, to go the extra mile, but they are routinely excluded”.

32. <https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/survey-of-specialty-and-associate-specialist-and-locally-employed-doctors>

33. <https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained#finance>

Encouragingly, we did hear examples of good practice to improve opportunities and experiences of non-training surgeons, for instance the BHR Academy of Surgery developed by Mr Veeranna Shatkar with the support from Mr Sas Banerjee and Mr T Amalesh at Barking Havering and Redbridge University Hospitals NHS Trust. The College could more proactively demonstrate its commitment to non-training surgeons by identifying and sharing such examples of good practice, or even endorse them and provide a means of scaling up their impact. In its submission to this review the SCTS highlighted an aim to increase the opportunities and support for career progression “to Clinical Fellows and Trust Doctors who are often from a Black, asian and minority ethnic (BAME) background. The Society is planning to enhance the SCTS education programme for these doctors to ensure opportunities for career progression, such as exam revision courses for the FRCS (C-Th) examination, and guidance on obtaining Article 14, applying for consultant posts and consultant interview practice. In addition, the SCTS is planning to develop a ‘role model’ infrastructure to provide career guidance and advice, where these doctors can contact those who have been in their position and overcome the challenges.”

6.1f What members say will help to remove barriers to leadership positions

There is a fairly even split across areas that respondents mention they would like to see more of. Around half suggest training programmes/education focused on ‘soft skills’ (leadership, management, wellbeing, work culture etc.) (53%), broadening representation at the College (48%) and advocacy to Government on wider issues affecting surgeons (50%).

As discussed above, the most commonly perceived barrier to leadership positions is the ‘old boys’ network’. Of those who view the ‘old boys’ network’ as a barrier and aspire to a leadership position in the next three years:

Over half or more rate the College as weak on ‘soft skills’ training (53%), opportunities for secondments to different roles or organisations (65%), networking opportunities (60%), developing attitudes and behaviours of the surgical community (57%), opportunities to be mentored by senior surgeons (68%), diversity and inclusion training (63%) and research into surgical careers, diversity and inclusion (56%). Broadening representation at the College is seen as the weakest area, with nearly three quarters rating it as weak (73%).

6.2 Conclusion

The lack of diversity in College leadership roles is **not going to sort itself out over time**. The College needs to get to grips with creating a representative Council, and pipeline through to Council. And it needs to see this challenge not just through a technocratic lens of processes and procedures, but through a lens of culture and environment – listening and adapting its ways of working to cultivate a sense of belonging **for every surgeon**.

On examinations, which we consider to be of pivotal importance to the College’s reputation and sustainability, we would like to see the College make a clear principled statement that differential attainment is absolutely not a function of learner deficit; it is a function of learner environment deficit, and to invest in research and solutions accordingly.



Recommendations: the 16-point plan

This should be in place for ten years only – to shift the dial on equality in leadership.

(See Appendix 2 for further details)

1. Commit to the RCS England Vision, putting diversity at the heart of College strategy



To be an inclusive, diverse, professional organisation committed to fairness, and anti-discrimination, supporting and promoting the highest professional/surgical standards and the best outcomes for patients in a spirit of respect and compassion – for patients and for each other.

2. Commit to The Reform Target

Within two Presidential terms the Leadership and Council will reflect the diversity of the wider medical workforce. That means within five to six years from now.

3. Reform Elections for Presidency

The Council should present a slate of potential candidates for this prestigious role. The slate of candidates should be presented to whole Membership and then voted upon.

4. Reform Election for the Three Vice-Presidential Roles

The Council should again present a slate of candidates for election by the Membership. If the two candidates with the highest votes are male, the third Vice-Presidential place should go the woman with the highest votes. This should be in place for 10 years only, to shift the dial on equality in leadership.

5. Reform Council

- There should be three tiers of elected members.
- Those entering surgery – four/six years.
- Those at mid/senior level – (this cohort should be the largest in number – for Council to decide detail).
- Those in senior years of practice or retired.

The Council should include representatives of Specialist Associations, Nominated Organisations and Lay Members. All should have voting rights. It is hoped that the Specialist Associations will reform their organisations in keeping with the spirit of this report as that will have a real impact on the diversity of the composition of Council.

