Differential Attainment Seminar: 14th November 2018

Much work is being done across the GP educational community to try and understand why differential attainment exists and which interventions are the most effective in helping GP trainees achieve their intended goal of Completion of Certificate of Training (CCT). The need for improving help for candidates in preparation for the Clinical Skills assessment was highlighted in the Judicial Review by Lord Justice Mitting of the RCGP and the GMC in 2014. Data has always been collected by the RCGP into the protected characteristics of candidates for the CSA and AKT, which has shown a differential outcome between UK trained graduates and international medical graduates (IMGs). A difference in pass rate however is also noted between UK graduates based on gender and those of black and minority ethnic back ground (BME). Data regarding differential attainment in Work Place Based assessments is less readily available. (1)

A day was held at the Royal College of General Practitioners, jointly organised with COGPED, to promote the learning that has occurred and facilitate further developments. This covered interventions that embraced all 3 components of the MRCGP.

In order to achieve success, key themes emerged:

1. All trainees and trainers need to understand and develop cultural competence.
2. Every GP Trainee and Trainer has their part to play in helping minimise differential attainment.
3. It is important to train the trainers to give effective feedback –one size does not fit all and needs to take into account the trainees previous educational paradigm
4. Intervene early - for example the STEP programme, iTAP and “a perfect day “
5. The need to help trainees with linguistics
6. Every trainee is different, and a holistic approach is needed in order to facilitate learning
7. The training community needs help in understanding the complexity of the issues and how to facilitate learning.

The GMC has mapped the requirements for the colleges to address Equality in Diversity across the five themes in Promoting Excellence. In addition, the GMC has issued guidance on evaluating the effectiveness of interventions. (2)

The following outlines the themes for the key note speakers and the 9 workshops that were run. We hope that this will provide not only a record of the day but also act as a resource that localities may use when considering what interventions to make to address the issue of differential attainment within their locality.

1. Licensing exams and judicial review: the closing of one door and opening of others? Sue Rendel, Pauline Foreman and Adrian Freeman. Br J Gen Pract 2015; 65 (630): 8-9.

2. Promoting excellence: equality and diversity considerations https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/promoting-excellence-equality-and-diversity-considerations.

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Key Note Addresses

Key Note 1: Differential attainment in postgraduate medical education: the evidence (Dr Katherine Woolf, UCL Medical School k.woolf@ucl.ac.uk)

Dr Katherine Woolf is Associate Professor in Medical Education at UCL Medical School. She is currently a National Institute for Health Research (NIHR) Career Development Fellow in Medical Education, leading the UK Medical Applicant Cohort Study. She is also educational advisor to the Membership of the Royal Colleges of Physicians (UK) examination, and a Fellow of the Higher Education Academy. Katherine has a BSc in Psychology and a PhD in Psychology and Medical Education. She has worked in medical education for 15 years, working primarily to understand and address inequalities in medical education, notably differential attainment by ethnicity, and more recently socio-demographic differences in selection into medical school. Her work has been used by the General Medical Council and Health Education England to improve the fairness of medical training at postgraduate and undergraduate levels. Katherine also has an interest in assessment and contributed to the recent redesign of the MRCP(UK) clinical examination 'PACES 2020', as well as HEE's 2018 review of the Annual Review of Competence Progression (ARCP).

Graduates of UK medical schools from black and minority ethnic (BME) groups, including Asian groups, have poorer outcomes in recruitment, ARCP (Annual Review of Competency Progression), and Royal College examinations compared to their white peers, on average. Differential attainment by ethnicity is also present at undergraduate level. (1,2) It is important to note that these are group differences on average: there are plenty of high performing BME graduates and plenty of poor performing white graduates, so one cannot make assumptions about individuals. That being said, it is important to address the group differences.

So the question is no longer whether differential attainment exists, but why it exists and how we can eliminate it.

Why does differential attainment exist?

Differential attainment by ethnicity is increasingly acknowledged to result from institutional practices rather than trainee deficits. The impact of ethnicity on academic outcomes remains after controlling statistically for socio-economic status and persisted after controlling for GCSE and A level results, school type, parental job, language, motivation for being a doctor, study habits, whether living at home, and personality. (3)

Examiner bias in clinical examinations is unlikely to be the sole or major cause, although there is much less evidence regarding bias in workplace-based assessments and recruitment. (3-7) It is important to rigorously guard against unfair bias in all assessments.

Evidence suggests that differential attainment results from BME trainee experiences of learning. Interactions between learners and teachers, and between learners and their peers critically affect attainment in higher education. (8)

Qualitative research has found that BME medical students and graduates face additional risks compared to their white counterparts, which can impede their progression and attainment. (9,10)

BME trainees can be negatively stereotyped by peers and teachers, can feel they need to work harder to prove themselves, and can find it more difficult to get support from seniors to cope with demanding clinical situations. (9,10) For example, in Woolf et al (10) an Asian GP trainee explained the experience of having a poor relationship with your trainers:

> "In General Practice, I think if you have an issue with your trainer -and I can relate to that because I've just had the very problem (laughs) – […] you're very very isolated, and things can escalate quite quickly."
>
> Asian/British Asian Indian UK graduate, female GP ST1-3 (4)

There was also the perception among trainees that biases could spill over into workplace-based assessments and recruitment. A white GP trainee explained how being white meant he found it easier to get his assessments signed off by senior doctors who were also white:

> All my [Case Based Discussions], everything has been from registrars who have generally said "Yeah, I'll just do one for you". It's not been a formalised thing. It's basically been the same as the rugby tie, but rather than wearing a tie, I've just known them and get on with them, and then they'll do the thing for me.
>
> White British UKG Male ST1-3 GP (4)

These experiences can have a negative psychological impact on BME trainees, as described by a Black psychiatry trainee:

> "I'm expecting to get a lower mark because I'm-I know it's a stupid way of thinking but actually it got to the point where I was thinking "What is it? Am I…?" I wasn't sure if it was my knowledge anymore, I wasn't sure if it was my confidence, I wasn't sure if it was my skin colour. So you start-I think it creates almost like a nasty way of thinking and how you perceive yourself to be. And if that someone's expectation of you is low subconsciously, your performance will be low."
>
> Black UK graduate Female ST4+ Psychiatry

In addition, BME trainees could be more likely to lack support from inside and outside work. Because recruitment is partly based on attainment, BME trainees are less likely to get their first choice of job, so more likely to have to move and thus be separated from support outside work. It was generally difficult for trainees to access support in work, and this could be harder for BME trainees if they had poorer relationships with their seniors. This could also be compounded by the fact that trainees, white and BME, preferentially form friendships within ethnic groups, which may magnify inequalities.

BME trainees in this study were more likely to talk about having poor mental health impeded their learning, as described by a psychiatry trainee who left GP:

> "I was so stressed I was getting panic attacks and things like that, and my trainer wasn't recognising what was going on."
>
> Mixed ethnicity UK graduate Male ST1-3 Psychiatry

Finally, diversity is generally poorly taught and does not reflect the fact that a third of UK trainees are from BME ethnic groups. Trainees and seniors are often ill-equipped to discuss ethnicity or to deal with racism.

What can be done to tackle differential attainment?

Differential attainment is a pervasive institutional problem requiring institutional solutions.

1. Provide time for trainees to get to know their seniors and peers; encourage seniors to show belief in their BME trainees and provide them with supported opportunities for taking responsibility.

A Foundation trainee in Woolf et al (10) explained how her GP trainers had build her confidence and skills by getting to know her learning needs and then giving her the opportunity to see patients alone while still being supported:

> At the beginning of my GP placement, my trainers took quite a lot of time out to give me time to sit and just observe them in clinic first, and discuss different cases, and observe me consulting patients. And now I see patients independently but then always discuss the case with them afterwards […] They've gone above and beyond supporting me in that environment and for such a short space of time I feel a lot more able now […] a lot more confident.

Arab UKG, Female, Foundation

In addition, the importance special educational relationships with a senior in the form of long term practical support, or sponsorship was highlighted. A meta-analysis by Ng et al (11) found that "career success is largely a function of two important career experiences: working hard and receiving sponsorship". Sponsorship is different from mentorship in that it is about being chose to receive additional targeted practical support: "Established elites pay special attention to those members who are deemed to have high potential and then provide sponsoring activities to them to help them win the competition. Once identified as potential elites, the chosen individuals are given favourable treatment to make them even better and differentiate them even further from the non-elite group. […They] are allowed to start the race earlier, gain momentum more quickly, and are more likely to be declared as winners." (11). Since the established elite tend to be white, it is probable that white trainees are more likely to receive sponsorship, although Woolf et al (10) did find a Chinese surgical trainee who described how sponsorship from a consultant had helped his career:

> I've been fortunate enough as a third year medical student, my third consultant now whom I knew then 11 years ago told me "if you want to do Surgery you have to start publishing now", which I did then. And he's pretty much supported me throughout the last 10 years and given me pointers in what to do.
>
> Asian Chinese UKG Male ST4+ Surgery

It is therefore important to create systems (such as UCL's inclusive advocacy scheme) to help ensure BME trainees are able to receive sponsorship.

2. Ensure systems are in place to counteract bias in recruitment and workplace based assessment.

In a study by Woolf (12), the Royal College of Ophthalmologists described how they train those involved in national recruitment to avoid bias and are collecting data to try to understand the effects of the training, and the Royal College of Psychiatrists described how they had introduced a standard script published in advance to try to avoid bias in recruitment.

3. Enable trainees to have a work-life balance so they can get support from friends and family outside work, including:
    - Arranging work so trainees can have a life outside of work
    - Facilitating peer support inside work
    - Undertaking 'getting to know you' activities inside work
    - Facilitating mixed peer support in learning sets at work (through random allocation to groups).
    - Arranging inclusive social activities ie not necessarily at the pub

4. Provide training and systems that enable and encourage everyone to report and tackle discrimination.

A core medical trainee in Woolf et al (10) described how difficult it can be to speak out about discrimination:

> No-one likes the one who's going to kick up a fuss or start saying "Oh it's because I'm an ethnic minority this, that, and the other". No you start getting yourself into problems if you start thinking like that.
>
> Asian Other UKG, Female, ST1-3 Medicine

This highlights the need for organisations to recognise that discrimination is everybody's problem, the need to build better systems to enable discrimination to be reported and dealt with; the need for active bystander training (13) which facilitates trainees standing up for one another and means the burden of dealing with discrimination doesn't only fall on minorities; and better training for seniors in dealing with incidents of discrimination.

5. Get support from other organisations.

Differential attainment is a widespread problem across sectors, and many organisations provide advice and resources on tackling it, e.g.:

- General Medical Council research and resources;
- BMA information and resources;
- Workforce Race Equality Standard resources ;
- Universities UK & National Union of Students project led by Baroness Amos ;
- National Union of Students resources;
- Dogra, Bhatti, Ertubey et al. (2016) Teaching diversity to medical undergraduates: Curriculum development, delivery and assessment. AMEE GUIDE No 103. *Med Teach*;38(4):323-37.;
- Nazar, Kendall, Day & Nazar (2015) Decolonising medical curricula through diversity education: Lessons from students, *Med Teach;*37(4): 385-393.

6. Rigorously evaluate interventions.

Actions to address differential attainment are rarely evaluated. Publication of evaluations is key to learn from best practice and avoid repeating mistakes. (12)

Summary

Differential attainment is a serious and pervasive problem that must be addressed by:

- Providing time and training for seniors to properly support BME trainees; opportunities for mixed peer support; and opportunities for support outside work.
- Organisations demonstrating how they are addressing concerns about bias in assessments and recruitment.
- Supporting conversations about race, including for trainees speaking out and training for dealing with discrimination.
- Seeking advice from other organisations.
- Evaluating.

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Keynote 2: International Medical Graduates in medicine and their issues (Dr Amit Gupta)

Amit Gupta: I am a Neonatal Consultant the John Radcliffe Hospital in Oxford since 2009. I did my basic medical degree and postgraduate degree (MD) from Surat, India in 1998. I did my MRCPCH in 1999 and did 3 years of specialist (grid) training in neonates followed by 2 years of research into the impact of preterm birth on growth of lungs at Great Ormond Street Hospital in London. I did a postgraduate certificate in Medical Education from Plymouth.

At Oxford, I was an Associate Dean for Oxford deanery from 2012 to 2017 and am currently Lead for International Doctors at Oxford. I set up the largest overseas neonatal UK's largest international fellowship in Oxford which now operates jointly with Southampton. I teach and train extensively in India and Sri Lanka. I led the development of the National Transport Service in Sri Lanka which is the first and largest national new born transport service in South Asia. For this work I was awarded with an Honorary Fellowship by the Sri Lanka College of Paediatricians (awarded by the President of Sri Lanka) for services to the country. I was also awarded the Lifetime Achievement Award by the National Neonatology Forum of India for my efforts related to teaching and setting up of a successful India - UK new-born training fellowship programme. My research interests are in neonatal respiratory medicine and I teach cultural awareness across the UK.

I love to teach and welcome the challenge to set up new neonatal projects internationally. International Medical Graduates make a huge service contribution to the NHS, and yet, their career progression continues to lag behind their British born peers. Performance is a complex phenomenon influenced by, amongst other factors, learning styles, culture, and working in an enabling environment.

This talk unpicked this complex issue by exploring cultural factors: consequent learning styles and their impact on performance.

In “Fair Training Pathways for All”. GMC 2016, Wolfe *et.al* found cultural differences and subtle unconscious bias against trainees who didn’t ‘fit the mould’, could affect doctors’ ability to get the support and encouragement they needed to learn and develop, particularly in stressful and chaotic NHS work environments. While reports of overt racism were rare, unconscious bias was felt to hinder success in recruitment and assessments. UK BME and international graduates were more likely to face separation from family and support outside of work and reported more mental health problems as a result of work.

Amit Gupta discussed how culture helps shape the learning styles of doctors, drawing from previous work by Hofstede et al 1971 who wrote culture is a “Collective programming of mind, which distinguishes the members of one group of people from another and leads them to live their lives in a way that are shaped by unwritten social codes….” It is the “This is how we do things here” Societies Programming, Unwritten Culture was described in the form of certain characteristics such as power distance, individualism and masculinity.

Quoting Hofstede’s work (Culture and organizations. Software of the mind. Hofstede 2013) the power distance ratio was explored and how this affects culture. The degree to which the less powerful members of a society accept and expect that power is distributed unequally was also considered.

Societies exhibiting a large degree of power distance index accept a hierarchical order in which everybody has a place. However, in societies with a low power distance index, people strive to equalize the distribution of power and demand justification for inequalities of power. The UK has a relatively low power distance index (35) whereas India has a relatively high-power distance index (77) Other examples of Power distance indices are Austria (11) Germany (35) and United states of America (40).

