

# Fair Training Pathways for All: Understanding Experiences of Progression. Part 2.

## Final Report

Prepared for the General Medical Council 17<sup>th</sup> March 2017. Revised 31<sup>st</sup> March 2017.

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## Glossary

AoMRC	Academy of Medical Royal Colleges
ARCP	Annual Review of Competence and Progression
BAPIO	British Association of Physicians of Indian Origin
BME	Black and minority ethnic
CT	Core Trainee
ECU	Equality Challenge Unit
GMC	General Medical Council
IMG	International Medical Graduate (graduate from a non-UK medical school)
LETB	Local Education and Training Board
MRCP(UK)	Membership of the Royal Colleges of Physicians (United Kingdom)
MTI	Medical Training Initiative
NHS	National Health Service
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
UK	United Kingdom
UKG	United Kingdom Graduate (graduate from a UK medical school)

## Executive Summary

### Background, Aims and Objectives

The *Fair Pathways* research project is part of a programme of research commissioned by the General Medical Council (GMC) to explore why UK medical graduates from black and minority ethnic groups (BME UKGs) have, on average, poorer outcomes in assessments and recruitment compared to white UKGs; and why international medical graduates (IMGs)<sup>1</sup> have, on average, poorer outcomes compared to UKGs (1).

*Fair Pathways* has been designed to elicit perceptions of the fairness of postgraduate medical education, and of the causes of differential attainment by ethnicity and country of primary medical qualification.

*Fair Pathways: Part 1* explored trainee and trainer perceptions, identifying 12 risks to BME UKGs and IMGs that could negatively impact on their progression through training (2, 3).

*Fair Pathways: Part 2* explored the perceptions of representatives of Royal Colleges and NHS Employers ('stakeholders'). It examined how significant the risks identified in *Part 1* were believed to be in hindering the progression of BME UKG and IMG trainees, and how amenable to change those risks were believed to be.

Main objectives were to:

- 1) Examine stakeholders' views of the risks, including any additional risks they identify.
- 2) Explore stakeholders' perceptions of how significant and amenable to change each of the identified risks is, and why.

We also sought to gather examples of good practice when they arose in the data.

The research questions were:

- 1) What are stakeholders' views on the risks identified in the first phase of the research as causing differential attainment in postgraduate medical education?
- 2) How significant are the risks perceived to be?
- 3) How amenable to change (could practically be mitigated or removed) are the risks perceived to be?

## Methods

### Participant sampling

The sampling frame included individuals with roles in examinations and/or curriculum design from ten of the largest Royal Colleges and the Academy of Medical Royal Colleges, and employees of NHS Employers with a remit around equality and diversity, education and training, and workforce management.

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<sup>1</sup> Doctors whose primary medical qualification is from a medical school outside of the UK.

## Data collection

Qualitative data were gathered in focus groups and one-to-one interviews conducted face-to-face, over the telephone, or online.

Before being interviewed, participants were asked to read the *Fair Pathways: Part 1* Executive Summary, including the 12 risks to trainee progression (2).

They then completed an online questionnaire in which they rated each of the risks for significance and amenability to change on a five-point scale.

Ratings were used as prompts within the interviews, which followed a semi-structured schedule.

## Data analysis

Thematic analysis (4) was conducted utilising NVivo 11© software (5).

Four researchers (KW, AR, HJ, RV) jointly produced the coding framework. Transcripts were divided equally between AR, RV and HJ, who coded them independently, meeting to discuss any areas of uncertainty and to ensure consistency. KW wrote the first draft of the final report, which all authors reviewed.

## Ethics and competing interests

Ethical approval was granted by UCL Research Ethics Committee (Ref: 0511/012). KW is educational advisor to MRCP(UK) for which UCL Medical School receives a fee. The research was funded by the General Medical Council.

## Results

### Participants

There were 31 participants from 11 medical Royal Colleges or Faculties or the Academy of Medical Royal Colleges (n=29), and NHS Employers (n=2). 55% were medically qualified, 61% were male, 71% were white British or white Irish, and 24% were Asian/Asian British (5% missing ethnicity).

### Significance of risks (Section 3.2, p.14)

On average all risks were perceived as significant, although the most significant were those relating to being 'different' from the dominant group, and the least significant related to trainee worries or concerns. Risks were felt to be greater for IMGs than for BME UKGs.

When rating the significance of risks, participants were influenced by evidence from four sources (p.16):

- personal experience of interacting with or observing trainees;
- evidence accessed as part of a professional role (e.g. within a Royal College);
- research evidence
- own personal experience of being in a minoritised group.

Most evidence was specialty-specific and sometimes location-specific. Research evidence referred to by participants tended to focus on examinations rather than recruitment, workplace based assessments, or training, and was from a few specialties.

Participants recognised that 'anecdotal' evidence from their interactions with trainees might not be generalisable. They placed particular value on research, especially quantitative studies published in peer reviewed journals.

Recognising the value placed on quantitative data, some participants described needing to collect data routinely, or publicise data that were already routinely collected, in order to guide action or to persuade others of the need for action.

When participants felt they lacked evidence about a risk they tended to downgrade its significance, even when this was because they had not had the opportunity to encounter evidence because their job or role did not offer it.

#### [Amenability to change of risks \(Section 3.4, p.21\)](#)

Participants were fairly pessimistic on average about the possibility of removing or mitigating risks, although there was some variation.

Two related factors influenced perceptions of how amenable to change a risk was: the level at which change is required, and participants' perceptions of their own ability to effect change (p. 23).

Risks that required change at the macro level - that is requiring large-scale political or cultural change - were perceived as most difficult to change, and those risks were also rated as highly significant.

Interestingly however, the most significant risk - that IMGs are inexperienced with UK systems and cultural norms - was perceived as highly significant but also fairly amenable to change, which probably reflects that fact that there are already interventions in place to reduce its impact, and it relates more to knowledge than to attitudes.

Risks that required action at the meso level (specialty, region, or employing organisation e.g. hospital Trust), and at the micro level (one-to-one interactions with trainees) were perceived as more amenable to change. This was largely because participants felt that they had the ability to effect change personally or had seen others attempting to do so.

Two participants described the importance of top-down support for change.

Participants' perceived ability to effect change personally was influenced by the following (see p.24):

- the scope and limits of their role(s): participants felt able to implement changes within but not without their workplaces, especially when changes had financial implications;
- whether participants felt they knew what caused differential attainment and which interventions might work: when participants knew of an intervention to address a risk it increased their rating of its amenability to change.
- participants' general outlook on life: whether they were an optimist or a pessimist.

#### [Interventions or actions to address differential attainment \(Section 3.8, p.31\)](#)

Participants mentioned five main types of interventions that they were aware of, or involved in:

- 1) Training for trainers;
- 2) Training for trainees;
- 3) Leadership;
- 4) Transparency around data and stakeholder engagement;
- 5) Design of recruitment and assessment systems to minimise bias.

Interventions were largely focussed on IMGs and none were targeted at BME UKGs.

Interventions typically addressed risks relating to unconscious bias in trainers; IMG adjustment to UK culture and systems and their integration in the workplace; bias in recruitment and assessment; and trainee anxiety about potential bias.

Only very rarely did participants mention interventions being evaluated.

#### [Barriers to change \(Section 3.6, p.28\)](#)

The experiences and evidence participants drew on to justify their perceptions of the risks arose from within their own specialty, or sometimes from their clinical practice. This meant participants could be unaware of good practice in other relevant areas. Together with the lack of evaluation, this might contribute to their perceived lack of knowledge about which interventions work.

Sensitivities around race could act as a barrier to change at all levels:

- At the micro level, participants recognised that it can be hard to talk about race-related matters with trainees;
- At the meso level, some participants felt that identifying bias within an organisation's activities could be damaging;
- At the macro level, some participants felt that 'positive action' such as giving trainees with poorer scores in recruitment better training opportunities, might not be fair to white UK graduates or high-performing trainees.

### Facilitators of change (Section 3.7, p.31)

The main facilitators of change were:

- Research evidence and data to prompt and guide action, and to persuade others of the need to change;
- Individuals feeling that they had the power to effect practical change within their role;
- Knowledge about which changes needed to happen and which interventions might work.
- Sharing of evidence and experiences across specialties and regions.

### Conclusions (Section 4.3, p. 42)

Going forward, the following actions could help organisations mitigate or remove the risks faced by BME UKG and IMG trainees:

- Developing and evaluating interventions to address ethnic differences in attainment among UK medical graduates;
- Finding ways to manage individual and organisational sensitivities around race;
- More research that spans specialties and that focusses on recruitment and training (including workplace based assessments) as well as on examinations;
- Increasing key stakeholders' access to information, including: research evidence from qualitative and quantitative paradigms, and from evaluations of interventions; examples of good practice from other specialties and regions, and from outside of medicine.



# 1 Introduction

## 1.1 Purpose of the research

This project aimed to explore key stakeholders' perceptions of previously identified risks to the progression of black and minority ethnic UK medical graduate (BME UKGs) and international medical graduate (IMG) trainees, in order to inform the development of interventions for positive change.

The stakeholders identified by the General Medical Council (GMC) as being of interest were medical Royal Colleges including the Academy of Medical Royal Colleges (AoMRC), and the organisation NHS Employers<sup>2</sup>.

Main objectives were to:

- 1) Examine stakeholders' views of the risks, including any additional risks they identify.
- 2) Explore stakeholders' perceptions of how important and amenable to change each of the identified risks is, and why.

We also sought to gather examples of good practice when they arose in the data.

The research questions were:

- 1) What are stakeholders' views on the risks identified in the first phase of the research as causing differential attainment in postgraduate medical education?
- 2) How important are the risks perceived to be?
- 3) How amenable to change are the risks perceived to be?

## 1.2 Context in which the research took place

### 1.2.1 Differential attainment in medical education and training

Differences in the average performance of IMGs and UKGs, and in the average performance of BME doctors and white doctors is called differential attainment. Background information on differential attainment in medical education and training in the UK and internationally is given in *Fair Pathways Part 1* (2); but in summary, it is well established that IMGs are more likely to fail postgraduate assessments and have poorer outcomes in recruitment compared to those working in the country in which they graduated from medical school (so in the UK, compared to UKGs (1, 6-10). Medical students and doctors from BME groups also have poorer academic and recruitment outcomes compared to white doctors, regardless of country of primary medical qualification (1)(11-13). These problems came into the spotlight in 2012 when the British Association of Physicians of Indian Origin (BAPIO) brought the Royal College of General Practitioners and the GMC to judicial review over the low pass rates of IMGs in the Membership of the Royal College of General Practitioners Examination (see: <http://www.rcgp.org.uk/news/2014/may/~media/Files/News/Judicial-Review-Judgment-14-April-2014.ashx>)

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<sup>2</sup> Further information about NHS Employers can be found here [www.nhsemployers.org](http://www.nhsemployers.org). It is important to distinguish between NHS Employers and representatives of NHS employing organisations (e.g. Hospital Trusts).

