Work Psychology Group
Thinking differently

"What supported your success in training?"

A qualitative exploration of the factors associated with an absence of an ethnic attainment gap in post-graduate specialty training

Final report

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Executive Summary

Background

Research programme

Since 2010, the General Medical Council (GMC) has worked with medical educators and researchers to understand the experiences of doctors as they progress through the training pathway. A key aspect of this work has been the **identification and investigation of differences in attainment** when comparing groups of trainees split by characteristics such as ethnicity, gender and place of medical training. Data analysis has identified that, across all measures of progression, there is a persistent gap in attainment between UK-graduated Black, Asian and Minority Ethnic (BAME) trainees and UK-graduated White trainees. This analysis identified patterns in some programmes and specialties related to the presence or absence of DA which provided the basis for this exploratory study to **explore the absence of differential attainment** in some medical training contexts. The research programme to date has included:

- A literature review on the topic of differential attainment (DA) in medicine conducted by Plymouth University Peninsula (de Bere, Nunn & Nasser, 2015)
- A two part qualitative study investigating the potential causes of DA and examples of interventions designed to close the gap and ensure fair training for all (Woolf et al, 2016; Woolf et al, 2017).
- A report and toolkit to support effective evaluation of interventions designed to close the DA gap (WPG, 2018).

Research into DA has also been conducted by other organisations, such as the BMA's 'Making medical training fair for all' report. This report summarises some of the causes of DA, provides examples of initiatives that make a difference for BAME trainees, and outlines practical tips for providers, trainers, students and trainees.

Purpose of this study

This research study was designed to **explore factors associated with specialties and/or training programmes which do not demonstrate statistical variation in attainment** of UK-graduated BAME trainees compared to UK-graduated White trainees. This research intends to further the evidence base on the factors that contribute to fair training pathways for all, and to explore the impact of these factors in practice including: how amenable the factor is to change; how it could be used to inform educational interventions which could help improve fairness of training; how available or accessible the factor is to UK-graduated BAME doctors.

Method

Sampling

Three years of outcome data was analysed to establish the programmes or locations where no statistical difference in outcomes between UK-graduated BAME and White doctors exists; 287 individual programmes showed no statistical difference in successful attempts at specialty exam. Specialties with outcomes for <10 LETBs/Deaneries and <200 BAME trainees were removed, leaving 231 individual programmes in the sample. Two groups of specialties were then shortlisted. Group A included specialties where >66% of available programmes exhibited DA but a minority of programmes within the specialty did not (17 specialties; 43 individual programmes) and Group B included specialties where >66% of available programmes showed no DA (13 specialties; 120 individual programmes). Group A programmes were included to explore what might be different in specific programmes compared to their counterparts in other regions, and Group B programmes were included as they might reveal characteristics of certain specialties with universally low DA levels.

Of the **163 shortlisted programmes, 28 were selected to form the final research sample**. These were selected in a purposive way to ensure a **breadth of coverage of specialties, regions and nations across the UK**. As broad a range of programmes as feasible were selected, and those with the largest number of BAME trainees were prioritised, to maximise likelihood of access to a representative sample and to provide opportunities to identify anything these programmes were doing differently to others. To enable triangulation of findings, specialties selected had at least two training programmes with no statistically significant differences in exam outcomes.

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Interviews

30 trainees from the 28 programmes completed an interview, during which they discussed experiences that had a significant impact (positive or negative) on their success in training. The interviewer probed to gain more clarity on how they understood experiences and why they attributed success or failure to them. **18 stakeholders representing LETBs/Deaneries or Royal Colleges from the 28 programmes were interviewed** and asked for their reflections on why their context showed an absence of DA and how they supported BAME trainees to succeed.

Analysis

Trainee data was analysed in three ways. **Attributional analysis** was used to extract excerpts where a trainee had spoken about an outcome and its cause; 1168 attributions were extracted which allowed exploration of the perceptions of trainees from BAME backgrounds to explore how *they* understood what had contributed to their success. **Thematic analysis** was used to theme each attribution in terms of how it supported success in training – these themes were refined and generated 10 'success factors'. **Content analysis** identified how often each factor was spoken about. Stakeholder data was also thematically analysed and triangulated with trainee data and the extant literature.

Results

What differentiated the programmes sampled

Analysis showed there was no clear pattern of unique factors which 'inoculate' the programmes or specialties of interest from differential attainment, or which differentiated them from other training contexts. Rather, trainees spoke about experiences which supported their success from across a range of settings from medical school to the final stages of higher specialty training, across a variety of rotations and specialties. The key themes identified were consistent with previous research identifying likely causes of ethnic performance differentials between UK-graduated BAME and White doctors. The fact that there were not unique factors present only in the identified programmes does not undermine the research design but illustrates how **any programme may be able to meaningfully reduce observed DA by ensuring greater accessibility of these success factors for their BAME trainees**, in order to support more equitable outcomes.

The Success Factors that support progression

The factors identified represented a combination of **environmental characteristics**, people across multiple roles (**who support learning**) and multiple strategies (**that support learning**) that can be combined in different ways to meet different needs. As such, there is some cross-referencing of common themes across the ten factors to reflect BAME trainees' practical examples of what made the difference for them. The 10 success factors are summarised below:

1. Success Factor 1: **An inclusive workplace that values diversity** (Working & Learning Environment)
   A working environment where diversity in all senses (background, culture, experience) is visible and valued
2. Success Factor 2: **Treating learners as individuals** (Working & Learning Environment)
   Recognition that an individual's background and experiences in and outside of work will meaningfully impact progression through training, providing support where necessary
3. Success Factor 3: **Working with inspirational senior colleagues** (Who supports learning)
   Access to senior colleagues who act as informal role-models, mentors or career coaches to help learners access opportunities and develop
4. Success Factor 4: **The supportive trainer or supervisor** (Who supports learning)
   Trainers and supervisors who encourage and support learners in the workplace with their development
5. Success Factor 5: **Having the support and validation of peers** (Who supports learning)
   Accessing a network of peers who can improve learning, make sense of experiences and provide advice and guidance on the practicalities of training
6. Success Factor 6: **Working arrangements that facilitate learning** (What supports learning)
   Shifts, rotas and work structures that support learners to build meaningful relationships with team members and dedicate time to learning
7. Success Factor 7: **Maximising the value of learning** (What supports learning)
   Ensuring learning at work and in training is valuable, holistic and helps inform career choices

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8. Success Factor 8: **Gaining clarity, certainty and support for career choices** (What supports learning)
   Accessing experiences, knowledge and learning and development opportunities that support informed decisions about career choices or next steps
9. Success Factor 9: **Support to pass exams or deal with exam failure** (What supports learning)
   Being prepared and supported to navigate the process of completing challenging professional exams
10. Success Factor 10: **Personal motivation and drive** (What supports learning)
    Drawing on personal commitment, drive and motivation to succeed in training

This report adds to the current understanding of how to ensure fair training pathways by identifying a range of success factors that BAME trainees felt gave them the opportunity to succeed. Psychological theory and models explaining why these factors are important for learning and work are included to show how and why these factors benefit all trainees.

Variable access to success factors for BAME trainees

Considerations raised by BAME trainees in this research, supplemented by evidence from the broader DA literature, shows access to, or availability of, these success factors is variable depending on an individual's background, and **BAME trainees are systematically less able to benefit from these kinds of support**. Closing the gap in BAME trainee experiences of these success factors is a critical next step. Practical examples from stakeholders and trainees illustrate how different strategies and interventions can support increased provision of success factors for all trainees.

The findings show there is potential for these success factors to be present in every training environment; the results did not indicate some specialties, programmes or education contexts are somehow intrinsically more 'inoculated' against DA. The report presents some questions for readers to reflect on, concerning the presence of these success factors in their context and how BAME trainees may experience or access them.

Some of the solutions to increase access to factors which support successful outcomes for BAME trainees could include:

- Dialogue in learning and workplace environments that encourages discussion on the value of diversity and inclusion at work; supporting majority groups to act as allies or advocates for minority groups
- Sharing more information on differential attainment with learners to explain the data and research indicating a deficit model does not explain the ethnic attainment gap
- Creating assessments to help trainers and programmes conduct early identification of trainees who may require support during training, including development of formative assessments at work to help inform this
- Sharing more information on individual trainee circumstances with trainers, such as information on relocation. This could be via trainees sharing more information with trainers, or organisations sharing information between themselves (although trainee consultation and permission is likely to be required for the latter).
- Providing BAME trainees at all stages of training with access to a range of mentors (consider allowing trainees to pair themselves with mentors based on what they desire or need support with)
- Providing training for trainers and all those involved in education and training on DA and the reasons why BAME trainees may struggle to access support
- Enabling trainees at all stages of training to spend more time with one another, including consideration of creating set study groups with trainees from different stages of training and a variety of backgrounds to build networks
- Implementing protected training time at all stages of training
- Providing increased opportunities for trainees to work with set teams for longer periods of time
- Encouraging more flexibility in training programmes to allow trainees to benefit from different opportunities or exposure to different environments or careers
- Increased sharing of examination data between colleges and deaneries to provide more support for trainees who either intend to attempt an exam or have failed an exam.

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Introduction

Background

Since 2010, the General Medical Council (GMC) has worked with medical educators and researchers to understand the experiences of doctors as they progress through the training pathway. A key part of this work was the **identification and investigation of differences in attainment** when comparing groups of trainees split by characteristics such as ethnicity, gender and place of medical training. Data analysis has identified that, across all measures of progression, there is a persistent gap in attainment between UK-graduated Black, Asian and Minority Ethnic (BAME) trainees and UK-graduated White trainees. The research programme to date has included:

- a **literature review on the topic of differential attainment** (DA) in medicine conducted by Plymouth University Peninsula (de Bere, Nunn & Nasser, 2015)
- a two part qualitative study investigating the **potential causes of DA** and **examples of interventions designed to close the gap and ensure fair training for all** (Woolf et al, 2016; Woolf et al, 2017).
- A report and toolkit to **support effective evaluation of interventions** designed to close the DA gap (WPG, 2018).

A full index of the research can be found at https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/differential-attainment/research, which also includes a summary of findings related to analysis of the published outcome data. Analysis of progression data split by demographic characteristics is published within the National Training Survey Reporting Tool, available at https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/national-training-surveys-reports. This analysis identified patterns in some programmes and specialties related to the presence or absence of DA which provided the basis for this exploratory study to explore the absence of differential attainment in some medical training contexts.

Research into DA has also been conducted by other organisations, such as the BMA's 'Making medical training fair for all' report. This report summarises some of the causes of DA, provides examples of initiatives that make a difference for BAME trainees, and **outlines practical tips for providers, trainers, students and trainees**.

The present research study was designed to reveal any factors associated with specialties and/or training programmes which do not demonstrate statistical variation in attainment of UK-graduated BAME trainees compared to UK-graduated White trainees. This research intends to **further the evidence base on factors that contribute to fair training pathways for all**, and to explore the impact of such factors in practice, including: how amenable the factor is to change; how it could be used to inform initiatives or interventions to improve fairness of training or reduce the ethnic attainment gap; how accessible it is or is not to UK-graduated BAME doctors. The research questions (RQ) addressed in this study are:

RQ1: What factors are associated with specialties or training programmes in which, as a whole, the outcomes of UK-graduated BAME doctors are on par with UK-graduated White doctors?

RQ2: What is the likely impact of each factor in terms of success in training?

- How amenable is each factor to change by training providers or the relevant body?
- How relevant is each factor to a broad range of trainees, or a broad range of specialties and programmes?
- What are the issues or considerations that might affect the success of initiatives or strategies aimed at targeting each factor?
- What specific examples of initiatives or interventions can be shared as example case-studies?

Method

Sampling

Since 2015, the GMC has published outcome data from UK postgraduate training programmes, including recruitment, Annual Review of Competence Progression (ARCP) and specialty exam outcomes. Data from years 2014-2015, 2015-2016, 2016-2017 has been aggregated to increase the sample size and analysed to establish if there is a statistically significant

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ethnic attainment gap at a specialty and training programme level (i.e. Core Medical Training in East Midlands) by comparing exam pass rates and ARCP outcomes across UK-graduated BAME doctors and UK-graduated White doctors. In addition, demographic data on the 'profile' of each programme showing gender, ethnicity, age, and place of medical training splits was also made available separately. These datasets were used in combination to guide purposive sampling for this research.

The approach to selecting a sample followed a number of steps as outlined in Figure 1. This figure shows how the outcome data allowed specific programmes to be selected, from which trainee and stakeholder interviewees could be sampled.

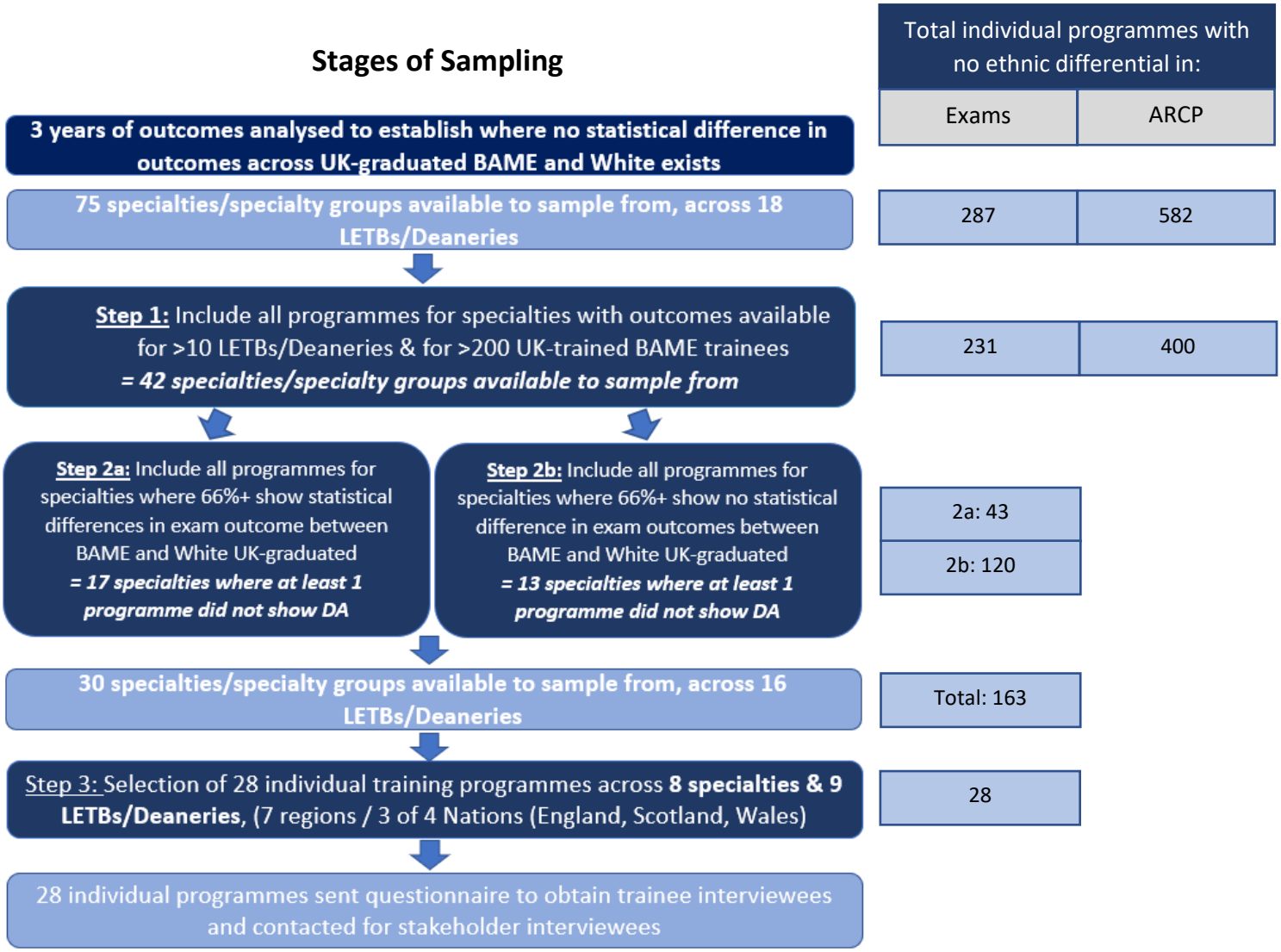

Figure 1: Sampling approach and number of individual programmes available at each stage

Two 'types' of programmes were shortlisted at Step 2. Step 2A identified specialties where most training programmes showed ethnic differentials in exam outcomes; individual programmes that did not show ethnic differences in outcome could be considered to be 'different from the norm' and may have implemented initiatives or interventions that have meaningfully reduced DA compared to their counterparts in other regions. Step 2B identified specialties where most training programmes showed no ethnic differentials in exam outcomes; this may suggest that these specialties may train their trainees in certain ways which leads to more equitable outcomes.

The final selection of 28 individual programmes in Step 3 was done in a purposive way to ensure a breadth of coverage of specialties, regions and nations across the UK. The trainee 'profile' (total numbers of trainees, splits of ethnicity, gender, age, proportion of trainees attended Russell Group universities) was used to sense check the selection. As broad a range of programmes as feasible were selected, and those with the largest number of BAME trainees were prioritised, to maximise likelihood of access to a representative sample and to provide opportunities to identify anything these programmes were doing differently to others. To enable triangulation of findings, specialties selected had at least two

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training programmes with no statistically significant differences in exam outcomes. A full list of the 28 programmes is shown in Table 1.

Specialty / Region	Group A					Group B		
	Clinical radiology	Core Medical	Core Psychiatry	Paediatrics	Core Surgical	Clinical oncology	Emergency medicine	Urology
% of specialty programmes with no significant ethnic attainment gap in exam outcomes	6.3%	17.6%	25.0%	25.0%	31.3%	78.6%	92.9%	100.0%
East Midlands		✓			✓	✓	✓	✓
East of England	✓		✓		✓	✓	✓	✓
London						✓	✓	✓
Scotland				✓	✓	✓	✓	✓
Thames Valley		✓				✓	✓	
Wales			✓	✓	✓	✓		
Yorkshire & Humber							✓	✓

Table 1: Programmes with no statistical ethnic attainment gap selected to take part in the research

Interviews

Current and recent trainees belonging to the identified programmes were contacted via email and asked to express their interest in contributing to the research. Trainees provided some demographic information about themselves which was used to ensure only **UK-graduated BAME doctors in an identified programme were selected for interview. 30 trainees completed individual interviews.** Before the conversation, they were provided with information about the purpose of the research and asked to reflect on their experiences in training. During the interview they discussed experiences that had a significant impact (positive or negative) on their success in training. The interviewer probed to gain more clarity on how they understood experiences and why they attributed success or failure to them.

Stakeholders from LETB/Deaneries and Medical Royal Colleges associated with the selected programmes were contacted to request an interview with an individual who could talk about **training provision or assessment in that context**. Stakeholders interviewed included Training Programme Directors (TPDs), Heads of School, and specialty or examination representatives from colleges. This element was included to allow triangulation of stakeholder perceptions to trainees' views or experiences. **18 stakeholders were interviewed** and asked for their reflections on why their context showed an absence of DA, and how they supported BAME trainees to succeed.

Both trainee and stakeholder (those from LETBs/deaneries) interviews included some **structured questions framed around the practical tips** in the BMA report "Making medical training fair for all"[1]. This report was valuable as it drew together initiatives from across the DA literature and creating a useful starting point for discussions about why the programmes sampled did not exhibit ethnic differentials in exam outcome and what they were doing to facilitate this.