6. Reform Election Process, Appointments, Committees and Conduct

Those standing for election should in their short electoral statement describe the positive *difference* not sameness that they will bring to Council. They should also commit to the Vision of the Royal College of Surgeons of England. There should be consistency and terms of reference for panels and committees and all should be diverse.

The conduct of Council and Committee Meetings and every element of the College from committees to Exam Boards and the Board of Trustees should pledge to be respectful, value the ideas of others and make space for new and diverse voices.

7. Develop a clear SAS Strategy

Work with the SAS Forum to create an overall action plan to give due recognition to the role of SAS practitioners.

8. FLAGSHIP PROJECT – Parents in Surgery

The experience of parents, who are training to be surgeons or are busy surgeons in practice, is extremely challenging and stressful; it demands urgent attention. A Task Force should be established to work with Deaneries, Trusts and Hospitals to address more supportive structures and career paths. The work of the Task Force should feed into the restructuring planned by government.

9. Deliver a Study on Differential Attainment in Surgical Exams

Make a clear principled statement up front that the current differentials are NOT the function of learner deficit. This firmly locates any study in the learning environment. This work should be undertaken with an independent academic partner with a declared intention that any gaps should be closed within five years of publication of the study. It should be fully resourced and prioritised.

10. **Launch Two Annual Research Fellowships into Surgery, Diversity and Inclusion**

These fellowships should focus on under-developed areas in the body of evidence such as careers in surgery and the LGBT+ community, disabled surgeons and surgeons from disadvantaged backgrounds.

11. **Support Diverse Grassroots Medical Organisations with Seed Funding**

Provide seed funding and/or support to grassroots organisations or collective efforts that seek to address diversity, equity and inclusion issues in surgery.

12. **Build on the College's strengths**

- Bring Women in Surgery closer to the heart of College strategy and operations.
- Refresh the Emerging Leaders' Programme to reflect the recommendations in this Report.

13. **Mentorship**

The end of the Firm structure within medicine, which provided a form of apprentice relationship between junior and senior surgeons, means that many young surgeons feel unsupported in their development. The College is the perfect home for Mentorship and one of the Vice-Presidents should have the specific role of developing a structured Mentorship scheme.

14. **Data Collection, Monitoring and Career Tracking**

An organisation cannot know whether it is making progress on making opportunities available in a fair and inclusive way if there is inadequate collection of information. Proper processes for this collection and analysis of information must be put in place.

15. Training

The Council and staff in the College will need training on how to implement the Report and in how to conduct anti-discriminatory recruitment and interviewing.

16. New Building

Make diversity clear in your new building – in the portraiture and publications, in the invitations to launches and gatherings and in websites and digital offerings.

The College will need an ACTION PLAN and TIMETABLE to deliver the ambitious changes involved in this Report and the recommendations will require an investment of resource.