### 1.2.2 Causes of differential attainment

Since the late 2000s, the GMC and UK Medical Royal Colleges have undertaken work to understand and reduce differential attainment. The current project is part of the GMC's expanding programme of work in this area (<http://www.gmc-uk.org/education/27486.asp>). In 2015 the GMC commissioned a rapid review of the literature on differential attainment in medicine between 2004 and 2014. The resulting narrative synthesis was published on the GMC website in 2015 (14). The review found that the majority of published research was quantitative and related to performance in high stakes examinations. That research showed that examinations *per se* were not generally unfair, but that more work was needed to understand how candidates were helped prepare for the examinations. The review also found that while research was moving towards understanding "the educational and social factors contributing to performance" (p.45), there were still too few studies to draw firm conclusions. Finally, very few evaluations of interventions to reduce differential attainment were found.

In late 2015, the GMC commissioned our team at UCL Medical School to undertake a qualitative study of stakeholder perceptions of the fairness of postgraduate medical training (*Fair Training Pathways for All: Understanding Experiences of Progression, or Fair Pathways*). In Part 1 of *Fair Pathways* we interviewed 137 doctors (96 trainees and 41 trainers) working across England and Wales across 6 specialties and Foundation training, about their perceptions of the fairness of postgraduate medical training. Results were analysed using a framework adapted from Mountford-Zimdars et al's (15) analysis of the causes of differential attainment in UK higher education. The framework had four major themes: i. Curricula, teaching, learning and assessment; ii. Trainee relationships at work; iii. Psychosocial and identity factors; and iv. Capital. These operated at a national policy (macro) level, an institutional or regional (meso) level, and at an interpersonal (micro) level. This work identified 6 risks to the progression of BME UKG and IMG trainees, and an additional 6 risks that only affected IMG trainees (see Table 1). Many acted at the micro level but some related to policies or practices at meso or macro levels.

Part 2 of *Fair Pathways* extends Part 1 by examining Royal College and NHS Employers perspectives on the causes of differential attainment, specifically by exploring their views on how significant each risk is in understanding differential attainment, and how amenable to change each risk is. Within this work, we explored perceptions of the facilitators and barriers to implementing change to improve equality of outcomes in postgraduate medical training.

**Table 1. Risks to the progression of BME UKG and IMG trainees identified by trainees and trainers in Fair Pathways Part 1**

**Risks to the progression of BME UKG and IMG trainees**

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1. Poorer relationships with seniors and problems fitting in at work sometimes because of unconscious bias can lead to fewer learning opportunities, lower confidence, and increased chance of mental health problems.
2. Bias in recruitment, ARCPs, and at work could result in poorer outcomes
3. Anxiety about potential bias could result in poorer outcomes
4. Less autonomy in job choice resulting from poorer performance in exams and recruitment can mean increased likelihood of being separated from family and support networks, and increased chance of mental health problems.
5. Fear of being labelled as problematic can impede trainees reporting or getting help for problems, including perceived racism.
6. Potential for lack of recognition from trainers about environmental stressors, especially because within medicine there is a belief that failure results from lack of motivation or ability.

**Risks to the progression of IMG trainees only**

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7. Inexperience with UK assessments, recruitment, UK cultural norms including communication, and NHS/work systems.
8. Cultural differences can impede relationships with colleagues and potentially patients, because of unfamiliarity with UK cultural norms, a feeling of not being understood by UKGs, and because trainers can lack confidence in IMGs' prior training.
9. Lengthy time to learn cultural norms.
10. Potential stigma of supplementary help.
11. Anxiety about increased probability of exam failure.
12. Visa difficulties and costs, and ineligibility for jobs can reduce training opportunities.

## 2 Methodology

### 2.1 Methods

The study used qualitative focus group and one-to-one semi-structured interview methods.

### 2.2 Participant sampling frame and recruitment

The sampling frame included individuals with roles in examinations and/or curriculum design from ten of the largest Royal Colleges (Royal College of Psychiatry, Surgeons, Radiology, GPs, Obstetrics and Gynaecology, Anaesthetics, Paediatrics, Physicians, Emergency Medicine, Pathology) and the Academy of Medical Royal Colleges. It also included employees of the organisation NHS Employers, especially those with a remit around equality and diversity, education and training, and workforce management.

Participants were recruited from within this sampling frame in several ways:

- Events:
  - Email addresses of people attending two relevant events (Sharing Good Practice event held at the Royal College of Physicians London; GMC Royal Colleges Quality Leads meeting) were shared with the research team, who used them to invite attendees to take part. This resulted in participants from two organisations outside of our sampling frame: the Royal College of Ophthalmology and the Faculty of Intensive Care Medicine.
  - The research team attempted to contact organisers of NHS Employers events, emailing and leaving telephone messages.
- Website searches:
  - Websites of the Colleges within our sampling frame were searched to identify relevant individuals. Names of individuals were rarely available on websites, so an email was sent to generic email addresses asking for relevant contact details or names.
  - The NHS Employers' website was utilised to locate individuals who had a remit around equality and diversity, and these individuals were invited to participate directly.
- Research team, GMC, and NHS Employer contacts:
  - The GMC made direct contact with their existing contacts within NHS Employers requesting their engagement with the research. This generated communication between the research team and the NHS Employers Diversity and Inclusion team, who sent an email invitation on the research team's behalf to 25 partner Trusts they were supporting to develop their equality performance.
  - The research team invited two of KW's contacts within the Royal College of Physicians, and a contact at NHS Employers.
- Snowball sampling:
  - Potential participants nominated colleagues to attend in their absence.

### 2.3 Data gathering

Participants were asked to read the Executive Summary of Part 1 of *Fair Pathways* which included the 12 risks to trainee progression (2). They were asked to complete an online questionnaire in which they rated each risk for significance and amenability to change on a five point scale (from very significant to very insignificant; and from very difficult to change to very easy to change). Ratings were used as prompts within the interviews, with participants being asked to explain their ratings, and change them ratings if they wanted. Interviews used a semi-structured schedule (see Appendix) which ensured we asked similar questions of all participants, but allowed us to explore particular areas of interest or importance that participants brought up. We allowed up to two hours for focus groups and

an hour for interviews. If we ran out of time, we prioritised discussing the first 6 risks since they related to BME UKGs and IMGs whereas the second 6 related only to IMGs.

To facilitate participation, focus group attendance was possible either in person or online using the video conferencing software, Blackboard Collaborate. Interviews were conducted face-to-face or over the telephone. Data collection was carried out by HJ (Asian Australian female neuroscientist and medical student), AR (white British female psychologist), RV (white British female linguist), and KW (white British female psychologist and medical educationalist). All focus groups and interviews were audio-recorded and professionally transcribed.

## 2.4 Analysis

Thematic analysis (4) was conducted utilising NVivo 11© software (5). HJ, AR, RV, and KW read all the transcripts, made notes and met to discuss potential codes and together jointly produced a first draft of the coding framework. The framework referred to Mountford-Zimdars et al. (15), categorising levels of change at the micro, meso, and macro levels.

All four researchers coded one transcript of a focus group independently and then met to discuss and compare codes, and refine the coding framework. HJ, AR, RV each coded one interview transcript and then met to compare their coding; there were no disagreements so the framework was not further refined. The transcripts were then divided equally between the same three researchers who coded them independently, meeting regularly to discuss any areas of uncertainty and to ensure consistency. KW wrote the first draft of the results using the coded data. All authors agreed the final version.

## 2.5 Ethics

Ethical approval was granted by UCL Research Ethics Committee (Ref: 0511/012). Participants gave their consent on the questionnaire and verbally at the start of the interview or focus group. All participants were offered a certificate of participation and focus group members received refreshments in recompense for giving their time.

## 2.6 Competing interests

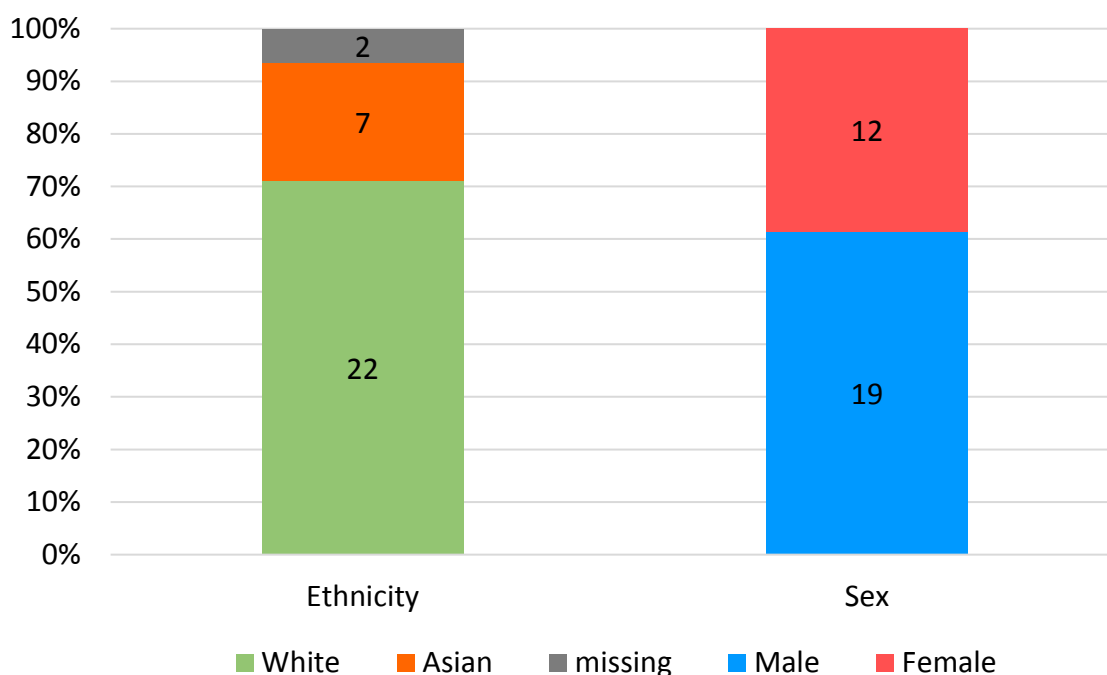
KW is educational advisor to the MRCP(UK) examination, for which UCL Medical School receives a fee. The research was funded by the General Medical Council.

# 3 Results

## 3.1 Participants

68 representatives from Royal Colleges and 56 from NHS Employers were invited to take part. 31 participated: 29 from Royal Colleges, and 2 from NHS Employers. 55% participants were medically qualified, 61% were male and 71% were white. See Figure 1. Data were gathered between September and December 2016, in 5 focus groups and 7 interviews. FG1,

FG3, FG4, FG5, and I4, I7 discussed the first 6 risks only. All participants rated 12 risks in the questionnaire. Quotes are allocated to participants by referring to their ethnic group, gender, whether a medical doctor or not, whether a representative of a Royal College or of NHS Employers, and focus group (FG) or interview (I) number.