Data analysis

The transcriptions of trainee interviews were analysed in three ways. Firstly, **attributional analysis** (Silvester, 2004) was used to extract excerpts where a trainee had spoken about an outcome and its cause; 1168 attributions were extracted. Attributions are a useful way to understand what people believe and how they may behave as a result. There is also

[1] "Differential Attainment - Making medical training fair for all", British Medical Association (2017) accessed via: https://www.bma.org.uk/collective-voice/policy-and-research/education-training-and-workforce/differential-attainment

extensive evidence to suggest attributions are influenced by group membership, i.e. the idea of 'in-group vs out-group' stereotypes and beliefs (Fincham and Hewstone, 2001). The use of attributional analysis in this context allowed the research to explore the perceptions of specific trainees from BAME backgrounds to explore how *they* understood what had contributed to their success. Coding and extraction was conducted by three researchers. Each excerpt was **coded to capture the type of attribution made**, using five codes:

- external (situational) or internal (personal) to the trainee;
- controllable or uncontrollable by the trainee;
- personal to the individual trainee or universal to all trainees;
- stable or unstable (reflecting the long or short-term impact of an experience);
- positive or negative (in terms of the actual experience).

Secondly, **thematic analysis** (Braun and Clarke, 2009) was used to theme each excerpt in terms of how it supported success in training – these themes were refined and generated 10 'success factors' which make up the bulk of the report. Thirdly, **content analysis** (Lee, 2012) quantified how often each success factor was mentioned, and each factor's profile showing how trainees conceived of it (i.e. an external factor that was universal, largely uncontrollable by a trainee, broadly positive and mostly resulted in stable outcomes). This analysis allowed all success factors to be described in the same way and enabled comparison across factors by readers. Inter-rater reliability, conducted by a separate coder on 110 excerpts, showed moderate-good kappa values for the core attributional codes (ext/int, contr/uncont, pos/neg).

Stakeholder interview data was also thematically analysed; this plus data from a **rapid literature review** was triangulated with the trainee data to provide practical examples of interventions or initiatives taking place in the programmes sampled.

High-level Findings

No 'success factors' identified as unique to selected specialties/programmes

Content and thematic analysis of trainee perceptions showed there was **no clear pattern of the presence of 'success factors' in the programmes or specialties of interest which differentiated them from other contexts**. Rather, trainees spoke about experiences ranging from medical school to the final stages of higher specialty training, across a variety of rotations, contexts and settings which contributed to their success in specialty training. Analysis showed that the selected **specialties or programmes did not systematically differ from one another,** or from programmes with an ethnic attainment gap, but did show commonalities about the factors that help any trainee succeed throughout the entire training pathway, and how those factors were made available to their BAME trainees. As a result of this finding, and to maximise the applicability of these research findings for all readers, the factors are described in a way that applies to most training contexts, supporting application across a breadth of specialties, programmes or settings. Stakeholder reflections on **how their particular environments supported their BAME trainees in accessing identified success factors** provides additional context as to how presence and availability of these factors can be maximised for the benefit for BAME trainees.

Relationship to previous research

The key themes or factors identified were consistent with previous research identifying the likely causes of ethnic performance differentials between UK-graduated BAME and White doctors, highlighting the relevance of core factors whose presence supports learning and absence hinders it. The fact that there were **not unique factors present only in the identified programmes without** an ethnic attainment gap does not undermine the research design but **illustrates how any programme may be able to meaningfully reduce observed differentials by ensuring greater accessibility of these success factors for their BAME trainees**, in order to support more equitable outcomes. This research aims to help readers focus on what support specifically makes the difference for trainees, and how access to this support may vary across demographic groups, clarifying the reader's understanding of interventions which are likely to reduce DA.

What characterised the themes and factors identified?

Of the 1168 attributions identified and analysed, 876 (75%) were classified as External, indicating **trainees attributed the majority of their successes to a factor external from themselves,** reflecting a situational factor more amenable to change. Of these 876 External statements, 739 (84%) were seen as uncontrollable, reflecting that trainees felt they had limited to

no influence over most factors which impacted on the outcomes they achieved. The remaining 16% were coded as more controllable, signifying that trainees felt there were some situational factors they had more chance to control.

Of the 1168 attributions, 567 (49%) explained experiences that were positive and the remainder (51%) were negative or neutral. This shed light on trainee perceptions about the likely impact of the presence, or absence, of these factors on their outcomes, as well as what might influence the presence or accessibility of these success factors for BAME trainees.

Identification and presentation of the 'success factors'

The ten success factors identified by trainees (RQ1) are split into 10 separate sections within the report (see Table 2), followed by additional stakeholder observations.

Success Factors	Factor Group	Amenable to change
1: **Valuing diversity**	**Working & Learning Environment**	
2: **Learner as individual**		
3: **Inspirational seniors**	**Who supports learning**	
4: **Supportive trainer**		
5: **Peer support**		
6: **Work arrangements**	**What supports learning**	
7: **Maximising Learning**		
8: **Career clarity**		
9: **Navigating exams**		
10: **Motivation & Drive**		

Table 2: Summary of Findings

The **10 factors have been categorised into 3 broad groups**:

- ***Working and Learning Environment***; focusing on the overarching success factors which underpin an environment that provides positive and equitable learning experiences for UK-graduated BAME trainees (Factors 1 and 2)
- ***Who Supports Learning***; describing how individual trainers and peers support success (Factors 3-5)
- ***What Supports Learning***; looking at the tools, approaches or strategies for progression (Factors 6-10).

It is important to note that there is a degree of overlap in these factors; this is the result of the various individuals (*Who*) using different strategies (*What*) within the context of a particular *Working/Learning Environment*. Thus, different combinations of these factors can provide different strategies or methods of supporting fair training for all.

The 3 factor groups are ordered by how amenable they are to change (RQ2). Trainees characterised factors within *Working & Learning Environment* and some of the factors in *Who Supports Learning* as more external – they suggested these factors were affected by the wider environment and they had less personal control over them. Hence, these factors are more amenable to change by training providers. In contrast, most factors in the *What Supports Learning* group were seen as a combination of external and internal, suggesting some might be open to influence by training providers but trainees may also influence the more personal factors such as Navigating Exams / Motivation & Drive.

Following the 10 factors, there is a short section **on stakeholder views about other reasons for an absence of an ethnic attainment gap** in their specialty or programme context. This provides insight into some other considerations or factors concerning what may reduce DA. The research concludes with **some broader implications for medical education and training** based on the research findings.

Contribution of this study to the DA research programme

This report adds to the current understanding of fair training pathways by identifying a range of **factors that BAME trainees felt gave them the opportunity to succeed**. The ten success factors act as themes to describe particular aspects

of training or support that 'made the difference' for BAME trainees and allowed them the best chance of success. In particular, this research draws out the **causal mechanisms for their success**. Psychological theory and models explaining how and why these factors influence learning and work show where the trainees' attributions are grounded in reality.

The supporting research draws on psychological literature to show how the presence of these factors are likely to **benefit all trainees**. However, the trainees' considerations, supplemented by evidence from the DA literature, shows that ***access* to these success factors may be variable depending on an individual's background, and BAME trainees may have less access in many instances**.

The conclusion from the research, that limited or reduced access to these factors can subsequently limit trainee success, serves to reinforce the conclusion that a 'deficit model' approach (i.e. the underpinning causation for DA is due to some failing, issue or deficit in the group being studied) is not an appropriate way of understanding or preventing DA (Mountford-Zimdars et al, 2015). Instead, closing the gap that BAME doctors experience in availability or access to these success factors, or increasing their agency to benefit from these success factors, is a critical next step. Practical examples from stakeholders and trainees show how **different strategies and interventions can support increased provision of success factors**. The findings show **there is potential for these success factors to be present in every training environment**; the results did not indicate some specialties, programmes or education contexts are somehow more 'inoculated' against DA. The report also presents some questions for readers to reflect on to prompt thinking about how training organisations might improve access to success factors for BAME trainees.

Each of the ten success factors is described in 3-4 pages. The information presented about each factor is:

Logo	Description
	A description of the success factor and how it leads to success, using trainee insights and informed by attributional coding showing if it is external/internal, open to trainee influence and universal/personal: RQ1
	Trainee considerations about the success factor, including if it has short-term or long-term impact (stable/unstable), what could affect the impact of any interventions or initiatives (positive/negative) and how accessible it may or may not be to different groups of trainees, including BAME trainees: RQ2
	Trainee and stakeholders' practical examples of that success factor in their context: RQ2
	A literature snapshot of some of the causal mechanisms underpinning the factor/attributions made, supported by psychological theory & a summary of how access to/availability of these success factors may vary across trainees, specifically BAME trainees.
	Some questions for the reader to reflect on, designed for a range of stakeholders to prompt thinking about current provision and how access to the success factors can be increased in various contexts. A range of questions are provided in order to generate practical considerations that can inform an action plan.

Some notes on terminology and formatting in the subsequent sections of the report:

- 'The learner' is used to refer to anyone that would benefit from the success factors identified. Whilst the research was conducted with core/specialty trainees, the term learner is used to encourage consideration of how success factors might be made available during any stage of training, and to emphasise the findings that early experiences can influence success in later training.
- 'The trainer' has been used to cover any individual in an official educational capacity, including clinical supervisors/educational supervisors, tutors or anyone providing a programme-led learning opportunity to a trainee. This is distinct from anyone doing the same but in an informal capacity (i.e. a consultant or senior colleague who provides informal support during a placement).
- 'Deanery' has been used to describe any LETB or postgraduate training provider (includes programme representation from England, Scotland and Wales). This is distinct from other postgraduate training organisations, such as Local Education Providers, Colleges and faculties.
- *"Direct quotes"* are distinct from 'paraphrased quotes or interpretations'. Trainees' own words are used where possible to retain the original meaning of insights and examples provided.

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1. Success Factor 1: An inclusive workplace that values diversity

A working environment where diversity in all senses (background, culture, experience) is visible and valued

How does this factor support BAME doctors' success in training?

1.1. One of the two overarching themes identified was the importance of working (and learning) in a 'diverse' and inclusive workplace. 'Diversity' as a term was used to describe many characteristics, including ethnicity, gender, place of training, working style, personality, first language and background. This success factor was portrayed as a **characteristic of the working/learning environment that had a meaningful influence on ease or difficulty of progressing through training**. This factor not only influences training success in its own right, but also influences the presence and value of the other success factors. Interventions designed to promote or increase the presence of this factor can be targeted at individuals, teams, programmes or workplaces.

1.2. Learners described how **the 'prevailing culture' they had to integrate within was largely out of their sphere of influence** but there were some aspects they felt more in control of. Because of the breadth of what 'diversity' meant to learners, discussions were broader in focus than just ethnicity. However, learners made the point that some aspects of diversity are 'more visible' or salient (age, gender, ethnicity) than others (work style, cultural background).

1.3. A number of learners identified that a more inclusive workplace meant they felt inspired by **colleagues that 'represented' them at senior levels in the hierarchy**. This representation both reassured them and drove their aspirations, allowing learners to see evidence of what could be achieved in training and in future work-lives:

> *"seeing yourself represented is a really important thing. [It] feel like you're on a level playing field to start with" (Learner)*

> *"it makes you feel like you can do it and it's been done… there's someone who has already had your battles… you're not the first one to pave the way or make a space for yourself" (Learner).*

> *"You'll have consultant colleagues who would like you to be part of their group… you would never be the odd one out. I think that's very positive where you see a future on the social side and not just the professional side" (Learner).*

1.4. Learners felt strongly that **more diverse environments respected individual perspectives and valued diversity of thought.** In this culture, a single characteristic of an individual, such as background or gender, became less relevant, and individuals were seen as 'whole' people who provided a valuable and unique perspective. Awareness of different cultures was prevalent in these environments, creating a sense of mutual respect, but critical to these cultures was the opportunity to work in a team where individuals were judged on merit or skill. Learners reported that, in these types of teams, the strong team identity and sense of belonging meant all other differences became less salient.

> *"When you work with a very diverse group of people, the cliques and clubs that form aren't necessarily based on colour or class. It feels more based on who you are as a person, your life experiences." (Learner).*

1.5. Some learners did flag **benefits of a diverse workplace as providing more chance to work with individuals from similar backgrounds**, including more opportunities to socialise and proactive accommodations to working arrangements when needed (i.e. less on-call shifts when fasting). A common explanation of these benefits was *"we understood each other, you didn't need to explain everything (Learner)"*, reflecting higher levels of cultural awareness in these settings. Having access to formal societies aimed at specific groups of doctors/learners (i.e. doctors from the Indian subcontinent) was mentioned as another useful support mechanism by a minority.

What were the considerations raised by BAME learners about this success factor?

1.6. During the interviews, learners spoke about memorable events during training that influenced their success. The majority of *negative* experiences recounted related to an absence of this success factor. Learners explained they had been able to 'move past' challenging experiences, such as rotations where they felt less represented (usually less diverse working environments), or relationships with certain individuals that did not respect cultural diversity, and still achieve success. However, these experiences often generated a lingering apprehension about BAME learners being judged based on background rather than skill. This suggests targeted support to help BAME learners

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work through their reflections of such experiences is valuable, as is continued investment in creating a culture of valuing diversity within learning and work.

1.7. Because of the belief that demographic differences should be respected but not used as a means of 'categorising' people, **most learners expressed concern about any initiatives that were targeted at specific groups such as BAME learners**. Demographic differences were something that learners felt should be de-emphasised as focusing attention on certain groups was likely to make people feel even more segregated or unfairly stereotyped. Learners described the discomfort they felt at the risk of being judged as 'lacking' based on stereotypes or assumptions; *"when we started off in training, there were some communication sessions directed towards International Medical Graduates. And I got an invite. Not everyone with a foreign sounding surname is necessarily an IMG" (Learner).* However, there were a minority of learners that felt they would benefit from specific initiatives if these were designed to 'level the playing field' and make certain opportunities more accessible to them, as long as these initiatives were offered in a thoughtful and respectful way.

1.8. Learners felt the best way to guard against interventions based on incorrect stereotypes was to emphasise that learners should be **offered help based on judgements about their individual performance**. Ideally these judgements were to be based on real examples of good or poor practice via formative assessments at work. Learners did not mention potential use of selection scores, examination performance, or data on prior attainment as a method of identifying specific learning needs. Using this type of data to highlight those learners that may benefit from early support can be justified if it is shown that there is a clear relationship between performance on these assessments and performance in role with regards to work-relevant skills and knowledge.

1.9. The potential to **increase understanding of diversity in the training environment by situating this learning within broader teaching about patient care** was described by learners as a method that often had positive, longer-lasting results. This reflects the concept of 'cultural safety' (recognition and acceptance of cultural differences and acknowledging differing views across cultures and between patients and service providers; Williams, 1999). A key principle of cultural safety is that a culturally diverse workforce provides an atmosphere of safety for a culturally diverse patient population. In turn, this can improve levels of cultural awareness and respect within the workforce.

> *"I think the way of introducing [cultural competence] best is not necessarily in terms of colleague-to-colleague, more colleague-to-patient, because I think people are more receptive to try and understand a patient's background or perspective, or cultural norms and values. And then they can bring that into their professional relationships with other colleagues from the same background, rather than the other way round" (Learner).*

1.10. Learners did note that relocation during training often meant having to adapt to **variations in local or regional diversity**. Some learners referenced the fact that moving into a less diverse area from a more diverse one made them feel less 'represented': *"I think it was just being out of London where it's just basically not as diverse a population. And so things [the workforce] are just not as representative as they could be" (Learner).* However, some learners also noted that moving somewhere different provided them with an opportunity to increase their own cultural awareness and learn about different populations (via patients, colleagues and people local to the area).

What is currently happening in practice in the programmes sampled?

1.11. Learners were directly asked for their views on some example initiatives to improve workplace inclusivity and valuing of diversity during training.

- Two thirds said diversity was recognised to some extent in their current training context: ideas about what this 'recognition' meant in practice were varied and concerns were raised about the risk of initiatives drawing attention to the fact that a minority of people were 'different', therefore making them feel 'segregated'. The same proportion of trainees also felt their trainers were encouraged to develop cultural competence. Learners' reflections on this suggested they felt their trainers were generally aware of the principles of equality and diversity principles but, despite this, trainer interactions with learners often 'started from a stereotype'.
- Half of the learners noted that their programme monitored data to flag potential ethnic differences in training performance. Measuring differences, rather than speculating or assuming, was seen as good practice but learners were uncertain about what to do then with that data, and uncomfortable about the risks of making generalisations about groups of learners based on ethnicity or other demographics.

- Two thirds said their training context tried to ensure access to role models with a similar profile to them. Learners flagged this was variable due to regional population differences but was helpful to feel 'represented'. An organic increase in numbers of BAME doctors for increased representation was preferred to an approach which could be interpreted as 'tokenism' – learners felt the latter increased the risk of stereotyping.
- Just over half of learners said their programme made it possible for them to give feedback if they observed any bias during training, to some extent. Available forums to do this included informal feedback gathering after training sessions and meetings, local surveys and the GMC National Training Survey. There was some uncertainty about how receptive seniors/trainers were to this type of learner feedback and if learners would feel comfortable doing this if it was not anonymous.

1.12. Stakeholders were also asked for their views on initiatives focused on recognising the value of diversity in medicine.

- Three quarters said their training context recognised the value of diversity but stakeholders suggested this was partly out of their control as it was dependant on the degree of diversity in the local area. They identified similar risks to learners; less diverse settings could make BAME learners feel isolated. However, there was no discussion of initiatives ensuring BAME learners were placed in more diverse training environments. All stakeholders felt their programme promoted and encouraged trainers to develop 'cultural competence'. How this happened varied from formal initiatives such as E&D training, to more informal, day-to-day exposure to a breadth of cultures/backgrounds by being based in a diverse regional area or within a diverse team.
- Under a quarter of stakeholders said their programmes/context monitored potential ethnic differentials in outcomes. There was concern about issues with splitting out certain groups (stereotyping, what to do with the group), and stakeholder concerns seemed to be that this type of approach went against the idea of treating everyone as an individual: *"It is important to treat anyone in terms of what they individually need. There is not a need to target specific groups" (Deanery Stakeholder).* Providers also questioned how valid this type of analysis was with smaller samples.
- All said they felt their programme/context tried to provide access to representative role-models for learners. However, this was largely attributed to the pre-existing diversity of the settings stakeholders worked within, and it was felt to happen 'naturally rather than deliberately'. There was consensus that good role-models were important for all learners. As discussed above, stakeholders did not reference any initiatives where BAME learners were deliberately allocated placements in more diverse locations in order to see more representation.
- Nearly all stakeholders said learners in their context were encouraged to give feedback if they experienced bias during training. The GMC National Training Survey was mentioned as one method of doing this, but stakeholders noted aggregated feedback could obscure more local issues and may need to be supported by local opinion gathering initiatives. Having faculty or teaching staff distinct from a learner's formal supervisors was also flagged as an avenue to encourage open and honest communication. However, trainers were dubious if learners would raise issues if they were providing contentious feedback or could not remain anonymous.

1.13. When reflecting on why there was no DA in their context, stakeholders frequently mentioned their specialties were 'increasingly' diverse in terms of background and demographics. They suggested greater diversity meant a greater likelihood of being a 'broad church', and that learners felt more welcomed and accepted as themselves. Most stakeholders were unsure how their context compared to others but flagged the risks of a lack of diversity in those involved in training: "*The trainers are in control of everything: [the] recruitment, [the] training, [they are] consultants, and [they are] examiners. Like sees like, so there are risks of unconscious bias" (Deanery Stakeholder).*

- A review of the profile of learners across each of the 28 programmes sampled showed there were varying degrees of diversity in learner ethnicity, gender and age split. It was not possible to establish the diversity of the wider workforce involved in training for programmes in this research, compared to other programmes not included (i.e. if the 28 programmes and their trainers/consultants were more diverse than others not included). However, 'broad church' reflections might indicate that, even if some of these programmes are not overly diverse in terms of demographics, they do welcome and value diversity of views and experiences.