Data tables

Table 1

Council elections, two-year perspective, ethnicity

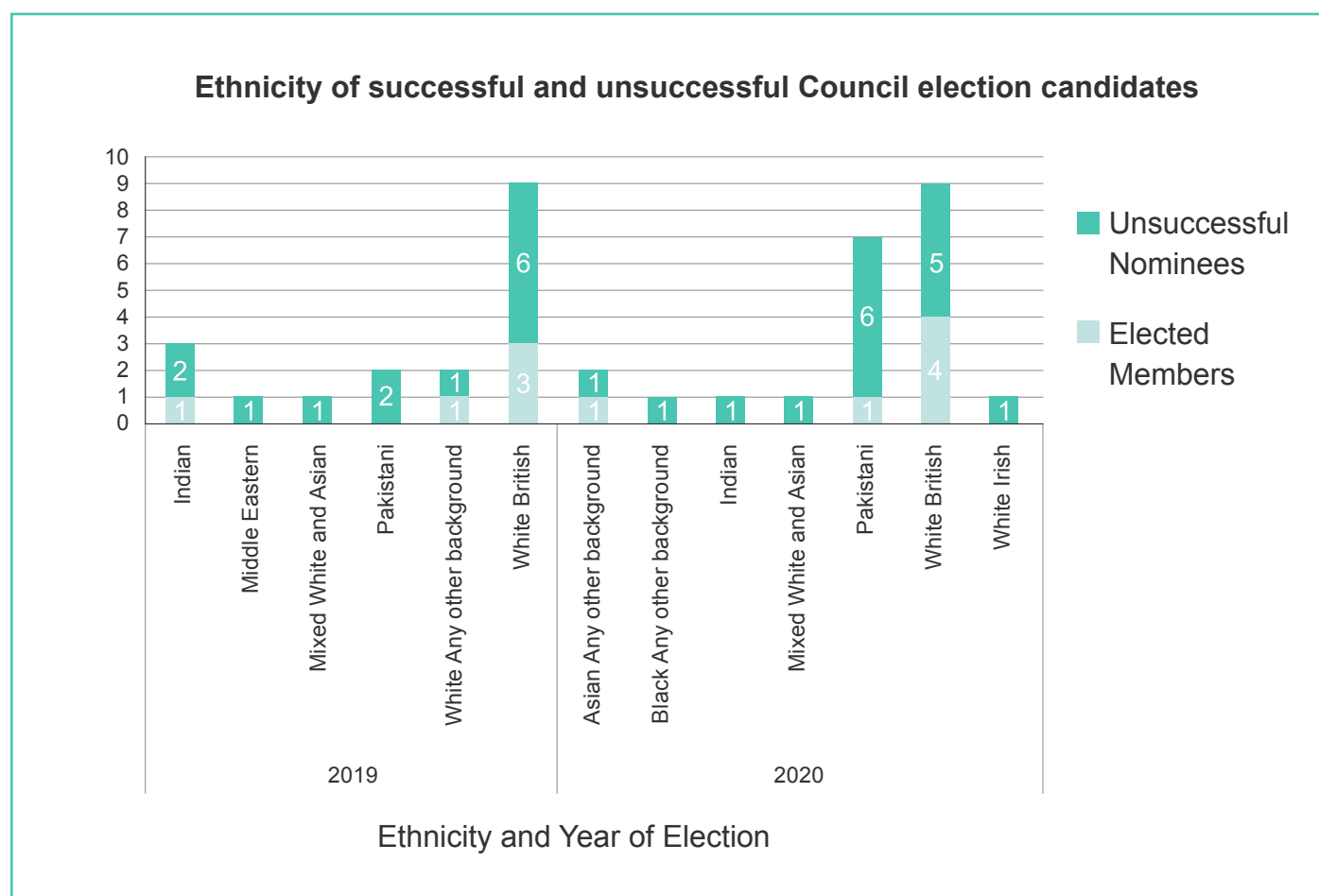


Table 2

Council elections, two-year perspective, gender

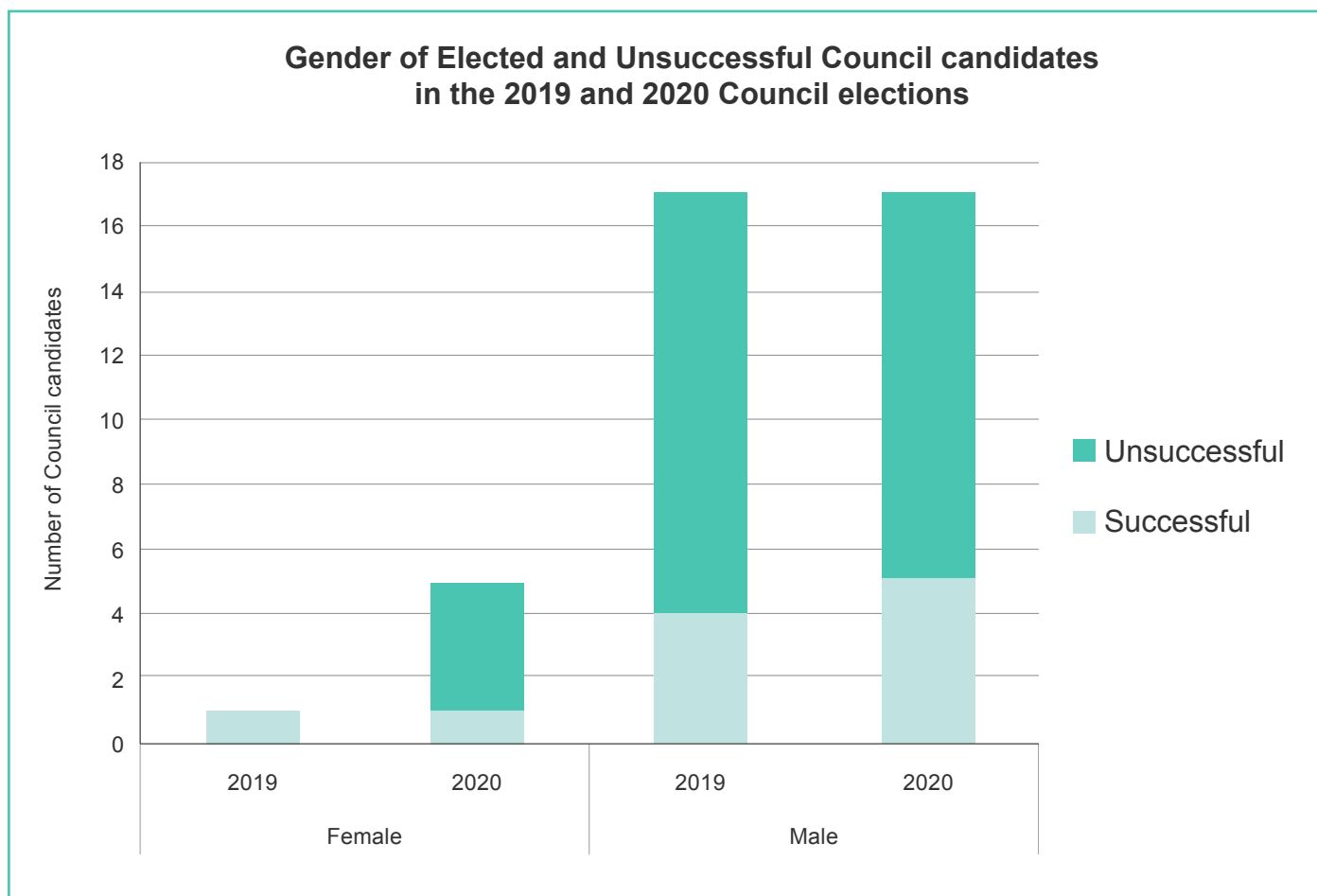


Table 3

Officers' data, five-year perspective

	2016–17	2017–18	2018–19	2019–20	2020–21
Male	4	4	4	4	5
Female	1 (President)	1 (President)	1 (Vice President)	1 (Vice President)	0
Total	5	5	5	5	5

Table 4

Trustee data, five-year perspective

	2016–17	2017–18	2018–19	2019–20	2020–21
Male	10	10	10	10	11
Female	2	2	2	2	1
Total	12	12	12	12	12

Table 5

College 'ecosystem' – diversity

Groups	Council	Court of Examiners	Regional Directors	Regional Speciality Professional Advisers	Research Assessors' Committee	Surgical Tutors	Faculty	Speciality Advisory Committees	Grand Total
Arab %	0.0%	3.9%	0.0%	0.0%	0.0%	0.0%	0.9%	0.0%	0.8%
Asian Bangladesh %	0.0%	2.1%	0.0%	0.0%	0.2%	0.0%	0.4%	0.9%	0.9%
Asian Indian %	4.7%	15.0%	25.0%	12.4%	3.7%	15.8%	10.7%	7.2%	9.5%
Asian Other %	0.0%	1.8%	0.0%	1.7%	0.8%	2.6%	2.6%	1.9%	2.1%