**Figure 1. Participant demographics. 17/31 were medically qualified.**

### 3.2 Significance of risks

On average participants rated all the risks as being significant causes of differential attainment. There was however some variability, discussed below.

#### 3.2.1 Most significant risks

The risks perceived to be the most significant were Risk 7 (IMGs’ inexperience with UK systems and cultural norms), Risk 8 (cultural differences impeding IMGs’ relationships at work) and Risk 1 (BME UKGs and IMGs having poorer relationships at work). These all arose from being ‘different’ to the majority or dominant group.

[Risk 7] is the most significant risk I think, for people coming from different cultures. [...] Medical knowledge the same but [UK assessments, recruitment, UK cultural norms including communication and NHS systems] are different. And people know English language but they don’t the nuances of English language. [...] It’s quite a steep hill for them to climb.

**Asian/British Asian Pakistani male medical Royal College I2**

[Regarding Risk 1:] Having been in clinical practice for probably 30 years, I suppose I've seen with a clinical lens how relationships work with seniors. And how difficult that is often for those seniors to change. And how if you're the right fit you, kind of, move on quicker.

**White female medical Royal College FG2**

M1: [Regarding Risk 8] I'm now talking from the Indian subcontinent point of view, because that's where I have the experience. Where, in the subcontinent, you know, your supervisor is like God. You know? And because we come from a culture where your teacher is basically, replaces your parents, in that setting. [...] If you go to India or Pakistan, it's always, "Yes sir". You never address them by first names. You know? And I think it's for [IMGs] to understand that it's slightly different here, that we're slightly more casual.

M2: I mean, I think that is a really good illustration of the cultural tightrope there.

**M1: Asian/Asian British Pakistani male non-medical Royal College FG2**

**M2: white male non-medical Royal College FG2**

All risks were perceived as being more significant for IMGs than for BME UKGs. Indeed, a small minority of (white male) participants questioned how many BME UKGs faced these risks, since they were not perceived as different from white UKGs:

In my experience, from the trainees I work with, the BME trainees are very good. [...] I've not seen anything specific in our hospital or in our Deanery where UK BME graduates are managed any differently [...] I wouldn't say that it is different for a UK white graduate or a UK BME graduate in the [region] of Scotland.

**White male medical Royal College I3**

### 3.2.2 Least significant risks

The risks rated as least significant were Risks 3 (Anxiety about potential bias could result in poorer outcomes) and 10 (Potential stigma of supplementary help), which were both about trainees' psychological reactions. These were rated as less significant because participants felt steps were already successfully being taken to address these risks, or because they didn't feel that trainees were justified in their concerns.

The [...] reason I think [risk 3] is slightly less significant is because it will be clear from our results that we want to publish for exams and recruitment and so on, that we are thinking about differential attainment and we are concerned about it. So I'm hoping that, I'm thinking that should make people less anxious that it could be happening to them.

#### **White female medical Royal College I5**

It's difficult to see where the stigma [Risk 10] comes from. Because it is common sense that, if you are an IMG, you are going to need a bit more help to get into it. And that should be accepted by both IMGs and their UK colleagues.

#### **White male non-medical Royal College FG2**

### **3.3 The influence of evidence on significance ratings**

When considering whether they believed a risk was significantly impacting on trainees, participants tended to draw on four main sources of evidence:

- Personal experiences of interacting with and observing trainees.
- Evidence gathered as part of their role(s).
- Research evidence
- Own personal experience of being a member of a minoritised group.

When participants felt they lacked evidence about a risk, this also influenced their ratings of its significance.

#### **3.3.1 Personal experiences of interacting with and observing trainees**

This was the most common source of evidence, especially for the medics who regularly interacted with trainees at work. This evidence was felt to be highly veracious although many participants did recognise that it might not be generalisable. No participants mentioned any other concerns about factors that might bias this evidence (for example, whether the power differential between themselves and trainees might influence how trainees interacted with or in front of them).



I was talking to a BME trainee yesterday and I said “What’s your thinking... Have you ever, at any stage, felt that you’ve been discriminated against?” And he said to me, “When I first came over here and I did my [Foundation Training] year in another area away from us and I said to somebody, several people [that I] wanted to take Cardiology, and they looked at me and said ‘you’ve got no chance’”. It was as blatant as that, and the perception was “Well, if you are from Pakistan you have no chance, you won’t go onto Cardiology training school”. And so if you’re made to feel that way about your prospects, then I think you’re more likely to just not care anyways because that might make your chances even less, if it’s already perceived as being reduced. [...] The other thing he did say when we were talking about exams, I mentioned the term differential attainment to him, he didn’t know anything about it. But what he said in the exam is, “Do you know something, we sometimes walk in and if we see a non-white examiner we will sometimes worry that they’re going to be stricter”. [...] Purely anecdotal evidence from him.

#### **White male medical Royal College FG5**

### **3.3.2 Evidence accessed in role**

The next most common source was evidence participants had access to in their role at a Royal College or in their clinical or training roles. This evidence could influence their perceptions of trainees’ experiences; of the magnitude of differential attainment; and of how fair assessments were. This evidence was frequently specialty-specific, and sometimes location-specific.

#### **3.3.2.1 Perceptions of trainee experiences**

This came from sources such as examinations appeals, monitoring of comments on social media, from formally supporting trainees ‘in difficulty’, and – for NHS Employers – from surveys or from experience of advising employees in Trusts:

During the exam conditions, the candidates that are most likely to come out and complain halfway through an exam – “I knew that examiner” or “I didn’t like the way that role player looked at me” or “they fell asleep” - they’re much much more likely to be the IMGs. I don’t know on UK BMEs, I’m sorry. I haven’t noticed that.

#### **White female medical Royal College FG1**

A lot of people do come and see me if they're perhaps thinking about "Should I make a complaint? what should I do? I don't know who to turn to". [...] They possibly see me as a neutral or third party but within the Trust. I mean, I don't, kind of, support staff in the way that union would. Again, my advice is very linked to the Trust policy and that. But I do see the reactions of staff "I don't want to be seen as a troublemaker" and the labelling.

#### **Asian/Asian British Indian female non-medical NHS Employers I4**

Training that participants received in their role could also influence their perceptions of trainee experiences. Two participants from the same specialty who were interviewed separately reported a similar story, which one of them said had come from examiner training at their Royal College:

We had a doctor of Indian origin who came to talk to us as examiners about his experience, and he said that, in driving down to the exam centre the three of them coming from the Midlands, they were all of Indian origin, and they sat in the car, and they said, you know, "percentage-wise only one of us is going to pass this exam".

#### **White male medical Royal College I1**

I've heard stories about four candidates, all Asian, coming down to London from Birmingham in the car and talking to each other on the way and saying "of the four of us there's a 50% fail rate, two of us are going to fail".

#### **Asian/British Asian Indian female medical Royal College FG3**

### *3.3.2.2 Perceptions of the magnitude of differential attainment*

This frequently came from administrative data such as examination and recruitment results, which participants had access to in their roles. Participants used this evidence to judge how significant the risks were in their particular specialty. For example, Psychiatry has difficulty recruiting and has a relatively higher proportion of IMGs and BME doctors at junior and senior levels, making Risk 1 and Risk 3 seem less significant; however the fact that communication skills are very important in Psychiatry and is a large part of the Royal College examinations made Risks 2, 7, and 8 seem more significant.

The single biggest success factor in [my specialty] is getting in, in the first place. So if there is bias there, then that is clearly going to be very significant. And I did, last week, just see some basic figures from our last round of recruitment that suggested that the proportion... Well, it showed that the proportion of UK BME applicants who succeeded was significantly lower than the proportion of UK whites entrants. [...] It's an area where it is, in effect, an exam. But it hasn't had the same attention and the same focus, and you don't get the same kind of reporting of reliability. And you don't get people out looking at the standard error of measurement all of this this kind of stuff that you get with exams. So I think it's the next big area that probably needs that kind of attention.

#### **White male non-medical Royal College FG2**

##### *3.3.2.3 Perceptions of the fairness of assessments and training*

This came from being involved in examinations, workplace based assessments, recruitment, or training. Some participants recognised that their personal involvement could make them less objective, but in general participants tended not to think critically about factors that might have influenced the representativeness or accuracy of evidence from those sources. For example, one participant took the fact that he heard complaints from trainees and none were about racism as evidence that trainees did not have a problem reporting racism if it occurred:

M1: I'm saying, not necessarily that I think it [Risk 5] is necessarily a huge problem. I think trainees in general, in my experience, tend to be quite forthcoming in telling us about [laughs] problems, so...

Interviewer: Does that include stuff to do with racism?

M1: In my experience?

Interviewer: Yes.

M1: I've never heard, you know, I've never heard anybody saying anything about it really. You know I think it's not... it's not something in my experience of training we've ever had accusations of racism. So I just have to say I have no experience of that really.

#### **M1: White male medical Royal College FG4**

##### *3.3.3 Research evidence*

Research evidence, especially from quantitative studies published in peer reviewed journals, was highly valued and rarely critiqued. Much of this research was specifically about

examinations rather than other aspects of teaching, learning, or assessment. As such, participants were unable to draw upon research evidence in their assessment of most risks. Participants' faith in research was demonstrated by the fact that many believed publicising research that purported to show lack of bias in Royal College examinations would persuade trainees that they would be treated fairly in examinations (see Section 3.8). The value participants placed on research perhaps reflects the evidence-based medicine movement, in which quantitative studies published in peer-reviewed journals are used in formulating guidelines for practice.

Participants from Psychiatry, Medicine, and particularly General Practice seemed to feel more under scrutiny and pressure to deal with differential attainment, especially since the BAPIO Judicial Review in 2014. Participants from these specialties were particularly likely to refer to research about their specialty that had been published, and interventions that were underway, whereas other specialties were still collecting data.

### 3.3.4 Own personal experience

A few participants, especially those who were BME and/or female, reflected on their own personal experiences when making judgements about risks.

I guess, the unconscious bias I notice more because I'm a woman. [It] has been there throughout my career and a lot of it can be very subtle.

#### **White female medical Royal College FG1**

I've had just so much experience with [Risk 3] with candidates, and of course I look back on my own training as a BME candidate in my time.

#### **Asian/Asian British Indian female Royal College FG3**

### 3.3.5 Lack of evidence

Participants were less likely to rate a risk as significant when they felt they were lacking in evidence that it was adversely affecting trainees. This arose when they had never witnessed or heard of a trainee experiencing a particular risk even though they felt they had had the opportunity to; or when their role didn't provide them with the access to evidence e.g. because they were not directly involved with exams, recruitment, or training.

I don't have any examples [of bias], to be honest. That's why I rated [Risk 2] as relatively low.

#### **Asian/ British Asian Pakistani male non-medical Royal College I2**

[Regarding perceptions of the significance of Risk 4] I don't feel I am equipped enough to answer that.