1.14. When asked what interventions they put in place to support BAME learners, the majority of stakeholders from deaneries and colleges stated they preferred to offer specific support to individuals rather than support to targeted groups – "*you have to be careful what you come up with and how it's perceived. I don't think [interventions for certain groups] is right – it's never perceived well by the rest. You have to take the best candidates and then treat*

them all the same" (Deanery Stakeholder). Whilst this approach is intended to mitigate risks of unintended stereotyping, it also may not reduce DA; it does not recognise that BAME learners may not be treated the same, even if that is the intention, as they are more likely to feel isolated during training or experience unconscious bias.

1.15. When interventions were discussed, the general consensus was that they were offered based on specific educational needs which were determined via trainer observations and trainer/learner dialogue. This approach was preferred over making interventions available for specific groups (the exception here being IMG doctors which were out of scope of this research). It was suggested smaller programmes (or specialties) were able to identify and react more quickly to prejudicial attitudes or behaviours, creating more positive learning environments as a result, but also that it could appear even more unfair or 'stereotypical' to focus on BAME learners in smaller programmes.

How does psychological theory explain this success factor?

The importance of diverse environments in relation to work and learning performance has been well documented. Concepts such as **social categorisation** have been used to explain how individuals follow natural impulses to create in-groups (those whom we identify with, and who reinforce a positive image of ourselves) and out-groups. **We spend more time with our in-group, get to know them better and see them as individuals, making us less prone to stereotyping them as a result**. As group identity strengthens, this can reinforce the risk of making initial judgements on group membership based on 'they're like me' and the cycle continues (Kandola, 2011). Those in under-represented or out-groups experience two major challenges – reduced access to opportunities/support, and higher risk of stereotyping impacting their perceived or actual performance. More diverse settings can reduce this risk.

Diversity of thought has been consistently shown to result in improved performance at work through access to a greater variety of perspectives, approaches and experiences. Diverse teams are more creative, quicker at solving problems, better at making decisions and have more engaged teams with reduced turnover of employees (Williams and O'Reilly, 1998). However, high levels of diversity does not equal diversity of thought; individuals in organisations have to be **willing** to share their perspectives (culture of safety and acceptance) and organisations have to be **ready** to hear them (encouraging the right behaviours) and create **opportunities** for sharing views (Woods, 2008).

What does the literature on differential attainment say about this success factor?

Diversity in learning environments is a common theme in DA research. Fair Pathways Part 1 (2016) identified BAME learners felt **subtle prejudice based on stereotypes was likely to impact their recruitment outcomes and day-to-day learning**. This led to **anxiety that they may be discriminated against** during recruitment and learning and **were more likely to fail exams**. Fair Pathways Part 2 (2017) recorded stakeholders from colleges, NHS Employers and faculty were aware of this risk but they felt there was limited evidence showing bias was the primary driver of differences in outcomes. Hence, stakeholders felt sharing this information could mitigate these concerns (to a degree). One example of transparency in sharing outcome data is noted in Fair Pathways Part 2 (2017). However, the interviewee identifies the same concern about **reinforcement of negative stereotypes** if results showing differential attainment between groups are shared without appropriate context or thought.

Mountford-Zimdars et al (2015, p.56) report similar stakeholder perceptions; a combination of universal and targeted initiatives should be used to reduce DA. 'Universal' are for all, such as initiatives to promote the value of diverse teams and workplaces; 'Targeted' are usually focused on individuals over groups, to avoid a perception of further stereotyping or stigmatising certain groups.

Elton (2018) **identifies feelings of isolation or separation** as a common theme in her experiences speaking to BAME doctors. This feeling, coupled with a wider culture of 'not speaking up', can result in **more missed opportunities or negative experiences at work for BAME doctors**. A strong role-model or representation at higher levels can act as a protective factor in feeling less isolated and more 'seen'. A lack of diversity in the workplace can not only mean less access to role-models, but can also create an imbalanced or majority-based learning culture, where **minority groups are expected to adapt to the norms of the dominant groups** (Verdonk and Janczukowicz, 2018), missing opportunities to respond to their specific needs or make learning climates/healthcare systems more inclusive.

Reflecting on current practice in your context…

- What support is given to learners if they experience discrimination or prejudice in the workplace? How are bystanders/allies/witnesses of such behaviour supported?
- How can cultural awareness and knowledge be embedded within clinical teaching?
- How might BAME doctors be provided with more access to role-models or representation?

2. Success Factor 2: Treating learners as individuals

Recognition that an individual's background and experiences in and outside of work will meaningfully impact progression through training, providing required support where necessary

How does this factor support BAME doctors' success in training?

2.1. The other overarching theme that came through from stories shared by learners was the importance of **'being treated like an individual'**. Similar to the value of a diverse and inclusive workplace, the philosophy that 'every learner is an individual' was raised as an important factor for success in its own right, and as a favourable condition for other success factors (how seniors and supervisors could act in accordance with this mindset, how work and learning opportunities could be organised to support it). Learners felt the **broader training system and everyone within it, including themselves, had a part to play in promoting this mindset** to ensure training was as fair and equitable as possible for all learners.

2.2. When speaking about this success factor, learners largely referred to it as **particularly important 'when things were tough'**. There was mention of the value of individualised learning approaches as used by trainers and role-models as strategies that enhanced learning or laid the foundations for meaningful relationships. However, more frequently this was a success factor that helped learners overcome hurdles or transition points in training, or to recover from negative experiences.

"My supervisor knowing me as a person [was really important]. He understood that I couldn't move anywhere to get a job, my personal circumstances meant that I couldn't move. So in order to get the one job [available in the area] I had to rank really highly and I had a lot of competition as well so I had to rank even higher than those people as well. He knew my circumstances and it really helped me that he understood that" (Learner).

2.3. Learners spoke about **personal challenges they had faced whilst in medical training and how these may or may not be acknowledged by training providers and trainers**. These challenges included relocation (either across regions or across workplaces within a region), commuting, financial pressures, family pressures, the challenges of operating in a second language (relevant for UK-graduated BAME in addition to IMGs), and broader mental health and wellbeing concerns. Learners accepted these challenges were somewhat 'par for the course' in medical training but noted that, in combination with working in a high pressure job, it meant *"you don't feel very human when you're doing it because you're just so busy and so under pressure all the time" (Learner)*. What made the difference in these circumstances was the **responsiveness of the system in recognising where the situation might be challenging** for the learner and **being willing to work with them to provide support**. This could be taking a more flexible approach to training commitments or placements or offering targeted support via a Professional Support Unit (PSU) or other source of pastoral support.

2.4. Support from PSUs that was positively received included Cognitive Behavioural Therapy (CBT)-type support, coaching and referrals to counselling services or Occupational Health. However, there was a **gap in terms of more practical support** concerning relocation, financial pressures, and contractual discussions (i.e. maternity leave whilst completing training). Learners accessed support from peers where they could, and from external support networks, but referenced generally feeling unsupported by trainers or programmes regarding these types of challenges.

2.5. Learners spoke positively about working with **those senior to them (in supervisory and non-supervisory roles) who shared their own experiences of negotiating challenges during training** and used this knowledge to help learners find solutions to their challenges. Learners felt this not only helped them practically in solving their own challenges, but also provided an important message that the system and their trainer empathised with learners, understood they may be managing these types of difficulties and *"are only human, like everyone else" (Learner).*

"Once I requested annual leave to take my daughter to the doctors as the appointment was the same time as work. She [my consultant] said 'Well… make sure you organise your clinic for that day, come in, do what you have to do and then leave. You don't have to take the whole day as annual leave'. It makes you feel like this organisation is really thinking about me, so I want to give my best in return" (Learner).

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What were the considerations raised by BAME learners about this success factor?

> *"There was a lack of diversity. I'm used to being in such a multicultural city, it was very different for me to have to face such an ethnically homogenous city; it was very difficult. I wouldn't say I faced overt, explicit racism, but I felt very different" (Learner).*

2.6. **Relocation was regularly noted as a particularly difficult challenge** by the BAME doctors interviewed. It meant a move away from support networks, acclimatising to a new place to work *and* live in, and, more specifically to this group, **often necessitated a move to an area that was different in terms of population diversity**. In these situations, learners felt like *any* efforts to recognise that individuals may need some time or support to familiarise themselves with the area and the workplace was very valuable. In addition, the challenges of relocation were sometimes conflated with disappointment about the results of a selection process or rotation allocation, which could mean learners felt less confident in their own abilities and took longer to acclimatise.

2.7. A significant number of learners who talked about relocation referenced the most difficult aspect as being **a feeling of being segregated or separate** from other learners. Learners mostly explained this like so; because they were now working alongside other learners who had spent more time in the local system, these other individuals appeared to receive more help/opportunities because they had more established relationships with other colleagues. Learners did not state that they were directly discriminated against in these settings, or that they struggled to form relationships because of differences in background but did gave examples where they perceived there was unconscious favouring of certain learners over others (the in-group/out-group effect in action).

> *"It's like a sort of hidden support network for white people from [X], because they just go to the consultants and they know that they've got a… fund and they say, 'Can I have some funding?'... And it's all taken care of. Whenever I've asked, I've always been told, 'Oh, I'll have a look, oh, there's no money'" (Learner).*

2.8. Another pertinent consideration was to do with **whether learners felt they 'could' ask for help or not**. Where learners had reached out for help, it was mainly to get the type of pastoral support that a PSU might provide. There was less certainty that learners reaching out for help with more practical matters was appropriate or the 'right' thing to do; the preference was that relationships with colleagues should be developed enough to the point that there did not need to be a 'formal request' for help but more a 'friendly chat'. Learners did not give a lot of detail about why they felt this way – the DA literature expands on this point below.

> *"Any doctor, you do need somebody to reach out to them, because it's unlikely that they will come to ask for help, and there's always a bit of a reluctance for that boundary to be crossed." (Learner).*

What is happening in practice in the programmes sampled?

2.9. Slightly over half the learners reflected that their training programme appeared to take a holistic approach to learner performance. There was some uncertainty as to where the dividing line was between the training provider's responsibility to learners and a learner's personal life. This was reflected in the type of support that was more commonly provided from the provider (training directly related to skills at work). There was a view from learners that it can be hard to correctly 'diagnose' issues with performance without understanding the aspects of a learner's life circumstances that might be affecting it. When reflecting specifically on what was available in their area, some learners did note that there was generic support generally available for all, but there did not appear to be support provided to manage challenges linked to relocation or isolation, which BAME doctors could be more at risk from.

> *"It is the same support that is available to everyone else, my clinical supervisor, my educational supervisor, the TPD, but there's nothing specifically geared towards acknowledging that things might be difficult or different for me. I tried to extend my training programme and take a year out to be with family… it wasn't possible for me to do, because the School didn't really allow something like that. So I had to continue, even though I was actually really stressed, and I could have done with some time out" (Learner).*

2.10. The majority of stakeholders said their programme took a holistic approach to learner performance to some extent but, as with learners, were uncertain where the division of responsibility between learner and trainer was.

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2.11. Stakeholders from deaneries surveyed all described the value of PSUs and pastoral care in providing learners with individual support. They encouraged learners to self-refer and were engaged in trying to change perceptions of the PSU from being a resource for 'failing learners' to representing an additional source of support for all.

2.12. One TPD explained additional strategies used to help learners manage more practical challenges. This was deemed valuable as *"We probably get more trainees who didn't get their first choice. It's more of an uphill battle. We expect most people to be new to the area" (Deanery Stakeholder).* This suggests that knowing some learners are new to the area, or are not in their first choice training location, may be a useful identifying mechanism for those that would benefit from such support. Targeted support that they provided included social events at induction to introduce learners to one another and faculty staff, increases in flexibility of training to accommodate requests to change rotation and a one-to-one introductory meeting to learn about the learner and discuss planned placements.

2.13. Two other TPDs discussed how they personally spent time interacting with all their learners, which was possible due to smaller numbers of learners on their programme. This allowed for more understanding of individual circumstances and was viewed as more appropriate than providing interventions for certain groups under an assumption that they may perform less well in exams or training – provision of such interventions was felt likely to make people feel stereotyped or 'singled out' and stakeholders described that they would not necessarily know what those interventions would cover in any event.

2.14. Whilst not mentioned by stakeholders in this research, the NACT UK guidance Managing Trainees in Difficulty (2013) contains additional examples of performance indicators that could indicate providing individualised support to a learner would be valuable. The guidance outlines how workplace based assessments can be used to help discover learning needs relating to clinical performance, behavioural issues, health issues or environmental issues.

How does psychological theory explain this success factor?

The Job-Demands-Resources model (Bakker & Demerouti, 2007) illustrates how **physical, physiological, social and organisational characteristics of an individual's work can result in exhaustion** (when they act as demands) or engagement (when they act as resources). Studies show a clear process of job demands impairing energy, performance or health at work, leading to burnout. Access to either personal (self-efficacy and optimism) or external resources (social support, development, talking therapy) can mitigate the risk of burnout.

Leader-member exchange theory (LMX) explains every relationship between a 'leader' and 'member' is unique. High-quality relationships are higher in mutual trust, respect, liking, interaction and support, and often lead to members receiving greater job direction and showing higher levels of competence. LMX theory has shown how **high-quality leader member relationships can result in lowered role stress** (Thomas and Lankau, 2009) via relationships built on trust that recognise employees as individuals**.** There is also a link between being in a high-quality leader member relationship and perceived membership of the 'in-group' as a result. Those in low-quality relationships have a more formal relationship with the leader and have less access to opportunities or support. Those in out-groups can feel socially isolated at work, de-motivated, or perform less well (Brodbeck, 2011).

What does the literature on differential attainment say about this success factor?

Kinman and Teoh (2018) identify **BAME doctors are more exposed to risk factors** such as workplace bullying, harassment, stress and lack of social support which have indirect negative effects on mental health. Woolf et al (2016) found BAME doctors perceived **difficulties on their part would be interpreted as 'personal failings'** (p20) and there was a stigma attached to seeking support as a result. This illustrates BAME doctors are more at risk from negative experiences at work, and may need more encouragement to seek support.
Moving away from the deficit model and **towards individualised support** is more likely to explain and counter variations in attainment in education (Mountford-Zimbars et al (2015). However, **recruitment outcomes show BAME doctors are more likely to need to move away from family** to a culturally different area. Individualised support to help doctors cope with this is useful, but is still a reactive response to DA earlier in the pathway.

Reflecting on current practice in your context…

- How much responsibility can, and should, training providers take for discovering a learner's personal circumstances, challenges and potential barriers to progression, and adapt training programmes in response?
- Bearing in mind the many challenges associated with relocation, what types of support are available for learners who are new to the area and without existing support networks?

3. Success Factor 3: Working with inspirational senior colleagues

Access to senior colleagues who act as informal role-models, mentors or career coaches to help learners access opportunities and develop

3.1. In addition to observations on the broader conditions to support success in training for BAME doctors (*Success Factors (SF) 1, 2),* learners discussed particular groups of people who were instrumental in their success. Three separate groups, relating to three separate success factors, are described in success factors 3, 4 and 5.

How does this factor support BAME doctors' success in training?

3.2. The most frequently mentioned success factor was the opportunity to benefit from the **positive influence of a senior colleague in day-to-day work.** These colleagues were described as distinct from clinical or educational supervisors and might or might not be part of a 'formal' mentoring scheme. On occasion, learners mentioned they had actively sought out these people themselves, but the majority presented the opportunity to benefit from these relationships as down to luck or being 'in the right place at the right time'.

3.3. A critical support provided by these colleagues was time taken to **share information about their own career, doing so 'with no agenda'** which gave clarity about the realities of work in that specialty or location. Learners were encouraged to ask questions, to reflect on own their career choices, and to consider if they would enjoy or value spending more time in that context. In some cases, learners outlined how these seniors invested time in building their confidence and sense of belonging, or positively reinforced that 'they were capable of succeeding in that career'. This positive reinforcement helped learners visualise future success and to set achievable, short-term goals, particularly when confidence was lower (being in early stages of training, an unfamiliar setting or area of medicine).

"… She was someone who was very much interested in everyone... she was interested in talking about her specialty and advocating for her specialty, … that resonated strongly with me" (Learner).

3.4. The value of these colleagues **providing advice on 'what next' and 'how to get there'** was frequently mentioned. Seniors providing sign-posting or guidance, informed by their own knowledge about how to progress through the system and gain entry to training or a long-term job, was viewed as essential in demystifying the system and helped learners to decide where to invest their effort.

3.5. Learners also reflected on influential senior doctors that had re-energised their desire to work in medicine or provided inspiration as to 'the kind of doctor I want to be'. **These doctors were often cited as role-models and were perceived to 'expect a lot' or 'have high standards' but gave a lot in return**. This expectation was viewed as a challenge rather than an unrealistic expectation. Learners felt like equals in the working relationship and gained in confidence and autonomy as a result. Taken in conjunction with the theory on in/out groups, there was an implication that these seniors expected the same of everyone and invested in everyone equally, reinforcing the view that opportunities were not only available to those in certain groups.

3.6. As well as showing enthusiasm for work, learners regularly mentioned these colleagues **showed a commitment to learning**, notable by an investment of their time and energy to share knowledge despite not being in a formal 'supervisory' role. This includes providing instant feedback, making the time to answer queries - *"he would make that time for you, even if it's five minutes, [he] appreciated he needed to invest a little time to answer your queries" (Learner)* - or taking the time to explain the benefit of completing certain tasks. Role-models that showed investment in the learning provided richer, more holistic and meaningful learning experience.

"All of the consultants [in my programme] love to teach… if you've ever got any difficulties or a weird case or anything… they have got so much time for you. For consultants to be able to accommodate you, make time and be able to teach you on a regular basis – not on one special occasion and that's it, that is extremely valuable and very appreciated I think by all on their training programme" (Learner).

What were the considerations raised by BAME learners about this success factor?

3.7. Learners noted that these individuals were **'interested in me as a person',** showing how *Success Factor (SF)2: 'Treating learners as individuals'* can be demonstrated by those not in formal education roles. Learners felt that demonstration of an interest in 'getting to know them' made creating a connection with these colleagues much

easier (possibly because they felt more welcomed to do so). The reasons behind positive connections were often 'similar working styles' or personalities; learners theorised this was why formal mentor pairing schemes were more 'hit and miss' as the method of pairing might or might not result in such a connection. In a few cases it was noted the role-model was from the same ethnic background or was the same gender; this was felt to be beneficial as the mentor understood the specific experiences of the learner. However, this was not the reason for forming a connection that was cited by other trainees. The implication here for formal mentoring systems is that creating a connection between mentor and mentee is important for establishing more sustainable relationships, and that **different learners are looking for different things in their mentors or role-models.** Having a range of mentors available to choose from may better support BAME learners.

3.8. Some BAME learners explained how **access to this support varied depending on 'who you were'**. Whilst some said they sought the support directly, others said they felt less comfortable initiating relationships as they perceived other learners more embedded in the local system were prioritised. Learners did not directly attribute this to ethnic backgrounds, but to some learners being more embedded in the local system and better known and networked as a result. Whilst this might be perceived to apply to all learners equally, as BAME learners may be more likely to have to relocate to a location which was not their first choice, they may feel even less able to establish such relationships and access such support as a result.

3.9. There was some disagreement from learners if this type of support should be part of the formal supervisor role. Most learners felt it should be **'something extra', separate from supervision and a 'safe space'** to ask questions informally that would not impact on a learner's formal assessment of progression.