Quoting “Cultural dimensions in the transition of overseas medical graduates to the UK workplace” by Gill Morrow, Charlotte Rothwell, Bryan Burford & Jan Illing Durham University, UK, Dr Gupta illustrated how Drs are perceived in their respective societies:

“You’re a small God and everyone respects everything you say’’ (35a, Nigeria)

‘‘Back home, they perceive doctors should know everything’’ (23b, Jordan)

‘‘Some of the doctors in our country . . . they can make some mistakes, they might not be challenged, sometimes, but here in the UK is very different’’ (30a, Syria)

‘‘I mean most of the Asian countries, let’s say the doctors are seen as a higher level compared to the nurses, but in this country, everything is equal basically. I mean you need to be aware of that aspect basically’’ (45a, Iraq)

‘‘I think it probably is coming from a very hierarchical society . . . whereas British graduates that have worked on the wards, they’ve got some idea, much more idea of how people interact and stuff and maybe are far more likely to ask a nurse’’ (ES5)

Hofstede has shown that the impact of this on learning is that trainees from a high-power distance index are:

- less likely to ask questions
- less likely to explore reflectively.

What is the Impact on performance? Trainees from a high-power distance index are:

- reluctant to challenge decisions
- reluctant to disagree
- less reflective in seeking solutions.

The implications for patient care from this power distance index were also explored.

Role of physician and patient is fixed. The power distance index between doctor and patient also varies in different cultures. Where this is high, the following behaviours may be more prevalent:

- “Doctors knows best”
- a paternalistic approach.

The power distance index may also impact on the behaviour of doctors working in Multidisciplinary team. This may be compounded by the fact that in other cultures nurses and patients belong to a different class. The doctor would never mix socially and therefore the trainee doctor may find it difficult to accept orders from a nurse and find it hard to contemplate treating the patients as equals.

Different power distance indices may also impact on exam performance. Trainees may differ in their:

- demonstration of an ability to explore solutions more widely
- reliance upon a codified system of knowledge acquisition.

Individualism vs Collectivism

Different societies have differing degrees of these behaviours e.g. China is a very collectivist society.

Individualism

- The degree of interdependence a society maintains among its members.
- Has to do with whether people´s self-image is defined in terms of “I” or “We”.

Collectivism

- Actions of the individual are influenced by various concepts such as the opinion of one's family, extended family, neighbours, work group.
- To be rejected by one's peers or to be thought lowly of by one's extended and immediate in-groups, leaves him or her rudderless and with a sense of intense emptiness.
- Loyalty by the employee and almost familial protection by the Employer.
- Personal relationships prevail over task and company.

Learning

Doctors from countries where collectivism prevails may appear less assertive than UK graduates in the classroom and on the ward more reluctant to offer an answer or engage in classroom critical debate.

Awareness of cultural differences:

- fosters understanding of learning behaviours underpinned by evidence
- helps us move away from silos of patterned thinking.
- helps us to consider different models of teaching learning and performance e.g. Pendleton's model of feedback may be confusing if the trainee comes from a culture where direct feedback is the norm. The trainee may not realise that they are not meeting the standard expected. Therefore, we may need to explore with the trainee how to give effective feedback.

Unconscious Bias

There is a continuum from unconscious bias to racism: Unconscious Bias -> Micro aggression -> Overt Bias -> Racism. An example of this subtle change in behaviour was given when an Asian Dr grew a beard and how that lead to a change in peoples' behaviour to the Dr and that in turn lead to a change in the doctor's behaviour.

Next steps for the educational community: What do we do?

- Make cultural awareness part of statutory and mandatory learning. It is different from equal opportunities sensitization type training.
- There is no substitute for a good conversation. Unconscious bias reveals itself and its revelation is its remedy.
- Race and ethnicity are not taboo subjects and we should encourage open dialogue.

Workshops

Workshop 1: PERFECT DAY – an intervention for 'at risk' trainees (Dr Richard Churchill)

Richard Churchill BM BS MSc DM FRCGP is a part-time GP in a large suburban teaching and training practice Nottingham. He has extensive experience in undergraduate medical education having previously been Director of Clinical Skills at the University of Nottingham. He now facilitates the PERFECT DAY programme as well as being Chair of the Vale of Trent Faculty RCGP.

PERFECT DAY is an innovative personalised educational intervention for GP trainees based on self-regulation learning theory. It evolved from a similar project aimed at supporting final year undergraduate medical students who were re-sitting a year. The PERFECT DAY programme is currently targeted at GP trainees in the East Midlands who are experiencing difficulty in their training programme or who have been identified as at risk of extended training.

This session outlined the theoretical basis and background to the intervention, and described how it is being delivered in practice, based on three years' experience with more than 50 trainees. International medical graduates are over-represented amongst participants.

PERFECT DAY – an intervention for 'at risk' trainees

Richard Churchill

PERFECT DAY is an acronym for an intervention targeted at 'at risk' trainees in the East Midlands, and stands for Performance Enhancement using Developmental Approaches, Dynamic Assessment and Educational Theory.

Introduction

The intervention is based on self-regulated learning theory. Self-regulation is defined as 'the way that learners systemically activate and sustain their cognitions, motivations, behaviours, and affects, towards the attainment of their goals' (Schunk & Greene 2018). It is usually described as a cyclical model beginning with goal setting before a task, followed by active monitoring, and then reflection after the task, which impacts positively on subsequent cycles.

Patel et al (2014) identified deficits in self-regulation amongst final year medical students who failed exams. This work resulted in the development of an intervention, which has since been extrapolated to other groups including GP trainees.

There are certain pre-requisites for addressing self-regulation. The basic building blocks, as illustrated by Maslow's Hierarchy of needs for example, need addressing first:

The intervention is based on three assumptions:

- Poor performance (in both assessments and practice) can be due to deficiencies in self-regulation.
- Principles and application of self-regulation can be taught and learned.
- Continued application of self-regulation principles results in improved performance.

The Research

Patel et Al (2) did some a thematic review with struggling undergraduate medical students, using semi-structured interviews in 55 students who had failed final re-sit assessments in Leicester & Nottingham. They found that students who struggled had an Inappropriate selection of learning strategies, goals & expectations They responded to failure with normalisation and external attribution They failed to seek or access support – either formal or informal. Their emphasis was on protecting self-worth.

The Intervention

Potential candidates for PERFECT DAY are identified by ITAP (In-training Assessment Profile) at an early stage in training, or by the Professional Support Unit, usually as a result of exam failure.
Perfect Day components:

- diagnostic interview
- two dynamic assessments (simulated consultations)
- structured feedback
- explanation and educational prescription
- follow-up.

Candidates attend an intensive personalised session with a facilitator. This begins with a one-hour exploratory interview which is aimed at building rapport, ensuring that the candidate has no significant impediments to self-regulation, and identifying the candidate's approach to learning and problem solving. Key themes from discussion with the IMGS that created challenges in their training were the issues of:

- cultural dissonance
- language and communication difficulties
- inadequate personal / professional support
- mismatched expectations of training process
- challenges of maintaining e-portfolio and reflection
- affective responses
- self-regulatory dysfunction.

The candidate then undertakes two moderately complex simulated consultations which are videoed. Before each they are asked to identify potential goals and strategies for the consultation and to reflect on their confidence level. After each they also reflect briefly on their performance and level of satisfaction. The final part of the session consists of an in-depth debrief on one of the consultations, focussing on metacognitive, emotive, and adaptive processes.

Effective Structured Feedback:

- is Non-judgmental – self-empowering
- helps the trainee re-evaluate goals and strategies
- helps trainee explore what they were thinking and feeling?
- helps the trainees explore how they react to their thoughts and feelings?
- helps trainee explore what might they do differently next time?

At the end the candidate is introduced explicitly to the self-regulation learning model and provided with tools with which to reflect on their second consultation, and to use regularly in subsequent training. The full programme includes a six-month follow-up session to review progress.

Outcomes

So far approximately 100 trainees have been through the programme. Anecdotal feedback is positive but there has not yet been significant formal evaluation. In the future it may be possible to identify and target trainees who would benefit most from the intervention.

Themes that were identified during the structured feedback to the trainees were categorized into forethought, performance during the consultation and self-reflection:

- Forethought: This area showed trainees demonstrated inadequate goal setting or strategic planning and low self-efficacy.

- Performance: Trainees exhibited inadequate focus, a lack of self-monitoring and meta-cognition and difficulty with dynamic modification of goals and strategies.

- Self-Reflection: Reflection may not be part of the educational paradigm and may contribute to a resistance to reflection and an inability to apply reflection to a change in future performance noted in this group of trainees. Trainees have been noted to have poor self-assessment and calibration skill and an inappropriate causal attribution.

Group Discussion

- A programme in the North West has introduced the self-regulation principles of consultation micro-analysis and metacognition to trainers, so that there is widespread application benefitting all trainees, in contrast to the targeted approach of PERFECT DAY. There is some evidence of effectiveness of this approach.

There was discussion about the value (or otherwise) and difficulty of formal evaluation for such complex interventions, particularly using a linear approach. However, it was acknowledged that such an approach is often needed to build a business case to support activities, and particularly to pump-prime new initiatives.

Credits

Original concept and development:
Rakesh Patel, University of Leicester / Nottingham

Developmental support & continued commissioning:
Professional Support Unit, Health Education England: East Midlands

Providers:
Andy Cook, GP & Trainer, Leicester
Dick Churchill, GP Principal, Nottingham

Research & evaluation:
Sarah Atkins, Linguistic Profiling for Professionals (LiPP), University of Nottingham

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Workshop 2: KSS interventions (Highly skilled TPDs turn around 25% to 5%) (Dr Christopher Warwick)

Dr Christopher Warwick is Head of HEE KSS GP Specialty Training School and works as an Out of Hours GP in Sussex. He has experience in all GP Deanery roles and has a special interest in communication and consultation skills. His own masters research considered the learning needs of International Medical Graduates, (available here: https://doi.org/10.1080/14739879.2014.11494252) and he has extensive experience supporting and developing trainees and their educators who need additional support. He is also committed to developing more meaningful leadership training for all primary care clinicians across the region.

HEE KSS GP School presented a number of targeted interventions which have improved the performance of doctors at all attainments levels, reducing the extension rate from a peak of 25% to the current level of around 5%:

- mandatory Targeted upskilling of all Training Programme Directors, cascaded to all GP trainers, in giving CSA preparation feedback
- focussed AKT support
- awareness of the additional learning needs IMGs have from day 1 of GP training - particularly around functioning in the NHS
- enhanced Induction for IMGs
- remedial CSA workshops with examiners giving structured feedback
- additional individualised support available to doctors failing to pass the exams.

The workshop presented KSS' work to date:

In 2008 KSS identified that the interventions they were using to support poorly performing trainees were ineffective. They identified that the real problem was poor diagnostics. They were unclear at that time whether the issue was fear / lack of skills / lack of appropriate language / poor confidence / anxiety.

KSS Intervention

KSS built additional capacity into the system:

- additional educator pathway courses, focused in coastal areas where the problem was greatest
- upskilled trainer network
- made PGCert compulsory for all new GP trainers
- offered PGCert to all existing trainers (Current PGCert rate 50% of trainers in 2018).

Upskilling of the educators

- Recognised an expert-based model was not sufficient:
    - Needed global upskilling – for extensions, but longer term to reduce them.
    - A new course was put on for all educators "Giving meaningful feedback**"** This course seems to have been the crucial intervention that made the difference.
    - Compulsory sessions for all TPDs & ADs.
    - Rolled out same training to ALL Educational Supervisors through local trainer groups.
    - Trained large cohort of Simulators to act as TiDs.
    - Developed large number of cases.
    - All facilitated by senior experts.
    - Full involvement of Lynne Rusteki, Linguistics expert.

Challenges of Upskilling Educators

- Significant costs:

    - case development
    - simulator training
    - additional Workshops for 54 TPDs
    - simulator fees for Trainer group sessions
    - admin to monitor penetration.

- Demoralisation of network:

    - trainers perceived failures were theirs too
    - overwhelming challenge to squeeze in where capacity already tightest.

Recommended early facilitative Interventions for International Medical Graduates

The following recommendations have been made by KSS as a result of their experience:

1. Consider an enhanced induction.
2. Use educational, not managerial, principles to plan induction. Include individualised learning needs assessment asap.
3. Give trainees much more detail about the NHS and the culture of GP. Explain who is GP is and what they do. as early as possible.
4. Make NO ASSUMPTIONS – especially that lack of knowledge equals stupidity. Destroy the 'Double Deficit model'.
5. Ideally place IMGs in GP placements first.
6. Arrange meeting with ES asap – IMGs view them – and NOT PDs – as key to success.
7. Consider developing a sub–group of IMG specialist ESs.
8. Instigate a meaningful 'buddy' system of peer support.
9. Enhanced induction to the MRCGP, as offered by the Deanery, could be locally delivered.
10. Central (national) system to support access to GP training – years are lost.
11. A simple glossary of terms would help enormously.

Workshop 3: ISU: interventions to help with linguistic difficulties. Did they evaluate particular interventions that work with poorly performing Drs, where linguistic issues had been identified? What works best? (Dr John Skelton)

John Skelton BA, MA, RSA Cert TEF(S)L, FRCGP (Hon) is Professor of Clinical Communication at Birmingham University College of Medical and Dental Sciences, and Head of Education Quality for the College. He is co-Director of the Interactive Studies Unit (ISU), which delivers training in communication and related issues to students and qualified health professionals. In particular, the ISU have worked with several hundred IMGs on a one-to-one basis, referred to us for further support. Before moving to Birmingham Medical School John was and worked as a teacher of English to non-native speakers in Spain, UK and Oman (where he was Director of Studies for the British Council), and as an academic Applied Linguist and teacher trainer in Singapore and UK. He has undertaken language-based consultancies in around 20 countries worldwide.

This workshop introduced delegates to a number of linguistic concepts which are likely to be of value in identifying the problems faced by some IMGs and BMEs and drew for discussion on a few of the hundreds of cases referred to the Interactive Studies Unit (ISU) at Birmingham Medical School for one-to-one language support over the years. The ISU works with a Typology of Referrals, which were shared with participants, and used in discussion. In particular, the discussion led to drawing distinctions between "language" and "culture" as causes of difficulty, and also between the "flexible" language resources normally available to UK graduates, and the "restricted" resources often available to IMGs and some UK BME graduates.

