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"For us, whatever we do is wrong, until we do something really good": a qualitative study of the lived experiences of doctors from minority ethnic backgrounds in Scotland

Charu Chopra ,[1,2] Amudha Poobalan,[3] Kathrine Gibson Smith ,[4] Esther Youd,[5] Peter Johnston [1,6]

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For numbered affiliations see end of article.

Correspondence to
Dr Charu Chopra;
charu.chopra@nhslothian.scot.nhs.uk

ABSTRACT

Objectives To evaluate the lived experiences of doctors from minority ethnic (ME) backgrounds during postgraduate medical training, in particular their experiences of discrimination (if any); any impact of intersectionality and perceptions on how ME doctors may be better supported in their learning and working environments.

Design This was a qualitative study grounded in social constructivism, using semi-structured online individual interviews as the data collection method and an exploratory thematic analysis process.

Setting Participants were recruited from postgraduate specialist medical training programmes within one Deanery (Scotland Deanery) in the UK.

Participants Fourteen doctors in postgraduate medical specialist training, who self-identified as being from a ME background, were recruited into the study.

Results Doctors from ME backgrounds faced: *Barriers to authentic interpersonal connections,* with a perceived lack of social inclusion in the workplace community. ME doctors faced challenges in earning others' trust and experienced microaggressions and exclusion behaviours that affected their self-confidence. *Impacts on identity and sense of belonging*, with perceived challenges in being understood across diverse cultures. Doctors felt negatively pre-judged (by patients and colleagues), with additional challenges of being pre-judged in contexts of intersectionality; and ME doctors felt they needed to conceal parts of their identity in order to assimilate. *Unjust systems—a playing field that is not level,* where doctors felt unsupported and unable to effectively report/challenge discrimination. ME doctors perceived a lack of appropriate adjustments to the learning environment (e.g., fuller orientation) as well as inequitable processes (e.g., job and academic opportunities for those requiring visas).

Conclusions Focused interventions to address unjust systems as well as improve intercultural awareness and understanding between all doctors may help to address some of the current inequities in medical education. Any such interventions require appropriate evaluation to determine their efficacy.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The one-to-one interviews allowed an iterative and deep exploration of ME doctors' experiences, generating rich data with some findings in keeping with other reports of the experiences of ME doctors in the UK.

⇒ The context of this study is postgraduate medical training, which is set up similarly across the UK, and hence our findings are potentially transferable to other UK contexts.

⇒ Voluntary participation is subject to participant self-selection bias; however, in order to promote open discourse, we purposely recruited using a broad inclusion criteria, which was ME doctors' experiences in postgraduate training.

⇒ The lead investigator in this study identifies as a female doctor from a ME background, and while the research team is aware of the potential bias this brings to the study, it was also noted that participants may have conversed more openly with an interviewer who was also from a ME background.

INTRODUCTION

Individuals from minority ethnic (ME) backgrounds face significant barriers within medical education such as attainment gaps with respect to examination outcomes and career progression.[1] The learning environment and experiences of ME doctors are influencers of achievement during training.[2] ME doctors' relationships with others in the workplace is recognised as influencing outcomes such as career progression and examination success.[3]

There is growing evidence of ongoing inequalities and systemic inequity affecting ME doctors. A British Medical Association survey showed up to 60% of respondents from Asian or Black backgrounds felt that racism has impacted their career progression.[4] There

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has been little progress in addressing racial discrimination, attainment gaps and inequity in the workplace for ME doctors, especially international medical graduates (IMGs) from ME backgrounds.[5] There is minimal understanding of how multiple minoritised protected characteristics (intersectionality) impacts learning and working experiences for this group of doctors.

To our knowledge, no previous studies address ME doctors' experiences in Scottish postgraduate medical training. This study aimed to explore ME doctors' experiences of discrimination (if any); any impact of intersectionality; and ME doctors' perceptions on how they may be better supported in their learning and working environments. Deeper insights may provide novel solutions to ameliorating challenges faced by ME doctors working and learning in healthcare environments.