**Asian/British Asian Indian female non-medical NHS Employers I4**

A few participants recognised that lack of research evidence or data could be problematic and made attempts to gather it in order to be able to make informed decisions, and also to persuade others to act:

My worry for ARCPs is that we have no data [...]. So we have designed, in our new portfolio design, we have now, we are recording the outcomes in it, but we are now also recording ethnicity [...]. So we should be able to see whether there's differential attainment in ARCP outcomes. [...] The reason I think it's very significant is I don't think anybody considers it. [...] I don't think we have training before our ARCPs. [...] But I'm not sure [educational supervisors] are really trained to think about what could have made the differences in a trainee's experience through the time, and to think about that. And that's something we need to be starting to address actively.

**White female medical Royal College I5**

I'm a PhD background from clinical research, and then I did my Master's in education, which had a big research element. I always think, you know, to try and make effective policy, if you have a good research grounding or an evidence-base like we do for medicine...whereas I think some of the educational policies that have come out...My own view is that, you know, the engagement you're not going to get from your peers and your colleagues if you don't show that this actually works and if it has a good rationale behind it, so I think that's why I try and do a lot of the research, kind of, evidence level and then try and put it into practice. And then it's much easier to sell it.

**Asian/Asian British Indian female medical Royal College I6**

### 3.4 Amenability of risks to change

On average, participants were fairly pessimistic about the possibility of mitigating or removing risks, although there was some variation.

#### 3.4.1 Easiest risks to change

The risks that were perceived to be the easiest to change were Risk 10 (Potential stigma of supplementary help), Risk 7 (IMG inexperience with UK systems and cultural norms), and Risk 5 (Fear of being labelled as problematic can impede trainees reporting or getting help for problems, including perceived racism).

Both Risk 10 and Risk 5 were about trainee attitudes to seeking or accepting support, and both were also perceived to be relatively low in significance since many participants felt that attitudes towards asking for and accepting help had changed and were continuing to change, and that trainee feelings could be improved easily by trainers:

Some people may perceive [additional help] as a stigma later on, particularly if it's an ingrained, ongoing problem, but again it's how we sell it as well as trainers [...] I always try and put a positive spin to it [...] From trainers' responsibility perspective, you can advise or sell things in a way that doesn't create a stigma.

#### **Asian/Asian British Indian medical Royal College I6**

Interestingly, Risk 7 was perceived as highly significant but also relatively easy to change, probably because it was one of the risks that had a larger number of interventions or actions in place to address it, and because addressing it required increasing trainees' knowledge of UK systems. Changing knowledge was perhaps seen as easier than changing culturally-bound attitudes and behaviours, which related more to Risks 1 and 8.

#### **3.4.2 Hardest to change**

The risks perceived as hardest to change were Risk 4 (Less autonomy in job choice resulting from poorer performance in exams and recruitment can mean increased likelihood of being separated from family and support networks, and increased chance of mental health problems) and Risk 12 (Visa difficulties and costs, and ineligibility for jobs can reduce training opportunities). Risks 1 and 8, which both related to cultural differences influencing relationships at work, were also rated as hard to change. All were rated as highly significant.

[Regarding Risk 4] I know it's important to have a scoring system, [...] I do the 'trainees in difficulty'-thing, but I also do the respecting the good ones as well, respecting the able ones. [...] You think, oh, you know, somehow we need to try and get that balance right, so... and we don't want to be seen to be... [...] I don't know what the answer is other than to just keep supporting.

#### **Asian/Asian British Indian female medical Royal College I6**

[Regarding Risk 12] Immigration is a hot potato at the moment, since Brexit, before that. And the Government is trying to shut all doors for these people and so it's extremely, extremely difficult. It's a political football, it's difficult to change.

#### **Asian/Asian British Pakistani male medical Royal College I2**

## 3.5 Influences on ratings of amenability to change

Two related factors influenced perceptions of ratings of amenability to change: the level at which change was required and whether participants felt they personally were able to influence that change.

### 3.5.1 Level at which change is required

The risks that were perceived as most difficult to change were those requiring action at a macro level, such as changes within the profession of medicine that spanned specialties and geographic areas; political change; and changes to cultural or psychological attitudes.

Risks 12, 4, 1 and 8 were all thought to require macro-level action, which contributed to the perception of them being difficult to change:

[Regarding Risk 4] You don't have oversubscription for jobs. So until you change that or until you change how trainees are allocated to training jobs - and that's a very political thing to do, but it will almost certainly never happen - then I think you're really going to struggle to change it. [...] [Regarding Risk 12] In my day-to-day job as a Clinical Director [...] we struggle to get people into work because the visa systems are complex and bureaucratic and we have a fairly inflexibly Government.

#### **White male medical Royal College I3**

[Regarding Risk 1] My perception is that to change unconscious bias needs culture change and I know from experience in lots of other ways trying to change a culture in individuals probably anywhere, but certainly in the NHS is nigh-on impossible. Culture change is very, very difficult.

#### **White male medical Royal College FG4**

[Regarding Risk 8] Culture is embedded in one's core [...] And to learn new culture takes fairly longish time unless we actively encourage people to try and almost de-learn what they've learned before and re-learn something new. But it's easier said than done.

#### **Asian/Asian British Pakistani male medical Royal College I2**

Although in general effecting change at a macro level was seen as difficult, two participants described how top-down support for change was important, although not sufficient:

The fact that the GMC have commissioned this piece of work, I think gives me hope. The fact that GMC are talking to all of us [in Royal Colleges] about flexibility in careers. [...] I'm, kind of, hopeful that we're in a different place this year than we maybe were three or four years ago.

### **White female medical Royal College FG1**

What the top-down does is acknowledges. It puts in place the proper policies to manage what the knowledge is. And it puts in place the resource and then to some extent it has a policing role. It polices its policies. And that's what the organisation should do. And it should provide the training for the individuals. So the organisations can influence it and they should influence it. But it can't just be about the organisation. It will probably need to be more than that.

### **White male medical Royal College I3**

Participants felt that risks that could be changed at a meso level (e.g. within a specialty or Deanery) and at micro-level (at a personal one-to-one level) were easier to change, and this was largely because they felt they had more power to effect those changes (see Section 3.5.2.1, below) and/or had started to see actions being implemented (see also Section 3.8).

#### **3.5.2 Personal ability to influence change**

Participants' personal ability to influence change was affected by:

- The scope and responsibilities of their role(s)
- Their knowledge and understanding about differential attainment
- Their general outlook on life

##### *3.5.2.1 The scope and limits of participants' role(s)*

Participants felt more confident that changes could be made when changes required action that was within the scope of their role, and often when they felt actions were already being taken by themselves or others. For example a participant with a senior role within his LETB as well as within his College felt that Risk 6 [potential for lack of recognition from trainers about environmental stressors] was something that could be dealt with:



[Risk 6] is definitely [something that] as an organisation, [my Royal College] and the LETB, [LETB name] can very much change. And I think, I know in [my LETB] we're trying to make all the education supervisors think about the context, so it's not just about an individual in the workplace struggling with an exam or patient feedback or clinical knowledge, there's health capabilities, professionalism, the wider pressures on somebody, their cultural issues, linguistic issues, personality issues. If you can get them to think in a much more multifaceted way, then you've only got to say that once. And then also almost give a form to the supervisor to say, "if there are any issues, run through this checklist". It just raises simple awareness to ask the question.

#### **White male medical FG1**

Participants, especially those who were trainers, also felt more optimistic about micro-level change:

Certainly in my experience, our CT1s [first year specialty trainees] are often very anxious about ARCP. [...] Having that conversation with individuals and explaining the process and getting them to understand a little bit where they fit into a bigger system can be very reassuring to them.

#### **White male medical Royal College FG4**

When participants felt that their role did not give them scope to act, they were more pessimistic about the possibility of effecting change. For example, one participant described trying to appoint a diverse panel for recruitment within his specialty and failing:

I diligently go out of my way trying to get people with protected characteristics but I have often found that the majority of offers come from people who do not have protected characteristics, and that's despite my best efforts and I think that's why I rated it slightly difficult to change. I've had to go out of my way this year and approach to get a woman, for example, last year we didn't even get a female on our panel of eight or nine people, so it can be problematic.

#### **White male medical Royal College FG5**

Frequently individuals with a role in a Royal College felt they didn't have much influence with Trusts or Deaneries. This was sometimes because changes had financial implications, and they did not feel able to influence another organisation's financial priorities.

I can't remember how many times I've done equality and diversity training with the Trust and the Deanery, and it's very variable quality. So there's a lot of key learning stuff the College have done that is absolutely fantastic and big face to face, big group, very expensive training [and people] got a lot out of that, but not everybody's getting it.

**White female medical Royal College FG1**

I've had probably about five [examples] this week and thousands in the last couple of years of trying to convince Trust to do seemingly incredibly straightforward things and they refuse. [...] It's "No, we will not, we have a financial bottom line we have to keep to."

**White male non-medical Royal College FG3#**

By contrast, one participant with a role in examinations at a Royal College described how she was able to take advantage of the fact that senior doctors often had professional roles in training as well as within the Royal College, to extend the reach of her actions from examinations out to ARCPs, and thus mitigate the impact of Risk 2 [bias in recruitment, ARCPs, and at work]:

Something that I've pushed the training committee to do is to make sure that people - our training committee is made up of Heads of Schools so obviously they're chairing ARCP panels - is to make sure that they've had unconscious bias training and to get it in the minds of people who are also making decisions related to progression. [...] They did [an unconscious bias training] session at College. I mean, I don't know what else is happening in Deaneries. It might be repeating it or supplementary to it, but [...] I don't think there's any harm in repeating it.

**White female non-medical Royal College FG1**

*3.5.2.2 Knowledge and understanding about differential attainment*

When participants were uncertain what was causing differential attainment they felt change would be difficult to effect. Two participants from different Royal Colleges in the same focus group described wanting more data and advice from the GMC in this regard, and several participants said one of the reasons they took part in *Fair Pathways* was to find out what others were doing or to get ideas about what to do in relation to differential attainment.

M1: We came to a meeting here [at the GMC, and we said:...] “tell us what to do. You’ve got a huge diversity and inclusivity team at the GMC with more experience than we do in our Colleges. Tell us what to do”. [...] It’s that kind of stuff that would be useful: something a bit more holistic and broad about how we can move forward rather than tiny, quick fixes that don’t actually achieve anything.

M2 [...] If we were given the information [on assessment outcomes and the National Training Survey] in a better way, we’re able to manipulate it in certain way. [...] Yes if we could have better information in that way, you know, probably find it easier... well, not easier, but at least start to try and maybe address some of the problems.

**M1: White male non-medical Royal College FG3**

**M2: White male non-medical Royal College FG3**

M1: I think [my rating of Risk 2] is a reflection of my general frustration in terms of recruitment in general. In the lack of evaluation at the end of the recruitment cycle. [...] We say we had X percentage that got through a particular stage. Half of them might drop out at a particular stage and I think, generally speaking, just a lack of consistency of evaluation which tells a story. [...]