Basic language terms

Surface and depth

This is a term used by Noam Chomsky, and one which appears everywhere in his work. Originally intended to define a precise process in language, it has been widely extended, sometimes with extravagant claims being made for it, into many areas of education. I use it here, and routinely at work, purely as a metaphor.

The original distinction is to do with what Chomsky calls the "deep structure" of a language – the abstract concept of, say, a woman called Mary reading a book – and "surface structure", which are the actual words used to utter the concept.

Sticking only to English, these actual words might include:

- Mary is reading a book.
- It's Mary who's reading a book [i.e. not her sister, Jean].
- It's a book that Mary's reading [i.e., not a newspaper].
- She's reading a book, is Mary…. Etc.

The relevant thing for education is that "surface structure" is perceptible, "deep structure" is not. Surface structure is behaviour, in other words – something we can see and measure. Amongst other things, within medical education, there are problems in testing with using surface structure as a proxy for deep structure, with using behaviour as a proxy for values.

A lot of medical education, in professional development, is about helping students to mirror their values (the deep values they want to show to the world) with their behaviours (the words they say and the things they do).

The nuances of language, and the complexity of cultural difference, make this very difficult indeed for IMGs. Showing respect for a patient may involve being briskly paternalistic, for example. Showing respect for medicine as a profession may involve demonstrating extreme deference for seniors – and so on.

Language as power

The Brazilian Paulo Freire's classic Pedagogy of the oppressed has been of considerable influence in education. Freire is not really a linguist, but this is so central to the role of language in society that it is useful to remember. Freire's original idea was that children from poor backgrounds could improve their prospects through mastery of language. I agree – but it is not just children in the favelas which can benefit. Medical students have the potential for a great deal of power within society, for instance, but the more articulate they are, the more they are likely to achieve…. starting with themselves, the more capable they are of describing their professional selves, their strengths and weaknesses and so on, the better.

Restricted and elaborated code

This is a much-discussed distinction dating back to Basil Bernstein in the 1960s. It was either misunderstood or dangerously controversial, depending on your point of view. The general idea is that restricted code is more widely used in relatively informal situations, where a lot of meaning is left to be inferred, where the language used is drawn from a narrower range of possibilities, and so on. More formal situations require a wider range of possibilities. The central issue is that some people (possibly from poorer backgrounds) may not have access to elaborated code.

The controversy surrounds whether this can actually be demonstrated – to be frank, most statements at this level of generality about language are difficult to provide evidence for: and above all, whether there is an intent to say that working class speech norms are somehow "worse". For our purposes, it is a useful way to think of such matters as helping people to be more articulate.

Within a professional context, such as medicine, a less controversial way of looking at things would be to talk of "membership of a discourse community" (Nystrand 1982: the term has been much popularised and used through the work on genre analysis of John Swales from the 1990s). So, a Year 1 medical student who (in 2018) says "innit" all the time is less likely, probably, to be perceived as a member of the discourse community of medicine. And therefore, in the sense in which the word was used during the Differential Attainment day, less likely to get "sponsorship" from senior figures in the community.

This can be terribly difficult across languages. Last week (so, late 2018) I overheard a German lady in the café of a London tourist resort, meaning to pay a compliment, tell the very pleasant and charming (black) waitress that she was "like a chocolate", meaning she was sweet, something to relish, and so on. The waitress was generous enough to understand it was well-intentioned.

Learning the rules of the discourse game in this way is a particular issue with IMGs, who may lack….

Flexible response

The fluent and articulate speaker of a language has many ways of meaning the same thing. An IMG – in other words, someone whose English is very good, but not (as the phrase is) "native-speaker standard", does not. If a patient looks puzzled and say, "Sorry, I don't quite follow…." The doctor may not easily find other words to describe what s/he wanted.

Extremely good speakers use their wide resources to creative effect. This kind of thing is often used in drama class. "You are an ageing hippy. Ask someone to open the window", which I suppose might lead to something like "Hey man, it'd be so like groovy to have the window open…."

Language has purpose

A central insight of Speech Act Theory (see John Searle, *passim*) is that language has purpose. This immensely rich field of study began with a paper from the early 1960s by JL Austin which noted and described the fact that certain people, by virtue of their social roles, could make something true just by saying it. So, "I pronounce thee man and wife", "I sentence you to three years", etc. Put like this, it will

seem odd that the theory has been so fruitful, but it had led to a far better understanding of the way we use language to fulfil our purposes.

For any doctor who has a problem with language, the question "What was your aim here?" is very useful indeed. A simple illustrative example:

A doctor I met was very interested in safety in hospitals. He was on placement at a particular trust where he felt there were too many procedures not being adequately followed. He ended up shouting in exasperation at a senior nurse.

> "What was your purpose in shouting?" I asked.
> "To get her to change the policy".
> "Did you succeed?"

This was the beginning of a discussion of other ways of doing things (of achieving one's ends).

Conclusion

I begin from the premise that (most) doctors are intelligent and enjoy being given ideas to think about. My experience is that doctors will respond very favourably (they're intrigued) to being invited to think in the abstract in this way.

Note Some of these terms are discussed in more detail in:
JR Skelton. Language and clinical communication: this bright Babylon. Abingdon: Radcliffe. 2008

Ten tips for language support for IMGs and others

(In what follows, I use the term "IMG" as a kind of shorthand. A degree from Dublin, or Harvard, makes you an IMG under some definitions: a medical student who had never set foot outside Malaysia, say, until the day they began a UK degree is not an IMG – but may have some of the challenges we think of as being typical of IMGs in general. In some cases, apparently IMG-like problems may be present to some extent in UK educated students, brought up in a home where the parents seldom or never speak English. The language background of many people across the world is in any case very complex. And – as I say below – there is a very considerable overlap between the potential difficulties of IMGs and others. I hope you'll bear with me).

1. "I have a regional accent too…."

Minimise the divide between yourself and the doctor. (As it happens, I do have a regional accent – this works very well for me when faced with a doctor who has, say, a strong Nigerian accent). "Perhaps, like me, when you're tired or under stress you become harder to understand…."

2. Discuss unforeseen consequences.

Here are some very common ones:

a) Typical speech-style in e.g. Indian English is more words per minute than UK English (probably). This makes it harder to process, particularly if the accent is relatively unfamiliar to the listener….and it can create a false impression of e.g. anxiety, excitability etc. A good idea is to slow down not on a word-by-word basis, but phrase-by-phrase, leaving longer pauses between phrases to give the listener a little more time to process. (Advice to doctor: "Look thoughtful while pausing. You'll get a reputation for being deep").

b) Some languages (e.g. Chinese dialects, German) have an inbuilt staccato delivery which in UK can give an accidental impression of abruptness. Generally, it's difficult to modify this type of thing. Advice? Compensate by smiling or being approachable in different ways

c) Some languages have a low tolerance of silence – i.e., they will perceive a long silence as rude. Make doctors aware of this - "Say what you have to say, then shut up".

3. Put some effort into "emotional nothings"

These are the tiny little phrases that come naturally to everyone in one language at least, but not always in another. Every IMG has to reflect on whether the emotional nothings they use in their L1, or in English, suit them, and are understood appropriately by others. Offer practice, e.g. through brief role-plays, on "oh dear….", "hmm….", "oh lord", "crikey" and the like. I've chosen these phrases, including the old-fashioned "crikey", because that's what I use. But "What works for me won't work for you…."

4. With every IMG (and some UK educated doctors with complex language backgrounds), ask: are they educated in LI or L2?

This can be an important difference. For some doctors, most obviously European/South American doctors, e.g., the language they were first taught higher order thinking in was their LI. For some doctors, on the other hand (often true of West Africans, South Asians) the language they were first taught higher order thinking in may have been English.

5. Don't create a problem where there isn't one

Plenty of UK educated doctors struggle for more or less identical reasons as those typical of some IMGs. It's just that, when the problems are accompanied by a "foreign accent", you may assume it's language or culture. <u>The next few points are highly relevant for IMGs and UK educated doctors alike</u>

6. Help people to reflect

Many IMGs are educated in a rich environment, where they are encouraged to become articulate. But some are not – for some, rote learning and memorisation are what they know. (But see point 5 – this is certainly true of UK educated doctors too, in some cases). Reflection is about providing a context, about moving from the particular instance to the general principle. It's about developing perspective. Talk about reflection and challenge the words that doctors use. "What do you mean by being 'patient-centred'?" And of course, ask for evidence. E.g.: "What did you see in this video which struck you as patient centred?" The aim here is to give the doctor a list of typical examples, and perhaps more than anything a way of talking about them – a vocabulary to talk about them with.

7. Use Burns' game

Named (by me) after the Scottish poet, one of whose most famous lines is "Wad some Power the gift tae gie us/ Tae see oursels as ithers see us". "So, you say Dr Patel, your Clinical Supervisor, doesn't like you. Ok – pretend you're Dr Patel. Tell me why you have problems with this particular doctor". This is a fantastically good exercise for gauging level of insight, and for helping people to think with a sense of perspective. (The point is that Dr Patel may not be correct – that's ok – but what would s/he say?) Obviously, an issue for IMG doctors and others, but with the IMG there may also be the issue of helping them develop the language which is available to them to discuss other people professionally.

8. Try the 3 x 3 game

(Also named by me). Ask the doctor to think of "Someone close to you – your husband/wife, your mum…. What three words would they use to describe you? – Use <u>exactly</u> three words". Followed by "What are your three strengths and three weaknesses as a doctor?" A doctor who struggles here is quite likely to have a passive approach to learning, though there are other possible reasons. Again, intellectual passivity is not restricted to IMGs, it goes without saying.

9. What are the doctor's basic study skills like?

Some qualified doctors struggle more here than one might expect. Some – even though they've passed exams and graduated – may in particular have a very passive view of learning as being e.g. reading lots of texts, so they can imbibe the wisdom of experts.

10. Some language "mistakes" are there forever

Back, essentially, to a difficulty for IMGs. Some errors are ineradicable because no-one in the world can offer a "rule". A classic example here is the presence or absence of the articles (a/an, the). East Europeans and many East Asians cannot do this correctly – but I don't know any way of teaching it, so I don't try. Incidentally, a useful concept here in general is that of "surrender value". Teaching time is valuable: one should use it to offer students maximum useful benefit. Even if one knew the "rules" for the use of the article they are hopelessly difficult to learn and seldom actually lead to misunderstanding in the world.

Note that some linguists will argue that there is no such thing as being "a native speaker of English", because there are so many different and robust varieties around the world, including some with very different conventions about the presence or absence of articles.

11. Finally – the 11th of my 10 tips

The advantages in the modern world of being multi-lingual and multi-cultural are very considerable indeed. The advantages of being an IMG sometimes need to be presented very clearly to the doctor.

Professor JR Skelton
November 2018

A brief typology of remedial support. By John Skelton Interactive Studies Unit (ISU)

University of Birmingham, College of Medical and Dental Sciences

This is a revised version of the "Typology of Referrals" document in use for some years. The headings have been reworked to reflect explicitly a division into problems at the level of interaction with others, interaction with the institution, and problems with the self. Similar divisions have been suggested by, e.g., Hodges *et al*, Med Teacher 2010.

All remedial problems affect Home and IMG doctors alike, but the difficulties may present in different ways, and some – e.g. understanding UK culture - are likely disproportionately to affect IMGs.
It is basic to ISU work that educational problems are viewed as being relatively "surface" or relatively "deep". Surface problems are behavioural, and therefore perceptible. Deep problems cannot be addressed in the same way, and concern aspects of attitude, values, and "personality" …. the prevaricating inverted commas here to indicate that we use this term pre-theoretically. We do not get involved in e.g. psychological testing.

Thus, a doctor who talks too much with a patient may have a behavioural problem (advice: "talk less"), or may be anxious, or indifferent to what the patient has to say, etc.
Problems of the self are placed last, as they may be the least surface in nature (the least "behavioural" in terms of remedial support).

Note: some hierarchies have a "societal" level as well, to cover things like the doctor's understanding of the role of the doctor within society (e.g. using resources). This is not discussed here as it tends not to form the grounds of a referral to the ISU.

Note that a common reason for referral to ISU is “exam failure”, sometimes associated with dyslexia or some other learning difficulty. In addition, exam failure is a common symptom for a different, undetected problem.

Finally – this is intended as a pragmatic document, to help ISU colleagues to place referrals. The headings clearly have considerable overlap.

Type 1: interactional problems

a) language and culture

English language not strong enough

Many doctors referred to the ISU are not native speakers (NS) of English, but of these the great majority are fluent and confident speakers of the language. Problems *just* with mastery of the spoken language are rare.

However, the doctor may lack sufficiently rich language resources to talk in a nuanced way and can come across as blunt and unsympathetic (“I can’t help you” rather than “I’m not sure there’s a great deal at the moment which would be worth trying….”). This sometimes creates difficulties with ePortfolio entries, and written language generally, where the additional resources available in the spoken language (intonation, say) cannot carry part of the burden of meaning. (Note there is an obvious overlap here with dyslexia, and other disabilities).

Where comprehensibility becomes an issue, it is often linked to increased rapidity of speech at times of stress. In fact, the effect is not generally different from what happens with any relatively unfamiliar accent (e.g. a UK regional accent). It is merely that with a native speaker, this is not usually perceived as a “problem”.

UK culture is difficult to understand

The overlap between this category and the preceding category is evident. For example, the doctor who says “I can’t help you” may lack lexical resources or may be mirroring a brusque honesty typical of the home culture.

The risk of stereotyping here is clear. However, parameters that are relevant include: directness/indirectness, formality/informality, rapidity of speech, tolerance of silence, gender differences, power etc.

Variation from person to person here is probably at least as great as from culture to culture, but there is a reasonable prior expectation that an Indian-educated doctor is more overtly respectful to seniors, for example.

In very general terms, the NS non-NS dichotomy is false (some linguists refuse to use the terms). Our linguistic resources and cultural understanding no doubt have a strong correlation with our NS status, but they are not identical.

b) “poor communication”

Poor communication with patients

The surface phenomena here may be defined as e.g. asking multiple questions at the same time, talking too much, offering too much detail etc. The effect may be of vagueness, indecisiveness, doctor-centeredness etc.

This is what is normally thought of as “poor communication skills”. However, the causes may be profound, and include insecurity, and disorganised thinking.

Poor communication with colleagues
There is a wide variety of problems here. There may be poor handover skills, for example. This may be linked to muddled thinking, poor organisation, getting flustered with seniors, never having learned a coherent method for handover, etc.

Alternatively, the doctor may be perceived as arrogant or rude. Doctors in this category will often refer to themselves as “committed”, or “passionate”, and the rudeness may be linked to a desire to ensure that patients get the best possible support. At the other end of the spectrum, the doctor is quiet, doesn’t say enough in meetings, and is not perceived as part of the team.