METHODS

This qualitative study was grounded in social constructivism.[6] We drew on social/cultural psychology theory,[7] in examining the role of the learning environment when understanding the experiences of individuals, which shaped the development of the topic guide (online supplemental information).

Participant recruitment

Doctors completing at least 1 year of specialty training within Scotland Deanery were eligible to participate. They were selected to ensure that we captured experiences of doctors who had spent time within postgraduate training systems and had likely undertaken some postgraduate examinations but had not yet completed training. Participants were eligible only if they self-identified as being from a ME background.[8] We anticipated requiring 15–20 participants, based on principles around information power[9] or data sufficiency, in that our aims were broad; we recruited those with specific participant characteristics; and aimed to attain a rich dialogue with participants through the one-to-one interviews. We also considered principles around data saturation. We aimed to include participants from all Scotland Deanery regions with representation across place of primary medical qualification (PMQ; UK or non-UK undergraduate degree), gender and different ethnic minority subgroups.

We invited participants by advertising the study in the NHS Education for Scotland Deanery newsletter, which is emailed to all doctors in training. The invitation to participate, including participant information sheet (via link to the Deanery newsletter), was further publicised through medical education departments, primary care leads in Health Boards, and via Twitter. Potential participants were able to contact the lead researcher by email for further information if they wished. All 14 eligible volunteers were recruited consecutively into the study.

Patient and public involvement

No patients involved.

Data collection

After obtaining informed written consent, one 45–60 minute one-to-one semi-structured interview was conducted with each participant via Microsoft (MS) Teams. Consent was confirmed verbally at the time of the interview. All interviews were carried out between March and September 2022 by the lead researcher who is a practising senior clinician with significant experience in conversational interviewing. Interviews were recorded via MS Teams and transcribed verbatim by a third-party University of Aberdeen approved transcribing company. Participation was voluntary, and no financial remuneration was provided. Each participant completed a demographics form, with information regarding gender, age, disability, religion, sexual orientation and specific ethnic backgrounds. There were 'prefer not to say' options provided within each section.

Data analysis

Transcripts were anonymised by ascribing them with a number, along with their corresponding demographic forms. The interview transcripts were analysed by the lead researcher, after every interview where possible, by open coding of the data. The codes were then tabulated (along with relevant quotes); and categorised to generate sub-themes and themes as part of the inductive thematic analysis process.[10] Fourteen interviews were conducted, transcribed and analysed. No new codes were generated after the 11th interview. All codes/themes and subthemes were discussed, and sense checked with two other researchers in the team, who are experienced qualitative researchers.

RESULTS

Participant characteristics

Although all participants were employed within three of the four regions of Scotland Deanery, many participants had previously worked in other regions, and thus were representing experiences from working in all four regions.

Eight participants identified as male, and five female. Five participants had acquired their PMQ from overseas (IMGs), and three others had migrated from overseas to study medicine as an undergraduate in the UK and had continued to pursue their postgraduate training in Scotland. Nine participants had acquired their PMQ in the UK. Participants identified as being from a range of ethnic backgrounds including Arab, Indian Scottish, African, Chinese and mixed/multiple ethnicities. Doctors identified themselves with religious backgrounds including Christian, Muslim and no religion. Participants included those who identified with having a disability (defined as a condition/disability that has lasted/may last 12 months or more); and identified as LGBTQ+, and heterosexual. Participants worked within specialities including medicine, surgery, psychiatry, diagnostics and paediatrics. Although one participant had changed from specialty training to a general medical post prior to their interview,

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it was felt that including their experiences would still be relevant for the purposes of the study.

Themes and sub-themes

Doctors' narratives around their experiences in their learning and working environment can be mapped to three main themes: *Barriers to authentic interpersonal connections; Impacts on identity and sense of belonging; Unjust systems—a playing field that is not level.*

Barriers to authentic interpersonal connections

Doctors from ME backgrounds reported a lack of social inclusion in the community; finding it more challenging to earn others' trust compared with the 'majority'; and microaggressions/exclusion behaviours that affected self-confidence (sub-themes and quotes—table 1).