F1: It’s difficult, isn’t it, when you don’t have concrete evidence of what you need to change. To respond to that.

**M1: Asian/Asian British Indian male non-medical NHS Employers FG5**

**F1: White female medical Royal College FG5**

### *3.5.2.3 General outlook on life*

Some participants spoke about how whether they were optimistic or pessimistic influenced their ratings of risks, one explaining that her leadership role required her to have an optimistic outlook.

I’m just an optimistic person, you know, solution focused, rather than problem focused.

**White male medical Royal College FG4**

I suppose in my role, I have to be [optimistic], you know. We need to sort this out, I’m a leader.

**White female medical Royal College FG1**

## 3.6 Barriers to change

Summarising Section 3.5, barriers to change included: lack of scope within one's role to personally effect change; lack of knowledge or understanding about differential attainment, and a pessimistic outlook in general. We also identified two additional factors that could act as barriers to change: isolation of evidence and good practice; and sensitivities about race.

### 3.6.1 Isolation of evidence and good practice

As described above, participants tended to get evidence from within their own realm of experience - typically from within their own specialty and sometimes within their own geographic area (LETB or clinical workplace). This meant they did not have access to examples of good practice from outside their specialty, which contributed to their perceived lack of knowledge about how to address differential attainment locally.

In addition, variability in systems by geographic region, even within the same specialty, might be a barrier to implementing change. For example, two doctors within the same specialty discussed how recruitment is done differently in their regions:

M1: I have seen bias at recruitment, I think, where correctly, perhaps, people are putting photos up to say "if you know this person you can't assess them", but then actually people are making her laugh because they can't pronounce the name or there's some sort of comment about hairstyle or something.

F1: We don't do names. We do numbers.

M1: Well, exactly, but this is moderation, therefore selection is different across the country, as you're saying with ARCPs.

F1: So you do names in [recruitment], do you?

M1: Unless it's changed this year.

F1: No, we've had it for years. We have pictures of candidate 104.

M1: But it's still a picture, so it's comments.

F1: Still a picture, to make sure we're talking about the right person.

M1: And therefore I think that's putting bias into the assessors by even a giggle about the surname. It's unconscious. It's not intentional, but it'll have an effect.

**M1: white male medical Royal College FG1**

**F1: white female medical Royal College FG1**

### 3.6.2 Sensitivities relating to race

Sensitivities around race were apparent. Participants recognised that concerns about appearing discriminatory at a micro level in interactions with trainees could prevent trainers from helping BME and IMG trainees develop and learn effectively:

With some of our trainers, they find it difficult to open up and discuss sensitive issues with IMGs. And it's about creating an environment where people can, you know, trust each other, and be honest with each other. Because I don't think there's enough honesty in that training environment. Trainers don't really want to tell people how they're really doing, or if they're having problems with their performance. Or if IMGs are coming across as [...] rude or arrogant.

#### **White male medical Royal College I2**

It was also apparent that – although most participants felt that being open about differential attainment was a positive step – there was some trepidation about being transparent about problems within their organisation, especially if those problems were not already public knowledge. For example, one participant felt uncomfortable talking within the focus group about bias that had been identified in recruitment in his specialty, despite the fact the problem had been recognised and addressed. He referred to talking about the issue within the focus group as:

Washing our - not dirty linen, but the linen we realised wasn't quite as clean as it could have been.

#### **M1: white male medical Royal College FG4**

Another participant in the same focus group from a different specialty later explained that his College was not investigating a potential cause of bias within their clinical examination because the College didn't:

...know how we get around that [problem] without opening up a whole can of worms that we shouldn't be opening

#### **M2: white male medical Royal College FG4**

Finally, although many participants believed that Risk 4 was a significant risk to trainee progression, they felt uncomfortable about the idea of giving targeted support to BME or IMG trainees because they believed it was unfair to white doctors, with one group of white doctors joking about how it was not politically acceptable to set up a white male doctors'

support group while it was acceptable to set up one for BME doctors. One female Asian participant also felt that actions to improve fairness, such as having diverse recruitment panels, were not worthwhile if they were done in a tokenistic fashion.

[Regarding Risk 4] I'm always really uncomfortable about the impact on the other trainees of trying to help a trainee with this sort of issues, because I think that's a real difficulty that we face. Sure, there are environmental reasons, I think, and I completely accept that if you're thousands of miles away from your support networks and you've got children to look after makes it much more difficult for you. But actually, it's really difficult to justify to the other trainees that therefore they have to be on call every night and they're never on call, or... I know that's an exaggerated... it's just squaring the circle, you know. There's always the trainee who doesn't want to work at Christmas and gets away with it every year, and there's always the trainee who will always put up with it. And the vast majority of people recognise it's their turn. It's just, you know, I think you can't impact on others out...you could probably do something about it, but we can't, you know, disregard the needs of the others can you?

#### **White male medical Royal College FG4**

M1: We accept people setting up, you know, a woman consultants group. Or a black and ethnic minority consultants group - although I can think of one, Arab consultant who went ballistic when he was invited to it. [...] You know, all of that is perfectly okay. The idea that you set up a white consultants group, mind you, it might would certainly cause...[laughter] ...or a male consultants group.

F2: Or a male support group.

M2: Middle-aged white men support group...[laughs]

M1: that meets at your golf club...[laughs]

F1: We've got one of those [laughs].

#### **M1: White male medical Royal College FG2**

#### **F1: White female medical Royal College FG2**

#### **M2: White male non-medical FG2**

### 3.7 Facilitators of change

Summarising the results, participants felt that change was more likely when:

- research and data were available to prompt and guide action and also to persuade others of the need to change (typically at the meso level within an organisation or specialty, but could also be at the macro and micro levels, depending on the focus of the research and data);
- individuals within organisations had the power to effect practical change themselves (typically at the meso- and micro-levels)
- it was clear which changes needed to happen and which interventions might work (those changes/interventions could be at macro, meso, or micro levels).

It was also clear that since most evidence and actions were speciality-specific, sharing across specialties may help provide participants with examples of good practice and also the confidence to enact change themselves.

### 3.8 Interventions or actions currently being undertaken

We recorded 63 examples of interventions or actions to address risks to the progression of BME UKGs and IMGs. These concentrated on Risks 1, 2, 3, and 7 (although 20/31 participants did not have the opportunity to discuss Risks 7 to 12). We have not conducted an audit of interventions, but have provided examples in Table 2 on page 33 to help facilitate sharing of knowledge. Very few participants said interventions had been evaluated. No interventions were targeted at BME UKGs. Because participants had multiple roles, they discussed interventions within Royal Colleges, in LETBs, and in their clinical workplaces, at the meso or micro levels. Some participants implemented interventions themselves, most described interventions they were aware of.

#### 3.8.1 Types of interventions

We categorised interventions into five types:

##### 1. **Training for trainers and examiners**

- a. Several participants described training specifically around equality and diversity, including unconscious bias training.
- b. Some participants described how when they ran 'training the trainers' courses they placed a particular emphasis on equality and diversity.

##### 2. **Training and support for trainees**

- a. Training initiatives generally related to IMGs, and none of the participants mentioned training or support specifically for BME UKGs.
- b. Induction was mentioned by several participants as a way of helping IMGs adapt to UK practice, sometimes it was targeted specifically at IMGs, other times it included topics especially relevant to IMGs.

- c. Two participants described mentoring and ‘buddying’ systems for IMGs set up by their Trust or Royal College, and one Royal College had conferences specifically about and for IMGs.
- d. Participants talked about training for trainees from all groups but that might be especially relevant for IMGs and BME UKGs, such as targeted training for those at risk of failing examinations run by the Royal College or by the Deanery/LETB.
- e. Several participants mentioned the Medical Training Initiative<sup>3</sup> which was set up by the Department of Health and is run by Royal Colleges, another talked about the Certificate of Eligibility for Specialist Registration (CESR) route to gaining access to the Specialist Register<sup>4</sup> (although this is not relevant to doctors in a recognised training programme). Another talked about ‘dual sponsorship’ programmes run by their Royal College and their Trust.
- f. Several participants said they had experienced trainees’ performance being improved by a supportive relationship with their trainer.

### **3. Leadership**

- a. Two participants from different Royal Colleges mentioned having senior individuals, teams or committees within their Royal College and/or Trust with particular responsibility for supporting IMGs.

### **4. Transparency around data and engagement with stakeholders**

- a. Several participants described how their Royal College was attempting to address trainee concerns about the fairness of their examinations by being transparent about their data.
- b. Related to this, a few participants described holding meetings with IMGs to try to understand their perspective and find out what they thought would help.

### **5. Designing recruitment and assessments to minimise bias**

- a. Several participants explained how their specialty’s recruitment processes, examinations, and ARCP systems had been designed or changed to minimise the potential for bias.
- b. Two participants described pilot schemes within their specialty and Deanery/LETB in which applicants with lower scores in recruitment were allocated to posts with better training opportunities.
- c. One participant explained how he took into account trainees’ personal circumstances when allocating them to rotas within his Trust.
- d. One participant talked about putting checks in place to see whether ARCP outcomes were reliable.

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<sup>3</sup> For more information on MTI see <http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/immigration-rules-and-the-points-based-system/recruitment-into-medical-and-dental-posts/medical-training-initiative>

<sup>4</sup> For more information on CESR see <http://www.gmc-uk.org/doctors/24630.asp>



**Table 2. Example of interventions or actions mentioned by participants as addressing risks to progression.**

<b>Risk</b>	<b>Type of intervention</b>	<b>Brief description</b>	<b>Organisation</b>	<b>Quote</b>
1	Leadership	Associate Dean for Trainees who focusses on supporting IMGs.	Royal College of Psychiatrists	<i>"We have an Associate Dean for Trainee Support who's done a lot of work about supporting all trainees but particularly about international medical graduates. And I suppose I just have felt and seen a really quite quick impact on people when it's been talked about. And a kind of relief and a quick understanding of what maybe might be going on."</i>
1 and 7	Training for trainees	The Medical Training Initiative provides training and support for IMGs when they first arrive in the UK.	Royal College of Physicians	<i>"One of the things obviously is the Medical Training Initiative through the Royal Colleges and the Physician Colleges. International medical graduates are coming in to the UK and are taking on their first medical role, and then I think the Colleges are very clear that there needs to be a much stronger infrastructure around supporting them in terms of the integration into the community. And that's about housing, it's about transport, it's about day-to-day living, it's about shopping, it's about opening bank accounts. So that they're being supported by someone who can know when they come into the job, we have a period where they are supernumerary so there's an opportunity to integrate into the workplace but in a supernumerary role which reduces, I think, the stress of coming to a very different and new system."</i>
1	Training for trainers	Training on giving feedback.	Royal College of General Practitioners and the Academy of Medical Royal Colleges	<i>"Doing a project with the Academy of Medical Royal Colleges recently on giving feedback to trainees. It was also identified, the learning environments and one-to-one relationships with supervisors who are also identified as being really crucial to being able to respond to feedback, essentially. Which is very important."</i>