Sometimes there is a failure to respect other colleagues’ position in the hierarchy appropriately. An uncertainty about how to treat nurses may be part of the problem for young doctors, for example.

Type 2: Working in an institutional environment

Type 2a: lacks leadership qualities/ is not a team player

This is a typical problem with people who are within a year or two of applying for consultant posts, but it has obvious parallels lower down the educational scale…. lack of teamwork, inability to function in a group, etc. The problem is associated with doctors from cultures where explicit deference to seniors is appropriate. It is also associated with people of a quiet disposition (the label “shy” may be used about them).
This implies a perception of leadership as necessarily a representation of high-profile, overt self-confidence. But one can only successfully be oneself. A lot of the work here is taken up with helping people find a “leadership style” that suits them, for example with the identification of ways in which a quiet persona can appear thoughtful: “She doesn’t say much, but when she speaks you listen….”
Teamwork is a common feature of similar difficulties at a more junior grade – a quiet person who appears to “go missing” on the ward, for example, or who does not socialise with colleagues….

Type 2b: Poor organisation and time management

This is common. Junior doctors who fail to keep up to date with e-portfolios or turn up late on the ward – this kind of thing is typical at one end of the scale. In some cases, the label “procrastination” is used.
On the other hand, poor time management can often be the label stuck onto a perfectionism that leads people to take too long and puzzle over minor problems. It can also be linked to an inability to say no.

Type 3: Aspects of the self

Many of the preceding categories, it will be seen, are at heart to do with the self, and are centrally concerned with (using these terms broadly) attitudes, values, or aspects of personality. In general, the presenting problem is behavioural, but the category “aspects of the self” is designed to cover these deeper areas.

Type 3a: Lack of self-awareness

Many doctors have an eccentric self-presentation which is well-perceived. The eccentricity is studied, and creates the effect of probity, seriousness, kindness, and such desirable qualities. Other eccentrics are unable to do this and tend to be distrusted in consequence.

More common is an inability to reflect. This may be manifest in a degree of concrete thinking, or an inability to nominate any faults they might have (faults are often presented as strengths in disguise: “My problem is I just care too much”). It may be manifest in a difficulty in writing reflective log entries, which may represent a difficulty with articulating ideas, or not having an understanding of the deeper context in which medicine takes place. A doctor may, for example, merely describe rather than evaluate a case or event.

At extremes, an apparent lack of self-awareness may be evidence of, or may mimic, a problem such as autism.

Type 3b: Attitudes and Values
The range here is considerable. Perhaps the doctor has doubts about working as a doctor or lacks resilience (or the desire to be resilient, perhaps one should say). At one end of the scale, a transient setback may have led to a temporary loss of confidence, morale or motivation: at the other end of the scale, an inability to resist poor role-models may lead to difficulties with the GMC or the criminal justice system. There may be evidence of inappropriate sexual advances, inappropriate language, or misuse of social media, for instance. At extremes, this may be an issue of probity: the doctor may defraud the NHS or be slapdash in clinical care.

(Version of January 2018)

Workshop 4: Developing cultural safety (Dr Vijay Nayar)

Vijay Nayar is the GP Dean for HEE in the east of England. He works closely with the Professional Support Unit and is committed to supporting trainees to enable them to reach their potential. He is the Deanery lead for cultural safety and aims to address issues related to differential attainment

Differential attainment is as yet the unexplained variation in attainment between groups who share a protected characteristic and those who do not share the same characteristic. In broad terms, across ARCP, Recruitment and Exams the following groups tend to perform less well:

- male
- older
- black, Asian and Minority Ethnic (BAME)
- international graduates.

The average exam pass rate for **all UK** medical graduates is 71%
This rises to 75.8% for those who are **White**
This falls to 63.2% for **UK BME** medical graduates
This falls to 41.4% for International Medical Graduates

Differential attainment is a symptom not a diagnosis and the causes are complex and multifactorial. Overseas Trainees confronted by a different culture, different educational system and different learning and teaching styles. BAME trainees report that they are faced by risks of unconscious bias in recruitment, assessments and day to day work. They also face separation from support networks, lack of autonomy about job locations, difficulties in fitting in at work and difficulties with relationships with seniors.

Barriers faced by BAME doctors:

- risks of unconscious bias in:
  - recruitment
  - assessments
  - day to day work.
- separation from support networks
- lack of autonomy about job locations
- difficulties in fitting in at work
- difficulties with relationships with seniors.

(K.Woolf)

Doctors, like any other group in society, may be prone to stress and this may adversely affect their performance. Trainees may have an added burden of stressors and some of these factors may be more common in International Medical Graduates.

Stress and Doctors	Stress and Trainees
• Excessive workload and constant demands • emotional burden when dealing with illness • responsibility for patients • dealing with uncertainty • dealing with one's own mistakes or fear of them • lack of professional support • reluctance to seek help • "change is the only predictable constant".	• Career choices • exam failure • relationships • health • housing issues • financial issues • bereavement • workload • lack of available training • discrimination • bullying and Harassment

	• long travel times • carer responsibilities both here and abroad.

Trainees report verbal harassment (consultants most common source followed by patients and families), discord with superiors, dissatisfaction with emotional support received from supervisors, and educational neglect from supervisors (Fnais).

In addition, ethnic minority doctors are more likely to feel bullying is linked to their identity (Paice and Smith).

Influence of Culture on Learning and Performance

Overseas Trainees confronted by a:

- different and new culture - “culture shock”
- different educational system
- different learning and teaching styles.

Educators need to try and flatten the curve for trainees.

One approach is to develop psychological and cultural safety for all trainees. Psychological safety is a shared belief that the team is safe for interpersonal risk taking (Edmondson). If there is psychological safety staff will feel confident in speaking out about errors, problems and uncertainties and feel empowered and supported to develop and implement ideas for new and improved ways of delivering services West).

Cultural safety provides an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together (Williams).

To develop cultural safety, you need to have cultural competence, i.e. the ability to interact with people from different cultures and respond to their health needs. However, this is a limiting term and we need to understand that culture is an expression of self and that no two individuals are the same. This can be achieved through cultural humility, a process of learning about each individual’s culture as a lifelong endeavour. For cultural humility there has to be a willingness to suspend what you know, or what you think you know, about a person based on generalisations about their culture (Tervalon).

Supervisors need to recognise and address the power imbalances that trainees perceive and build more supportive relationships with their learners. These principles also need to be applied at the organisational level as well to promote respectful partnerships. Individuals need to create a working culture and practices that recognise, respect, value and harness difference for the benefit of the organisation and individuals.

Making Psychological and Cultural Safety real

What changes do we need to make? This is analysed using the GMC framework.

- Theme 1. Learning environment and culture:

    - Promoting Cultural Safety through Faculty Development.
    - Developing Educators who support fairness and diversity in clinical education and training.
    - Tackling bullying, harassment and discrimination.
    - Appropriate adherence to the Public-Sector Equality Duty.
    - Supervision.

- McKimm (2009) suggests building in 10 minutes of ‘talk time’ at the beginning or end of supervision.
- Trainee is invited to talk about any personal issues that may be causing concern.
- This approach acknowledges and validates the interplay between ‘work’ and ‘life’.

- Theme 2. Educational governance and leadership:

  - Involve trainees and PPV members in our activities e.g. faculty board meetings, assessment processes, interviews.
  - HEE Quality Framework for raising concerns about education and training.
  - Systems for recruiting, selecting and appointing learners and educators are open, fair and transparent.
  - Equality, diversity and fairness training for anyone involved in recruitment and selection.
  - Analysis of Equality & Diversity to address issues of Differential Attainment.

- Theme 3. Supporting Learners:

  - All learners have an appropriate induction.
  - Cultural Induction.
  - Effective Professional Support Unit to deal with issues of conduct, capability and health - Referral should be seen as supportive, non-punitive, impartial and confidential. 12% of all trainees are referred to PSU. 9% are UK graduates and 20% of referrals are International Medical Graduates (HEE – EOE).
  - Learning plans and career advice based on individual needs.
  - Early warning systems to identify trainees who may face difficulties in training.
  - Tailored support systems available for all and trainees.
  - Detailed and constructive feedback for learners.

A good induction should include 3 components. A cultural Induction, an understanding of how to develop resilience and what support is available for trainees should they need it.

Cultural Induction

This should include the following areas:

- raise awareness of culture
  - its effects on learning
  - its effect on performance
- discuss models of learning and understand trainees preferred learning style and previous cultural norm
- requirements of exams
- educational contract
- self-Directed Learning
- reflective practice
- professionalism
- good Medical Practice
- confidentiality
- the Dr-Patient relationship
- leadership
- team-working
- compassion
- communicative capability.

Communicative capability

Poor communicative capability may make people appear awkward or difficult. A lack of English can make someone appear less intelligent or lack a sense of humour or result in misinterpretation.

There are 3 components to communicative capability:

1. Linguistic competence: grammar, vocabulary, pronunciation, fluency
2. Sociolinguistic competence: pace, volume, intonation, body language, turn-taking, interactive style, cultural influences ('manner')
3. Applied language competence (consultation skills): question forms, signposting, summarising, sequencing, explaining, negotiating etc.

Understanding and reflecting on the influence of all these components can help trainees improve their communication skills.

Resilience

Part of the education package available for trainees should include discussing the following:

- optimism
- coping skills
- role models
- supportive network
- feedback on performance-good and bad
- correct performance problems as they occur
- work-life balance
- reflective practice.

Reflective practice
It is important to help trainees understand that reflection plays a vital role in helping doctors to learn from clinical experiences. Acquiring reflective learning skills helps learners to identify their learning needs stimulates learning that focuses on comprehension and understanding.

Educators need to facilitate reflective learning skills in their trainees. They need to:

- provide challenges
- give explicit attention to reflection
- reflect with the trainee on what made an action successful -just as valid as learning from a mistake
- ask questions rather than give answers
- ask questions that stimulate concreteness (what did you do? what did you want to find out?).

Support

The trainee may need help with any or all of the following:

- help with frustration and other emotions
- fear of failure/criticism
- exam support
- trainee/Trainer relationship
- mentorship
- induction days
- Professional Support Unit (PSU)
- ARCPs.

- Theme 4. Supporting Educators:

- fair recruitment and selection of Educators
- appropriate induction to their role with regular appraisals and access to professional development
- faculty of Education and Leadership
- faculty development to address Cultural Safety and Differential Attainment
- giving Effective Feedback, Role Modelling, Emotional Intelligence
- coaching and Mentoring.

- Theme 5. Developing and implementing curricula and assessments:

In order to promote cultural safety, the educational community needs to ensure:

- that all learners have equitable access to the curriculum
- assessments are fair, reliable and valid – ARCP process.
- assessors are appointed using a fair recruitment and selection process
- a diverse pool of assessors is attracted
- assessors receive training relevant to issues of equality, diversity, fairness and bias
- detailed and constructive feedback for all candidates
- exams and ARCP outcomes are analysed in terms of Equality & Diversity.

In summary, cultural safety can be promoted by:

- reflecting on one's own culture, attitudes and beliefs about 'others'
- clear, value free, open and respectful communication
- developing trust and be aware of power imbalances
- recognising and avoiding stereotypical barriers
- recognising biases and their impact
- being prepared to engage with others in a two-way dialogue where knowledge is shared
- Understanding the influence of culture shock.

Take Home message:

- Some doctors face significant hurdles to progression, includes IMGs and UK BAME graduates
- Doctors in training do not all start from the same place and have different trajectories: support to remove barriers or overcome them will provide more **equity** for training.
- The whole system needs to introduce change at national and local levels.
- What will you do to promote cultural safety?

Workshop 5: Health Education England North West interventions: The Clinical Skills Assessment Support On eXtension (CSA SOX) programme outcomes & evaluation (Dr Anne Hawkridge)

Anne Hawkridge: Trainer in Bolton and MRCGP examiner HEENW CSA SOX Programme Lead. Anne co-authored the CSA model and **North West England CSA Toolkit.** Leading on the CSA SOX educator recruitment and training, Anne co-ordinated the support programme which has produced such an encouraging **improvement in pass rates for both IMG and UKG doctors.**

Workshop title: A unique, personalised support programme from HEENW which is enabling more IMG doctors to achieve MRCGP Clinical Skills Assessment success

HEENW trained a group of educators (called 'CSA SOX' educators - short for CSA Support on eXtension). These educators met with the *resit trainee* and their trainer and analysed the trainees' consulting behaviours and knowledge gaps using a purpose-built CSA model and trainee self-assessment. The learning needs reappraisal was used in the formation of a shared educational plan to guide the improvements needed before re-attempting the CSA.

We delivered this **CSA SOX support programme** to trainees in North West England who were retaking the CSA in 2016 and 2017. Most of these trainees were undertaking periods of additional training time; all had multiple fails in the CSA. After the programme, we compared CSA pass rate in our group of trainees with national CSA pass rates and stratified the results by number of previous attempts, and source of primary medical qualification.

Both cohorts of trainees who took part in this programme had pass rates that compared favourably to national pass rates within the limitations of the data available. **Our results were particularly encouraging for the group of International Medical Graduates (IMGs) who had previously failed the CSA two or more times.**

We suggest that these results are due to four features of the educational programme. Firstly, all trainees, helped by their trainers, reappraised their learning needs. Secondly, the educational tools used were derived from the CSA and written by CSA assessors. Thirdly, support was delivered within the training practice, facilitating the development of shared educational strategies. Finally, trainees and trainers benefited from the extra training community support, particularly from educators experienced in the CSA assessment.

Our programme has the potential to be used by other training communities to improve CSA pass rates for all trainees. Our lead educators work with the trainees and their trainers to reappraise learning needs by using our generic tools and toolkits. The three-way meeting within the training practice not only enables *calibration,* but also strengthens the trainee- trainer relationship. The resulting CSA preparation work is effective and focussed and enables trainees to move towards exam success. Moreover, the early adoption of the programme in 2018 has **prevented twelve trainees from requiring additional training time.** This significant outcome has not only avoided the financial and personal cost of exam failure, but reduced the costs borne by the training community.

Trainers are also to be further resourced through access to a range of teaching videos accompanying the online **North West England CSA Toolkit.** The aim for the future is to continue to deliver both increased CSA success and to diminish the effect of differential attainment [1] [2] particularly for IMG doctors, training in the North West of England and beyond.