Lack of social inclusion in the community

Certain perceived differences meant that individuals were often excluded from social interactions in the workplace. They described social barriers across many staff groups. Doctors described interpersonal connections influencing the nature of their learning opportunities in the workplace. Social networks were linked to career progression:

> …like if you've had fewer opportunities because of various networking things to get the same achievements as your colleagues, when you turn up you see …(your CV is) not as beautiful as everybody else's, and obviously the conclusion's foregone, you've turned up, you're the less qualified contestant, you're out. (Participant 13)

One ME doctor felt that having neurodiverse traits posed additional challenges to feeling socially integrated across their teams and with wider colleagues. Those with their family/friends overseas faced further challenges of social isolation, which had a negative impact on well-being. ME doctors described a lack of a sense of 'being looked out for' by others in the workplace:

> Let's say in football…, the professionals are trained every day and supervised every day: there's a coach, there's a manager, there's a squats person, there's a health person. They are looked after every single day. If you look at our training…, you just do what you do… no one is looking after you, no one is giving you feedback. (Participant 4)

More challenging to earn others' trust compared with the 'majority'

ME doctors faced challenges in gaining the trust of wider team members. Their knowledge and skills were questioned with no objective reasons, and they were required to 'do more' to gain the trust of their team as compared to their majority colleagues. This lack of trusting relationships between doctors had a direct impact on learning and learning opportunities for ME doctors. Interestingly, being female and from a ME background posed additional challenges in 'earning trust' from colleagues and senior educators. For some doctors, they were starting from a different position when earning the trust of colleagues, as compared with their peers who were not from a minoritised background:

> I would say that the IMGs, basically… the moment you say that you graduated from another country, and you have an accent, that… at that moment…, that cuts the confidence of the consultant in you by half immediately. He loses trust in (you) (Participant 10)

Another female ME doctor shared that:

> I was the FY2, and if I wrote medication or did anything, the nurses would go and double check it with an FY1 just to make sure, so I've felt like I've had to work harder to prove that I am competent, that I am capable… (Participant 5)

Microaggressions and exclusion behaviours affect self-confidence

Doctors described experiences of racist comments from patients. Whilst all doctors appreciated that challenging unwell patients in these scenarios may not always be appropriate, fellow colleagues and staff members offered no support or debriefing opportunity to those doctors who were facing racial discrimination either during or after the said incidents. None of the doctors reported these incidents formally:

> It just felt a bit strange that none of the staff kind of backed me up to say that it didn't feel like this was acceptable. (Participant 12)

ME doctors did not describe frequent overt racism in the workplace; however, they reported more subtle forms of exclusion and discriminatory behaviours:

> Comments like, "You're very exotic." Or people touching my hair without asking. Or, people asking to touch my hair, and then touching it without waiting for a response. (Participant 12)

Microaggressions were reported by both IMGs and UK graduate ME doctors:

> I remember sort of educated friends of friends saying, "Your English is really good." I had to say, "Well, thank you, so is yours." (Participant 14)

Doctors described a negative impact on their sense of self-belief and self-confidence. A female UK medical graduate described:

> I don't know if it's because I'm a woman or if it's because I'm from a different background, but I definitely feel less willing to kind of take up space and be assertive and suggest things than other people around me……. I don't necessarily think of myself as a leader or as a person who should be listened to. (Participant 12)

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Table 1 Barriers to authentic interpersonal connections