Asian Pakistan %	2.3%	3.1%	0.0%	0.0%	0.5%	1.5%	3.1%	0.9%	2.4%
Black African %	0.0%	1.6%	6.3%	0.0%	0.4%	1.0%	1.2%	0.9%	1.0%
Black Caribbean %	2.3%	0.0%	0.0%	0.0%	0.1%	0.5%	0.2%	0.0%	0.2%
Black Other %	2.3%	2.3%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Chinese %	2.3%	2.3%	0.0%	0.8%	1.7%	2.0%	1.6%	0.6%	1.6%
Irish %	0.0%	0.0%	0.0%	0.0%	1.0%	1.0%	0.9%	1.6%	0.9%
Mixed Other %	0.0%	0.0%	0.0%	1.7%	0.3%	1.0%	0.7%	0.0%	0.6%
Mixed White and Asian %	0.0%	0.0%	0.0%	0.0%	0.2%	0.5%	0.6%	0.3%	0.4%
Mixed White and Black African %	0.0%	0.5%	0.0%	0.0%	0.1%	0.0%	0.3%	0.0%	0.2%
Other %	2.3%	6.2%	12.5%	5.0%	4.2%	7.7%	3.4%	3.1%	3.9%
Prefer not to say %	0.0%	0.5%	0.0%	0.0%	0.2%	0.0%	0.2%	0.0%	0.2%
Unspecified %	37.2%	33.7%	37.5%	46.3%	54.4%	18.4%	41.3%	48.9%	43.2%
White British %	44.2%	18.7%	12.5%	17.4%	20.9%	28.6%	22.6%	19.1%	22.1%
White Other %	4.7%	10.6%	6.3%	14.0%	11.6%	19.4%	9.2%	14.4%	10.4%
Mixed White and Black Caribbean %	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Members	43	386	16	121	1,321	196	4,093	319	6,495