<b>Risk</b>	<b>Type of intervention</b>	<b>Brief description</b>	<b>Organisation</b>	<b>Quote</b>
1	Training for trainers	Unconscious bias training for MRCP(UK) Examiners	Federation of the Royal Colleges of Physicians/ Membership of the Royal Colleges of Physicians (UK)	<i>"That's what we aim to do in our course, is to make people conscious of their potential unconscious bias, if that makes sense. Then they will have to make their judgement."</i>
2	Designing recruitment and assessment to minimise bias	ARCP designed to prevent judgements being made on anything other than the evidence presented in the e-portfolio.	General Practice (participant speaking in role as senior educator in LETB)	<i>"In General Practice for ARCPs, we're only allowed to base judgement on the evidence that is in the e-portfolio and general practice is alone in that. You don't take any information unless there's really extraordinary circumstances. If it's not in the portfolio, it doesn't exist. It's evidence based."</i>
2	Designing recruitment and assessments to minimise bias	Collating data on recruitment outcomes. Structured marking of communication skills within selection centre. Checking of selection test questions for potential bias.	Royal College of Ophthalmologists	<i>"We know that bias in recruitment can be an issue, because we know that the scores for people involved in recruitment can be different, depending on their background. And so, in our College, as we have national recruitment, we have training on avoiding bias beforehand. We are now collating data on the background of our applicants so that we will have some understanding of it to see what difference we can make. ... We have a communication station with a very structured scoring matrix for all the different aspects of communication including for example empathy, body language and the explanations so that it's very clear what is being expected. This makes us able to mark people on specific points rather than just having more global views. And whereby things that might be affected by a cultural difference are paid attention to. ... To again, try to make the questions exclude anything that may have any bias in and to try to break down the questions and make them straightforward so that they are interpretable by any trainee."</i>

<b>Risk</b>	<b>Type of intervention</b>	<b>Brief description</b>	<b>Organisation</b>	<b>Quote</b>
2	Designing recruitment and assessments to minimise bias.	Published standardised interview questions in advance.	Royal College of Psychiatrists	<i>"At recruitment in Psychiatry we not only have a standard script but it's published in advance. And initially interviewer's instinct about that was 'this is crazy', you know, and yet I've become persuaded that it makes sense."</i>
3	Training for trainees	Training for trainees to reduce exam anxiety	Health Education Wessex	<i>"In Wessex, we have an acting coach we can use for performance in exams and presenting your non-verbal behaviour et cetera"</i>
3	Transparency around data and engaging with stakeholders	Transparency around exam outcomes and regular meetings with stakeholders to quality assure the examination.	Royal College of Physicians	<i>"We're increasingly engaging with stakeholders. So one of the things that the Membership of the Royal Colleges of Physicians(UK) is doing, and this comes more to the policy side, is that we acknowledge that there is differential attainment and we acknowledge that it is complex and we don't fully understand it. And we acknowledge that we do the things that we do in terms of quality assuring our exams to make sure that it's not, there is not discriminating behaviour which is can be counted to it as someone suggests."</i>
3	Transparency around data and engaging with stakeholders	Transparency around exam outcomes and attempts to reduce differential attainment.	Royal College of General Practitioners	<i>"We have done quite a lot to try to address differential attainment. We've been quite transparent about it. It's always a fine line, because sometimes being very explicit about the thing can also be unhelpful in terms of reinforcing the stereotype reference stuff. So it's a fine judgment. But I think being transparent about your data, and what you're trying to do to improve things can actually help the perception that you're taking it seriously, doing outreach work, that sort of thing. [...] And certainly, in our case, there is definitely far less anxiety, in terms of the correspondence, et cetera, and feedback I get from candidates".</i>

Risk	Type of intervention	Brief description	Organisation	Quote
4	Designing recruitment and assessments to minimise bias.	Asking trainees for their personal circumstances and allocating rotas taking that into account.	Participant speaking as a Training Programme Director. Organisation not identified.	<i>"One of my roles is to allocate jobs within a large rotation. Within that if somebody is doing badly, getting a bad outcome on ARCP, or haven't got exams, they are not disadvantaged. We do not have a ranking system whereby they have less choice. So if people say to me "Look, I have childcare commitments, or I live in a particular location, and so I have to be at this particular hospital" that actually weighs quite heavily with me. [...] So we allocate once a year - and this comes onto the point of how far in advance you plan the rotation, so this is a local policy decision - [...] so we write once a year and say "what are your job preferences?" I say "I will take into account geography, family reasons", and I meet with them as a group to say "don't try and be strategic."</i>
6	Training for trainers and examiners	Unconscious bias training for MRCP(UK examiners to help examiners understand BME and IMG trainees' behaviour in context.	Royal College of Physicians	<i>"From our diversity and equality course that I'm trying to help develop, we are trying to address that and trying to emphasise not labelling people. So, may make a minor difference. It may make a difference to people who are examiners. We have about 800 examiners on our books. That would only be a small contribution towards change is required."</i>
7	Training for trainees	Induction for all new trainees, which may particularly benefit IMGs.	Royal College of Radiologists	<i>"We offer to all our new entrants each year in two specialties, we run a series of trainee welcome days, where we kind of invite you along, and talk you through things. Like the basics of the curriculum, the basics of workplace-based assessments. And some of the stuff about the first exams they'll experience, and that kind of thing. So we, so that's potentially anyone who's starting out in the specialties."</i>
7	Training for trainees	e-learning induction tool for IMGs	Central Manchester University Hospitals NHS Foundation Trust	<i>"One of our trainers [has ...] organised an e-induction learning tool, a package, for all international medical graduates which is free to access as an e-learning tool. And it's various modules that trainees are offered, up to a week of learning for individual trainees which addresses different modules around communication, settling in, interactive things on clinical environments, as well as just overall broad working within teams, culture, how the NHS works. We've shown fairly effective integration into the clinical working environment. [...] We're trying to, sort of, promote it to all trusts for international medical graduates"</i>

<b>Risk</b>	<b>Type of intervention</b>	<b>Brief description</b>	<b>Organisation</b>	<b>Quote</b>
7	Leadership. Training for trainees.	Associate Director of Medical Education with a special interest in overseas and IMGs. IMG sub-committee within Education. Induction programme for IMGs.	Central Manchester NHS Foundation Trust. Royal College of Ophthalmologists.	<i>"In our Trust we have an Associate Director of Medical Education with a special interest in overseas and international graduates, and we have an induction programme especially for them. It's been an award-winning development and the Royal College of Ophthalmologists now has a link to it, on our website, as well. We have an IMG sub-committee within the Education Committee, and they deliberately try and promote it to all IMGs coming into ophthalmology, to give them some knowledge around these areas, such as how the HNS works, and let them know what the difficulties might be for them."</i>
8	Training for trainees	Dual sponsorship system in which they know the consultant sponsoring. There is a personal connection.	Royal College of Ophthalmologists.	<i>"We have quite a strong dual sponsorship process, based in the College. It helps that we're absolutely certain that the UK consultant knows the consultant sponsoring or sending somebody over to the UK. It's not just an introduction by letter. So I think that our dual sponsorship trainees do fairly well at settling in because of this connection. I think they may be considered a select group."</i>
8	Transparency around data and engaging with stakeholders.	Set up a group for IMGs to find out from them what they think would help them.	Participant speaking as a Training Programme Director. Organisation not identified.	<i>"We've set up a group within the training programme for IMGs to think about what we could do to support them more. I think what came out of it was an interesting observation from them was that they want trainers to tell them when they're not communicating. As you've mentioned this kind of communication is key. They want people to explain to them "don't use that word, don't, that sounds wrong, you haven't phrased that properly, you've come across this way", but I think trainers are very wary of doing that in a case they're seeing as racist."</i>
11	Training for trainees	During teaching, helping IMG trainees to feel positive about overcoming barriers.	Participant speaking as a trainer. Organisation not identified.	<i>"When I do the teaching to our IMGs or trainees as well, I just... "You can make the best of anything [...] Yes, there'll be barriers along the way, that's life, you know, but turn it into a positive. You know, you've got an opportunity to be here and do [something] significant."</i>

## 4 Discussion

### 4.1 Summary of the findings

Thirty one individuals with a role in assessment and/or curriculum planning within a medical Royal College, Faculty, or the Academy of Medical Royal Colleges, or who had an equality and diversity role within NHS Employers, took part in focus groups and interviews between September and December 2016. Participants were asked their views on the significance and amenability to change of risks to progression faced by black and minority ethnic UK medical graduates (BME UKGs) and international medical graduates (IMGs) that had been identified in a previous research study (2).

Participants recognised that BME UKGs and IMGs faced significant risks to their progression, and that risks could be fairly difficult to change. The most significant risks were those relating to a trainee being 'different' to the majority or dominant group; and indeed risks were generally perceived to be more significant for IMGs than for BME UKGs. The most significant risks were felt to be difficult to change since they required action at a macro level - that is political or cultural change within the NHS or within the profession, or changes to how individuals from non-UK cultures behave. Participants felt that they did not have the power to effect those changes within their roles, and they felt hampered by a lack of knowledge or understanding about the causes of differences, especially ethnic differences within UK graduates. Interestingly, Risk 7 was perceived as highly significant but also relatively easy to change. This may be because it was one of the risks that had a larger number of interventions or actions to address it, and because addressing it required increasing trainees' knowledge of UK systems rather than changing culturally-bound attitudes and behaviours (which related more to Risks 1 and 8).

The risks that were perceived as least significant were those that related to trainee anxiety about potential bias or to the stigma of additional training requirements. These were felt to be less important in explaining differential attainment and more easily addressed, for example by publicising research showing that examinations were unbiased, or by trainers reassuring their trainees.

When judging the significance of a risk, participants valued research published in peer-reviewed journals highly; however frequently a lack of research meant that participants fell back on their own personal experiences of interacting with or observing trainees, or on the data and observations that they had access to within their roles. This evidence was typically specialty-specific and sometimes location-specific, and was not necessarily generalisable. Participants recognised the need for more research or data gathering on recruitment and workplace-based assessment, and some said they had taken part in *Fair Pathways* to try to learn more about differential attainment and how to address it.

The main barriers to change were those mentioned about participants feeling they could only act within the confines of their role, and could not effect change in other organisations

especially when there were competing financial priorities; and feeling hampered by a lack of knowledge, which was exacerbated by good practice, research, and data being isolated within specialties and to some extent within regions. As such, the main facilitators to change were participants having access to research and examples of good practice to prompt and guide action. The feeling that change was supported from the top down, for example by the General Medical Council, was also mentioned as helpful.

Sensitivities about race was identified as a barrier to change, with participants feeling that talking about race could impede trainee-trainer relationships; that being open about potential or actual bias could be damaging to organisations; and that positive action to address inequalities could be unfair to white UK graduates or high-performing trainees.

Several interventions or actions to reduce differential attainment were mentioned by participants. None were targeted at BME UKGs and participants rarely discussed evaluation.