Sub-theme	Quote
Lack of social inclusion in the community	*"even if it's just other ST4s and the SHOs and FYs who are working with us, sometimes they do work dinners and stuff, quite often I don't get invited"* *"…what does your accent say about where you're from, and wider cultural stuff? I think there's a tendency to perceive that people who've come from elsewhere won't fit in and just won't want to get involved in the banter and won't want to socialise outside of work or whatever, which is unfair. Not truth."* *"They might say I'm closed off, but I think you've got to have that rapport. I think people have got to know you as individuals, and not just relate to you as a training number or a trainee."* *"…or it would be the consultant coming in the ward and completely ignoring me and saying hello to everyone else, and having a joke and laugh with everyone else while I'm just standing there being like… invisible"* *"I'm that one person that will go the extra mile, I still feel like I'm a colleague more than a friend, whereas with the others I feel like they are also really good friends"* *"….rather than more of a looking at you and your career goals and how to facilitate that because I had big careers goals but I felt like I was working on them alone"* *"I watch a lot of sports … I relate to sports, but I think if you've got a football team, I think a manager understands certain individuals. You just can't have a generic approach for everyone because even though it might be a safe option, for some individuals it doesn't work."*
More challenging to earn others' trust compared with the 'majority'	*"I'm basically the only trainee who's not white… it seems like everybody else has … been really facilitated to use their time to get their clinical training, but also have other time to do other things that they need to do."* *"you've almost got to work twice as hard to (get) nurses on board. You've got to work twice as hard to get your assessments done… then when you sit down with another colleague of yours who isn't from a BAME background, you feel they've probably done half the amount of work or the grafting as you to get the same sort of output as you"* *"I've certainly overheard where you've had sort of other BAME colleagues who have started new, and people have said, "Right, okay, we need to keep an eye on them."* *"It was odd because it felt as if…I mean, the whole point of supervision and the role and the relationship is to be supportive and to help me as a trainee to get through any difficulties, but it just felt more like they were waiting for me to make a mistake. It was really quite horrible and difficult to talk about… you just question, you know, you're questioning yourself. That was hard."* *"Yes, I didn't get anything on my e-portfolio signed because … I was scared of the feedback that they were going to give me, whether they're going to be fair… or maybe say that I'm a horrible doctor and… or unsafe, … something that will … stay on my record for the rest of my life"* *"I'm resentful sometimes. I'm a good doctor. I'm hard working. I know my skills and I find it difficult that I constantly need to prove myself to patients, to colleagues."* *"My… challenge is lack of self-confidence; I'm carrying that with me all the time and it makes me doubt myself and work extra hard, which is sometimes a good thing, or sometimes it will cause me to be burnt out"*
Microaggressions and exclusion behaviours affect self-confidence	*"I'm really worried for my younger colleagues who are ethnic minority and there is… you can't see it – it's a body language. You can't even complain because you don't have evidence, it's a body language."* *"Certainly, I almost feel I've got to look out for BAME colleagues who are working… I had a BAME colleague who … was shouted at. This was by a nurse in charge who had accused him of not knowing the systems, and I felt very uncomfortable by the whole situation. There were a number of consultants sitting there…"* *"(In) terms of overt racism from staff members, you probably don't see that. It's just that sometimes you would notice that some people will get asked to do a lot more work than other people. So, sometimes you do see some subtle hints, but it's not overt, not like straight up abuse, you know."* *"….and if somebody's off sick and somebody would get asked to cover the evening shift or the night shift or whatever without a lot of choice, whereas they wouldn't approach another trainee to cover it first"* *"you start to think, "Am I not good enough because I don't understand the culture as much, or because I didn't have the same background education maybe, or…" I don't know, it just sometimes feels… it makes you question yourself a lot."*

Impacts on own identity and sense of belonging

ME doctors described their experiences around developing mutual understanding across different/diverse cultures. They felt pre-judged (by patients and colleagues) and that they needed to conceal parts of their identity to assimilate (sub-themes and quotes—table 2).

