Editorials

Levelling up medical education:

getting comfortable with being uncomfortable

The term differential attainment has become part of the vernacular for medical educators. It describes the unexplained variation in the attainment of groups of individuals who share protected characteristics when compared with groups who do not share the same characteristic. Differential outcomes have been identified as being related to age and sex, but by far the largest differentials are for those from ethnic minority backgrounds and in particular for those who have qualified abroad. It exists in both undergraduate and postgraduate contexts, across recruitment outcomes, progression through training, and in exam pass rates.[1]

DIFFERENTIAL ATTAINMENT

Previous studies have found that the odds of exam failure in non-white ethnicity doctors and medical students was 2.5 times higher than for white candidates.[2] Recruitment data for specialty training posts shows that doctors from ethnic minority backgrounds are less likely than white colleagues to be considered appointable (53% versus 75%).[3] Progression through specialty training, as judged by Annual Review of Competence Progression (ARCP) outcomes, shows that unsatisfactory outcomes (2018/19) are 10% more likely for international medical graduates (IMGs).[4] This manifests as extensions to training, and Health Education England (HEE) data for general practice shows that three-quarters of trainees requiring an extension to training (2021/22) were non-UK graduates, as well as over two-thirds being from an ethnic minority background (personal communication, HEE, 2022). Aggregated postgraduate exam rates (2018/19) have been estimated to be lower for UK qualified ethnic minority doctors compared to their white peers (−12.3%), and even lower for IMGs (−29.4%).[4]

This evidence supports the supposition that medical education is far from being on a level playing field. The health warning is that the data represents averages and generalisations and there are many highly performing ethnic minority doctors from both the UK and abroad just as there will be less well performing UK qualified white doctors. However, this should not detract from the findings that trainees from ethnic minority backgrounds, IMGs, and indeed those with disabilities and long-term conditions have a poorer experience and disproportionally worse outcomes from medical training when compared to their peers. While not making assumptions about individuals, aggregated data allows the issue to be addressed at a system level and to attract the appropriate resources.

> *"Differential attainment is* de facto *a symptom not a diagnosis. We need to take a step back and … try to understand the experience for our learners that led to these outcomes."*

Differential attainment is a thorny issue, with little progress being made over the last 20 years to address it. Worse still it creates fear; fear among trainees of being negatively stereotyped and being in the 'demographic' that is going to fail and need an extension; fear among educators of being accused of bias or discrimination when giving feedback; fear of litigation for colleges and regulators. Furthermore, the differential impact of COVID-19 on ethnic minority communities and the Black Lives Matter movement have all helped to put the spotlight on issues of equality, diversity, and inclusion. However, the underlying causes for differential attainment remain far from clear. It exists even after correcting for factors such as language skills, prior academic performance, socioeconomic status, motivational factors, study habits, and examiner bias.[5] Differential attainment is *de facto* a symptom not a diagnosis. We need to take a step back and rather than look at outcomes, try to understand the experience for our learners that led to these outcomes. Indeed we need to step back further and consider the access to the curriculum that led to that experience.

> *"This is not just about prejudice but also about the advantage we give to others. And privilege is not about the benefits you have had but the barriers you have not had to face."*

CHALLENGES FACED

Previous research has identified many additional challenges faced by ethnic minority doctors and IMGs.[5–8] There is a perceived risk of unconscious bias in recruitment, assessments, and in their day-to-day work. They report difficulties in fitting in at work and poor relationships with their seniors who may assume IMGs have an inferior prior educational experience. Lack of autonomy about job locations means these doctors are often separated from their family and support networks. Consequently they have a poor work–life balance and report higher levels of stress, anxiety, or burnout that affects their learning and performance. The recent British Medical Association (BMA) survey of racism in medicine identified that over three-quarters of responders had experienced racism in their workplace in the last 2 years, with negative impacts on their wellbeing and career progression.[9] These uncomfortable statistics cannot be ignored. Ethnic minority doctors make up 42% of all licensed doctors on the General Medical Council (GMC) register, and 28% on the register are IMGs.[10] In 2021, half the doctors joining the workforce were IMGs compared to 39% being UK graduates.[10] In the 2022/23 intake for GP specialty training in England more than half of the trainees (57%) had qualified abroad (personal communication, HEE, 2022). The NHS would not have survived over its 70-year history without the contribution of overseas doctors.

"... diversity is a fact, not just to be tolerated but embraced. We need to create an ethos of psychological safety and, beyond this, cultural safety that engenders inclusion and belonging ... "

A paradigm shift is required if we are to level up medical education. We need to address the fact educators may have lower expectations from ethnic minority trainees and IMGs. The risk is that they pay less attention to them and provide them with fewer opportunities. This is not just about prejudice but also about the advantage we give to others. And privilege is not about the benefits you have had but the barriers you have not had to face. We need to get away from the notion that if you differ from the norm in a significant way from your peers you have 'deficiencies'. The paradigm shift is from this deficit model, a problem to be solved, to a strengths-based change approach where we consider the system to be deficient not the individual.

LEVELLING THE FIELD

Over the past 2 years, HEE has developed a primary care strategy to provide additional support for GP trainees with non-UK qualifications and those from ethnic minority backgrounds, as well as others with protected characteristics. Additional funding has been allocated, which has largely been used to appoint educators to deliver this programme and develop a community of practice.[11] By focusing on research that has shown to benefit the experience of trainees,[12,13] a programme of best practice has been developed and is being delivered across every local GP training location.

This includes the early identification of trainees who may require additional support and placements according to need, not their recruitment scores; enhanced induction, not just covering local policies and protocols but helping trainees and their families to settle into new communities; providing individualised support with personalised learning plans and monitoring of their wellbeing; communication skills support, acknowledging that language is a social construct that helps to create shared meanings and build rapport; and advice on ARCP and exam preparation. Alongside this there is faculty development to address issues of unconscious bias, active bystander training, and cultural competence: the ability to interact with people from different cultures.

However, levelling up will need to go further and tackle issues of discrimination if we are to succeed. Prejudice may begin with individuals but soon pervades through organisations and systems. The fact is that diversity is a fact, not just to be tolerated but embraced. We need to create an ethos of psychological safety and, beyond this, cultural safety that engenders inclusion and belonging, with no assault on one's identity. Only then can we have any hope of creating a level playing field for all our learners.

Vijay Nayar,
(ORCID: 0000-0001-6165-5455) Primary Care Lead for Differential Attainment, Health Education England, Cambridge.

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ADDRESS FOR CORRESPONDENCE

Vijay Nayar
Health Education England, 2–4 Victoria House, Capital Park, Fulbourn, Cambridge CB21 5XB, UK.

Email: Vijay.nayar@nhs.net

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