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A description and evaluation of an educational programme for North West England GP trainees who have multiple fails in the Clinical Skills Assessment (CSA)

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Abstract

Background and aims

Candidates who have failed the Clinical Skills Assessment (CSA) component of the Membership of the Royal College of General Practitioners (MRCGP) licensing examination present an educational challenge. This study describes a CSA re-sit programme and evaluates the outcomes when doctors reattempt the CSA.

Methods

We delivered an educational programme to trainees in North West England who were re-sitting the CSA in 2016 and 2017. Most of these trainees were undertaking periods of additional training time; all had multiple fails in the CSA. After the programme, we compared CSA pass rate in our group of trainees with national CSA pass rates. We also compared pass rates stratified by number of previous attempts, and source of primary medical qualification.

Results

Both cohorts of trainees who took part in this programme had pass rates that compared favourably to national pass rates within the limitations of the data available. Our results were particularly encouraging for the group of International Medical Graduates (IMGs) who had previously failed the CSA two or more times.

Conclusions

We suggest that these results are due to four features of the educational programme. Firstly, all trainees, helped by their trainers, reappraised their learning needs. Secondly, the educational tools used were derived from the CSA and written by CSA assessors. Thirdly, support was delivered within the training practice, facilitating the development of shared educational strategies. Finally, trainees and trainers felt well supported by the training community, and by educators experienced in CSA assessment.

INTRODUCTION

The Membership of the Royal College of General Practitioners (MRCGP) tripos examination was introduced in 2007 as a licensing qualification required to practise as a GP in the UK. The MRCGP components are Work Placed Based Assessment (WPBA), the Applied Knowledge Test (AKT) and the Clinical Skills Assessment (CSA). The CSA component is the focus of this paper and aims to ‘test a doctor’s ability to gather information and apply learned understanding of disease processes and person - centered care appropriately in a standardised context, make evidence-based decisions, and communicate effectively with patients and colleagues’ [1].

The standard set is that of being 'fit for independent practice as a GP in the UK' and the assessment consists of 13 ten-minute simulated patient cases selected from the RCGP curriculum, marked by different MRCGP CSA examiners.

Most GP specialty trainees pass the CSA in the final year of their GP training, known as the ST3 year. Those trainees not passing the CSA by the end of the training period must apply for Additional Training Time (ATT), which typically lasts for six months and involves a change of training practice. The continued failure of candidates in the CSA creates problems, primarily for the trainees themselves, but also for their local Health Education Team (HET), who are obliged to resource the ATT and find placements for educational supervision in already stretched GP practices. The doctors remain unable to join the GP workforce, adding to local GP recruitment pressures [2].

HETs across the UK offer a variety of types of support for trainees who fail the CSA. Some HETs provide mentoring and practical support to CSA re-sit trainees [3]. Others provide programmes which may include a mock CSA examination with varying numbers of stations. Historically, most of these interventions have not been written up at all or are presented as descriptive studies [4-7]). Importantly, there are no published accounts of the effectiveness of CSA re-sit programmes in terms of subsequent success rates in the CSA examination. Nor are there published comparisons of intervention-related pass rates with pass rates in control groups or with national pass rates.

In the North West of England, each year about 35 GP trainees fail the CSA on multiple occasions and are provided with ATT. Between 2008 to 2013, our local HET commissioned a CSA re-sit course consisting of didactic teaching and small group video analysis. The courses were popular with trainees but produced at best a small increase in subsequent CSA pass rates. After discussion with our local HET we concluded that support needed to be offered to the *trainer* in addition to the trainee, as the majority of exam preparation and educational activity takes place within the GP training practice. This approach resonated with a qualitative study [8] of trainers, many of whom reported feeling isolated and unsure of the best educational strategies to adopt during supervision periods of trainees in difficulty.

We were also aware that at least two-thirds of our group of re-sit trainees had gained their Primary Medical Qualification (PMQ) outside the UK. It is now accepted that as a group, International Medical Graduates (IMGs), underperform in both the AKT and CSA examinations [9-12]. One of the authors of this paper (AH) explored this issue of differential attainment during a series of interviews with a group of IMGs who had passed the CSA after a number of fails. These IMGs talked about the importance of reappraisal of exam performance within a supportive relationship with their GP trainers. Similar themes emerged in a study from NHS Scotland [13], which also emphasised the importance of focused feedback within a supportive supervisor relationship.

Our revised CSA re-sit programme therefore incorporated these themes. We offered improved reappraisal of learning needs within the supportive educational environment of the GP training practice in the form of a face-to-face tutorial involving their trainer and specially trained GP educators. We called these educators CSA Support On eXtension (CSA SOX) educators. They received specific training on the CSA assessment; what competencies are tested and how learning needs can be evaluated after failure. The CSA SOX educators subsequently used a CSA-related consultation model and educational Toolkit, developed by ourselves and explained below. This North-West England CSA Toolkit was key to the implementation of the educational plan by the trainer and trainee following the tutorial with the SOX educator. This paper describes the practicalities of this approach and evaluates the success of the educational intervention.

METHOD

How we ran the CSA SOX programme

The same approach was used for two cohorts of trainees, the first in 2016 and the second in 2017.

a) Recruitment and training of SOX educators

We recruited the SOX group from our local community of educators who were either already CSA examiners or showed a strong interest in providing CSA support. The SOX educators attended a training course covering the use of the CSA model and toolkit and how to undertake the required learning needs reappraisal. Skills training was also undertaken to strengthen the ability to facilitate the three-way meeting in the training practice and therefore enable effective implementation of the derived educational plan.

b) Development of educational materials

We used our experience of both successful and unsuccessful candidates, together with a range of RCGP feedback statements, to produce a CSA consultation model. This model consisted of a one-page CSA Overview (see Figure 1) and a set of word pictures to help judge the readiness of the trainee to sit the CSA. Subsequently, we wrote the North West England CSA Toolkit to enable educational strategies to be matched with the identified problem areas. In 2017 these three educational aids were combined into an electronic document.

In addition, we developed a trainee questionnaire (TQ) and a CSA case-bank of practice cases. The TQ recorded previous exam preparation methods, RCGP curriculum coverage and trainee confidence levels and the CSA cases were set at a similar level of difficulty as the live exam.

c) Mandatory programme completion

CSA SOX programme engagement became a mandatory condition for a trainee offered ATT. A small number of trainees yet to require ATT were also offered places on the programme following CSA failure.

d) Trainee sitting of a 'mini' mock CSA exam

Each trainee sat a three-case mock CSA examination, using experienced role players and cases that provided challenge in the interpersonal skills domain. Each trainee's mock examination was video recorded, and a copy of the video sent to the trainee, the trainer, and the SOX educator. No oral feedback about their performance was given to the trainee on the day of the mock, but each role player made notes on the consultation for later feedback to the trainee.

e) Reappraisal of trainee learning needs

HEENW assigned to each trainee a SOX educator, who subsequently analysed the three mock CSA role plays using the CSA consultation model. With permission from the trainee, the SOX educator accessed the trainee's learning portfolio to provide further information relating to learning needs such as CSA feedback statements [1] and the content of previous educational reviews. This information was used in combination with information from the TQ described above to form a holistic assessment of the trainees learning needs. In their GP training practice, the trainees and their trainers were encouraged to make a preliminary analysis of the mock cases using the CSA consultation model and to consider the information recorded by the TQ, particularly relating to curriculum coverage and previous methods of CSA preparation.

f) Three-way meeting

Soon after the mock exam, the SOX educator contacted the trainer and the trainee and arranged a joint meeting at the GP training practice. This meeting lasted about three hours and was based on the three mock CSA cases and the information from the TQ and trainee portfolio. The meeting allowed sharing and refining of the trainees learning needs analysis through discussion and therefore increased the ownership of the resulting educational plan. The SOX educator followed the meeting with a written record of the final plan to allow the trainer to continue to implement and reinforce the suggested strategies.

g) Continuing support

The SOX educator subsequently kept in touch with both the trainer and the trainee after the tutorial and if requested continued to offer support by telephone and email.

How we assessed the intervention

Attendance at both the mock examination and the three-way meeting was 100% for both cohorts. We followed up the trainees via CSA exam board results and calculated pass rates for those who had taken part in our CSA support programme. The results were stratified according to whether the trainee had taken the exam for the second, third or fourth time. The 2016 cohort results were compared with equivalent data from the MRCGP Annual report 2016/17, but comparison of the 2017 cohort's results with MRCGP report 2017/18 data was not possible as this data was not available at the time of submission of this paper. We used a questionnaire to assess the trainee, trainer and SOX educators' satisfaction with the programme. The SOX educators and the GP trainers were very satisfied, with the vast majority of trainers enthusiastically welcoming the three-way meetings. Unfortunately, as the response rate from the trainees was extremely low, though uniformly positive, no useful conclusions could be drawn, despite a repeated questionnaire distribution. We did however receive informal feedback from successful trainees that the programme had contributed to their success.

DISCUSSION

Analysis of pass rate data

This is the first published attempt to quantify the effectiveness of a CSA re-sit programme. By following up the trainees completing our programme, we were able to investigate the outcome when the CSA was reattempted. We were also able to make a rudimentary comparison between the pass rates within North West England and national pass rates [11,12] and make more specific comparisons between groups of trainees based on the sources of their primary medical qualification (PMQ), and the number of times they had previously attempted the CSA.

We wish to stress the methodological and statistical limitations of our study. We had only limited information about the previous educational attainment of our cohort of trainees and our comparison group. Our study was not randomised and there was no attempt at matching other factors that may have contributed to alteration in pass rates such as AKT success [10] and male gender [15]. With these limitations in mind, we wish to make the modest claim that the CSA pass rates following the CSA SOX programme are encouraging. As can be seen in Table One, pass rates for trainees who participated in our re-sit course was over 70% (75.7% in 2016 and 70.5% in 2017). Furthermore, this pass rate was consistent across almost all sub-groups, the exception being the tiny number of IMGs taking the examination for the second time.

Our results are particularly encouraging in the group of IMGs who were taking the examination for the third and fourth times. These candidates achieved high pass rates and these results are consistent in both the groups who experienced the intervention. The SOX programme shows promise therefore, as an approach that HETs might adopt to address the issue of differential attainment in the CSA [10].

Direct comparison of sub-groups with national groups is somewhat problematic due to confounding factors. However, in almost every sub-group where comparison is possible, our results are better and sometimes considerably better, than the comparable national figures. Such differences could be due to chance, but the size and consistency of the difference over all the sub-groups would argue against this explanation.

Alternatively, the differences could be due to the North West England trainees being in some way more educationally able *before* the educational intervention. This explanation seems unlikely for two reasons. Firstly, our trainees like those in the national figures have already failed the examination two or three times previously, and this suggests equivalence of ability between the groups. Secondly, we obtained National Recruitment Office (NRO) scores for the machine marked 'Clinical Problem Solving' and 'Professional Dilemmas' components, for a majority (75%) of our re-sit candidates. We found their NRO scores to be substantially worse than the national scores; for example, 47% of our re-sit candidates were in the 'below average performance' band compared to 22% nationally. As NRO scores have been shown to correlate

well with CSA exit scores [16], this would support the hypothesis that our re-sit candidates were *not* of greater educational ability than the national comparison groups.

Possible explanation of pass rates

We feel there are several good educational reasons why an improvement in pass rates following the CSA SOX programme might be expected.

Firstly, all trainees underwent a reappraisal of their learning needs which was shared with their trainer. Secondly, the CSA consultation model is a generic calibrated tool developed directly from the CSA assessment and written by examiners. This enabled an objective appraisal of consultation skills and completion of tasks, which had credibility with the trainees and formed the basis of the educational plan derived from the North West England CSA Toolkit.

The toolkit was also closely mapped to the CSA by the examiner authors and incorporated a wide range of educational strategies acquired from the training community.

Thirdly, trainers were offered support and calibration from an external SOX educator, thereby strengthening their role and enabling consistent educational planning. Initial fears that the trainers might feel undermined were proved unfounded, with the vast majority of trainers feeling empowered to assist the trainee in preparing for exam success. Trainer feedback also confirmed the confidence gained through the use of the tools and toolkit and how delivery of the three-way meeting within the training practice had reinforced the trainee-trainer relationship.

Lastly, the local GP HET made a significant investment in the CSA SOX programme, resulting in the trainees also feeling valued and supported rather than being 'cut loose' without means to gain insight into their exam failure. This was particularly important for the group of IMG doctors who often expressed dismay at their chances of success in further attempts [13]. Similarly, the trainers felt the HET was offering tangible means and support for their central role.

We are optimistic that our programme can be used to improve CSA pass rates in other training communities. Our lead educators work with the trainees and their trainers to reappraise learning needs by using our generic tools and toolkits. The three-way meeting within the training practice not only enables calibration, but also strengthens the trainee-trainer relationship. The resulting CSA preparation work is effective and focussed and enables trainees to move towards exam success. Moreover, the early adoption of the programme in 2018 has prevented twelve trainees from requiring additional training time (ATT). This significant outcome has not only avoided the financial and personal cost of exam failure, but reduced the costs borne by the training community.

Trainers are also to be further resourced through access to a range of teaching videos accompanying the online CSA Toolkit. The aim for the future is to continue to deliver both increased CSA success and to diminish the effect of differential attainment [10, 17] particularly for IMG doctors, training in the North West of England and beyond.

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Workshop 6: TEP in the right direction? Scottish Trainee Enhanced Programme (Drs Amjad Khan and Nitin Gambhir)

Amjad Khan is the Director of PG GP Training for Scotland. He has long experience with managing trainees in difficulty and liaising with Professional Support Units and, until recently, has chaired the STEP programme.

Nitin Gambhir is Assistant Director of PG GP Training in Scotland. He is an experienced GP Educator and CSA examiner and chairs the STEP programme. He has been involved with STEP since its inception.

The STEP (Scottish Trainee Enhanced Programme) was established in 2015. It was set up primarily to help address Differential Attainment amongst IMG GP trainees. Trainees are invited as soon as they commence ST1 training for a full day package of evidence-based interventions. This is in addition to the standard induction programmes offered to all trainees starting ST1.

The programme is delivered by group of experienced GP educators and is delivered twice a year.

The topics covered are:

- Introduction to Differential Attainment - setting the stage
- Culture and Transition
- Small Groups- Knowing You Knowing Me (sharing journey's)
- Positive Factors and Videos (success stories)
- Communication Skills and Linguistics
- Reflection and Self-Regulation

The programme has the unique added value through inviting the trainee's educational supervisor to attend at the same time. Feedback suggests trainees appreciate the added effort taken, they take away several useful messages and feel motivated to achieve good outcomes. Educational Supervisors value the opportunity to understand their trainees' individual needs and feel more able to support them in practice.