Table 6

College 'ecosystem' – diversity

	Female	F%	Male	M%	Grand Total
Council Members	12	27.91%	31	72.09%	43
Court of Examiners	43	11.14%	343	88.86%	386
Regional Directors	3	18.75%	13	81.25%	16
Regional Specialty Professional Advisers	10	8.26%	111	91.74%	121
Research Assessors' Committee	182	13.78%	1,139	86.22%	1,321
Surgical Tutors	42	21.43%	154	78.57%	196
Faculty	1,035	25.64%	3,001	74.36%	4,036
Specialty Advisory Committees	79	24.76%	240	75.24%	319
Grand Total	1,406	21.84%	5,032	78.16%	6,438

Detailed recommendations

The scale of change we are talking about is transformation – it is about reimagining the College in line with the Vision and it is about investing to achieve change. It is also about compromise and may be about sacrifice on the part of some. But we see this as an extraordinary, career-defining opportunity and an extraordinary time in surgery – it could be by design rather than circumstance that this Review follows the Future of Surgery Commission.

The College should not underestimate the volume of work involved in delivering these recommendations, which we estimate, with adequate resourcing, will take up to three years. We note that College staff are already working to capacity and so investing in additional resources and creating adequate capacity for staff to understand, take on board and implement these proposals will be critical to success. We remind the College of both the strategic and moral importance of this work – as outlined in **Chapter 2** – in making this proposal of significant investment.

A. Symbolic change

What	Starting when	Completing by
 Review Response		
Make an explicit and high-profile commitment to the Vision of the College as an inclusive, diverse, professional organisation committed to fairness, gender equality and anti-racism, supporting and promoting the highest professional/surgical standards and the best outcomes for patients in a spirit of respect and compassion – for patients and for each other.	Upon receipt of this report	Report publication
Make an explicit commitment to an underpinning objective to this Vision, that within two presidential terms, the staff and professional surgeons who undertake College roles will reflect the diversity of the wider qualified medical workforce. That is the clear target which is being set. Underpin this commitment with explicit examples of immediate change. We suggest that these should include, but not be limited to: • No ‘manels’ (male-only panels at College events). • Asking Council members to sign up to a pledge not to speak on panels or at events that do not reflect the diversity of surgery.	Upon receipt of this report	Report publication
Within three months of the publication of this Report, produce an Action Plan with specific objectives, deliverables and time lines and including clear commitment to necessary resourcing and transparent governance of plan delivery. We encourage nominating one of the College Vice-Presidents to lead and oversee the delivery of this plan.	Report publication	Three months in