3.10. Bearing in mind that BAME learners talked about a range of mentors being valuable, **there was also a view that some senior colleagues were more invested in performing this role than others.**

> *"[Some] consultants go out of their way to help learners find sponsorship and alternative career paths. But I don't think it's a formal job they have, it's just their personality makes them approachable. I think it's unrealistic to expect anything better [from others]" (Learner).*

This has implications for the breadth of mentors available either via formal schemes or as groups of senior colleagues who make themselves available to engage in informal interactions with learners. This in turn is likely to further limit access to mentors or role-models for certain groups of learners. An opportunity to encourage more senior staff to act as formal/informal mentors is to link this behaviour with organisational E&D initiatives focused on creating more inclusive environments.

What is happening in practice in the programmes sampled?

3.11. When asked directly about mentoring or sponsorship, three quarters of learners said it was available to some extent in their current training context (mostly informally). Formal schemes were recognised as one way to make access to this type of support more open to all, and less variable due to location-specific limitations in senior staff availability. However, learners did not discuss how formal programmes might be set-up to ensure meaningful relationships were established.

3.12. When asked about the value of mentoring or sponsorship in supporting equitable outcomes for their programme, three quarters of stakeholders stated it was happening to some extent in their area. Stakeholders echoed the view that formal mentor schemes may not 'work as well' or have the same impact as informal mentoring connections. There was a concern that 'sponsorship' (interpreted as senior colleagues helping certain learners access certain experiences) of some learners by seniors would reinforce inequity of experiences further because *"aren't we trying to get away from all that?" (Deanery stakeholder)*. However, there was little discussion of the fact that BAME learners as a group may find it more difficult to access opportunities without access to additional support.

3.13. Some stakeholders from deaneries and colleges gave examples about non-supervisory senior clinical staff investing time in learner support to make training accessible for all. Understanding a learner's individual interests and profile was useful in providing more meaningful support for development. Stakeholders explained rationale for senior investment from an organisational perspective included retention (initial investment to build long-term commitment), promotion (of the specialty to those who may not be aware of the details), and a desire to invest in learners who will be part of the team for a relatively long period. These reflections suggest it might be challenging to get similar levels of investment from senior staff with learners in the earlier stages of training, but it is likely to

be equally valuable at this stage. Interestingly, no-one mentioned another benefit of senior staff engaging in this type of behaviour as supporting a more inclusive culture or reinforcing principles of equality and diversity.

3.14. Stakeholders reflected that a greater proportion of consultants and senior learners being involved in the examinations process often helped facilitate a broader learning and mentoring mindset in the senior team.

What does the literature on differential attainment say about this success factor?

Woolf et al (2016) explain the importance of good relationships with senior doctors in both building learners' confidence and providing access to more learning opportunities (p.22). However, **access to such mentoring relationships is 'not meritocratic'**, but influenced by factors such as gender, ethnicity and accent (p25). BAME learners are systematically less able to access these high-quality relationships; Vaughan et al (2015) and other researchers attribute this to lower levels of social capital (effective interpersonal relationships based on shared norms, shared sense of identity, shared values, trust and reciprocity). This is a common experience of BAME doctors as a minority group.

Beech et al (2013) completed a systematic review of the research on mentoring programmes for under-represented groups in academic medicine (where a large amount of medical mentoring research is based). They highlight that this group have particular challenges linked to **overt and covert racism, marginalisation, and spending a disproportionate amount of time on activities that do not typically advance careers** (serving on committees, advising minority students, community outreach). The number of mentoring programmes focused on overcoming these specific challenges, and evaluation of such programmes, is scarce.

The research shows mentoring can meet different learner needs at different times (learners can have multiple mentoring relationships serving multiple purposes) and that BAME doctors will require more support to access mentoring opportunities. Formal schemes can provide specific support relating to challenges experienced by under-represented groups but may not deliver all the benefits that informal mentoring relationships can.

How does psychological theory explain this success factor?

Thomas and Lankau (2009) outline the benefits of a **'nonsupervisory mentor'**. Having access to mentors**,** in addition to a formal supervisor, lowers 'role ambiguity', enhances an individual's expectation about their career, and supports higher levels of job satisfaction and commitment to an organisation.

Ragins and Cotton (1999) identify two 'functions' of mentoring: **career development functions** (sponsoring mentee's promotion/progression, providing coaching, protection of mentee from adverse forces, providing challenging assignments and increasing mentee's visibility) and **psychosocial functions** (enhancing mentee's sense of competence, self-efficacy and professional/personal development). The former in particular reflects the value learners in this research obtained from 'senior colleagues as mentors and role-models'.
Ragins and Cotton also explore differences between **informal and formal mentoring.** Informal relationships develop based on mutual identification and fulfilment of career needs (for both parties). Mentees select mentors who they view as role-models; mentors are seeking to accomplish more at work and avoid stagnation. These types of relationships also develop on the basis of perceived competence and 'interpersonal comfort' with each other. Formal mentoring relationships are generally coordinated by the organisation and 'matched' by a third party. **Informal mentors were seen as more effective** and their mentees received greater compensation from the organisation. The researchers noted that formal schemes are often established to link under-represented groups into existing networks but may not achieve this if a mentor and mentee do not develop a high quality relationship.

Reflecting on current practice in your context…

- How might senior colleagues optimise contact time with learners given the constraints of clinical environments?
- How might learners gain access and insight from doctors not in formal supervisor roles?
- What opportunities exist to create longer-term mentoring relationships when learners are only present for short periods of time?
- How might BAME learners be more supported to form informal mentoring relationships with senior colleagues?
- What could be included in formal mentoring schemes to respond particularly to the challenges some groups experience?
- How might E&D initiatives be designed to encourage/promote senior colleagues to offer informal mentoring?

4. Success Factor 4: The supportive trainer or supervisor

Trainers and supervisors who encourage and support learners in the workplace with their development

How did this factor support BAME doctors' success in training?

> *"…always having had supportive supervisors in my current training programme has been really, really helpful. I've struggled a lot, actually, in the last two to three years with exams, and without their support, understanding and patience, there's no way I would have been able to continue to the point that I'm at" (Learner).*

4.1. Complementing *SF3*, learners also spoke about the importance of working with **effective and supportive supervisors or trainers**. This group were mentioned frequently, but less so than the more informal relationships in SF3, possibly because learners feel they are entitled to appropriate levels of support from these formal relationships whereas the more informal relationships are differentiating factors 'over and above' basic programme provision.

4.2. Nonetheless, working with a supportive trainer or supervisor was identified as an independent 'success factor' as learners compared and contrasted their experiences and what had made the difference for them. This group included those in formal roles such as tutors, teachers, clinical and educational supervisors, Training Programme Directors (TPDs) or Heads of School. More so than mentors (where learners may have some control over choosing who to engage with), learners felt there was an element of luck in being allocated a trainer/supervisor that was supportive and encouraging, and that this varied across rotations, settings and stages of training.

4.3. A key benefit of a good quality relationship with a supportive trainer was receiving **feedback on clinical and professional skills**. Timely feedback, based on observations of practice or behaviour, was described as essential for development. Many learners noted feedback was more helpful and more positively received when it was context-specific over personal ('in that situation you' vs. 'you tend to'); this distinction meant observations about areas to improve were rooted in the clinical context with a clear link to future exam or assessment performance. One issue raised was when supervisors did a poor job of communicating or interpreting 'second-hand' feedback (for example, where someone else had provided feedback during a Multi-Source Feedback exercise and a supervisor tried to interpret it). In these instances, BAME learners said the better supervisors did not jump to conclusions or make generalisations about feedback but framed or reflected on the feedback with the learner to ensure it led to a positive developmental experience.

4.4. Learners flagged the importance of building an **open and honest relationship** with their trainer, particularly their educational supervisor. It was acknowledged that learners need to be willing to share their feelings and be open about challenges, but learners also noted some trainers, or the system supporting these trainers, make this harder to do. Reasons for this included a lack of time from trainers, lack of regular contact, or confusion about the primary focus of the supervisor relationship: 'is this person supporting me or representing the training programme?'. If the supervisor was seen to be primarily there on behalf of the programme, rather than an advocate for the learner, this reduced the learner's desire to share in an open and honest way.

4.5. Supportive trainers **helped learners overcome anxiety or low confidence**. Positive reinforcement, encouragement and reassurance after a set-back was seen as very helpful in rebuilding confidence.

> *"He gave me guidance throughout, and really picked me up again to be honest when I didn't get the job first time around. I was absolutely devastated… he knew my circumstances and he did everything he could to strengthen my application to help me… But it was a little pep talk that he gave me that really [helped]" (Learner).*

4.6. Learners talked about **supervisors who were willing to help learners 're-frame' or make sense of a negative experience**. This included helping learners to understand their own challenges by providing more context from their greater experience or exposure to a work place (e.g. one example given was a learner who talked about issues she had experienced with a consultant; her trainer then told her that many early stage learners found this individual's communication style challenging which helped her realise it was not personal).

4.7. Learners also talked about some occasions where supportive supervisors or other staff with defined educational roles took the initiative to intervene on behalf of a learner, who might themselves be unsure about whether or not to raise issues. Learners provided all sorts of reasons for why they had experienced challenges with other individuals at work, some examples of which they felt were partially caused by racism: *"something subtle about differences, at*

best unconscious bias and at worst something more sinister" (Learner). Common reasons for feeling able to raise something with these supervisors were a high level of trust or confidence that a learner's concerns would not be downplayed or view as 'trouble-making'.

4.8. Another aspect to a supportive trainer was **someone who took an active interest in the individual's development as a doctor**. Helpful support included trainers helping learners reflect on their career aspirations, and many learners cited the value of being 'pushed' or encouraged to take chances and set challenging goals. Trainers that provided support at more challenging times, i.e. transition across rotations, or preparation for exams or selection, were also remembered positively. This type of support often involved 'keeping spirits up' during times where learners might be doubting themselves or helping learners feel more prepared for future challenges. This type of broader support for 'training' complements the context/career-specific support that mentors might provide.

> *"I was in the odd job, where I moved right at the end of that year ... I said to her [clinical supervisor] 'I don't really know anyone and I'm not sure if I'm going to pass this, because I need to revise with people'...she gave me the soundest advice…she said 'Don't even worry about it. You don't need to revise with anyone. You just need to stand in front of the mirror and practice'. That is what I did and then I got full marks and it was really bizarre! She really reassured me. She said, 'you know your stuff; you just need to work on your confidence'" (Learner).*

What were the considerations raised by BAME learners about this success factor?

4.9. Learners noted that, similar to the feedback on mentors, they felt like supervisors were able to create a trusting relationship with learners when **they provided insight into their own training or work challenges.** More often than not, learners described how this made them feel better about their own challenges such as preparing for the next stage of training or for exams.

4.10. Learners were keen to stress that they felt motivated to manage their own challenges, but sometimes they felt more direct support from supervisors was necessary. This was particularly salient **if the learner was struggling because of a difficult relationship with another senior member of staff**. The impact of this support not being available was variable; in some instances learners said they just ignored the issue until they could leave whereas others reported more substantial impacts, including switching training programmes or considering resignation.

4.11. One frequently raised reflection was **if it is possible to be open and honest with a supervisor when they are also often acting as the individual who may also 'sign off' a successful period of training**. Learners were worried about saying anything that could have an unintended impact on their progression. Another consideration was that being honest about issues could be challenging because of **pre-existing relationships between more established staff**: *"I did try to tell the TPD and my educational supervisor, but I realised afterwards they are all friends. Everyone in our system is… interconnected, we all know each other. So it's not their fault, but they are biased" (Learner).* This consideration may be particularly relevant for BAME learners if they are raising issues or challenges related to ethnicity or possible prejudice/discrimination at work in a less culturally diverse environment.

What is happening in practice in the programmes sampled?

4.12. When asked directly about feeling able to ask for support, three quarters of learners said this did happen to some extent in their current training programme. Trainers who showed the attributes discussed in *SF2: 'treating learners as individuals'* were seen to encourage this.

4.13. Stakeholders within postgraduate training organisations all agreed good supervisor support is essential in making training fair and accessible for all learners, and learners should be supported to ask for early support. Stakeholders from deaneries and colleges identified initiatives to develop supervisor skills within the selected programmes, including giving supervisors information on pastoral support systems such as PSUs, training for trainers, ad hoc observations of supervision sessions, training on portfolio review or targeted sessions for trainers as educators, i.e. differences in generational attitudes to work.

4.14. Deanery and college stakeholders from the same specialty described their process of getting trainers together to support one another: *"We meet as a Training Committee relatively regularly. So the first part of the meeting, the trainee representative will discuss any issues. Because we've got a small number of [trainees], there is quite intense scrutiny. We then discuss all trainees, and any trainees in difficulty; we take a group approach. You're not taking it all on yourself, and there are often very different voices in the room" (Deanery stakeholder).*

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It was noted that smaller specialties often enabled this type of interaction more, as "everyone knows everyone" but that it could be replicated in medical schools via tutor networks, or larger specialties via regular trainer meetings. Stakeholders presented this as an opportunity for trainers to support one another and hear a diversity of views, but there is a risk that some bias may be introduced if trainers are collectively agreeing a 'view' of a single learner – BAME learners (and other protected groups) should be protected against this.

4.15. Another deanery stakeholder explained how they handpick trainers by establishing which clinical staff are interested in education and training, and who will commit to coaching learners in a focused way. In some instances, they use a deliberate matching process that paired very skilled supervisors with learners that have been identified early on as likely to require more support. The ethos all trainers work to was clear from the start – *"our job is to coach them through the training process; it is our duty to give them the best experiences with the resources we have".* This approach was believed to provide *all* learners with access to the best possible quality of supervision, provided by trainers who would be more equipped to respond to a breadth of needs as represented by different learners (possibly resulting in more equitable access to support (and outcomes) for BAME and White learners.

How does psychological theory explain this success factor?

A growing research body explains the 'optimum conditions' for training, including individual and situational characteristics. **Supervisory support** consistently predicts improved transfer of learning into the workplace and is critical in creating a 'positive learning climate' via feedback and reinforcing the positive consequences of training.

Supervisory support is also important to build a learner's motivation to learn; trainers and supervisors can influence a **learner's ongoing engagement with the training experience** by helping the learner to maintain their self-efficacy (belief in capability to do the job well). This could be via demonstration of the 'goal' of the training (what learners are working towards in terms of behaviours or skills) or reassuring them they are capable of succeeding (Colquitt, LePine and Noe, 2000). All research on trainers identifies a specific set of skills is required on the part of the supervisor to maximise the value of the training relationship, e.g. flexibility in use of training strategies, high levels of interpersonal skills, being good listeners and questioners, being technically competent in the area being taught. However, Buckley and Caple (2009) note the single most important aspect in a trainer is that the individual actually wants to be a trainer, and shows genuine investment in learner outcomes as a result.

What does the literature on differential attainment say about this success factor?

A recent report on the GMC's trainer recognition framework (Burford et al, 2019) noted there was relatively little awareness of how trainers were selected, recognised or evaluated. With the exception of GP trainers, the GMC do not approve specialty, Foundation or undergraduate trainers, but do provide the recognition framework as a mechanism to help ensure trainers meet required criteria (the requirements for training and appraisal are defined by their local organisation). Burford et al found trainers felt increased availability of 'training for trainers' was positive but **the scope and practical value of training for trainers varied widely across contexts and may not be sufficient but is often a box-ticking exercise** (p12). Customisable training online and meeting other trainers were noted as opportunities where trainers felt they could develop their skills more effectively.

Woolf et al (2017) summarise **interventions designed to support trainers to reduce DA,** and give some examples of current 'train the trainer' initiatives, such as college training on providing feedback, and note some courses have a specific focus on awareness of E&D. **Supervisors are also seen as holders of many 'protective processes' for BAME learners** (as summarised in Woolf et al, 2016, p37). However, BAME doctors are also exposed to risk factors such as poorer relationships with seniors, lack of recognition from trainers about effects of additional stressors and a fear of being labelled as problematic if issues are raised, which can limit opportunities to benefit from supervisor support.

Reflecting on current practice in your context…

- How can learners and trainers be supported to build open and honest relationships with one another?
- Is the role of 'the trainer' clear to learners and trainers? How does this differ across contexts and settings, or different types of trainer role? How do trainers work with mentors and recognise the role of support outside of the work environment?
- How are trainers supported (by colleagues and training providers) to develop their skills in this role? What support are trainers given to understand and mitigate the particular challenges of BAME learners?

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5. Success Factor 5: Having the support and validation of peers

Accessing a network of peers who can improve learning, make sense of experiences and provide advice and guidance on the practicalities of training

How did this factor support BAME doctors' success in training?

5.1. In addition to the value of formal and informal relationships with senior colleagues and supervisors at work, BAME learners interviewed specifically referenced the **importance of spending time with their peers**. This included individuals at the same, or slightly advanced, stage of training, from medical school to higher specialty training. Learners gave examples of how they had accessed this type of support via early stages of training in medical school, but sometimes found it harder to maintain during postgraduate training as they moved around more and had less chance to work with peers.

5.2. The **provision of mutual support amongst peers was critical**; learners discussed how they and their peers at the same stage of training provided one another with help to prepare for exams, debrief challenging experiences at work and develop based on feedback received. Learners also organised meetings around formal teaching sessions to learn together, get to know one another and expand their networks in new contexts. Learners who were more established in a certain setting often provided an invaluable 'signposting' service for resources, familiarisation in a new setting or wider local knowledge: this was facilitated via buddy systems but also occurred more informally.

"I've met colleagues who now I rely on as mentors, who are a little more senior than me and nearing the end of their training, and they've been helpful in giving some near-peer coaching, a bit of a career heads-up. It's someone else watching your back, giving you tips which you would have to learn the hard way otherwise" (Learner).

5.3. Learners also discussed the **important role their peers played in driving and motivating each other**. This was especially important if the learner need a 'nudge' or encouragement to recover from a negative experience. The broader social benefits of being able to link with a network of peers also helped to feel 'at home' in new surroundings and to manage stress by being able to talk openly and honestly without any likely repercussions. This point was related to *SF1: diverse environments* (and networks) as, often in this context, learners referred to the benefits of socialising with those that were from a similar cultural background and understood their circumstances.

[What would have helped?] … Having a really good support network of peers who understand where you're coming from and your background, because I've certainly found I often related better with people who were not necessarily graduates from the UK [than with my UK peers]" (Learner).

5.4. Peers with a more developed knowledge of the situation or setting also provided **an important source of validation or 'benchmarking', often through 'near-peer' mentoring or networking**. Learners gave examples where they had checked their understanding or interpretation of a challenging situation with peers and received reassurance or a 'confidence boost' as a result. Validation was also critical when learners were at points of transition: *"Having that time, that… debrief after work, and realising that when you felt like you didn't know what you were doing, actually everybody felt like they didn't know what they were doing, and that's just part of learning on the job" (Learner).*

"In my first job, which I hadn't done before... I struggled with adjusting to the environment and had very much taken that as a personal thing. But then speaking to my buddy, they would reassure me that it was really how the unit worked. It was very helpful to realise, okay, it's not that I'm not necessarily doing a good job, I am doing my best, and it's just the intensity of the unit, and that's how things after that for me improved" (Learner).

What were the considerations raised by BAME learners about this success factor?

5.5. Whilst peer networks were mostly seen as an invaluable resource, some learners noted a **risk they can become insular, encourage 'one way of thinking'**, don't encourage reflection on different approaches, or stop networks growing further. With these risks in mind, it was useful to receive prompting on 'different ways of thinking' from other sources, such as more senior colleagues. More is discussed on network homophily in the literature text box below, but BAME learners flagged that White or mixed peer groups appeared to have more access to opportunities.