The workshop covered the background to how this programme was developed, the key contents covered, and feedback themes received so far from both trainees and Educational supervisors.

Trainees were identified as being at risk based on the following criteria:

- Source of PMQ out with UK (acknowledging that country of PMQ does not necessarily = country of origin/secondary education)
- UK Graduates of Black and Minority Ethnicity BME
- GPST Recruitment Score – ideally the total score but SJT score of 2 easier to access.

The following were considered insufficiently reliable indicators to include:

- years since PMQ (>9years)
- sex (male) were considered
- sickness absence record
- professional behaviours.

The STEP programme is run as a single day to introduce trainees and trainers to the principles behind the Scottish Enhanced Training Programme.

Culture and Transition

The following tools are used to explore this topic:

The Dimensions of Culture

Geert Hofstede et al came up with six basic issues that society needs to come to terms with in in order to organize itself.

(Med Teach. 2013 Oct;35(10):e1537-45. doi: 10.3109/0142159X.2013.802298. Epub 2013 Jun 19. Cultural dimensions in the transition of overseas medical graduates to the UK workplace. Morrow G1, Rothwell C, Burford B, Illing J.)

The STEP programme covers these six areas to help trainer and trainee understand these different approaches they each might use to approach life. The six areas are:

1. **Power Distance Ratio** - the extent to which less powerful members of society accept and expect that power is distributed unequally

2. **Masculinity** - the extent to which force is endorsed socially

3. **Uncertainty tolerance** - societies which tolerate uncertainty less have more fixed rules and rituals and a desire to know the truth.

4. **Long term vs. Short term orientated culture** - long term cultures accept the world is a constantly evolving and accept change as inevitable. Short term cultures expect the world to stay the same and sticking to the moral compass that has evolved from the past is morally beneficial.

5. **Indulgence vs. Restrained Cultures** - In an indulgent culture people seek out the good things in life, friends are important. People seek gratification from doing what pleases them. In restrained cultures, life is more regulated, it is taken for granted that life is hard, and there is a strong sense of duty.

6. **Individuality.**

Small group work

This is a key part of the day

The following areas are explored:

- The trainees are asked to share their individual “Journey”.
- “Knowing me Knowing You”.
- The Positive Factors of cultural diversity.

Learning to Learn

Reflection and Self-Regulation may be a different educational paradigm to that which the trainee is familiar with.

Great British Bake-off video

This is used to demonstrate key learning points in relation to self-regulation theory (reflection, goal setting, resilience etc.) Individuals may be quite inspirational, for example one recent winner, who was a Physics graduate from India, working in the UK and living alone. He took up something new with the hope of making new friend and integrating into British Culture.

Feedback

Educational Supervisors and Trainees need to explore how to give effective feedback. This may vary according to culture and educational paradigms that trainee is used to.

Reflection

Trainees who are not familiar with reflection need guidance. A simple tool to teach reflection: What? So What? Now What? AoMRC guidance on Reflection updated post the Bawa Gaba case has some helpful tips and a wide range of resources on reflection.

e-Portfolio and Work Place Based Assessment

Application of their learning can then be applied to the trainee's:

- e-portfolio WPBA
- Personal Development Plan
- Learning Logs.

Culture and Communication

Communication and Linguistics is explored using a variety of techniques for example using:

- back to Back exercises
- videos - the 2 Ronnie's- Four Candle's to illustrate the potential for misunderstanding
- metaphors and Colloquialisms e.g. "Korean Billy" you-tube clips.

Language is more than just words. Mehrabian, Edward Hall: When people from different cultural backgrounds communicate, even in a shared language, the intent behind the message may be very different from the effect it creates.

293% of our communication depends upon whom we are speaking to and not what (Mehrabian) 5% of what we communicate is about the actual words, 33% is the way it is spoken (voice tone modulation pauses) and 55% is about the context and body language.

The benefit of using recordings of the consultation skills is also explored.

Communication and the CSA

The following areas are discussed during the day:

- the structure of the consultation and Consultation models
- open vs closed questions
- the attributes of passing vs failing candidate
- available resources to help trainees achieve success.

Key Messages to Educational Supervisors

- **Intercultural awareness** - Lack of support and cultural awareness amongst colleagues may lead to a risk of stereotyping, prejudice and discrimination.
- Perception of **unconscious bias** and fear of being labelled as 'problematic'- vulnerable, confidence and morale.
- Understanding of vulnerabilities and **demonstrate acceptance** towards IMG's.
- Supportive environment is highly valued by IMG's.
- **Leadership and commitment**; time and resources to support IMG's acknowledge extra work and seek expert input if required.

- Learning environment- build on previous learning rather than unlearn everything (**Appreciative Enquiry**) Deficit vs. Asset based model.
- **Do not make assumptions** EITHER WAY! (Culture or capabilities).
- Individualised needs assessment; (hidden curriculum).
- **Intercultural dialogue** (using tools such as Kiddy's Ring) and **Culture Shock** (where are the trainees on the graph?).
- Encourage trainees to develop a support network that involves **mixed groups** to allow improvement in 'social capital'. '**Ethnic Homophily**' is a risk factor (**Homophily** from Ancient Greek ὁμοῦ (homou, "together") and Greek φιλία (philia, "friendship") is the tendency of individuals to associate and bond with similar others, as in the proverb "birds of a feather flock together").
- **Learning styles**; Experiential learning e.g. role play, simulation creates better participation and application of knowledge (Engagement often better in small groups and one to one).
- **Reflection**; Deep learning was associated with understanding whereas superficial learning was
- associated with memorising (often seen in IMG's).
- **Feedback** is welcome, should be early, constructive and directly linked to goals.
- **Role modelling**; Hearing other IMG stories, journeys and transition was helpful. Buddying or Mentoring helps.

Evaluation

Trainee feedback

- "I talked about things I have never spoken to anyone before."
- "Felt my perceived disadvantage of being an IMG was resolved as the day went on."
- "Review of positive factors was helpful."
- "Hearing journeys, we were all in a similar boat."
- "Very useful, made me feel welcome and felt encouraged, thank you for the effort taken."
- "Reflection - is challenging and not a format I am used to but now understand it better."
- "Stats were an eye opener but not surprised or disappointed, it's just I need to work harder."
- "Learnt Communication is more than just words, I need to learn the non-verbal aspects and cultural differences."
- "Importance of submerging yourself in the local culture and build your cultural capital."
- "Videos and tips from recently successful IMG's made me realise the task ahead, increased my motivation."

Trainer Feedback

- "Helpful to openly discuss IMG issues with my trainee."
- "Important for trainees to have the ES present and support them, understand the issues so we can support them better."
- "Good to attend with trainee- it strengthened our relationship and I understood the challenges faced by my trainee, everyone's journey is different."
- "That is definitely a strength of this course. I think this was an excellent idea."
- "IMG journeys/stories were inspirational for ES's and therapeutic for trainees."

Workshop 7: Differential attainment in the applied knowledge test: understanding causes to find solutions (Dr Niro Siriwardena)

Professor Niroshan (Niro) Siriwardena is Research and Development Lead for Assessment at the RCGP and Professor of Primary and Prehospital Health Care at the University of Lincoln. He trained in medicine at St. Bartholomew's Hospital Medical College London and in general practice in Lincolnshire, followed by research training at Nottingham and De Montfort Universities.

His research expertise is in quality improvement, implementation and educational assessment, including studies investigating the validity, reliability and fairness of the MRCGP, as well as evaluation of quality measures and health technologies in primary and ambulance care. He has published over 100 research studies published in international journals and has led and collaborated in research supported by funding from the National Institute for Health Research (NIHR), Research Councils, Health Foundation and Welcome Trust.

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What does research tell us about possible causes of differential performance?

Pattinson J, Blow C, Sinha B, Siriwardena AN. Understanding reasons for variations by ethnicity in general practice specialty trainees' performance in the Membership of the Royal College of General Practitioners' Applied Knowledge Test: cognitive interview study. Ottawa ICME 2018, Abu Dhabi, March 2018. 'identified the following issues: Cultural barriers' including language barriers and unfamiliarity of the NHS system; 'Theoretical versus real-life clinical experience'; clinical exposure enhanced learning in all candidates; theoretical learning advantaged OST candidates who had learned disease patterns by rote; 'Recency, frequency, opportunity and relevance' of training affected all candidates' AKT performance.
The importance of training experience was also identified Woolf K. et al. Fair training pathways for all: understanding experiences of progression GMC, 2017.

Performance was found to be affected by:

- differences in relationships with trainers/supervisors,
- inexperience with UK assessments
- perception of bias, lower confidence, separation from family etc.
- differences in experience of undergraduate and postgraduate training
- differences in educational exposure, 'recency, perceived relevance, language, culture, NHS guidance and jargon.

How can we investigate these factors?

Two studies were presented:

Study 1: A study was undertaken looking at the MRCGP AKT computerised questionnaire at Pearson View test centres.

Candidates completed questionnaires immediately on completing AKT. Consent was obtained to link test performance, previous test, and attribute data. Ethical approval was obtained via University of Lincoln.
The responder characteristics were as follows.

The utility of the educational environment was also assessed, and no major differences were found between white British / Irish and BME apart from the Trainer relationship and whether or not the trainee had participated in an RCGP or non- RCGP Exam course.

BME candidates felt they performed better in administration questions but were less likely to feel they had adequate time or that the AKT was a fair test of knowledge compared to white British-Irish candidates.

Sex: confidence, performance, timing relevance and fairness

Female candidates were:

- more confident in data interpretation and statistics
- less confident in practice administration.

Male candidates felt they performed better in clinical medicine.

Factors affecting AKT score

In a multivariate analysis AKT performance was significantly lower (p all<0.01) for candidates having more attempts, BME doctors and those trained abroad. Estimated score (insight) was as significant factor in performance whereas sex was not once insight was taken into account. County of PMQ reduced all measures, but especially evidence-based medicine and administration questions.

Strengths and limitations of the study

Strengths: Large number of candidates; Captive Audience; data completeness; Recent completion; Ethical and complies with information governance and GDPR; Cross sectional and cohort design rather than questions on specific items; linkage relies on consent. Unknown confounders test multiple hypothesis.
Limitations: Fewer consented; Biases: test completion social desirability, missing data, Missing data not at random; General questions on exam (areas).

Summary and conclusions

- Some causes of differential attainment (e.g. education, insight) are amenable to intervention.
- The effect of such interventions on pass rates can be tested.
- Five studies demonstrated that poor performers lack insight into their shortcomings even in real world settings and when given incentives to be accurate. An additional meta-analysis showed that it was lack of insight into their own errors (and not mistaken assessments of their peers) that led to overly optimistic estimates among poor performers.

Study 1 demonstrated that participants with an entity (fixed) theory of intelligence, those known to avoid negative information, showed significantly more overconfidence than those with more incremental (malleable) theories. In Study 2, participants who were taught an entity theory of intelligence allocated less attention to difficult problems than those taught an incremental theory. Participants in this entity condition also displayed more overconfidence than those in the incremental condition, and this difference in overconfidence was mediated by the observed bias in attention to difficult problems. Finally, in Study 3, directing participants' attention to difficult aspects of the task reduced the overconfidence of those with more entity views of intelligence. Implications for reducing biased self-assessments that can interfere with learning were discussed

- Study 1 Kruger & Dunning. Unskilled and unaware of it. J Personality and Social Psychology 1999.

- Study 2 Ehrlinger J et al. Why the unskilled are unaware: further explorations of (absent) self-insight among the incompetent.

- Study 3 Ehrlinger J et al. Understanding overconfidence: theories of intelligence, preferential attention, and distorted self-assessment. J Exp Soc Psych 2016.

Study 2. Do candidates who declare dyslexia do worse or better in the AKT compared to those who do not declare dyslexia?
Asghar ZB, Siriwardena AN, Elfes C, Richardson J, Larcombe J, Neden KA, Salim A, Smalley D, Blow C. Performance of candidates disclosing dyslexia with other candidates in a UK medical licensing examination: cross-sectional study. Postgrad Med J. 2018;94(1110):198-203.

- 14 examinations (2010-2015)

- 14,801 candidates
- 2.6% (379/14801) declared dyslexia.

A significantly greater proportion of candidates declaring dyslexia were male, aged 30 years or over, and had multiple attempts at the examination compared with candidates who did not declare dyslexia who were more likely to be female, aged under 30 years and making their first attempt.

Overall 83.6% (317/379) candidates who declared dyslexia passed AKT during 14 examinations compared to 95.0% (13,702/14,422) candidates who did not declare dyslexia.

The pass rate for first time examination candidates declaring dyslexia early was 75.7% (181/239) compared with 83.0% (11,379/13,702) for those who never declared dyslexia.

Older candidates performed worse. Asian and Black candidates did worse.

Most AKT candidates who declared dyslexia did so before their first attempt (239/379=63.1%), but this varied according to ethnicity and country of primary medical qualification of candidates. Candidates declaring dyslexia before taking the AKT for the first time were more likely to be white British doctors trained in the UK whereas those making a declaration of dyslexia later, having initially failed the AKT, were more likely to be minority ethnic candidates with a primary medical qualification outside the UK.

Conclusion

- There is no evidence that AKT unfairly discriminates against candidates with dyslexia.
- When monitoring examination performance in candidates with disabilities one needs to take into account other determinants of success.
- Training programmes should consider processes for dyslexia screening particularly for IMGs.

Future studies planned include:

- Perceptions of GP specialty trainees and trainers on contributory factors and possible solutions to unsatisfactory outcomes in ARCP arising from WPBA.
- Investigating differences in performance in the MRCGP AKT/CSA associated with candidate attributes and experience.
- Comparing performance of candidates with and without dyslexia in the CSA.

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- MRCGP examinations: Tom Dastur
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Reading

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- Siriwardena AN, Irish B, Asghar ZB, Dixon H, Milne P, Neden C, Richardson J, Blow C. Comparing performance among male and female candidates in sex-specific clinical knowledge in the MRCGP. Br J Gen Pract 2012, 62(599):e446-450.

- Pope L, Hawkridge A, Simpson R. Performance in the MRCGP CSA by candidates' gender: differences according to curriculum area. Educ Prim Care 2014, 25(4):186-193.

- Wakeford R. International medical graduates' relative under-performance in the MRCGP AKT and CSA examinations. Educ Prim Care 2012;23:148–52.

- Woolf K, Potts HW, McManus IC. Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis. BMJ 2011;342:d901.