 Leadership and governance	Starting when	Completing by
Commit, in principle, to a reinvigorated and representative Council, with space for specialties, those at the peak of their surgical careers, those entering their surgical careers as well as those coming to the end of their careers; supported by an election process that requires candidates to highlight the positive difference, not sameness, that they will bring to Council, as well as a demonstrable commitment to the Vision and a set of shared values. Expand the Terms of Reference for the review of College ordinances to cover: • The implementation of the principle above, including working through how trainee perspectives can best be represented (including with voting rights). • Encouragement to the Specialty Associations to consider this report in selecting their Council representatives. • Rendering specific the mandate and expectations of representatives of affiliated groups (e.g. Specialty Associations, trainee associations). • A robust look at the way Council meetings and other College meetings are run, which voices dominate, whose ideas are valued, and the adoption of a new charter or behavioural code for College meetings that prioritises purpose, inclusion and belonging and is accessible to all through the College website. • Accountability mechanisms for Council committees and ecosystem roles – published terms of reference, role descriptions, tenures, minutes.	Upon receipt of this report	Report publication
Review the election mechanism for the President role. Council should elect a 'slate' of candidates (from the existing Council membership), which should then be put to the wider College membership for election of a President.	Report publication	Three months in
Set the expectation that there will be at least one woman acting as Vice-President in the future. In the spirit of this report there should be a note accompanying voting papers in all future elections urging voters that in voting for the Vice-Presidency at least one of the votes should be for a woman candidate. This should be in place for 10 years only, to shift the dial on equality in leadership.	In line with election timetables	
 New building launch		
Make every opportunity to reinforce diversity, inclusion and belonging in the new building launch – portraiture, digital, priority invitees to any launch, accompanying communications collateral and so on.	In line with new building launch plans	



Parents in Surgery: Flagship research and strategy

Invest in a *Parents in Surgery* study and strategy as a flagship programme. And then strongly advocate outcomes of this work to Deaneries, Trusts, etc. We think that this is the single most important thing that the College can do to indicate support for working parents – particularly of babies and younger children – which will be essential to growing talent in surgery generally and in the College ecosystem.

This Parents in Surgery strategy should be prioritised, highly focused and done at pace; delivered with an independent academic partner. It should be inclusive (involving working mothers and fathers) and bold and radical in its definition and outcomes.

Within four months of report publication

Findings completed and implementation plan in place by end 2021



Sustaining visibility and momentum

Create an annual ring-fenced award for at least two annual grants of research fellowships that focus on issues of surgery, diversity and inclusion.

In line with Action Plan

In place by end 2021

Create or reallocate a budget of £50,000 per annum to be awarded as seed funding and/or support to grassroots organisations or collective efforts that seek to address diversity, equity and inclusion issues in surgery.

In line with Action Plan

In place for academic year 2022/23

Pilot a super-charged engagement programme with three non-London medical schools, providing Mentorship, offering students roles as reverse mentors to College leadership, committing diverse speakers and giving opportunities to meet/present to College leadership.

In line with Action Plan

In place for academic year 2022/23

Bolster the investment in, and creativity of, digital content on careers: for example new narratives on surgery (using some of the content from the Future of Surgery report for example); selecting channel partners and editorial takeovers of digital channels to coincide with medical school term beginnings, GCSE results days, National Careers Week or other key events. Ensure College's channels are used to amplify outreach work already being done by members.

In line with Action Plan

In place for academic year 2022/23

B. Institutionalising good practice

What	Starting when	Completing by
 Policy, process, insights and performance improvement		
Introduce an anti-discriminatory selection policy for appointment to roles in College ecosystem (Council committees, examiners, faculty etc.), monitor and govern.	In line with Action Plan	End of September 2021
Require and provide in-depth training on this policy, prioritising first Council members, Chairs of other groups (Court of Examiners for example) and key staff.	In line with Action Plan	By the end of March 2022 (All Council members and Chairs of Committees, Court of Examiners and staff)
Institute a continuous process of track, monitor, improve for all recruitment/selection into the College ecosystem. Monitor performance improvement through a clear internal governance structure, led by the nominated Vice-President.	In line with Action Plan	The process of track, monitor, improve should be fully embedded in College governance, management information and planning by 1 January 2022
Build a data set and ongoing data monitoring plan that focuses on interest in careers in surgery with a view to garnering better insight on points of attrition and therefore the ability to create more targeted interventions. The College can look to the multiple sources including the King's Fund³⁴ and the Workforce Race Equality Standard for the Medical Workforce³⁵ for inspiration and evidence to guide the development of this dataset.	In line with Action Plan	End of December 2021

34. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Making-the-difference-summary-Kings-Fund-Dec-2015.pdf
<https://www.kingsfund.org.uk/publications/workforce-race-inequalities-inclusion-nhs>

35. <https://www.england.nhs.uk/wp-content/uploads/2020/09/WRES-INDICATORS-FOR-A-MEDICAL-WORKFORCE.pdf>



Examinations

Deliver a study with an independent academic partner that identifies the reasons for differential attainment in surgical exams, making a clear principled statement upfront that the current differentials are not a function of learner deficit, and so positioning the exploration or study as one of learner environment. Commit to a fully-resourced action plan to close the gaps within a five-year time frame from study publication. We recommend factoring into this study an expected output of appropriate performance measures for trainers (e.g. do their trainees pass exams?) as well as trainees (are they passing their exams?).	In line with Action Plan	End of June 2022
Begin a process of advocating for the mandatory inclusion of the evidence base on health inequalities, diversity, inclusion and patient outcomes to be included in the medical school and College exam curricula.	In line with Action Plan	Ongoing, through each exam diet
 Embedding a narrative and practice of belonging		
Create a clear editorial policy that stems from the Vision – embedding and emphasising the Vision in practice guidance, post-grad training courses, sample job descriptions, trainings and tools and make sure that there is reference to current literature and evidence. The aim should be that diversity, inclusion and belonging comes through in all College outputs.	In line with Action Plan	By end December 2021
Develop an offer of support for surgeons who are under review (e.g. under a College review mechanism or who have been referred to the GMC). Although (we hope) volumes requiring this service will be low, its psychological importance – the message that the College ‘has your back’ is high. We would suggest, that if he is willing to participate, David Sellu is asked to consult to the College on developing this proposition due to his personal experience.	In line with Action Plan	By end December 2021
Adopt, amend and implement the RACS Operate with Respect mandatory training and develop a code of practice and pledge (to accompany membership renewals) to support sustained attention to the issues of diversity and inclusion, starting with the most ‘powerful’ College ecosystem roles – Council, senior staff, examiners, clinical leads and assessors.	In line with Action Plan	By end June 2022
Write to the Trusts and Deaneries making the case for the inclusion of work for the College in job plans.	In line with Action Plan	By end September 2021

C. Building on strengths



What	Starting when	Completing by
Strengthening the voice and influence of cohorts		
Develop a clear SAS surgeon strategy, working with the SAS Forum and informed by existing insights (e.g. GMC's 2019 report, ³⁶ SCTS work, best-in-class NHS Trust initiatives), to support and use the College's voice and influence to advocate for change, resulting in a clear action plan.	In line with Action Plan	SAS Action Plan ready for implementation 1 January 2022
Bring Women in Surgery closer to the heart of College strategy and operations, with a clearly defined budget and plan proportionate to its key role in the delivery of the overall Action Plan. Make the Chair of WinS a voting member of Council.	In line with Action Plan	In line with Action Plan, College budgeting cycle and review of ordinances
Develop a strengthened mentoring offer, bringing mentoring to the heart of the membership proposition and using the College's voice and influence to enhance the role of mentoring in the trainer role.	In line with Action Plan	By end December 2022
Refresh the Emerging Leaders' programme to reflect the commentary in this report – and expand to a pilot regional (diverse) cohort, working to the principle of developing diverse teams – rather than exclusive groups.	In line with Action Plan	Refreshed Emerging Leaders' Programme for 2022 launch Regional Leaders' Programme for 2023 launch
Create a speaker register, or seek partnership with an existing one (such as Women Speakers in Healthcare), and gain commitment from a diverse range of medical school students and surgeons to speak at schools. (Note that anecdotally we heard that there is already plenty of such provision for London schools, much less for those outside London).	In line with Action Plan	By end of December 2021

36. https://www.gmc-uk.org/-/media/documents/sas-and-le-doctors-survey-initial-findings-report-060120_pdf-81152021.pdf

Review Panel



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The Association of Surgeons of Great Britain and Ireland
The Black Medical Society
The Black Surgeons' Network
The British Association of Physicians of Indian Origin
The British Association of Urological Surgeons
The British Medical Association
The British Orthopaedic Association
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