5.6. Learners flagged that **networks need to change or 'reset' as the needs of the learner change**. Often this 'reset' or growth happened organically when individuals gained greater clarity about their career plans; learners would then expand their networks to find peers that could provide specific context-relevant support but this was easier for some than others. Learners reported difficulty with accessing new networks when they moved location or worked in contexts with limited peer interaction: this is something likely to be compounded for BAME learners because of lower levels of social capital (see literature box) and the possibility that they have moved to an area with less cultural diversity. In this instance, strategies organised by the training provider such as set teaching time allowing peers to meet one another, learner forums or inclusive social gatherings were valued. Buddy systems were also useful for overcoming practical challenges where a learner was completely new to an area and were away from their external support network.

5.7. Some learners flagged a challenge of peer networks **as the risk of anxiety or a feeling of isolation if an individual's experience diverged from others in the network**. In these instances, learners looked elsewhere for support, from trainers, more senior colleagues, or from external support networks: "*I was really alone, and I sat those exams seven times, all my colleagues and friends had passed the exams and were moving on with their careers. Had it not been for my supervisors who suggested I sought counselling, saw the Professional Support Unit (PSU), Occupational Health…If I hadn't done those things, I would have had a mental breakdown" (Learner).*

What is happening in practice in the programmes sampled?

5.8. Three quarters of learners did believe their programme provided access to peer support to some extent but there was uncertainty as to how well 'formal' systems worked compared to more informal relationships. Learners stressed the value of working alongside peers and being able to interact with like-minded individuals, similar to when discussing how some connections with senior colleagues were more long-lasting and impactful than others.

5.9. All stakeholders felt their context provided access to peer support where it could. Deanery stakeholders noted that peer support was generally easier to access if learners were in one place for longer periods of time.

5.10. Some stakeholders did touch on access to peer support as a specific intervention to help BAME doctors achieve success but this was mentioned less regularly than *SF3* and *SF4*. Often it was noted as the by-product of another initiative or support offering, such as exam preparation courses, training days or specific working arrangements that allowed learners to spend more time working alongside their peers, rather than in isolation. One college stakeholder explained that national training courses were deliberately organised to rotate around the country which meant increased travel but that learners had more exposure to networks across the country and had opportunities to learn *"outside of regional silos" (College Stakeholder).*

5.11. One college stakeholder gave an example of initiatives where supporting networking for particular groups was the primary focus. Specific networks were available for doctors of a certain ethnicity working in the specialty; this was seen as particularly necessary for learners working in less multi-cultural regions to get exposure to senior role-models. This might be seen to contradict earlier views in *SF1: Inclusive workplaces*, but in this instance was positioned as a positive way to allow those in minority groups to meet other doctors with a shared background, and to discuss the health or service requirements of particular segments of the population from an informed position. Presented as an intervention drawing on the strengths of the specific group in question, rather than an intervention to reduce a 'deficit', may make the difference.

5.12. Deanery stakeholders referenced the value of buddy or pairing systems to help individuals new into a training stage become familiarised with the specific working environment, the specialty context and often the broader regional area. Other buddy systems were set up to help learners deal with particularly challenging years or stages of training where senior and junior specialty learners were paired on request. Some deanery stakeholders referenced encouraging learners to set up small study groups but did not monitor this.

5.13. Deanery stakeholders also described learner forums which were largely learner-run, sometimes after initial set-up by training providers. These forums provided an opportunity for doctors to come together and collectively provide feedback on any aspect of training, but also allowed them to meet others training in their area.

How does psychological theory explain this success factor?

The benefits of peer access whilst learning are explained in both the training and medical education literature. Blume et al (2010) note that peer support, coupled with supervisory support, are the main contributors to a positive climate for learning. Peer support can be direct, where learners learning together motivate each other and benefit from observing others' learning, or indirect, where **learners create norms of 'cooperativeness' that allow them to help one another during learning** (Sonnentag, Niessen and Ohly, 2011).

In the medical context, Rashid et al (2016) note that peers are a valuable source of information to guide learning behaviour and **represent a 'safe group' that serve as a useful starting point for support** as opposed to a more formal request for support. Observation of one another's coping strategies is also seen to build individual self-efficacy through improving a learner's beliefs in the controllability and predictability of their environment.

What does the literature on differential attainment say about this success factor?

Todres et al (2012) found higher performing medical students had stronger peer networks ('socialisation'), whereas poorer performing students had weaker social networks. However, *who* is in the network is important.

A preference for homophily – building networks with people from similar backgrounds – can lead to disadvantages for minority ethnic groups because of reduced access to opportunities due to lower levels of network social capital (McPherson, Smith-Lovin and Cook, 2001). Vaughan et al (2015)'s study in a UK medical school found that patterns of ethnic and religious homophily was evident in the networks that formed but these factors were not directly linked with achievement. However, students in higher achievement quartiles were found to have more social capital and named a tutor or clinician within their network, whereas ethnic homophily meant minority students had lower levels of social capital that reduced access to resources that facilitate learning (indirectly affecting achievement). Woolf et al (2012) found that students randomly allocated to tutor groups were socially closer to students of the same sex or ethnic group but also to the members of their tutor group, and those friendships related to subsequent exam performance. Therefore, random allocation of students to mixed networks may be one way for BAME doctors to benefit from the social capital of others within their network.

Reflecting on current practice in your context…

- How can training providers support learners to develop peer networks, particularly in unfamiliar settings or areas?
- How might colleges ensure diverse representation and support learner doctors to build their networks?
- How can learners be encouraged or supported to draw on their peers for support in training? What formal and informal opportunities exist to promote this? How might socialisation across ethnic groups be encouraged?

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6. Success Factor 6: Working arrangements that facilitate learning

Shifts, rotas and work structures that support learners to build meaningful relationships with team members and dedicate time to learning

6.1. In addition to 'Who' supported success in training (*Success Factors 3, 4, 5*), BAME doctors interviewed also described 'What' supported success in training (*Success Factors 6-10*). These have been split out and presented separately as there are multiple aspects to these success factors which can be provided in a breadth of ways by trainers, training programmes and through design of the work and learning environment. As such, some overlap with sections above is visible but these sections are designed to act as standalone summaries of five factors that learners felt aided their progression: *Working arrangements (SF6), maximising learning opportunities (SF7), careers advice (SF8), support to pass exams (SF9) and personal motivation and drive (SF10).*

How did this factor support BAME doctors' success in training?

6.2. A commonly mentioned success factor for learning were the **working arrangements learners were situated in whilst learning.** Learners described huge variation in working arrangements in different placements, and how environments were more or less conducive to learning as a result. Learners felt this factor was entirely outside their sphere of influence and often the result of many variables interacting (specialty, location of training, type of setting, broader timetabling/organisation of rotations, placements or jobs).

6.3. **Protected time for training, or the lack thereof**, was consistently mentioned. Examples where this happened were set training days/hours, mandatory courses, allocated training time on the floor and time available not covering shifts to accumulate experience required for ARCP and to develop careers. Successful use of this training time was facilitated by a well-organised department who supported learning at work using strategies like:

- Set training sessions delivered by a rotating group of consultants/senior learners in the department
- Having some time working alongside a set consultant/senior learner to get feedback on basic skills
- Accommodating short slots after ward rounds/clinics for learners to debrief or ask questions of the consultant

6.4. Where learners spoke about contexts that were positive working and learning environments, a common factor was **senior doctors in the department who took advantage of any opportunity for learning**, especially in environments where time to learn was limited. This was visible via their efforts to integrate learning into daily tasks like ward rounds and prioritising learning on behalf of junior staff when necessary:

> *"This is probably the only one of two jobs where I've had protected teaching time. It's a teaching hospital so it was well organised. It was all structured in the sense that we brought in doctors to cover the floor so that we could go away and learn. It was protected time. We were not expected to see patients. In fact I was called up for being late. I was always one of these people that if I had 15 minutes I'd take another card and see another patient and I'd always run late whereas I think I was called up once. My consultant said, 'You're always late for teaching, if you've got 15 minutes and you can't see that patient in 15 minutes, don't see that patient'" (Learner).*

6.5. Another important aspect was the **perceived benefits of working alongside a consistent team**. In some circumstances this was the exact same group of people, in other situations it was a rotating group of individuals but with a consistent ratio of doctors and other MDT team members both junior and senior. Learners emphasised various benefits of this increased interaction with colleagues in making them feel less daunted, more capable and more supported: *"we were all part of the team, they had my back" (Learner).*

6.6. Learners also gave examples of certain teams where they felt they had better learning experiences. A common characteristic of these teams was the feeling that everyone was comfortable to ask questions. This resulted in increased communication between team members. The literature box explains why such a climate of psychological safety is important to encourage learning. This type of team culture might also reflect a team that are more inclusive and more respectful of the diverse opinions and experiences different team members contribute.

> *"I felt I could ask them all [consultants, registrars, nurses] anything. I was never scared, I think [that] is the main thing, to ask questions and I never felt like I was going to be shouted at, which…yeah, so that I think really helped with, me enjoying [that job]" (Learner).*

What were the considerations raised by BAME learners about this success factor?

6.7. Learners referenced a number of challenges applicable for all learners in training, including the new training contract terms, the European Working Time Directive and broader system pressures such as rota gaps. However, they also flagged that experiences were very variable and often felt **what made the difference was a 'well-run department or team'** where people knew their rotas well in advance, could plan time to attend training or other events and knew how the department worked and what their avenues for getting support were.

> *"It was a good working environment. The rotas were tough, there's no denying that, I don't think there's any way you can avoid that. But the nurses and consultants and team were supportive, it was a good team. It's really daunting when you start a new job, but you just felt that it was a well-run department. There was a lot of stuff you were still learning on the job but you knew what your back up was and if you didn't know what to do you could ask" (Learner).*

6.8. **Having the opportunity to build relationships with the wider team** was seen as beneficial to learning but also important for learners to feel more confident that a learner was adding value at work. One example of support that made an immediate difference were permanent team members taking the time to familiarise new doctors with the department (beyond 'normal induction about how the department works'), which generated a feeling of inclusion and an ability to 'hit the ground running'. Learners acknowledged this support came from colleagues in a breadth of roles including doctors, nurses, allied health professionals and other hospital staff, and felt this made it easier to feel as if they could contribute to the team from the very start, rather than being 'more hindrance than help'.

6.9. Learners spoke frequently about the **challenges inherent in speaking up if their work environment meant they did not have enough time to learn**. These situations included a lack of opportunity to work with other people, obtain feedback, attend training sessions, or being unable to get time off to attend learning or development opportunities outside work. There were feelings of frustration where shift patterns/ staff availability resulted in missed learning opportunities or falling behind in training. Learners acknowledged they had some control over this - *"it can be very frustrating, because you think, I'm wasting all of this learning time. You have to… be greedy for your own learning sometimes, and you've got to invest, and I felt like maybe I could have been helped with that" (Learner)* – but noted raising it was often met with a lack of interest or a perception 'you aren't tough enough' or 'not a team player'.

What is happening in practice in the programmes sampled?

6.10. Stakeholders from deaneries and colleges across the full breadth of specialties sampled felt protected training time was essential to ensure learners had time to interact with each other and receive equal access to learning opportunities. This did include time out of work to attend training days, but also rota plans that included time to attend clinics, multi-disciplinary team meetings and other events attended by the senior team.

6.11. It is worth noting that this factor was not mentioned as much by stakeholders, possibly because those interviewed felt working arrangements are less under the control of deaneries and colleges. However, an example provided by the Welsh Deanery showed how they worked with local Education Providers (Health Boards or Trusts) and learners to set up an Education Contract to provide 'ring-fenced time for learning': https://www.walesdeanery.org/wales-deanery-education-contract. Postgraduate training organisations may influence this through identifying which locations provide good quality training environments and some colleges are developing quality standards for training locations.

6.12. A range of stakeholders from postgraduate training organisations noted that working alongside a consistent team, for longer periods of time, was instrumental in helping learners progress, as they had opportunities to learn from different team members, had better clarity about their role in the team, and could be more effective as a result. If this was not possible, either due to normal specialty working practices or constraints in the working environment, stakeholders felt it was likely to result in disparity in experiences in training.

6.13. There were some differences in the specialties selected relating to this factor which can encourage consideration of aspects that could be replicated in other settings.

- The shift system of specialties such as Emergency Medicine was perceived to help with learning as it provided exposure to a variety of learning experiences 'on the job' which was different to experiences learners may not see if they were on a single shift pattern for a whole post ('firm' type training environments).

- Another specialty-specific theme was the variable use of learners as a solution to service provision challenges. In consultant-led services, such as Clinical Oncology, the focus was on the learner to shadow and engage with more senior doctors, not to run the service. They received more immediate feedback and much more learning time as a result. An indirect benefit of learners spending time in consultant led services was also the chance for consultants/supervisors to get a better idea of the learner's strengths and development areas, which in turn was a useful tool to guide supervisor interactions and to give learners individualised support in reaching their goals.
- Stakeholders did not describe situations where service design was based on learners running services, but those that did not use learners for service provision stated that learners working in this manner seemed to be at odds with the model of medical education as an apprenticeship-type scheme where learners learn by doing with appropriate supervision.

6.14. When describing their views on this point, stakeholders did not distinguish between different groups of learners but suggested that working arrangements conducive to learning would help all learners.

How does psychological theory explain this success factor?

The 'apprenticeship' training model is commonly used in the context of medical education as a training method that supports 'structured on-the-job development' and is a primary mechanism for learning from late medical school. Rotations allow experience to be gathered from working alongside a more experienced doctor, although learning can be opportunistic and from a variety of teachers (Millward, 2012). **Working within a team can support learning purely through greater access to interactions with others**, in addition to encouraging greater levels of team learning and shared development of mental models (thought processes about how things work in the real world) (Noe, Clarke and Klein, 2014).

Learning will be compromised if learners are expected to learn in this manner but work in isolation. Training theory also stresses the **importance of a 'team climate' that supports learning**. Team climates conducive to learning are those that are high in 'psychological safety', where individuals trust their other team members and feel trusted. Learners feel encouraged to learn and reflect in collaboration with others (Weller, Boyd and Cumin, (2014)).

What does the literature on differential attainment say about this success factor?

Woolf et al (2016, p40) also identify that inclusion in a **"functional, well-organised, multi-professional team**", where learners feel valued contributes to a broader sense of belonging, is seen as a key element of a supportive learning environment for *all* learners. The Shape of Training (2013) report recommended longer placements to allow learners to work in teams and alongside supervisors, reflecting the original intent of apprenticeship training.

Woolf et al (p24) also note that **relationships with other team members can be detrimental if they were impeded by cultural differences or preconceptions** – a risk more likely to negatively impact BAME learners and a symptom of a broader workplace culture which may not provide cultural or psychological safety. An added pressure of the regular rotation of learners in and out of teams meant there was often pressure to 'quickly acclimatise and fit in', which can result in a reduced sense of belonging for individuals who are in the minority and don't 'fit the mould' (p.24).

Reflecting on current practice in your context…

- How can providers, learners, employers and the GMC work together to ensure work arrangements support learning?
- What risks are present if learners have limited opportunities to work within a team? How can they receive feedback if this is not possible? How might this vary in your context?
- Have you considered implementing protected training time?
- What opportunities are available to provide learners with more comprehensive department inductions?

7. Success Factor 7: Maximising the value of learning

Ensuring learning at work and in training is valuable, holistic and helps inform career choices

How did this factor support BAME doctors' success in training?

> *"Here, we have the flexibility to choose the jobs we feel are helpful, and I picked quite challenging jobs but ultimately I think that helps me learn a lot. So, I think that's helped with my clinical progression as well" (Learner).*

7.1. Another relatively frequently mentioned factor that describes 'What' helps BAME doctors achieve success were the **opportunities to 'maximise the value of learning', i.e. the particular aspects of a job, rotation or programme that allowed them to feel it had been a valuable learning experience** as part of their training. Learners felt that maximising the value of learning at work was somewhat dependant on *who* they were working with (*SF3: Inspirational seniors and SF4: Supportive trainers and supervisors)*, in addition to the characteristics of that environment (*SF6: working arrangements*). Learners felt they had some influence over how valuable different learning experiences were, more so than the factors previously described. However, this varied across learners, as it also related to personal factors such as *SF10: motivation and drive*.

7.2. Being allowed to be **more independent at work was important in helping learners to develop**. Learners noted that being allowed to take more responsibility by senior doctors and encouraged to set more stretching goals or objectives whilst in placement, was helpful in developing confidence and pushing them to be more independent. Where this didn't happen, it was often noted a lack of time meant seniors 'stepped in and took over' and learning opportunities were lost. When it did happen, learners learned more and felt they were a more effective member of the team: *"Being given that freedom and responsibility of having meetings by yourself, then receiving personal letters that are written to you really makes you feel valued, respected and also like you're helping" (Learner).* This element was somewhat dependent on access to a senior colleague that allowed learners autonomy, but also on the learner interpreting the chance to work autonomously as a learning opportunity. However, learners stressed they felt supported if they could access senior support *if required* (as opposed to working alongside seniors), in contrast to working arrangements where learners were covering rota gaps, did not have that support and felt unsure or 'out of their depth'.

7.3. Learners also explained **having clarity about critical learning objectives** in any context was helpful to ensure they could self-manage and pursue the right opportunities for valuable learning experiences. Learners also felt that greater clarity of learning objectives for placements gave them a better basis for evaluating their own strengths and development areas. Importantly, this was not just about clinical knowledge but also how they needed to develop as a rounded practitioner to achieve future success. Achieving clarity on learning objectives was often **facilitated by a trainer/supervisor who considered each learner as an individual with specific needs** (in accordance with *SF2: Treating learners as individuals*). This approach recognised that all learners had different experiences, learning styles and learning needs. A supervisor or mentor that understood a learner's level of knowledge and skill and then helped sign-post or shape relevant learning opportunities for learners was essential here.

> *"I didn't mind being pushed in that way, so if someone said, 'what do you do about this, what do you do about this', I felt like this is actually stimulating to me and I think that's how I learn. So that was a big positive in terms of my learning and my confidence in the job. I think, initially [it happened] because I said, 'I want this engagement, why am I not getting it', but then also I think they knew that I was investing [so] they also trusted me and they would push me. I think also because I said, 'I'm interested in this job and I'm doing this' in return they gave me that engagement back" (Learner).*

What were the considerations raised by BAME learners about this success factor?

7.4. Learners mentioned two issues where they had experienced more problems with feeling like they could maximise their learning. Within Foundation and Core programmes, **organisation of rotations and exposure to required events/cases as a result** was often problematic. Learners referenced this as a source of anxiety in the short-term, and very negative in the long-term if it led to getting an unsatisfactory outcome in ARCP (despite the learners feeling they were progressing well in all other aspects):

""In Core Medical Training (CMT) and in Foundation year, I did jobs that are not common, so I spent three years working in medicine having never been to a cardiac arrest. So, at the end of CMT, it meant I felt like that aspect of my training was inadequate. A cardiac arrest [is] a requirement for passing your portfolio for CMT1 and I was very worried I wasn't gaining that experience. But I would say that doing those unusual jobs probably helped because those are things that people don't meet very often, so it didn't scare me when I did see them" (Learner).

In these contexts, learners noted the experience they had gained in other ways was very valuable but it didn't seem to align with 'the normal training pathway' – this meant they felt they were unable to show how what they had learned was valuable development in its own right.