Workshop 8: Closing the Gap: One area's response to Differential Attainment. Health Education England Northeast and North Cumbria (Dr Graham Rutt)

Graham Rutt was a GP for 32 years and trainer for 26 before he retired on health grounds in order to concentrate on educationalist role. He is now Director of Postgraduate School of Primary Care Health Education England Northeast and North Cumbria a position he has held for ten years now. He is also a visiting Professor at the University of Sunderland. His special interests lie in Recruitment and Selection of trainees, ensuring assessment procedures complement rather than replace teaching, and supporting trainees whose place of graduation is outside the UK. He is also an avid if rather slow cyclist, and writer of mediocre pantomimes.

Rubi Vijayakumar is one of the Lead Training Programme Directors of the Durham Tees Valley GP Training Programme and leads on trainee support. She is an International Medical Graduate who had her training from the Durham Tees Valley Programme. She has been in General Practice on Teesside for 15 years and has been a GP trainer for 10 years. She runs the Closing the Gap course at the Training Programme which introduces IMGs to aspects of Primary Care in the UK with which they are unfamiliar.

CLOSING THE GAP – one School's response to what it heard

Contents

1. What the trainees said:

Twice UKCEA conferences have heard the views of a non-UK Graduate who has struggled and then passed, and here is what one of them said in 2012[1]:

> "I am Christian by faith, in Pakistan we are in [a] minority and got limited opportunities. I wanted to move to a country where I have been given [a] level playing field and I should not be discouraged or discriminated because of my faith and belief. Therefore, I moved to UK. My Entire education from nursery to graduation was in English. One needs to take IELTS and PLAB exam for GMC registration. PLAB2 is very well-structured exam and I really liked it. They give 16 stations, each of 5 minutes duration to check one's skills of communication, counselling and other clinical skills of F1 and F2 levels. [Studying for] PLAB2 gives a clear picture of how NHS works, what they expect from a junior doctor. Through PLAB2 an overseas doctor learns their limitation and encouraged to seek help when not sure."

This is not a picture of an unprepared or unintelligent person.

> "My brothers and their families and other extended family members live near Burnley Lancashire and I heard them saying that they live in North. The time when I applied for GP training scheme I

[1] Dr Victor Sunil (at the time a GP Registrar on East Cumbria GP Training Programme) speaking to Dr Tim Sanders (at the time Training Programme Director for East Cumbria GP Training Programme) in 2012

> wasn't familiar with the geography of UK, I chose Northern Deanery in back of my mind to live and work near my family. When I came for my stage 3 in Newcastle Upon Tyne, only then I learnt that North is 120 miles further up from Burnley. I got married during my GP training, my wife is working in London and we planned to settle near Burnley Lancashire once I finish my training. Like anything else, living away from family has its advantages and disadvantages. Main disadvantage was that I miss my family in particular my daughter. Although iPhone, Skype etc have made communication very easy but still I missed a lot of things."

This is a picture of social isolation and distance from any friend or family support. As for the work and the training what he said was:

> "There were few surprises. At start of my training I was struggling, general practice was a complete different world. With my personal issues, I found it difficult to adjust and didn't perform well. I was expecting some support in that period, but I end up with strong and draconian feedback from educational supervisor… In my difficult time [my Training Programme Director] supported me and when I felt myself rejected and humiliated he gave me the confidence. When I look back on all that, it gives me the impression that it could be all scripted and everyone involved in my training is doing their job. There was someone who was doing his job by jolting me with harsh feedback and then there was someone who neutralise all the bitter feeling and helping me back on the right track."

Given that his trainer was an experienced one with an excellent track record, that is a picture of someone from a different educational paradigm and one unused to the kind of feedback we routinely use. My personal experience of working in a practice which served a population of strict Catholics and listening to trainees and colleagues who have worked in a practice serving a population of orthodox Jews and another which serves a population of strict Muslims, confirms that decision-making within families and the consulting room is often vastly different within those communities from that in others. This influence is not confined to non-UK Graduates, but tends to be stronger and more common in them.

And what helped?

> "I would also like to mention about one of the half day release session with title 'creating level playing field', I found it very useful. The idea behind it to bring all 3 years GP trainees together in a cafe environment and engage them in non-academic activities, which was excellent. It really helped me to understand the importance to know about local culture. It helped me in my CSA preparation. When I was in Cumbria I was busy with work or with my e portfolio, and when I was off then I was with my family. I haven't actually lived and socialised with the Cumbrian people until a few months before my CSA, when I realise its importance. After reading different books and different material on CSA, I come to my own conclusion that to pass CSA I need to mix up in local culture. I have to break my shell and socialise with local community. So, I took the start where I was most comfortable, such as Church. I am Christian by faith I started going to Church where local community was in obvious majority. After church service, I started to socialise with them. I tried to understand things of their interests, their sense of humour, priorities of their life and involve in discussion. In my surgery I see people of all sorts of backgrounds and beliefs. That helped me to realise the importance of meeting people outside of Church congregation. When I got confidence, then I started going to local pub (despite of the fact I don't drink alcohol) and later to Botchergate in Carlisle (the most rough area of Carlisle). My intention was clear, to learn more about local culture and use that experience to construct my consultations."

> "It was difficult [going to a pub]. It was a place I had never been in before and it was very obvious with my body language. I was feeling like everybody was staring at me, which probably was all in my mind. I didn't know what to do, where to sit, what to drink. I wasn't sure if they serve non - alcoholic drink and what would be their reaction if I would ask for one. [But] it was [a] turning point. I took it as a challenge and part of my CSA preparation. I was actually kept a note book with myself and kept making note of the things or words or sentences I never heard or used. I strongly believe that helped me directly and indirectly in my CSA."

This is a picture of someone who is determined, knowledgeable and willing to take risks. As his TPD of the time, Brad Cheek, said to him: 'If you are in a GP training programme then it means you are good enough to be a GP, not many people manage to clear the selection exams therefore don't worry about CSA and AKT statistics for overseas. You have come through a process and you are good enough to be on the scheme, so concentrate on your training, be honest to yourself and to your trainers. Tell them about your weaknesses and learning needs, make a plan with them to achieve those set goals.'

The trainee we had listened to previously in the Art House in London had said pretty much the same but went to the cricket club, not the church. The Deputy Director of BAPIO who we listened to at the RCGP conference recently said this too. The truth is that, if you have come from a different family decision making paradigm, a different consulting paradigm, and a different educational paradigm, and reflection is not the norm; and if you do not socialise with the local community and in some cases only speak English at work, then it becomes a no brainer: of course you will take longer to make progress. The same would be true for an English person in Tuscany. You are in fact on a different trajectory!

2. What the trainers and TPDs said:

- They are often rather 'shell-shocked 'when beginning UK General Practice (maybe they are being fed the wrong expectations before they apply. If so I am not sure where they are getting their info from, but we frequently see non-UKGs who had little idea how difficult the training and the job would be.
- As we know most will qualify given enough time to train as they are simply coming from a position of knowing little about the UK and/or UK General Practice and be working in second/third language.
- The number of non-UKGs who are not very competent and who do not improve significantly over time is extremely small.
- They have financial/family pressures and are often supporting a family abroad.
- They suffer from the pressure of finishing training without extension for visa purposes.
- Health/outside work issues can cause problems because some non-UKGs do not make a link between them and performance at work, presumably because they have not been taught this. It can be a big relief to some when they learn and understand this link. Experience from receiving requests for second extensions confirms this – information about health or stress-related issues which have not previously been declared include one trainee whose partner had died, and several whose effective mother or father had died in their home country. They had been trying to carry on as if nothing had happened while repeatedly returning to their home country to sort out their relatives' affairs. In all these cases, the educationalists had noticed the signs of ill-health and offered them the chance to talk / access help; those opportunities had been declined. Listening to them, many of them seem to see succumbing to these outside pressures (as they see it) as failure; and failure as bringing shame to the family. In doing this, they are simply conforming to a different cultural norm. The cultural differences for non-UKGs often make it more difficult to separate out the issues and get them dealt with (recognising personal ill health in non-UKGs- especially males can be difficult).
- Trainers repeatedly tell us that their non-UKG trainees are developing the skills but had a much steeper learning curve and ran out of time (and number of CSA sittings). Most non-UKGs do pass in the end. Many improve with each exam sitting – and those that do not are often simply reverting to a harder-wired method of working as the pressure increases. This is something we all do!!
- What would help registrars who are international medical graduates? Be upfront about difficulties IMGs may face and directly address the problem.

Given the paths these doctors have often followed for protracted periods of time before becoming GP trainees (multi lingual, extra exams, family pressures- distances involved etc etc) they're (usually) not lacking in motivation or intelligence.

3. Exam considerations

Esmail and Roberts GMC report states:

> "The CSA is not a culturally neutral examination and nor it is intended to be. It is not and nor should it be just a clinical exam testing clinical knowledge in a very narrow sense. It is designed to ensure that doctors are safe to practise in UK general practice. The cultural norms of what is expected in a consultation will vary from country to country. So, for example, a British graduate will have difficulty in practising in a general practice setting in France or India until they become acculturated to that system of care. British graduates have much greater exposure, both personally and through their training, to general practice when compared to the majority of non-UKGs who graduate from health systems which are not as dominated by primary care as the NHS. Most medical schools in the UK now have well developed programmes for communication skills training, reflective practice and direct exposure of students to General Practice as a discipline."

Analysis of 5095 candidates sitting the Clinical skills exam between November 2010 and November 2012, revealed a significantly higher failure rate in black and minority ethnic candidates who trained abroad. This group were more likely to fail the clinical skills assessment than white UK candidates (65% *v* 4.5%). (Ref Esmail BMJ 2013). This difference was "no longer significant" after controlling for scores in the applied knowledge test, English language capability test (IELTS), and Professional and Linguistic Assessment Board (PLAB) examinations. Esmail suggested that UK trained black and ethnic minority candidates were more likely to fail the CSA than white candidates, despite controlling for age, sex, and scores on the applied knowledge test. Locally the implications of exam failure include resource pressures for the training programme. Trainees who fail exams may need additional time in training. Clearly this also has serious implications for the trainees involved: cost of exams, potential delay in CCT date (which in turn may affect future employment) and the psychological impact of repeated exam failure.

4. What the School did.

In advance of the Judicial Review the School noted the differential attainment in all facets of their work as GP trainees, as well as the exams. It also noticed that, when it used an allocation process based on R+S ranking, all the IMG trainees ended up in the remote and socially deprived towns in the area. In the absence of definitive evidence of what would ameliorate the situation, the School did three things:

i. Allocation of trainees by random numbers, not R+S performance, to avoid unequal distribution of IMGs and clustering of IMGs in unpopular, generally remote, areas. The legal opinion on this policy is that: "In the circumstances, it is not unreasonable to do something"
ii. Pro-active mixed distribution of trainees of different origins in self-directed learning sets as well as Regional Teaching groups
iii. We then asked the training programmes to explore potential solutions <u>with the affected trainees</u>. Each set up a different programme of learning and have regularly discussed progress with each other. Evaluation has so far been qualitative (trainee feedback), but a programme of more in depth study is in hand. The courses cover the same sorts of subjects, those identified by either the trainees or their trainers as being subjects they struggle with. The programme is also informed by the personal circumstances of putative outcome 4s – those claiming extenuating circumstances when asking for a second extension. The outcome is a course of support for IMGs, delivered differently in the School's three programmes, but which essentially covers the same topics. Whilst targeted at IMGs, anyone is welcome to attend them, and they are in addition to the standard Regional teaching programme. They are described in detail in the documents embedded in sections 5, 6 and 7.

Since then the School has also approved some specific <u>AKT support,</u> using Fourteen Fish as a resource for all trainees who failed at their last attempt at AKT. This is largely (though not exclusively) non-UK graduates. The aim is for trainees to receive individualised feedback on their performance in a mock AKT and use this feedback together with their trainer/link TPD to help develop an appropriate learning plan. This will be evaluated once the first cohort has re-sat their AKT.

It is estimated that 5-10% of the general population have *dyslexia*. We estimate that 70%- 80% of non-UK graduate trainees who have failed AKT more than twice are found to have dyslexia on formal assessment.

It is clear that trainees with dyslexia will find AKT result harder to pass for many reasons including taking longer to read long questions, difficulty in understanding 'wordy' questions, poor time management and specific difficulty with numbers for some trainees.

We encourage trainees with repeated AKT failure, or with a low score on first sitting, to be assessed for dyslexia. Trainees self-fund this assessment. If dyslexia is diagnosed, then the College will give additional time in the exam. All trainees in NGPTP, with a diagnosis of dyslexia have subsequently passed AKT.

5. Extensions and Targeted Training

Recently the School has started to go one step further and encourage trainees in extensions to stop studying for their exams, and instead focus on addressing their culturally-driven needs. The aim here is to get them speaking everyday English in a non-clinical environment. The latest research from Fiona Patterson et al (Unpacking the dark variance of differential attainment on examinations in overseas graduates, Medical Education 2018 52: 736–746) supports this approach. To quote: "… we would recommend that efforts directed at reducing these group differences should focus on 'sociolinguistic' factors, rather than on clinical knowledge." A typical entry in the Educational Plan agreed with their support TPD would read:

Learning Objective X: Address CSA marks and feedback before re-sitting the exam.

> "Trainee is not able to recognise the issues or the priorities of consultation, does not develop a shared management and does not identify psychosocial impact in their consultation."

Action Plan

Focus on developing sociocultural understanding of patients through some community involvement. Time taken for this exercise will be during his Regional Teaching/PSL sessions.

The notes from the TPD's meeting to discuss this the trainee might read:

We looked at ways of improving the understanding of the cultural and socio-economic background of the population and communication skills. We discussed different ways of addressing these learning needs. The Trainee expressed their interest in being involved in Charity organisations. I agree it will give them the opportunity to improve their communication skills, knowledge on the patient population. We looked at charity organisation websites like British Heart Foundation, Red Cross etc. Being a volunteer and getting involved in helping people who are lonely looked like a good idea. Talking to people not in their capacity as a GP trainee but as a volunteer from a charitable organisation will give them the opportunity to address some of their learning needs.

The Trainee will write reflective entries on meetings with the charity organisation, their training and encounters with the clients. They also agreed to reflect on how it has helped them with the understanding of the cultural and socio- economic background and communication skills. They will write reflective log entries for every session attended, which will be weekly.

At the review meeting it was noted:

We looked at Trainee's educational plan and progress made so far and talked about their involvement with the charitable organisation in detail. The Trainee tells me they started by emailing the charitable organisation for volunteer work. They had a response from the local team within a week. They then met the team and explained the objective in detail including their learning needs. During the meeting they were able to look at the services suitable for their need and got a placement. It was agreed that the Trainee will be part of the team involved in visits to lonely people and fund-raising events. The visits were based on demand and preference.