## 4.2 Implications of the findings

### 4.2.1 Increased focus on BME UK medical graduates

The lack of interventions targeted at improving the attainment of BME UKGs is problematic, since ethnic differences within UK medical graduates are persistent and widespread. This probably reflects the perception among participants in *Fair Pathways Parts 1 and 2* that it is easier to explain why IMGs on average perform more poorly than UKGs than it is to explain ethnic differences within UKGs.

It may be beneficial for future research and interventions to address the ethnic attainment gap in UK graduates separately from differences by country of primary medical qualification, to ensure the former receives sufficient focus.

### 4.2.2 Addressing the barriers to being open about race

The fact that race is a difficult subject to talk about is well known. Roberts and colleagues (16) explored medical students' perceptions of race, ethnicity and culture at two UK medical schools. They found that white medical students were anxious about talking about race for fear they might offend or be thought of as racist, whereas BME students described feeling marginalised and stigmatised. Other research has shown that BME doctors will avoid discussing racism for fear of being blamed (17); indeed, a trainee in Part 1 of *Fair Pathways* described this fear:

No-one likes the one who's going to kick up a fuss or start saying "Oh it's because I'm an ethnic minority this, that, and the other". No you start getting yourself into problems if you start thinking like that.

#### **Asian Other UKG Female ST1-3 Medicine**

Sensitivities around race are known to be a barrier to addressing differential attainment in higher education, with a report by the Higher Education Academy and the Equality

Challenge Unit in 2011 describing differential attainment as “a sensitive and highly politicised issue” (p.30) (18). Barriers include fear of instigating a counterproductive blame culture (blaming staff for poor teaching practices and/or blaming BME students for their lower performance), concerns about lowering academic standards, and fear that admitting problems to do with race and racism can damage an institution’s reputation. Sara Ahmed has written extensively about how universities’ need to be seen by others to be performing well in terms of diversity can be a barrier to instigating meaningful change.(19)

In their 2008 report, the Equality Challenge Unit (ECU) made a number of recommendations for ways in which UK universities can address differential attainment in higher education (20). The recommendations are lengthy but individuals from medical institutions with responsibility for training and assessment may find the report useful. We have drawn out some of the ECU’s key recommendations below; these were written with respect to how higher education institutions (universities) function, but may also be applicable to other relevant institutions such as medical Royal Colleges, Deaneries/LETB’s, and Hospital Trusts:

- Initiatives and research into differential attainment should avoid a ‘deficit model’ with regard to causation (i.e. differential attainment should not be blamed on people from BME backgrounds lacking knowledge or skills).
- Changes and initiatives should be within a model of education for all, but being mindful of particular issues arising in the area of ethnicity.
- Seniors must be engaged with differential attainment issues. To achieve this, it is necessary to set up a continuous dialogue between different groups about values, beliefs and visions concerning educational processes and learning environments.<sup>5</sup> It is also important to promote, support and expand the recruitment of seniors from BME backgrounds.
- The role and scope of an institution’s equality and diversity committee should be reviewed. That review should ensure that committees are able to outline specific improvements and embed those improvements in an action plan with clear responsibilities and mechanisms to check progress. Equality and diversity committee actions might include: ensuring that the overall ethos of the institution is based on equality and transparency; creating an effective structure to implement corporate and local improvements; creating mechanisms to deal with explicit discrimination; encouraging initiatives to support and expand the recruitment of seniors from BME backgrounds.

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<sup>5</sup> Within medical education, discussions around what ‘good’ patient care looks like from different perspectives may be important. Trainees are (explicitly or implicitly) being assessed on their ability to provide ‘good’ patient care, but ‘good’ can be subjective and may differ depending on a person’s ethnic and cultural background. This can create a situation in which trainees whose cultural backgrounds differ from the dominant culture are required to change their approach rather than the dominant culture changing to encompass different but perhaps equally valid approaches.



#### 4.2.3 Access to research evidence that participants can apply to their own context

The findings point to the need for more research on important aspects of differential attainment other than descriptive data on the magnitude of the attainment gap (although that is also important). Areas that warrant more attention include recruitment and selection, workplace based assessments, and training environments. It is also important to publish evidence from rigorous evaluations of interventions. One participant mentioned the opportunities that the UK Medical Education Database ([www.ukmed.ac.uk](http://www.ukmed.ac.uk)) opened up for exploring differential attainment in UK medical graduates, and several participants were positive about the ability of *Fair Pathways* to provide new insights.

Although in general quantitative research published in high profile medical journals was valued by the participants we spoke to, many were influenced by trainee narratives. A few participants also mentioned being influenced by qualitative research including the *Fair Pathways Part 1* report, although one participant explained how lack of familiarity with the qualitative paradigm could make understanding qualitative research challenging:

It took me a long time to get used to the language. It's a very different paradigm to what I'm used to.

#### **Asian/Asian British female medical Royal College FG3**

The Equality Challenge Unit has emphasised the value of qualitative research in understanding and addressing differential attainment in higher education (20); going forward it may be helpful to consider how to help medical education stakeholders engage with qualitative research.

It may also be that some participants lacked awareness of relevant research. No participants mentioned the literature review of differential attainment in medicine commissioned by the GMC and published on their website in 2015 (14); research from outside of medicine in higher education or other organisations were only mentioned by three participants (one from NHS Employers); and only two participants mentioned research from within medicine that was about training rather than about the validity of examinations (excepting Part 1 of *Fair Pathways*, which participants were asked to read before being interviewed). One participant had searched for evidence that unconscious bias training worked but had not found any. This suggests that better ways of providing relevant individuals and organisations with research evidence would be beneficial.

#### 4.2.4 More sharing of data and initiatives across specialties and regions

It was clear that participants worked very much within their own specialties. Very few discussed sharing data or initiatives across specialties (or with non-medical organisations in which differential attainment is also a recognised problem), and only one participant mentioned that the GMC have published outcomes for all specialties. Indeed, one participant described how her Royal College was collecting trainee ethnicity and ARCP outcome data to assess the magnitude of differential attainment in her specialty, seemingly

unaware that the GMC also had those data. There is some suggestion from our findings that national organisations whose remit spans specialties, such as the GMC, but also Health Education England, and the Academy of Medical Royal Colleges, may be able to facilitate cross-specialty sharing of data and initiatives, and in doing so demonstrate leadership in addressing differential attainment.

### 4.3 Conclusions

Representatives from a variety of Royal Colleges and from NHS Employers recognised that trainees from black and minority ethnic backgrounds and international medical graduates can face significant risks to their progression. Interventions are focussed on international medical graduates rather than BME UK medical graduates, are often specialty-specific leading to isolation of potential good practice, and are rarely formally evaluated. The results suggest that the following will help organisations address the risks faced by BME UKG and IMG trainees:

- Developing and evaluating interventions to address ethnic differences in attainment among UK medical graduates;
- Finding ways to manage individual and organisational sensitivities around race;
- More research that spans specialties and that focusses on recruitment and training as well as on examinations;
- Increasing key stakeholders' access to information, including research evidence from both qualitative and quantitative paradigms, evaluations of interventions, and examples of good practice from other specialties and regions, and from outside of medicine.

## Standalone Summary

### Background, Aims and Objectives

The *Fair Pathways* research project is part of a programme of research commissioned by the General Medical Council (GMC) to explore why UK medical graduates from black and minority ethnic groups (BME UKGs) have, on average, poorer outcomes in assessments and recruitment compared to white UKGs; and why international medical graduates (IMGs)<sup>6</sup> have, on average, poorer outcomes compared to UKGs (1). *Fair Pathways* has been designed to elicit perceptions of the fairness of postgraduate medical education, and of the causes of differential attainment by ethnicity and country of primary medical qualification. *Fair Pathways: Part 1* explored trainee and trainer perceptions, identifying 12 risks to the progression of BME UKG and IMG trainees (2, 3). *Fair Pathways: Part 2* explored the perceptions of representatives of Royal Colleges and NHS Employers ('stakeholders'), examining how significant the risks identified in *Part 1* were felt to be in hindering BME UKG and IMG trainee progression, and how amenable to change those risks were believed to be.

Main objectives were to:

- 1) Examine stakeholders' views of the risks, including any additional risks they identify.
- 2) Explore stakeholders' perceptions of how significant and amenable to change each of the identified risks is, and why.

The research questions were:

- 1) What are stakeholders' views on the risks identified in the first phase of the research as causing differential attainment in postgraduate medical education?
- 2) How significant are the risks perceived to be?
- 3) How amenable to change (could practically be mitigated or removed) are the risks perceived to be?

## Methods

### Participant sampling

The sampling frame included individuals with roles in examinations and/or curriculum design from ten of the largest Royal Colleges and the Academy of Medical Royal Colleges. It also included employees of NHS Employers who have a remit around equality and diversity, education and training, and workforce management. 31 participants from 11 medical Royal Colleges/Faculties and the Academy of Medical Royal Colleges (n=29), and NHS Employers (n=2) took part. 55% of participants were medically qualified, 61% were male, 71% were white British or white Irish, and 24% were Asian/Asian British Indian or Asian/Asian British Pakistani (5% missing ethnicity).

### Data collection

Qualitative data were gathered in focus groups and one-to-one interviews conducted face-to-face, over the telephone, or online. Participants were asked to read the Executive Summary of *Fair Pathways: Part 1* which included the 12 risks to trainee progression (2).

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<sup>6</sup> Doctors whose primary medical qualification is from a medical school outside of the UK.

They were then asked to complete an online questionnaire in which they rated each of the risks for significance and amenability to change on a five-point scale. Ratings were used as prompts within the interviews, which followed a semi-structured schedule.

### Data analysis

Thematic analysis (4) was conducted utilising NVivo 11© software (5). Four researchers jointly produced the coding framework. The transcripts were then divided equally between three of these, who coded them independently, meeting regularly to discuss any areas of uncertainty and to ensure consistency.

### Ethics and competing interests

Ethical approval was granted by UCL Research Ethics Committee (Ref: 0511/012). KW is educational advisor to MRCP(UK) for which UCL Medical School receives a fee. The research was funded by the General Medical Council.

### Key findings

#### Risks perceived as significant, but more so for IMGs than for BME UKGs

On average all risks were perceived as significant, but more so for IMGs than for BME UKGs. The most significant were those relating to being 'different' from the dominant or majority group, and the least significant were those to do with trainee worries or concerns.

#### Significance ratings influenced by personal experience though research also valued

When rating the significance of risks, participants were influenced by evidence from four sources:

- personal experience of interacting with or observing trainees;
- evidence accessed as part of professional role (e.g. within a Royal College);
- research evidence;
- own personal experience of being in a minoritised group.

Most evidence was specialty-specific and sometimes location-specific. Participants recognised that 'anecdotal' evidence from their personal interactions with trainees might not be generalisable. They placed particular value on research, especially quantitative studies published in peer reviewed journals. The research referred to by participants tended to be from a handful of specialties, and focussed on examinations rather than recruitment, workplace based assessments, or training. Recognising the value placed on quantitative data, some participants described needing to collect data, or publicise data already collected, in order to guide action or to persuade others of the need for action.