7.5. The other related issue **was the risk of negative responses when learners raised issues with rotations or environments providing poor learning experiences**. Learners referred to breakdowns in working relationships (with supervisors or with deaneries) when the issue was raised. Learners reported they often felt concerns were dismissed or they were identified as 'problem learners' with no opportunity to discuss potential solutions:

"I asked my Foundation School if I could swap one of my jobs… I felt that I was just getting too much of the same after three rotations in geriatrics. They just said, "no", straight away and there was no debate about it, there was no way of talking to them, I got this one word email saying "no" … It made me as a junior trainee feel completely undervalued. Made me feel a bit more negative about my employer, my training school, and discouraged me from making contact with them in the future" (Learner).

What is happening in practice in the programmes sampled?

7.6. Interestingly, there were some differences when learners and stakeholders were asked about provision of support to maximise the value of learning. This may come down to differences in how 'early intervention' is interpreted across the two groups; the research team did not provide a definition to interviewees.

7.7. All learners felt it was positive for training providers to facilitate early intervention with any learner who might be at risk of struggling and felt this would help *all* learners to succeed. Two thirds said it was available to some extent in their current training context. However, learners appeared to define this type of support as pastoral support (for example, referrals to the PSU) and provision of training on resilience or communication skills if a learner was 'having difficulties coping'. In terms of support from training providers in accessing valuable learning experiences, learners felt the most useful source of support were trainers who were receptive to hearing feedback about poor learning experiences, or a lack of opportunity to learn at work, and were willing to work with a learner to change this (i.e. by making more learning opportunities available, or supporting rotation changes).

7.8. All stakeholders also felt providers should prioritise early intervention and support to learners at risk of struggling and the vast majority felt their context provided this. They also referenced use of the PSU in supporting this. However, they also flagged mechanisms within the programme that could proactively help learners to make sure they were maximising the value of their learning across placements, for e.g. the importance of trainers identifying if their learners might be struggling and pre-ARCPs for early identification of issues. This might be a proactive strategy to ensure learners can progress through training without issues at formal progression points. However, providing this support to a 'learner that is struggling' seems to place the emphasis back on the learner and misses the point that the wider learning environment or programme design may not be conducive to learning.

7.9. Interestingly, no-one identified 'early intervention' as something available from the start of a programme that attempted to mitigate challenges unique to the individual (see *SF2: Learner as individual*). This was the research team's definition of this term but neither learners nor stakeholders spoke about anything like this happening.

7.10. Stakeholders from postgraduate training organisations felt that learning objectives and outcomes are much improved in their contexts from 10 years ago, which aids learners and trainers in working together more effectively. Objectives are set at the start of training; for some Core Training programmes these were designed to help learners obtain relevant experience that 'sets them apart' from other applicants at the higher specialty selection point. It wasn't clear if this was the same for other programmes appearing at different points in the training pathway.

7.11. Set teaching programmes containing a mix of clinical and non-clinical content was described by all deanery stakeholders interviewed and were designed to be engaging for learners regardless of their stage of training or

number of exams achieved. In some instances, these were also offered to staff grade doctors (whilst not relevant to this research sample (UK-graduated BAME doctors), this can be seen to further promote an inclusive environment that values the diverse experiences of all employees and learners (*SF1*)) .

7.12. Stakeholders across Core Training programmes also described the increased use of simulation programmes and provision of training equipment that doctors could take home and practise with. Increased provision of 'out of work' training like this, supported by online modules and regular in-class assessment, had improved learner overall satisfaction levels with teaching and equity of access to learning opportunities. This more flexible approach to training reflects the ethos that all learners are individuals *(SF2)*, who learn in different ways, and may have varying personal circumstances meaning that traditional learning methods are less accessible to them.

7.13. Some stakeholders also described the use of pre/mini-ARCPs to identify if learners were 'off-track' in good time before the actual ARCP (this was described as a useful preventative measure to avoid the type of situations described above developing to the point where learners would receive an unsatisfactory outcome. Usually, a TPD reviewed all portfolios, then worked with the relevant tutor/supervisor and learner to flag where more evidence needed to be collected or improvements made; this was done 2-3 months before actual ARCPs. This type of proactive approach to providing support seems to link to the challenges learners raised about not getting opportunities to learn, but at odds with what learners perceived 'early intervention and support' encompassed. This may be because this type of intervention is not consistently available (so there is limited awareness that it is a possible source of support). It might also be related to the learners' perceptions that raising the issues with a poor learning environment could be viewed as 'trouble-making' (i.e. the implication being it is something the learner has to cope with or try to resolve themselves).

How does psychological theory explain this success factor?

Ford, Quinones and Sorra (1992) identity factors that can affect an individual's 'opportunity to perform' and learn at work, including **organisational-level factors** (clear understanding of the goals of the team/ department), the **learner's supervisor** (supervisor perceptions affecting access to different tasks at work) and the **working climate** (supportive environments allowing individuals to feel comfortable stretching themselves).
Access to stretching experiences, coupled with appropriate support, allows more holistic learning and builds learner self-efficacy and confidence. The concept of being challenged but in a safe environment is used in simulation training: stress-inoculation theory explains exposure to challenging situations in a safe environment helps learners proactively ready coping strategies for similar future events (Meichenbaum and Cameron, 1989).

What does the literature on differential attainment say about this success factor?

Woolf et al (2016) identified a similar need for access to stretching experiences, with appropriate support and feedback to help 'steel' learners (p11). If these situations are experienced with a lack of support, this can create a negative experience for *any* learner. However, this may result in increased risk for BAME learners as potential bias or negative stereotypes can mean **negative experiences are more likely to be attributed to a 'failing' on their part**, and they may not feel comfortable seeking support as a result. This is influenced by the broader culture in medicine that failures are related to a lack of motivation or ability.

While not raised by the learners in this study, the 2015 Peninsula literature review highlights a breadth of research that shows some **minority groups such as BAME students are at risk of disadvantage due to the 'standardised' methods of teaching** used in medical (and higher) education being less accessible. The review calls for greater reference to the broader literature on topics such as learning styles to help create learning that is accessible to all; this aligns with 'individualised' learning approach discussed in *SF2.*

Reflecting on current practice in your context…

- What additional objectives could be shared with learners to help them maximise learning opportunities?
- How can experience 'outside' the normal curriculum be referenced as valuable learning experiences?
- How are learners supported to set stretching goals in placements/rotations of variable length?
- What specific consideration should be given to the experiences of BAME learners in ensuring fairness in access to good quality training experiences?

8. Success Factor 8: Gaining clarity, certainty and support for career choices

Accessing experiences, knowledge and learning and development opportunities that support informed decisions about career choices or next steps

How did this factor support BAME doctors' success in training?

"When you go into [that specialty] you have to specialise...so you have to starting thinking about networking with other consultants that share a similar interest because it's very likely you'll be applying to their department in the future; they can tell you what kind of qualities or qualifications they're looking for in potential candidates" (Learner).

8.1. Another regularly referenced support factor was help received for learners to navigate the broader career pathway. Learners felt they had more personal influence over this compared to their *working arrangements (SF5)* or *the individuals supporting their learning (SF3/SF4)* but they referenced that external support to guide them further was very helpful for a number of reasons. This factor encompasses activities or experiences that supported learners to commit to and progress within a chosen career path.

8.2. Learners spoke about the importance of gaining enough experience in a specialty to be confident in their career choices. This allowed them to **assess their 'job-person fit'**- whether they felt their skills and interests were aligned to a particular specialty or career, and if they could see themselves in that career in the future. Spending some time working in the job-specific environment was useful, as was engagement with more experienced staff who could explain how experiences in one setting compared to alternative ways of working in the area. Learners also needed time to reflect on their experiences in training to understand what aspects of a job they enjoyed and how this aligned to their personality, working preferences or personal motivators and drivers. Some links to *SF1: An inclusive workplace that values diversity* were made here, as learners referenced that seeing role-models or feeling like they were accepted had a positive impact on their perceptions of different environments and specialties.

8.3. Some learners spoke positively about being **prepared to be flexible and take a different route to help increase certainty about career choices**. Taking time to work in different contexts (nationally or internationally), taking an 'F3 year' and delaying making specialty applications, completing an MSc or PhD, or setting goals for being fulfilled in the short to medium-term rather than long-term were all useful strategies for improved reflection and self-awareness. The benefits of taking a more flexible approach to career planning were referenced by some, but not all, of those learners interviewed. These experiences contrasted with other situations where learners said their circumstances meant they could not move locations, so this is unlikely to be feasible for some BAME learners.

8.4. Having decided on a career path, it was viewed as essential to **'build a personal profile' reflecting commitment to that area**. This provided an advantage in getting a job or training number, via demonstration of experience and engagement that could make a CV 'stand out', but also via connections with colleagues in that area to learn about opportunities and validate what was required. Learners described speaking to senior colleagues about who to talk to, what marked out strong applicants, and how to build their CV to show how they differed from other applicants.

What were the considerations raised by BAME learners about this success factor?

8.5. Access to knowledge of the medical world was a challenge for some from before medical school. **Learners who had doctors in the family spoke about this as providing insight into the field** that gave perspective and helped navigate training and decisions – *"my mum and dad are both doctors, so I guess that helps because they understand the stresses of the career and being able to help advise me on different career paths" (Learner).* Those that didn't have this noted it was more challenging to navigate medical career options from early on in training.

"I think if you don't come from a certain medical family, you don't have people who might be able to steer you, it can be quite difficult to know how to succeed" (Learner).

8.6. Learners reported that it could be difficult to obtain guidance on career progression or relevant opportunities if their **supervisor did not have experience of the relevant area of medicine** they were interested in (more relevant at earlier stages of training). This difficulty is likely to be worse for BAME doctors as reduced levels of social capital mean that access to networks, information sources or opportunities can be limited compared to their peers. At points where careers decisions were still being made (i.e. during medical school and Foundation), this was

particularly important as learners referenced the fact they were often unsure if different careers would be a good fit with their personal circumstances or were 'realistic' or 'attainable' for them. Whilst learners did not directly relate this uncertainty to their personal circumstances, this is likely to be a more prevalent concern for BAME learners as they may have less access to networks that can give them more insight into the practical realities of different medical careers, or less access to opportunities to build their CVs. Those who had a good relationship with a *senior doctor acting as a role-model or informal mentor (SF3)* or with a *supervisor/trainer (SF4)* expressed their views that these people provided encouragement and validation that they would be able to succeed in their career pathway as well as any other learner.

8.7. Learners often spoke about the **impact their Foundation placement experiences had on their commitment to a particular medical career, or medical training in general**. Being able to debrief and validate if these experiences were representative was very valuable in maintaining engagement, particularly with negative experiences. Positive experiences were re-energising and motivating (if a learner worked in a job that aligned with their personality and preferences). **Negative experiences were demoralising, and could have a longer-term impact on personal confidence and self-efficacy** (if they worked in a job where they did not feel welcome or at ease): "*Seeing that kind of toxic atmosphere made me think 'if this is what the common experience of [that specialty] is, I don't want any part of it" (Learner).* This was important as it helped learners to feel more confident in their choice of career and their eventual success in training.

8.8. Where learners talked about being prepared to diverge from the 'normal' training route by taking a year out, completing an F3 year, working abroad or completing a PhD (as some examples), there were interesting reflections on their own and others' perceptions of doing this. Learners reported that **decisions to diverge from the 'usual training pathway' was made challenging by financial and family pressures and could feel unusual or indulgent.** Therefore, feeling encouraged by seniors to invest time in this activity could be valuable and empowering.

> *""When you come from an Asian background… there is that 'sacrifice yourself when you're young to get where you want to be when you're older' [idea]. I think different cultures and different professions can sometimes be a bit more sympathetic to what 'do you feel will satisfy you next year?' Being allowed to ask those questions when I was in my 20's and make decisions based on those was just turning how I'd traditionally been thinking about things on its head" (Learner).*

> *"It's about being given permission to be who you are and who you want to be. It was just really helpful to have somebody above you give you the freedom to make a different decision to what everyone else was telling me you should do. You want to make these slightly different decisions to 'normal' and then you feel like you're being rebellious… you're not playing the game" (Learner).*

> *"I had to make a decision about… coming back part time, doing a PhD and taking time out of training, rather than just going straight through to consultancy. I've been able to sit down honestly with the consultant and say 'I don't know what the right thing to do is' and be able to be completely open and honest about my feelings and what I'm trying to get out of my career. And because they know me as a person, they've been able to really support me in that decision, and I haven't felt like anybody's judging me along the way" (Learner).*

What is happening in practice in the programmes sampled?

8.9. The research sample (deanery and college stakeholders) did impact discussion of this factor. Stakeholders were reflecting on why their context (core/specialty postgraduate training) did not show DA. Hence, their learners had often already made career decisions; stakeholders appeared not to question this or implied that targeted careers support was more relevant earlier in the pathway. Nonetheless, some practical strategies were shared.

8.10. Stakeholders talked about opportunities to provide learners with additional insight into career pathways such as selection processes that allocated time to discussion of applicant CVs and providing a realistic preview of working life in the specialty so learners 'knew what they were getting into'. This continued via inductions designed to explain how to navigate the training pathway in the most effective way (what to aim for and by when).

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8.11. Careers education happened in other forums, including events put on by colleges, specific University societies, and conferences for medical school students to learn more about career choices or job families. College websites and specialty societies that contained specific advice for early stage learners were also referenced.

8.12. Some stakeholders noted that informal access to knowledge about careers can be variable. Specialties that interface directly with the general public, such as General Practice and Emergency Medicine (EM), are often also the 'public face' of medicine in the media, which may help early familiarisation (but can create myths or false perceptions!). However, EM usually has locum shifts available, which increases availability of realistic job previews.

8.13. When reflecting on why their context did not show statistical differences in attainment between BAME and White doctors, some stakeholders referenced an increased need to recruit enough learners often resulted in more investment in learners to 'collaboratively realise their career aspirations'. The implication here was an investment was made in making sure all doctors were given individualised support, which then maximised their chances of success (reflecting *SF2: treating learners as individuals*). One avenue where this could be demonstrated was helping doctors navigate the career pathway successfully.

- *"The strategy in our area is to 'grow our own'. [It's] difficult to attract experienced doctors and consultants to the region so we 'look after our own' and provide a clear career pathway to Certificate of Completion of Training (CCT) or a consultant post" (Deanery stakeholder).*
- *"[I am] amazed how many colleagues from other specialities are appalled about trainees going out of programme. We expect our trainees to want to explore something, that's the norm so if they want to do it, we facilitate that. I was interested in other specialities [that] this was seen as a barrier or threat" (College stakeholder)*

How does psychological theory explain this success factor?

Personality-job fit theory identifies **certain personality characteristics are more suited to certain jobs** or job environments. Individuals with a better 'fit' to the job will perform better, have higher levels of wellbeing, and be more satisfied with their jobs (Kristof-Brown and Guay, 2011).

To understand the extent of person-job or person-organisation 'fit', **individuals need to engage in 'career exploration'** (self-assessment of skills, strengths, weaknesses, values, interests and plans, and accessing job-relevant information from a variety of sources). More complete career exploration creates more nuanced understanding; individuals with higher levels of career exploration are more motivated in training (they can clearly see the link between learning and personal development). **Career planning** is the extent to which individuals can use career knowledge to create clear, specific plans for achieving goals; this has also been shown to link to motivation and drive to succeed at work (Colquitt, 2000).

What does the literature on differential attainment say about this success factor?

Kassim et al (2016) found that **knowledge of careers was directly linked to feelings of preparedness** for *all* medical students (not just certain groups). Farrokhi-Khajeh-Pasha et al (2014) illustrated that medical students who had not made an informed choice to enter medicine had a higher tendency to say they would change their minds if applying again – an 'idealistic', uninformed choice to enter medicine is more likely without access to careers advice.

There is limited research that explores differential access to careers information, or the differences between BAME and White learners in terms of career satisfaction. However, much of the research that explains how BAME learners have reduced access to networks and senior support references knowledge about careers, and opportunities to build CVs/experience, as an aspect of support that these networks provide. Data published by the GMC on postgraduate recruitment outcomes shows disparity between BAME and White UK-graduated doctors which may, in part, be linked to reduced access to career development opportunities for BAME doctors.

Reflecting on current practice in your context…

- How can relevant information on careers be made available for learners throughout the pathway?
- Are learners given enough opportunity to experience a range of jobs before making career decisions?
- How are requests to flex training managed? How could decisions be made in collaboration with learners?

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9. Success Factor 9: Support to pass exams or deal with exam failure

Being prepared and supported to navigate the process of completing challenging professional exams

How did this factor support BAME doctors' success in training?

> *"Having such a challenging exam, it does highlight some of the problems that you might face in a clinical situation, your psychological coping mechanisms [and other things]. It's definitely made me stronger and know the kind of help I need to get if anything else happens in future but these exams are a real struggle, very difficult" (Learner).*

9.1. As the scope of this research was to explore what factors BAME learners felt contributed to their success in training, it is not surprising that learners spoke about support related to successful completion of exams (mainly postgraduate). Learners largely described exams as the responsibility of themselves, but with access to support where required. Compared to other factors that were seen to contribute to success in training, this factor was spoken about the least by learners (possibly because they were asked to reflect on the positive moments during their training pathway that contributed to their success, and exams did not immediately come to mind as a positive experience). There also appeared to be an assumption of the part of the learners that exams were the responsibility of the learner, and the role of the programme in supporting learners to complete exams was somewhat unclear. However, this factor provides some immediate insight into strategies that learners and stakeholders felt contributed to positive outcomes.

9.2. The most **common source of support was in preparing for exams.** Learners described attending courses either designed to support good exam technique or support with specific elements of exams such as communication skills. Learners also reflected on the value of their medical school education in getting them 'ready' for postgraduate exams – this was very personal as benefits ranged from having been required to develop a strong work ethic to having attended a medical school strong on science, which supported later success in Membership of the Royal College of Physicians (MRCP) Part 1 (as one example).

9.3. Learners also reflected on the **different sources of support** they accessed when they were dealing with failures in exams. In a formal or informal capacity (*SF3; SF4*), senior colleagues provided encouragement, reassurance or support to work through why a learner had failed and what they might be able to change in future attempts. There were also referrals made to **sources of support such as the PSU, counselling and Occupational Health**. Learners also referenced support received from peers such as support with revision and sharing useful resources, and support received from family and friends.

What were the considerations raised by BAME learners about this success factor?

9.4. It is important to note that, of all the factors identified as aiding a successful training journey through training, this one was the one where **learners had the least to offer about useful sources of support**. The most common feedback was how challenging the exams were; learners were honest about the very real impact this had on them at work and **the psychological pressure preparing** for challenging exams on top of tiring and pressurised shifts at work. The general feedback was that learners felt it was largely not recognised by training providers and trainers how challenging the process of successfully passing exams whilst within a training programme was, and the toll this could take on learners. If individuals involved in training recognised the impact that exam stress or failure had on individuals and dealt with this in a sensitive manner, this was seen as invaluable in keeping learners 'on track' and helping maintain their motivation and confidence (related to *SF2: treating learners as individuals*).

9.5. Learners noted that there was often a **'culture shock' of dealing with failures after getting through medical school exams with little trouble** – *"I failed my exams and that's, in my whole career, that's the first time I've failed exams, so that was a real downer. And I didn't just fail them once, I failed them three times" (Learner).* This was compounded by the belief in medicine that failure is down to a lack of drive or motivation within individuals.

9.6. Learners differed in how **they made 'sense' to themselves about exam failures**. Lack of success in selection was most likely explained as 'I didn't have the right experience' or 'someone had better/more experience than me'. In contrast, less sense-making was given for exam failures – learners reflected on how hard the exams were but many did not talk about why they had failed. It was unclear if learners could not or did not want to explain this (to the

researchers or themselves), or if they did not know. A lack of attribution in this context is interesting, because it makes it harder to understand what support might help without further investigation.