They were able to meet two independent elderly clients living in sheltered accommodation. The main reason for the visit was to offer psycho social support. The visit was for about 45 minutes. The Trainee was able to have a general chat with the clients (on LLE). They tell me they met a client living on her own. Finding out how they were missing their children made them appreciate the similarities in the cultural background. They were also able to pick up non-verbal cues like minimal eye contact and change in voice when they were talking about their children. They also learned the meaning of the word 'pet' when they were addressed in conversation. This is something they were not used to before.

They also attended a charity event, standing in the charitable organisation stall for the day. Liaising with their team members, answering questions from the public helped them improve their communication skills a lot. The trainee says they were able to understand more about the local population, available support services when they were asked about food banks, queries on tax exemption on donations.

The Trainee was also involved in forward planning meetings. They had offered suggestions to the team which have been taken on board. Trainee felt that the summer holidays, weather, Xmas seasons played an important part when planning events. They tell me this is completely new to them.

6. Closing the Gap Course in Durham and Tees Valley GPTP

Closing the Gap Course in Durham and

This Training Programme hosts circa 45 trainees p.a. (with a capacity for 72). 43% of the current trainees are IMGs. It is not an outlier for extensions, outcome 4s or exam failures.

7. IMG support in Northumbria GPTP

IMG support in Northumbria.docx

This Training Programme hosts circa 96 trainees p.a. 15-20% are non-UK graduates. It is not an outlier for extensions, Outcome 4s or final exam failures.

8. IMG support in North Cumbria GPTP

IMG support in North Cumbria.docx

NCGPTP are a much smaller programme than NGPTP and DTVGPTP. Consequently, TPDs are able to get to know the trainees better. The information covered during the trainee's time on the programme is similar to that described by DTVGPTP and NGPTP but is often delivered in very different ways. The approach is to develop 1:1 TPD: Trainee relationships from the beginning of training in order that issues can be identified at the earliest possible stage and bespoke solutions found.

9. Closing the Gap with Trainers

The School runs a number of workshops over the year aimed at helping them help their trainees with these concepts. This includes an annual 1-day session for trainers from ex- CSA examiner 'how to help your trainee to prepare for CSA' as well as specific sessions on the challenges faced by IMGs.

Workshop 9: East Midlands in Training Assessment Profiler (iTAP) day (Dr Bevis Heap)

Bevis Heap is a graduate of Leicester University Medical School and works as a GP Educator in Health Education England working locally across the East Midlands doing a variety of roles there across GP training and retention and recruitment. Having previously worked as a GP for nearly 30 years, GP Trainer for 27 of those and with a strong interest in education and the GP consultation he has also written a journal article based on his MA research and contributed to a book on Advanced Consulting.

This session introduced and discussed iTAP; a system for identifying those registrars who are potentially at a 50% or more risk of needing additional training time. It will cover the origin and use of the system and the interventions provided in Health Education England working locally across the East Midlands (HEE- EM).

This was originally designed by:

Dr Sathya Naidoo, HEE-EM
Safiatu Lopes, Psychologist, Work Psychology Group (WPG)
Rachel Driver & Anna Rosselli -WPG
Dr Helen Mead, GP Dean, HEE- EM
Prof Fiona Patterson, WPG; University of Cambridge
Prof Sheona MacLeod, PG Dean, HEE –EM

Patterson F, Knight A, Stewart F & MacLeod S. (How best to assist struggling trainees? Developing an evidence-based framework to guide support interventions. Education for Primary Care (2013) 24: 330–9) identified the following causes of poor performance:

Early prediction, to enable early supportive interventions being put in place, were felt to be key to a successful outcome for the trainee. The fact that GP training is only 3 years increases the importance of early interventions. Some issues are likely to be present at the beginning of training i.e. trainees don't suddenly become dyslexic in ST3 therefore early prediction and support is reasonable.

In HEE EM, it was felt that the ARCP process was not good at picking up problems early. There were issues of trainers failing to fail, etc. All portfolios have a formative as well as assessment element. iTAP focussed on the assessment elements. In the summer of 2013, HEE EM analysed the data for trainees for the 186 GPSTs that had completed training i.e. intended CCT. 37 had required Additional Training Time at end of training (ST3). Only 13 of these trainees had been identified at end of ST1 as not progressing satisfactorily. (ESR & ARCP panel)

Data collection from 2010 & 2011 looked at the following parameters to identify if it was possible to identify positive predictors of poor performance.

- selection Centre scores (Stage 2 & 3)
- demographic data (Primary Medical Qualification, age, gender, ethnicity)
- structure of training programme (Inc. Less Than Full Time & Out of Programme)
- educational Supervisor (ES) - Competency ratings
- ARCP Outcomes
- WPBA – Patient Satisfaction Questionnaire (PSQ) & Multisource Feedback (MSF)
- additional support
- AKT & CSA (above or below pass mark)
- additional Training Time
- end – Date of GMC GP registration
- data sources, - e-p, NRO, GMC, HEEM data.

The aim of the in-Training Assessment Profiler was to: identify of trainees early, who might need additional support, by using data available after 6 months of training; define their issues by trainees completing self-administered online questionnaire; and Provide support by using the questionnaire as basis for structured interview to signpost to appropriate support.

The trainee self-assessment questionnaire to measure how trainees perceive themselves along 7 domains, using evidence-based scales**:**

1) Organisational support (Perceived Supervisor (Organisational) Support: Eisenberger et al (2002) 8 statements about support at work. e.g. 'Help is available from my employer when I have a problem'; 'My employer really cares about my wellbeing')
2) Perceived work-life balance (Work-Life Balance (WLB): Haar (2013) Statements relating to balance between their roles at work and home e.g., 'I am satisfied with my work-life balance, enjoying both roles'; 'I manage to balance the demands of my work and personal life well.')
3) Job satisfaction (Job (Role) Satisfaction: Thompson & Phua (2012) A 4-item scale containing items relating to enjoyment of their role e.g., 'I find real enjoyment in my role'; 'Most days I am enthusiastic about my role'.)
4) Motivation (self- & non-self-determined) (Motivation: Intrinsic & Extrinsic, Deci & Ryan (2000) Items refer to the reasons why participants are involved in this training programme, measuring intrinsic and extrinsic motivation. For example, 'Because I chose this training pathway to attain my career goals' (intrinsic motivation); 'Because it allows me to earn money' (extrinsic motivation)
5) Self-efficacy (Occupational Self-Efficacy: Schyns & Collani (2002) 8 statements relating to their self-efficacy, e.g., 'I feel prepared to meet most of the demands in my current role.; 'When I am confronted with a problem in my role, I can usually find several solutions'.)
6) Burnout (disengagement and exhaustion). (Occupational Self-Efficacy: Schyns & Collani (2002) 8 statements relating to their self-efficacy, e.g., 'I feel prepared to meet most of the demands in my current role; 'When I am confronted with a problem in my role, I can usually find several solutions'.)
7) Language proficiency & daily use (Language: Proficiency & Daily use, Gee et al (2010)
8) Two sub-scales, each measuring a relevant aspect of language proficiency: the first measures participants' perceptions of their reading, writing and speaking ability in English. The second measures level of proficiency and use in daily life. For example, 'How well do you speak English?' (proficiency) and 'What language do you speak with most of your friends?' (daily use)).

A matrix was developed using 7 predictors. They were as follows.

Selection centre Clinical Problem Solving, Situational Judgement Test & Stage 3 PSQ MSF (Professional Behaviour) & MSF (Clinical) ES – "Below Expectations"	Each predictor 'weighted'. Produces score 0 – 10 for AKT, CSA, ATT 0 = Low risk 10 = High risk

The matrix allowed trainees at high risk of needing additional training time by using a cut of score of 6 and above. PSQ & MSF. Tests of mean differences found that trainees who require Additional Training Time (ATT) achieve significantly lower PSQ and MSF scores than those who do not require ATT. A logistic regression analysis showed that PSQ and MSF are able to significantly predict ATT outcomes. Furthermore, A trainee who is rated 'Below Expectations' achieving the competencies in their educational supervisor's report at any point during training is almost 12 times more likely to require Additional Training Time, compared to a trainee who is marked as 'Needs Further Development – Meets or Above Expectations' throughout their training programme. A final logistic regression analysis showed that GP selection scores (Clinical Problem-Solving test, Situational Judgement Test and Selection Centre) are able to significantly predict whether a trainee will require Additional Training Time.

The following graph shows the accuracy of the i-TAP Matrix prediction mapped against known outcome.

Educational Interventions

Day 1: In Training Assessment Profiler

Trainees who have been identified as potentially needing extra support are invited to attend a study day facilitated by two Programme Directors.

The day involves:

- role play with Two Simulated Patients.
- a Session on Reflective Practice, looking at their Learning Log entries so far and what happens to assess their e-Portfolio
- a Session on consulting and giving and receiving feedback.

As a result, trainees who have attended the day are aware of their risk of requiring extra training time. It is noted that they have better log entries and PDPs and are more willing to look at consultations and video Although initially this group of trainees were upset to be singled out, feedback after the event has been positive. The course is now actually sought by trainees.

Day 2: A Perfect Day - Performance Enhancement using Developmental Approaches, Dynamic Assessment and Education Theory

- Another type of simulation.
- Looks at planning for and during the consultation.
- Based on self-regulation theory.

ITAP Discussion

- Early intervention based on risk calculation at ST1.
- Issues over access to data – no problem in East Midlands.
- ?benefit due to Hawthorne effect.
- Blind to IMG status – but risk of unconscious bias in subjective assessments.
- ?Any surprises - false positives and false negatives: sometimes identifies apparently strong candidates; but also unexpected AKT fails e.g. due to specific learning difficulty.
- Low risk score – more accurate prediction of success.
- Intervention not confined to ITAP Day and PERFECT DAY session but includes ongoing monitoring by PDs and ESs with additional support if needed.
- ITAP Day – maximum of 8 per session in two groups of 4 for simulated consultation.
- Self-administered questionnaire – no longer used due to staffing rather than lack of evidence of efficacy.
- ITAP Day is about 8-9 months into training and PD follows at various stages afterwards, preferably during a GP placement.
- ITAP could be affected by whether trainee has had GP attachment or not by 6 months.

- Sometimes ESs are surprised by ITAP scores.

- Difficulty of ‘selling’ process to trainees – through carefully worded letter – to avoid any sense of victimisation.

- Now being used by West Midlands and East, and Defence (stage 2 selection score [CPS] is high predictor and correlates with AKT; and SJT for CSA – scores are weighted within calculation). Defence uses different cut-off.

Conclusion and The Next Steps – Graham Rutt

Graham Rutt was a GP for 32 years and trainer for 26 before he retired on health grounds in order to concentrate on educationalist role. He is now Director of Postgraduate School of Primary Care Health Education England Northeast and North Cumbria, a visiting Professor at the University of Sunderland and a member of the RCGP/COGPED Differential Attainment Working Party.

As part of its response to the issue of Differential Attainment, RCGP + COGPED hosted this conference with the aim of sharing ideas on practical steps that might be taken at deanery level. The conference did not reach a conclusion as to the cause of differential attainment, but some themes did emerge.

Issues identified

Delegates were uniformly keen to acknowledge that:

- IMGs in particular face a steeper learning curve than anyone else
- Having some introduction to the NHS in additional to the standard trainee induction does help
- Awareness of cultural and socio-linguistic factors is important.
- Other system factors play a huge part. As one speaker told the conference: “I had to unlearn what I had already learnt before I could move on to learn that which I was supposed to be learning”. In saying that he was referring to the challenges faced by a trainee of engaging, for the first time, with relatively non-hierarchical systems of practicing medicine and of education, where questions and challenging of seniors and of the teacher are invited, and open reflection expected. This is a culture shock of enormous proportions to many of them. In fact, it represents a cultural change over the last 50 years in the UK to which both patients and doctors have become acclimatised rather than de facto differences.
- Not all IMG trainees need extra time to complete training– and many of them are very successful
- Systems issues such as any bias/inadvertent negative behaviour of colleagues and peers/relationships with trainers need to be resolved at the same time
- As with the need for resilience, it must not be inferred or implied that the doctor is at fault – it was felt that many UK graduates faced with practicing medicine abroad would face a similarly steep learning curve and/or progress slowly when compared to that country’s graduates
- It is important to communicate to the affected doctors that they are also valued and perhaps they need to be helped to value themselves so that the negative perceptions they may have of themselves (itself a response to their life- and learning experiences) can be removed. Unless it is acknowledged as one of the issues in cases where it is, steps will not be taken to rectify it.
- Many delegates agreed that the biggest factor that made a difference to their trainees’ performance was honest and effective feedback by TPDs and ES etc. Well-communicated positive personal regard is an important part of successfully giving effective feedback.
- Lack of insight is more common in all trainees who don’t do well
- This is compounded in trainees who are expecting to be told what they are doing right or not - having to learn the reflective way takes time
- Candidates declaring dyslexia after initially failing the AKT were more likely to have a primary medical qualification outside the UK. IMG trainees may be less likely to seek help or declare disability, but rectifying this with adjustments equalises their chances.

This begs the question: what next?

Potential actions identified

- The system should move on from using the deficit model of remediation, and instead provide a pro-active system of support for trainees in this situation.
- The need for extra time for those facing bigger challenges than others should be normalised. This will involve them progressing more slowly through training as they simply have more to learn. Slower progress then becomes Satisfactory Progress.

- This will entail ensuring that the list of ARCP outcomes for people in this situation does not read as if they are repeatedly making Unsatisfactory Progress
- These thoughts should be shared during the current Gold Guide 8 revision consultation
- All stakeholders should be encouraged to engage with research including that being undertaken by the GMC on the matter
- Consideration should be given to making the offer of a dyslexia assessment mandatory after 2 fails at AKT. Junior doctors or dentists who suspect they may have dyslexia are able to access a free screening tool which is supported by the British Dyslexia Association. This can be accessed on the following website: http://doitprofiler.com/personal-profilers/dyslexia/
- The current initiatives need to be explored, evaluated, developed and preferably researched.

Helpful resources

The GMC have dedicated pages to the subject: https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/differential-attainment.
This resource includes sections on:

- What causes differential attainment?
- What are we doing to address it?
- Experiences shared
- Research
- Practical guide to evaluation including a table exploring a wide range of measures which may be useful for evaluating an intervention targeting differential training outcomes.

Clearly, more action will be needed if the thorny issue of Differential Attainment is going to be successfully addressed beyond enthusing a generation of educators to be more proactive in their support of the affected doctors.

Graham Rutt HEE NE+NC