#### Lack of evidence about a risk tended to lead to its significance being downgraded

When participants felt they lacked evidence about a risk they tended to downgrade its significance, even when this was because they had not had the opportunity to encounter evidence relating to that risk, for example because their job or role did not offer it.

### Macro-level change perceived as harder to achieve

Participants were fairly pessimistic on average about the possibility of change, but there was some variation. Two related factors influenced perceptions of how amenable to change a risk was: the level at which change is required, and participants' perceptions of their own ability to effect change. Risks that required change at the macro level - that is requiring large-scale political or cultural change - were perceived as most difficult to change, and those risks were also rated as highly significant.

### Change perceived as easier when it fell within a participant's remit, and when they felt they had enough knowledge to act

Risks that required action at the meso level (specialty, region, or employing organisation e.g. hospital Trust), and at the micro level (one-to-one interactions with trainees) were perceived as more amenable to change. This was largely because participants felt that they had the ability to effect change personally or had seen others attempting to do so.

Participants' perceived ability to effect change personally was influenced by three factors:

- the scope and limits of their role(s): participants felt able to implement changes within but not without their workplaces, especially when changes had financial implications;
- whether participants felt they knew what caused differential attainment and which interventions might work: when participants knew of an intervention to address a risk it increased their rating of its amenability to change.
- participants' general outlook on life: whether they were an optimist or a pessimist.

Although risks that were perceived as significant were usually also perceived as difficult to change, one of the most significant risks - that IMGs are inexperienced with UK systems and cultural norms - was perceived as highly significant but also fairly amenable to change, probably because it requires increasing knowledge more than changing culturally-bound attitudes and behaviours. Two participants described how top-down support for change, including from the GMC, made them feel optimistic that change would happen.

### Interventions aimed at IMGs rather than BME UKGs and rarely evaluated formally

Participants mentioned five main types of interventions that they were aware of or involved in, which could address differential attainment:

- 1) Training for trainers;
- 2) Training for trainees;
- 3) Leadership;
- 4) Transparency around data and stakeholder engagement;
- 5) Design of recruitment and assessment systems to minimise bias.

Interventions tended to address: risks relating to unconscious bias in trainers; IMG adjustment to UK culture and systems and their integration in the workplace; bias in recruitment and assessment; and trainee anxiety about potential bias. Interventions were largely focussed on IMGs and none were targeted at BME UKGs. Only very rarely did participants mention interventions being evaluated.

Barriers to change included the isolation of good practice and sensitivities around race

Much of participants' experiences and evidence arose from within their own specialty or sometimes from within the geographic area in which they worked clinically. This meant participants were not aware of good practice in other relevant areas, and this could contribute to their perceived lack of knowledge about which interventions might work, making them more pessimistic about the possibility of change.

Sensitivities around race could act as a barrier to change at all levels:

- At the micro level, participants recognised that it can be hard to talk about race-related matters with trainees;
- At the meso level, some participants felt that identifying bias within an organisation's activities could be damaging;
- At the macro level, some participants felt that 'positive action' such as giving trainees with poorer scores in recruitment better training opportunities, might not be fair to white UK graduates or high-scoring trainees.

Facilitators of change included increased access to research and ideas for interventions, and increasing feelings of personal power to effect change.

The main facilitators of change were:

- Research evidence and data to prompt and guide action, and to persuade others of the need to change;
- Individuals feeling that they had the power to effect practical change within their role;
- Knowledge about which changes needed to happen and which interventions might work.
- Sharing of ideas, research, and initiatives across specialties and regions.

## Conclusions

The findings from this project suggest that going forward, the following will help organisations address the risks faced by BME UKG and IMG trainees:

- developing and evaluating interventions to address ethnic differences in attainment among UK medical graduates;
- finding ways to manage individual and organisational sensitivities around race;
- more research that spans specialties and that addresses recruitment and training as well as examinations;
- increasing key stakeholders' access to information, including both qualitative and quantitative research evidence, and examples of good practice from other specialties or regions. The Academy of Medical Royal Colleges, the General Medical Council, and Health Education England may have a role in facilitating this sharing.

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## 6 Appendix

### 6.1 Focus group schedule

#### Materials

- Information sheet and consent form (1 each per participant)
- Handout with list of risks, including additional risks identified in advance by participants WITHOUT ratings (1 each per participant)
- Pen (1 each per participant)
- Laptop with screen OR flipchart & pen
- List of risks with pre-focus group ratings + additional risks and space for ratings

#### 1) Explaining the research and gaining consent

My name is [name] and I am [job] at UCL Medical School. This is my colleague [name] who is [job] at UCL Medical School.

I am going to be reading this verbatim so that it is standardised across focus groups.

Thank you for taking part in this research, which aims to explore the perceptions of Royal Colleges and NHS Employers on the causes of differential attainment to increase our understanding and to develop interventions to reduce such differences.

You each have received the information sheet about this study by email when we initially contacted you also have a copy here [Ensure everyone has a copy]. Equally, you should also have ticked a box on the questionnaire consenting to take part; but you've all got another copy of the consent form here. This is just for information as you have already consented to take part when you did the survey. Just to remind you:

We are going to be audio recording this focus group and my colleague [name] will be taking notes. This is to help us accurately remember what everyone says. The recording will be sent to a professional independent transcriber, and we will remove identifiable features to anonymise the interviews. All notes will also be anonymised. The data will be kept confidential and only published in a way that means it cannot be attributed to you as an individual. If you give particular examples of things your organisation is doing to try to address differential attainment, we will seek your consent afterwards to write up that example as a case study in a way that identifies their organisation but not you as an individual.

We would also like you to agree to Chatham House Rules and keep everything that you and your colleagues say in this room confidential. Can we agree that? [Make sure everyone agrees.]

Today we will be discussing the risks to UK black and minority ethnic (BME) trainees and International Medical Graduate (IMG) trainees that we identified in the report that we produced for the GMC on differential attainment in postgraduate training. We are particularly interested in your perspectives from a policy point of view, rather than about your personal experiences of undergoing training or being a trainer. We will be using your



ratings of the risks identified in the report as a prompt to help our discussions. The ratings themselves will not be used other than that.

## **TURN RECORDER ON**

Is that OK? [Ensure verbal consent from everyone captured on tape]

### **2) Participant introductions**

Before we start I'd like you to very briefly introduce yourself. If we could go around and say your name, your position in your Royal College or NHS Employers, and in one sentence explain how or indeed whether you are involved with equality and diversity in your role. Please can you also say whether you have a role in curriculum development or planning?

### **3) Discussing the risks**

The main task today is to discuss the risks to BME UKG and IMG trainees that can affect their progression. Now we are going to go through each risk in turn, and I'd like the person who gave the highest and the lowest ratings to explain their ratings, and then I'll open it up for a wider discussion. The first 6 relate both to BME and IMGs, the last 6 relate only to IMGs. We need to get through at least the first 6 in the time we have and we will only cover the last 6 if we have time so I may move the discussion on to keep us to time.

[Moderator reads the first risk, and then invites the person who gave it the highest rating for significance to explain their position, the person who gave it the lowest to explain why, and then open up to the group for discussion. Do the same for amenability to change ratings. Then move on to the next risk. Ensure we cover the first 6 risks as a minimum.]

Why did you give this risk this rating for importance?

*Prompt: Can you give me an example?*

Why did you rate this risk as of rating for amenability to change?

*Prompt: Can you give an example?*

What did everyone else think about this?

### **4) Rating additional risks**

When you completed the survey prior to the focus group, we asked you whether there were any other risks you have identified and we will now discuss these. [Display spreadsheet of risks with pre-task ratings].

[Ask person who identified a risk:] Would you mind explaining the risk you identified? [Go round all relevant participants.]

How significant do you think this risk is? Why?

How amendable to change is this risk? Why?

What does everyone else think?

#### **5) Final questions/comments**

Does anyone have any questions or comments?

Thank you for taking part in this research. We will keep your responses confidential, and please can you also maintain confidentiality about what we have discussed here as well.

## **6.2 Interview schedule**

### **Materials**

Ensure participant has the following to hand at the start of the interview:

- Information sheet
- Consent form
- Copy of the list of risks from the report with their ratings, plus any additional risks that the participant identified in advance of the interview.

#### **1) Explaining the research and gaining consent**

My name is [name] and I am [job] at UCL Medical School.

I am going to be reading the following introduction verbatim so that it is standardised across all the interviews that we do.

Thank you for taking part in this research, which aims to explore the perceptions of Royal Colleges and NHS Employers on the causes of differential attainment to increase our understanding and to develop interventions to reduce such differences.

You should have received an information sheet about this study by email when we initially contacted you and you should also have ticked a box on the questionnaire consenting to take part. Just to remind you:

I'm going to be audio recording this interview to help me accurately remember what was said. The recording will be sent to a professional independent transcriber, and we will remove identifiable features to anonymise the interviews. All notes will also be anonymised. The data will be kept confidential and only published in a way that means it cannot be attributed to you as an individual. If you give particular examples of things your organisation is doing to try to address differential attainment, I will seek your consent afterwards to write up that example as a case study in a way that identifies your organisation but not you as an individual.

Today we will be discussing the risks to UK black and minority ethnic (BME) trainees and International Medical Graduate (IMG) trainees that we identified in the report that we

produced for the GMC on differential attainment in postgraduate training. I'm particularly interested in your perspectives from a policy point of view, rather than about your personal experiences of undergoing training or being a trainer. I will be using your ratings of the risks identified in the report as a prompt to help our discussions. The ratings themselves will not be used other than that.

Is that OK? [ensure verbal consent captured on tape]

## **2) Participant introductions**

Could you tell me your position in [your Royal College/NHS Employers, as applicable], and in one sentence explain how or indeed whether you are involved with equality and diversity in your role? Please can you also say whether you have a role in curriculum development or planning?

## **3) Discussing the risks**

The main task today is to discuss the risks to BME UKG and IMG trainees that can affect their progression. Can you look at the list of the risks identified please? [Ensure participant is looking the list with their ratings].

Now we are going to go through each risk in turn and I'd like you to explain why you rated it as you did. The first 6 relate both to BME and IMGs, the last 6 relate only to IMGs. We need to get through at least the first 6 in the time we have and we will only cover the last 6 if we have time so I may move the interview on to keep us to time.

So starting with the first risk (read out)

Why did you give this risk this rating for importance?

*Prompt: Can you give me an example?*

Why did you rate this risk as of rating for amenability to change?

*Prompt: Can you give an example?*

## **4) Identifying and rating additional risks**

[if applicable] At the end of this list are some additional risks not covered in the report that you identified. Would you mind explaining it/them to me?

How significant do you think this risk is? Why?

How amendable to change is this risk? Why?

## **5) Final questions/comments**

Do you have any questions or comments before we finish up?

Thank you for taking part in this research.