9.7. A minority of learners explained they had failed because they **had attempted the exams too early.** Early attempts were attributed to the time pressure to achieve them by a certain point in training, because their completion was seen as a way of demonstrating commitment to the specialty, or because they expected to fail at least once so wanted to start early and 'have a go'. **A minority reflected that they had been told beforehand that the exams were biased against certain groups** so they might expect to fail because of that: *"I'd been told beforehand that actually they're a bit racist really and that plenty of people from those sorts of backgrounds failed" (Learner).*

9.8. A minority of learners said that, with the 'benefit of hindsight', **they felt they were more resilient having failed an exam**. However, more learners focused on the short-term, negative impact, of exam failures on their confidence at work and in training, which were often described as significant knocks to their confidence. Learners talked about how exam failures often 'spilled over' into confidence at work, even if they felt they had been working effectively before taking the exam. Recognition of the impact of exam failures on confidence and positive feedback from colleagues) was seen as valuable in helping to rebuild confidence but few learners described telling anyone at work about exam failures.

9.9. In contrast, BAME learners frequently talked about their 'surprise' or 'shock' when they passed an exam. There were also examples given where **exam success was seen as important not only because it marked a personal achievement, but because it appeared to affect other peoples' attitudes towards them**. This suggests that BAME doctors may place more emphasis on successful completion of exams than other learners, as being able to state that a BAME doctor has passed exams could provide an 'objective' indication of competence or skill that provides protection against possible bias or assumptions of competence based on stereotypes.

> *"the perceived difficulties I had [with the exam] were thought to be innate, rather than something that could be worked on. So, it was quite noticeable sometimes, it wasn't discriminating to me personally, but it was just as if the feeling was that I wasn't worth the time to train. And when the exams were all done and dusted, and people realise: 'oh, you've just passed your exams, you're here to stay', people then started thinking: 'oh, well, maybe it's worth investing in this fella after all!' It was quite a noticeable difference in interaction with people after the exams." (Learner).*

9.10. Learners did highlight the **variable accessibility of exam preparation courses**. Some noted the benefit of mandatory courses, in terms of ensuring preparation was not only available to some. However, there were issues preventing attendance that were raised, including financial pressures and availability of time to attend (both time off from work, and available time outside of work).

What is happening in practice in the programmes sampled?

9.11. All learners felt that training organisations had an obligation to ensure examination (and selection) processes were as fair as possible and bias was minimised, and most said this happened to some extent in their current specialty. There was variation in responses when learners were directly asked if exams were seen as fair or not – respondents said that **they thought (and hoped) exams were fair but there was a risk of unconscious bias in face-to-face examinations which a diverse group of examiners would help to offset**. In contrast, there was no discussion of the fairness of ARCPs and selection – it was unclear why this was but a minority of learners made reference to them being 'based on evidence' (i.e. portfolios and CVs).

9.12. Whilst learners said relatively little about strategies for dealing with exams, stakeholders across deaneries and colleges gave a lot of detail about provisions designed to help learners pass exams or cope with exam failure. The interview design explains this in part: learners were asked what factors meant they were successful in training, whereas stakeholders were asked for their views on why their context showed non-significant levels of DA in exam outcomes, hence exam support and strategies were one of the first aspects discussed. Some stakeholders were already aware of their area's results whilst others became aware after being contacted by the research team.

9.13. There was a common theme from stakeholders that DA in exam outcomes is most likely linked to different experiences in the training pathway up to that point. Deanery and college stakeholders both noted if every learner is given the support they specifically need, there will be an absence of DA: *"they are related in that there will be no*

differential attainment if you get it right for all trainees" (Deanery stakeholder). This reflects previous research (Woolf et al, 2016; deBere et al, 2015) that variable experiences within learning environment, and variable access to support, is the likely reason for DA (not academic achievement as DA still exists when prior attainment is controlled for; Mountford-Zimdars et al, 2015).

9.14. For practical exams such as Objective Structured Clinical Examinations (OSCEs), mock exams were provided to give learners a chance to familiarise themselves with exam format and expectations, and to receive feedback from examiners. In some contexts, learners were either offered, or expected to attend, mandatory exam preparation courses – however this was largely because the content of the exam had to be 'taught' outside usual learning. Practice question banks were also available for some exams.

9.15. Deanery stakeholders also reflected the value of teaching exam technique as part of work. Focused teaching sessions were offered by seniors in a format that mirrored an OSCE-style case vignette. Bedside one-to-one training where consultants or senior learners volunteered to coach learners through specific cases was also offered. A common view was that failures in exam were *"the result of issues with technique, not knowledge" (Deanery stakeholder)* so exam training was often offered alongside clinical training as a fundamental component of the training programme.

9.16. A focus on ensuring a diverse group of examiners was recruited, trained, and used in combination to assess and calibrate examinee performance was also regularly referenced. Stakeholders noted that specialties with a diverse mix of experienced doctors and consultants, which the majority of stakeholders interviewed felt they were working within, may support this and therefore result in fairer examination processes for all.

9.17. Likewise, college stakeholders spoke about best practice in constructing and monitoring examinations to reduce any risk of bias. This involved standardised methods of setting exam questions to minimise unintended bias through poor choice of language, choosing a breadth of exam question writers from a range of backgrounds, and making sure content *"reflects what they are doing on the shop-floor" (Deanery stakeholder).* Standard setting processes, providing multiple marking points to reduce the impact of variation across examiners, and assessors sitting in sessions to assess the examiners and provide feedback were also used. Provision of supporting information and a well-publicised exam curriculum were also seen as valuable. Exam outcome data was monitored to understand where DA occurred.

9.18. Stakeholders from deaneries reported having fairly limited knowledge concerning their learners' exam attempts and failures. In a minority of instances, this information was provided by the college or there was small enough numbers of learners that the information was shared quite easily but in most contexts and bigger programmes, the programme was reliant on the learner informing them. This variation in practice has implications for the ability of educational supervisors or Training Programme Directors to react and intervene early to offer support if a learner fails an exam.

9.19. There were some examples of stakeholders that had identified common reasons for exam failures and put in place targeted revision sessions as a result.

- *"Anatomy is a concern: we saw most of the failures in Part A are due to [lack of] anatomy knowledge. This does link to feedback that medical schools teach this differently. We arranged the anatomy department to provide 6 days of teaching; all learners were able to attend for 2-3 days. This broadened knowledge, we got good feedback. Learners with repeated exam failures provided feedback that this is useful" (Deanery stakeholder).*
- *"We identified a few years ago, the oral exam pass-rate was an issue and this was a hurdle which relied heavily on communication skills. We brought in a communications skills workshop available once or twice a year across the region. Rather than exam practice, it went back to the fundamentals of communication skills. [It was] run by someone with an acting background, rather than a very good communicating consultant. It was deanery funded; approved based on helping IMGs, but there was uptake across the board" (Deanery stakeholder).*

9.20. Stakeholders did reflect on the challenge of using exam results (in isolation) to understand the fairness of training pathways for all learners. The first reason given was the concept that 'success' is broader than exam results: *"Exam failure is a very easy outcome to measure, as is ARCP outcome. But other aspects are useful as well; success at selection, success going into consultancy, time in remedial training" (Deanery stakeholder)*.

9.21. The most common consideration was the unintended impact of exams being available to sit when learners felt they were ready. The implications of this were wide-ranging: "*There are still restrictions on when you take exams, but*

now the training model is focused on competency outcomes, so trainees can take it when they feel ready. But then trainees are drawing their own conclusions on when they might have a higher chance of passing. So … there is a risk that their perceptions are leading to people moving through the system in a certain way" (Deanery stakeholder) – i.e. that perceptions of likely pass/failure are driving inappropriate behaviour. There was reference made to the fact that exam attempts have to be approved for those not in training schemes, but nothing was mentioned by stakeholders interviewed about a similar process for learners in training programmes, or any process that recorded the stage of training a learner was at when attempting an exam. Whilst there are processes in place for some postgraduate exams where all candidates have to have support to make attempt, this is not universal practice.

9.22. Suggested 'perceptions' that might influence learners to take an exam too early include a belief they will fail their first attempt anyway, either because everyone does (the exam is hard), or because certain groups of people do (the exam is biased). Stakeholders flagged that challenging this anecdotal perception, particularly bearing in mind the tight timeframes of training programmes, was very difficult. They were clear on the rationale for setting exams at the current difficulty levels: *"The exam is tailored to test someone when they are at that point in experience – when they have seen a number of patients or done a number of procedures" (College stakeholder)* and suggested that more might be done to ensure any trainee does not knowingly attempt an exam before they have the relevant experience. However, it is difficult to know if overly early attempts have much influence on observed DA.

How does psychological theory explain this success factor?

Theories of resilience at work now include **a number of 'protective factors' or 'resources'** that are useful to proactively prepare for future challenges and 'bounce back' from past ones. These may be internal to the individual but also encompass external sources of support and guidance (Pangallo et al, 2015). Personal factors that 'buffer' against resilience, such as self-efficacy and goal orientation, are relevant because they safeguard individuals against negative self-perceptions as a result of challenging experiences, but also enable learners to remain motivated and focused on learning. Learners in Fair Pathways (Part 1) spoke about motivation at work being strengthened by keeping focus on goals and 'a love of medicine' and **reflecting on exam failures as opportunities to learn** (p53).

What does the literature on differential attainment say about this success factor?

As a critical outcome measure, it is not surprisingly that there is a significant amount of research into whether exams show bias as a measurement method which contributes to the DA gap. The Peninsula literature review (2015) provides a comprehensive review of research relating to postgraduate exams. Whilst ethnic differences are observed, these were not attributed to examiner bias and exams were shown to be valid.

Learners (Woolf et al, 2016) felt **exams were more robust and standardised than ARCPs**, but exams were not reflective of the 'real skills' needed in work (particularly communication) and needed individuals to 'learn to play the game' (p17). BAME learners are exposed to additional pressure when sitting exams, because of prior knowledge that they are more 'statistically likely' to fail. Some of the rationale for differences in performance, i.e. embedded cultural knowledge, was perceived as necessary to test to ensure good clinical practice, but it is unlikely that this is the reason for differences between UK-graduated BAME and White learners.

Reflecting on current practice in your context…

- What do training providers know about their learner cohorts and exam attempts? What additional data could be used to aid identification of learners that might benefit from earlier support or intervention?
- What efforts could support learners to attempt exams only when sufficiently prepared/ready?
- How are assessments of performance standardised to ensure objective measurement? Is this communicated and explained to learners and assessors? Are learners aware of steps currently taken to reduce the risk of unconscious bias and the ongoing monitoring of data?
- Is enough support available to learners to pass exams (proactive as well as reactive)?
- How can colleges and LETBs/deaneries work together to understand common reasons for exam failure in more detail?

10. Success Factor 10: Personal motivation and drive

Drawing on personal commitment, drive and motivation to succeed in training

How did this factor support BAME doctors' success in training?

10.1. The previous success factors illustrated a range of aspects relevant to learner success, including environmental conditions, and factors explaining 'Who' and 'What' can support progression. Learners felt that some of these were more out of their control than others. This final factor was a common theme that had supported progression but could be interpreted as largely 'internal' or personal to a learner: **an individual learner's personal motivation, drive or enthusiasm for their training and career.** This may initially appear as something that stakeholders from training organisations have less control over, but it is important to remember that motivation is not just a factor that predicts success, but also a factor that is influenced by it (i.e. all the factors discussed above will have an impact on learner motivation and drive).

10.2. Learners reflected on the **value of showing enthusiasm in, and for, their work**, partly as a proactive investment in better working relationships with colleagues but also as a strategy to support relationship building in a particular location or career. Enthusiasm enabled deeper relationships with higher levels of trust between learners and senior doctors, being given more responsibility, or having increased access to career development opportunities. Learners flagged this could be done in more ways than just reaching out to senior doctors, including spending time becoming more embedded in the broader department or team and making efforts to experience a range of activities.

"that's where I got that experience from, you've just got to go out of your way to find it. That enthusiasm, but also attending all the meetings with the multidisciplinary team, just getting involved with things in the ward, helping out on the ward, I think it's just getting yourself more involved completely" (Learner).

10.3. Learners also felt it was worthwhile investing time in **understanding what they wanted out of work and incorporating this into decisions** about what opportunities to pursue, as this was necessary to remain motivated or driven in training. Learners spoke about how being honest about what they wanted from a career meant better long-term decisions. Learners recognised it can be hard to define "what you want" in earlier training stages so being prepared to take a more flexible approach to planning next steps (one or two steps ahead, being prepared to take some time out) was critical to avoid the trap of 'sunk costs: invested so much that might as well continue.' However, it is also important to note that the current model of training which often requires BAME doctors to move around, is directly at odds with the value placed on, and motivation generated by, strong relationships with friends and family outside work (Woolf et al, 2016, p.32).

What considerations raised by BAME learners about this success factor?

10.4. This factor was quite personal to individual learners. They noted they felt motivated by different things at different points in their training. ***What* motivated them was often a good experience related to another success factor**: *working with an inspirational senior (SF3) or supportive trainer (SF4), getting the chance to feel part of a team (SF5), being in an open and welcoming environment (SF1*), etc. They then used these motivational experiences to *stay focused and maximise their learning (SF7), bounce back from failure (SF9) or commit to a particular career (SF8)*. This indicates that, whilst a learner controls the level of motivation and drive they bring to work, training providers can support this by creating a climate that allows learners to demonstrate and maintain their motivation, engagement and drive as they progress through training.

10.5. However, a few learners did note they felt a **particular drive to work hard and succeed as a response to others' biases or perceptions about their background and abilities**.

"I'm cautious about developing a sort of victim mindset... you don't want to accuse people of being the victim but it is very easy to fall into that trap, [because of] whatever kind of perceived stigma. The method I've always had is just to be better than everyone else and if the only way to get their respect or their kind of approval professionally is to be able to operate at a really high level, then that's what you have to do" (Learner).

Many learners reflected that they 'hoped it wasn't like that' and that they as doctors were judged on their performance alone. Learners felt having an ethos where everyone was *treated as an individual who may be*

experiencing their own challenges (SF2) and having enough time to build meaningful relationships with colleagues mitigated the risk that others were making judgements about them based on potential bias or stereotypes.

10.6. There were also some learners that made reference to **their personal circumstances meaning they had to be very driven to achieve to a high enough standard** that they could get jobs or placements in more competitive areas. This referred to circumstances that meant they wanted to stay in a particular location to remain close to family or preferred to stay in a culturally diverse area. Whilst this point might be applicable to a range of learners, the analysis of recruitment outcomes indicates this is likely harder for BAME doctors to achieve.

"I met my wife halfway through medical school and we always had plans to settle down; we got married a few years after I graduated and I'm very lucky that my parents are local to us in London, and I managed to find a job in London and just stayed in London throughout my career. I think a lot of that motivation came from wanting to keep the family unit together; both my immediate family and the extended family" (Learner).

What were the observations from stakeholders in the programmes sampled?

10.7. When stakeholders were asked what might explain the more equitable exam attainment rates in their context, many mentioned that their learners were uniformly 'driven' or 'committed', which was mainly attributed to learners having made a conscious decision to pursue a specific career and having a good understanding of the specific context (competitive specialty, small specialty, specialty with many opportunities to sub-specialise) that allowed them to succeed. However, stakeholders did not appear to believe that a lack of motivation, commitment or drive was what explained DA in other contexts. Therefore, it could be hypothesised that this observed motivation or drive is another outcome of learners in their contexts having more equitable access to the types of support that will not only result in equal levels of attainment but also influence levels of motivation.

10.8. There was no consistent reference to higher quality applicants in a certain area being the reason for better results 'across the board' – stakeholders represented large and small programmes, across the UK, from a variety of specialties, serving different cohorts of learners, and made no mention of prior attainment. This reflects the research summarised in the *SF9* section on exam DA not being explained by academic ability.

How does psychological theory explain this success factor?

There is consensus in the training literature that an **individual's increased motivation and drive to learn will positively influence training value** and outcomes, but also that **motivation to learn is affected by personality characteristics of the learner** (goal and mastery orientation as 2 examples) and **the broader workplace environment**. Motivation to learn can be negatively affected where other variables important to training success, such as supervisor support, peer support, learning climate and opportunity to perform, are limited (Bell et al, 2017).

What does the literature on differential attainment say about this success factor?

There is a consistent theme in the DA literature that **BAME learners feel more at risk of poor performance (both at work and in formal assessments) being interpreted by those around them as failure due to lack of motivation or ability** (Woolf et al, 2016, p.6), without due attention being paid to the environmental factors involved. Stakeholders interviewed felt this risk was within their remit to change (Woolf et al, 2017, p. 25) by taking early action to reassure learners and by encouraging supervisors to take a more holistic, multi-faceted approach to understanding the performance of their learners (*see SF2: Treating learners as individuals*). This may also mitigate the risks identified by stakeholders that talking directly about race might damage learner-trainer relationships; understanding an individual's personal drivers and motivations would be more valuable in providing support than making assumptions about possible challenges due to membership of a particular group.

Reflecting on current practice in your context…

- Personal motivation, drive and enthusiasm becomes easier to show when learners are more certain about what they want from a career and what area of medicine they may be interested in. How might early stage learners be supported to reflect on their career aspirations and goals?
- Are there enough opportunities for learners to build meaningful relationships with their colleagues?

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Other inputs from stakeholders

What other factors support fair training for all?

The most common feedback from stakeholders across all contexts was they were uncertain about reasons for an absence of differential attainment in their context. Some stakeholders were aware of their results beforehand whilst others were given a summary of their context prior to the interview. All said they were not doing anything specific or special for UK-graduated BAME learners.

Stakeholders found it challenging to compare their context to other training programmes or specialties. The point that selection, examinations and broad training curricula are set at a national level was regularly raised, as was the point that there is significant variation in training experiences *within* individual programmes or contexts (depending on the organisation of the programme, specific rotations or working environments, the diversity of the local area, etc.). Therefore, they could not definitively state that something specific to that context was the reason for an absence of DA.

Stakeholders agreed with learners that an **individualised approach to supporting learners**, i.e. working with individuals to understand specific learning needs or personal circumstances, and providing targeted support, was the best way to ensure all learners could succeed. 'How' individualised this was, if support was proactively or reactively offered, and how able they were to achieve this, was less clear. The majority of examples of support that stakeholders provided were related to the success factors and have been included in the relevant sections above. However, some additional theories for an absence of DA in specific contexts were suggested.

A number of stakeholders hypothesised that the **small size of their specialty or programme** might be the reason there was an absence of DA. However, the conclusion drawn from this was that a smaller specialty allowed the building of more in-depth relationships with learners (*SF2: Treating learners as individuals; SF4: the supportive trainer; SF8: Clarity about careers*) and meant targeted support or guidance (to learners or trainers) could be provided earlier to aid progression.

Other stakeholders suggested that the **region** was related to the absence of an attainment gap but gave a number of differing explanations as to why this was. Some suggestions were conflated with the relative popularity of some locations over others for training (either at a broad level or specialty level); see below. However, other rationales included the region including a centre of excellence or national training centre for a specialty (enabling *SF5: Access to peers* and *SF7: Maximising learning opportunities*), a more diverse or multi-cultural demographic profile (supporting *SF1: Inclusive workplaces*) or a better lifestyle outside of training (i.e. more affordable accommodation, less commuting, access to nature – related to *SF2: Treating learners as individuals*). The breadth of variables discussed suggest that regional differences are not a success factor per se (and will not cause/prevent DA as a result) but may also impact the availability of the other success factors.

A minority of stakeholders from deaneries or colleges suggested that **an absence of DA might be expected in more competitive specialties**, (where performance on exams and previous attainment was likely to be uniformly high). This view is not supported by analysis of outcomes showing DA exists in highly competitive programmes, and research showing prior attainment does not explain DA. More stakeholders raised the point they knew their area was not necessarily 'first choice' but did not directly link this to an absence of DA. It could be the case that these programmes made concerted efforts to provide a good training experience as a response to the possibility of lower levels of engagement from learners.

One interesting reflection was a number of stakeholders in contexts that showed universally low levels of DA (Urology and Clinical Oncology) across the majority of training programmes gave anecdotal feedback that their **specialty in particular had a reputation for being 'nice' or 'welcoming'**: *"Urology is seen as a friendly and welcoming specialty" (College stakeholder), "you [clinical oncologists] are generally a certain type of person and we tend to like each other!" (Deanery stakeholder).* Stakeholders suggested that this played out in a number of ways: more individuals felt welcomed into the specialty, so the specialty attracted a more representative group of doctors, who were encouraged and *"nurtured"* in training and then stayed in the specialty as a result, role-modelling this for a new cohort of learners. Whilst it is difficult to know if the reputations of different specialties are directly linked to an absence of DA, some suggestions about how such reputations manifest in practice do support greater prevalence of some success factors (*SF2: treating learners as individuals, SF3: inspiring seniors, SF4: supportive trainers*).

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Implications and notes on the research

The focus of this research was to explore a breadth of programmes where there is an absence of differential attainment by ethnicity (i.e. where UK-graduated BAME and White doctors achieve similar levels of attainment), in order to understand the factors contributing to the success of BAME doctors, and how these factors may differ across contexts. The research also aimed to identify the level of impact of each 'success' factor, and how amenable each was to change by a training provider.

Using attributions to reveal what influences success

The research used attributional theory to 'surface' the perceptions BAME learners had about the causes for their success, supporting a deeper understanding of the factors they felt led to positive experiences and **'why' these factors were instrumental in their success.** This gives readers more insight into how they may design programmes or learning to maximise the availability of these factors for their learners.

As learners described their experiences, it became clear that **they were not describing factors that were specific or time-bound to a particular programme, context or specialty, but factors that contributed to success across the training pathway in its entirety**. When the 10 factors are considered as a group, it is clear that some factors are more open to influence at different stages of the training pathway (see Figure 2), due to differences in learning at each stage. However, the experiences provided by learners show that educators, training providers and organisations responsible for designing and delivering training programmes throughout the pathway can design their programmes to include access to the different factors. A version of Figure 2 with factor descriptions is in the Appendix.

This report explains what factors made the difference but also provides considerations from BAME interviewees and supporting literature that illustrates why **access to these factors may be more limited for BAME learners than White learners**. Improving the provision of these success factors within programmes may result in a more positive experience for all learners, but this will not necessarily close the attainment gap. Attention needs to be given to ensuring that BAME learners have sufficient access to this support through programmes removing institutional barriers to access and encouraging others in the wider environment to do the same. The reflection questions are designed to allow stakeholders and readers to challenge their own understanding of what is available in specific contexts as regards each success factor, and how accessible this may be to BAME learners.

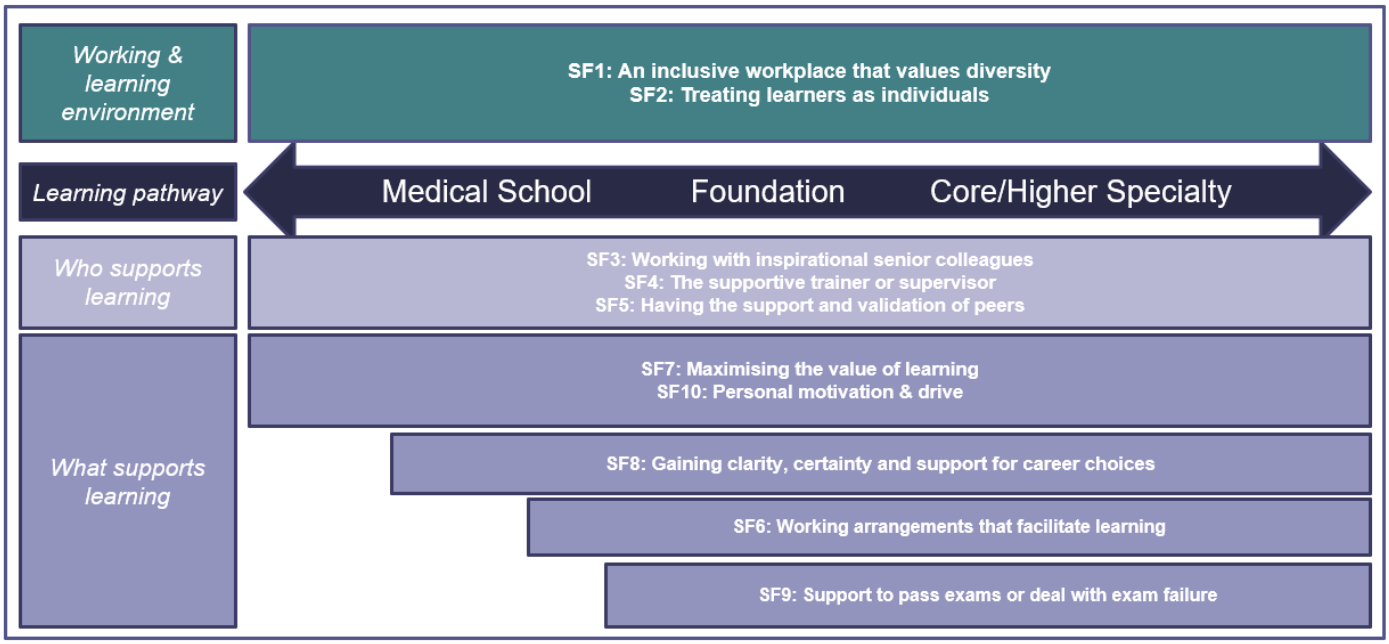

Figure 2: Success factors across the training pathway

The views of stakeholders supported those of learners; **the general consensus was that an absence of DA could not be explained by 'something different' happening in the context of their specific training programme**. Reflections on size, 'profile' or region of the programme were shared but why this may have made a difference to attainment usually related

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back to a greater presence of the success factors identified by learners. However, stakeholders provided insight into the various strategies they used to help their learners successfully complete training.

Some implications for training based on the findings

The process of triangulating the data from across the learners and stakeholders revealed some broader themes about the experiences of BAME learners, which are summarised below.

Commencing a stage of training: Learners explained that they felt meritocratic systems of selection were fairer than alternative selection processes informed by positive action, and more likely to be perceived positively by everyone. This reflected a common perception of preferring to be judged on your own merits as opposed to being pre-judged based on membership of a group (*SF2: Treating learners as individuals*). However, analysis of DA in recruitment outcomes shows that UK-graduated White doctors are more likely to receive offers from their preferred location, which are often more competitive (and culturally diverse) locations such as London. This means that BAME doctors have less autonomy in job choice and often have to move away from existing support networks and to less culturally diverse areas of the country (Woolf et al, 2016, p.6). Many learners in this study described the negative impacts of selection decisions on them.

Therefore, **continued use of existing systems to assign learners to training programmes is likely to disadvantage BAME doctors from the outset,** making it harder for them to succeed in the subsequent stages of training. If perceptions of fairness (amongst other reasons) mean that selection systems remain as they are, learners felt that awareness on the part of training organisations about the individual circumstances of learners as they started training would enable increased support to be available sooner. Learners made the point that all learners, not just BAME learners, could benefit from this.

Accessing support during training: Learners identified a broad range of factors as linked for success in training, a view reflected in the perspectives of stakeholders. Whilst some factors were mentioned more frequently than others, **it was clear the relative importance and impact of factors was dependant on the individual**. There was very little mention of any 'targeted' interventions or initiatives designed to help only UK-graduated BAME doctors; learners spoke about a breadth of factors that aligned with psychological literature and theory on the impact of training in the workplace.

A critical enabler of success was **strong, trusting relationships with those supporting learning** *(SF4: supportive trainers)*. However, there was some uncertainty about whether these relationships were being used to their full potential. If learners were experiencing difficulties in training, there was some reluctance to raise this until things were really bad, possibly related to a concern that issues would be dismissed or interpreted as a failing on the part of the learner. Likewise, some stakeholders explained it was often difficult to know how learners were progressing (lack of time to do this, or lack of information), and they often were not aware of learners' personal circumstances. **In addition, the conflicting roles of the trainer as 'evaluator of performance' and 'coach/guide' meant learners felt they could not be completely honest about challenges.** This all meant that often support was offered only *after* a learner had experienced a negative outcome in training. **Previous research on DA (Woolf et al, 2016) has illustrated that BAME doctors are at higher risk of poorer relationships with seniors (p.6) so a reluctance to seek supervisor support may be heightened for that group of learners.**

Readiness for exams: Another common theme was the perception from learners and stakeholders that exams are primarily the responsibility of the learner. This seems logical and is underpinned by the process allowing learners in training to decide themselves when they wish to attempt exams (within certain constraints). However, there appears to be a lack of information sharing in this area that means training organisations are somewhat limited in the support they can provide to learners. Whilst stakeholders from deaneries and colleges offered support to learners to prepare for exams (in a variety of formats), deanery stakeholders largely reported **limited knowledge of the details of exam attempts by their learners**. This meant they might not know when or what support learners would benefit from (either to prepare for an exam or to prepare for a re-sit) and they suspected that some learners were attempting exams before they are ready. Early exam attempts (attempts before entry to training) are excluded from GMC data reporting so this type of early attempts is not contributing to published figures on DA, but further investigation of this could be supported by colleges recording and sharing the training grade of candidates. To support programmes in providing more support to learners regarding exams, colleges could also share information on exam attempts, enabling a conversation between trainer and learner if a candidate fails (or passes), and investigate the possibility of providing information on reasons for failures.

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Programmes could also help learners assess their own readiness to attempt exams. Appropriate use of formative assessments in the educational context can mitigate risk of failure at a summative stage. **Exploring if formative support and assessments are functioning as expected, or if they could be further developed to help inform decisions about exam readiness** could help ensure learners are given the best chance of success when they do attempt an exam.

Broader systemic change

The implications of **differential treatment at work for BAME doctors are not limited to poor learning outcomes**. The Fair to Refer report (2019) by Atewologun, Kline and Ochieng, notes similar factors as the ones contained in this report that can guard against disproportionate referral action being taken against doctors. If these factors are available to all, they are 'neutralising factors', if only to the insider group, 'protective factors'. There are a number of commonalities with factors in this report, such as mentors and support of teams. This suggests that an increase in accessibility of the success factors for BAME doctors may not only reduce ethnic differentials in training outcomes but also help support reduction in other negative outcomes for BAME doctors at work.

A very positive theme that emerged from these conversations was the idea of 'paying it forward'. When talking about successes in training, learners often reflected they **now used their strategies or insights from their training journey to encourage and support other learners**. In most cases, this was reflected by acting as an informal mentor or source of support (*SF3: the inspirational senior*) for more junior doctors, often inspired by their own experiences with a senior doctor that invested in them. Focusing on providing realistic insight into careers *(SF8),* help to navigate the training pathway (*SF8; SF9*) and helping to create or signpost valuable learning experiences (*SF7)* were all seen as ways to pay forward the investment they had received to get where they were. Engaging more experienced BAME doctors in education, mentoring and buddying, and recognising their recent experience of training as members of a minority group, could make good use of their desire to help others. Likewise, drawing on their experiences as a valuable source of support in developing programmes with more equitable access to success factors for BAME doctors would be valuable.

Next steps

The research study revealed common themes about the factors that support learners to succeed in training. There was also a consensus from learners and stakeholders about the importance of recognising the diversity of background and experience of each learner so all can be supported to succeed, neatly summed up in the quote below.

"I think we should… take note of differential attainment, and that is really important to do. But the main thing is about recognising trainees as individuals, and that their ethnicity or cultural background is only a part of that. It's an incredibly difficult line to tread, I think, is to recognise that there is a problem, but not try to isolate people even more by making it just about where they've come from, or their cultural background. I would say that me being mixed race is one very small bit of who I am as a person, and of course it does give me a different view. But also growing up in [X], that gave me a very different view, going to state school then a public school and going to [X university]. I think during the whole of our training, we should be recognising doctors as individuals. That's what is being lost by the way that training is now in terms of not being part of a team, so not having a firm structure, and by just being on rotas where you're on and off. So junior doctors, consultants don't invest any time in you because you're not there a lot, and you're not on call with your team, and that, to me, compared to the beginning of my training, that's what we've lost. And I think the ethnicity is part of that, it's part of a wider loss of recognising all of us as individuals. [DA] is a relevant component but trying to work on the wider issue… is the important thing to do" (Learner).

Whilst there is agreement that the success factors will support **all** learners to succeed in training, there was also a view from learners, borne out by the research literature, that accessing such support can be more challenging for those from a BAME background. **Until support is equally accessible to all learners, it is likely that attainment gaps will continue to exist across medical programmes**. This research is intended to help readers:

- Understand the various strategies that can support BAME doctors to successfully progress through training
- Learn more about how access to support may vary across groups, and how this variable access might be reduced.

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Some of the possible solutions to increase access to success factors for BAME learners could include:

- Dialogue in learning and workplace environments that encourages discussion on the value of diversity and inclusion at work; supporting majority groups to act as allies or advocates for minority groups
- Sharing more information on differential attainment with learners to explain the data and research indicating a deficit model does not explain the ethnic attainment gap
- Creating assessments to help trainers and programmes conduct early identification of trainees who may require support during training, including development of formative assessments at work to help inform this
- Sharing more information on individual trainee circumstances with trainers, such as information on relocation. This could be via trainees sharing more information with trainers, or organisations sharing information between themselves (although trainee consultation and permission is likely to be required for the latter).
- Providing BAME trainees at all stages of training with access to a range of mentors (consider allowing trainees to pair themselves with mentors based on what they desire or need support with)
- Providing training for trainers and all those involved in education and training on DA and the reasons why BAME trainees may struggle to access support
- Enabling trainees at all stages of training to spend more time with one another, including consideration of creating set study groups with trainees from different stages of training and a variety of backgrounds to build networks
- Implementing protected training time at all stages of training
- Providing increased opportunities for trainees to work with set teams for longer periods of time
- Encouraging more flexibility in training programmes to allow trainees to benefit from different opportunities or exposure to different environments or careers
- Increased sharing of examination data between colleges and deaneries to provide more support for trainees who either intend to attempt an exam or have failed an exam.

Reflections on the research

- We spoke to learners who were completing training in programmes with an absence of DA between UK graduated white and BAME doctors. The data that identified programmes or specialties with non-significant differences in exam outcomes was based on outcomes from 2014-2017, so it is possible that some of the interview sample were not represented in the original dataset (i.e. that the two samples were different in some way). However, we confirmed all learners who participated were progressing through the latter stages of higher specialty training and made an assumption that exam DA in a context is likely to be relatively stable if the basic training experience is not radically altered.

- UK-graduated BAME learners nominated themselves to participate in the research and purposive sampling was only applied to give coverage of programmes/specialties rather than even representation of ethnic groups, gender and socio-economic background. This may mean that certain perspectives were over or underrepresented in the results, particularly as it could be hypothesised that those willing to take part in this type of research may also be similar in terms of certain personality traits and attitude to training.

- Learners were asked to talk about their success but allowed to speak about any aspect they felt relevant (rather than being asked specific questions about their experience as a BAME doctor). Researchers probed their attributions related to experiences but did not raise ethnicity if learners did not. The aim of the research was shared beforehand but it was a deliberate decision to let learners explain what factors mattered to them rather than 'cueing' them to talk about ethnicity. Learners responses to this approach validated this decision; some had a lot to say about their experiences as a BAME doctor whilst others didn't think this had an impact on their experience of training. At the end of the interviews, ethnicity and its impact on training was explicitly mentioned as learners were asked to reflect on interventions designed to reduce DA.

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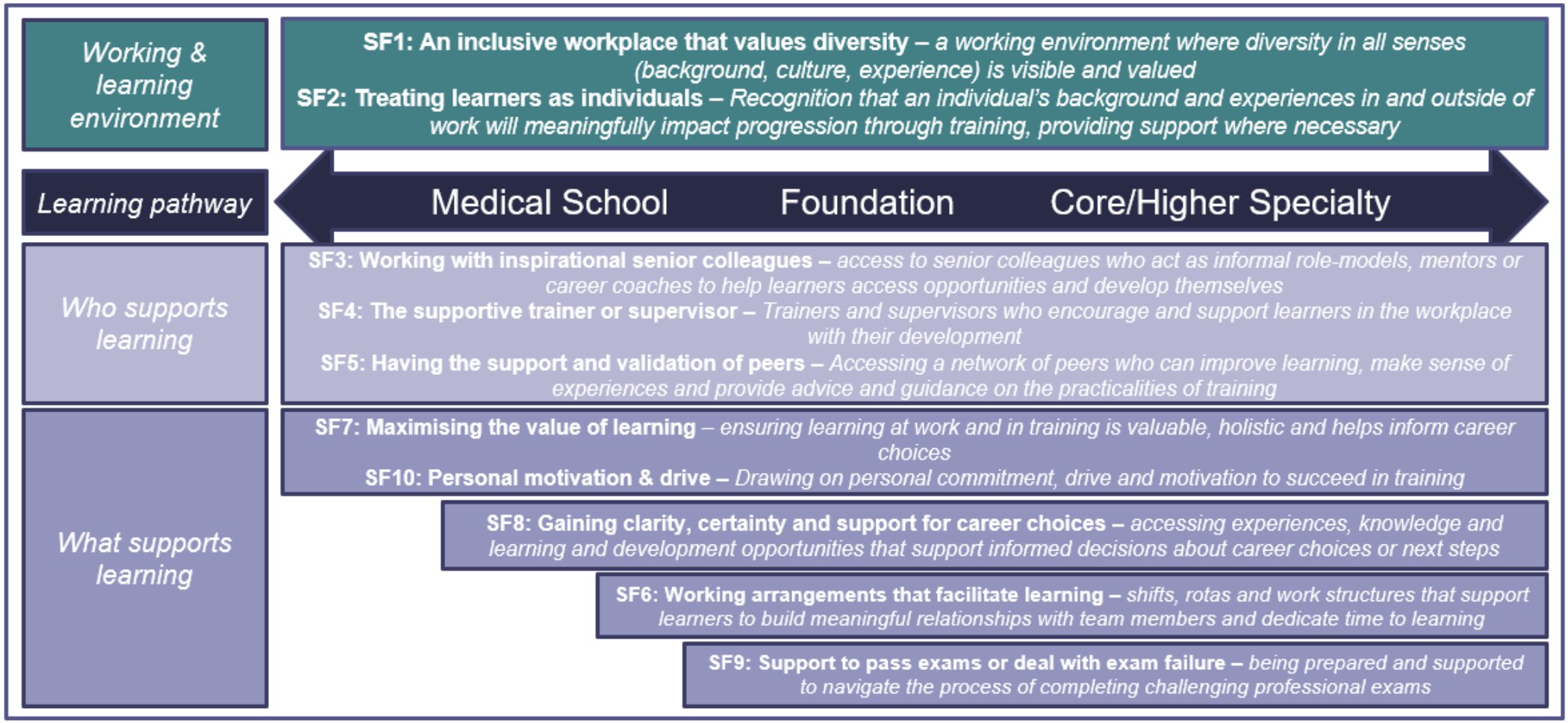
Appendix: Success Factors with Descriptions



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