Certain day-to-day experiences such as colleagues not knowing their name or confusing their identity with

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Table 2 Impacts on own identity and sense of belonging

Sub-theme	Quotes
Understanding about differences across diverse cultures	*"it's going to be Ramadan………. it's always a bit weird to explain it to someone. "Why are you doing that to yourself?" kind of is usually the response that I get sometimes. Or, also, people feeling awkward around you"* *"there are nuances of the culture, I guess, the expressions… Even though I've been living in the UK for quite a while… but there's always stuff that you need to learn"* *"when you're having an interview… there's also the part like body language, the language that you use, your speech and everything, so that sort of bits where it's not the direct answers to the interview. I think because interview is very subjective, I think that bit becomes more prominent… and I think interviews become a bit more biased…… because there's just not a clear marking scheme"* *"I think I still respect the hierarchy quite strongly, so to me the idea of going to another consultant about an issue…"* *"I think that's probably the thing that can be implemented – teaching more about culture and language use"* *"…. our culture and the way our mum and dad … taught us is, do not speak against your elders…. seniors. If anyone says anything you just keep quiet and take it in. We don't sort of appreciate how that is so ingrained in us to the point that we actually, I think that's detrimental to us right now."* *"I was advised to do the question bank twice, but that was it. Every time people said you have to recognise the pattern… and I was like, "I don't know what pattern… it's all new to me. Our exams in ------ (different country system) it's more of a recall exam, like just write all you know about this"* *"…the feedback was fine, but it's just I wish we got it much earlier, … Because then you can actually change but I'm not really going to change the way I practice if I've now got (it much later in training)"* *"Like, I would appreciate someone telling me in my face that I'm not doing a great job and that I should work on a few things, rather than treating me horribly and me not know why is that happening"*
Feeling prejudged (by patients and colleagues)	*"I felt really resentful. I felt angry. I felt as if I wasn't really accepted or welcomed, and I did wonder if it's because there's fewer numbers of Africans or doctors from ethnic minorities"* *"I wear a turban, I've got a beard, and actually, I do look different. But you almost just feel pre-judged"* *"I always feels slightly as (an) outsider, but I think that's something as an immigrant"* *"I'm the senior trainee and I'm on call, and I went to do a senior review for an older lady, and when I got there the nurse said, "Oh, I'm sorry. She says she won't see you." I said, "Right, okay. That's okay. Why?" She said, "Because you're black"* *"I feel like being ethnic minority…. a woman in surgery, I do feel like the extra pressure is on me to do better, to work harder. I probably have to do an operation five times more than another person who's not me, to just prove to that consultant that I can do that thing."* *"I've had jobs where consultants have suggested to me things like, "Oh, perhaps you shouldn't pursue this training path because you'll want to have children and you won't have time because of your age and things."*
Additional challenges of being pre-judged in contexts of intersectionality	*"…so I think I've been given the privilege of sounding native basically. I think the other thing that helps is being male…. (I saw how) a slightly dim view of (another doctor was taken)… because of the way he sounded……. 'Oh, he can't speak English properly, he must be an idiot', which is an unfair and untrue assumption to make."* *"I've walked into rooms for senior reviews and the patients look at the junior doctor, who is Scottish or British, and defer to them because they think they're the senior doctor"* *"or… if you don't speak English as your first language and you're hunting around for that word, and you have that slight pause, then people will think you're not as smart as somebody else who doesn't have to think. But actually, if you look at their medical practice, it's fine."* *"I think it's mostly the belief that disabled people don't belong in medicine"*
Identity and concealing parts of identity to assimilate	*"sometimes we do things to just blend in. As sad as I feel myself saying that, it was very necessary at that point"* *"Like, when I first did my CMT interview, I realised… there's some things you have to learn and change…. obviously you have to change your accent and stuff a little bit."* *"I go by the name of ------ because it makes things a lot easier for staff and patients - it's one of the things I advise my east Asian colleagues - if they have a difficult name, most of them will pick an 'English' name and it makes a world of difference to the day-to-day interactions."* *"(my) professional side I always try and keep quite separate from my out of work side, and whilst I feel like I have really grown as a person in terms of my own identity, in terms of my identity as a doctor, I think that is a separate thing."* *"many white doctors, don't seem to be able to differentiate doctors who are people of colour; they all just blend into one to them… I don't think they even necessarily see you as an individual or as a complete person, really."* (Others have no value for my differences for example, being cross-lingual) - *"That makes me feel a bit like I need to fit in more rather than be more like myself as well."*

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another ME doctor; others assuming that they were not the senior/lead doctor of the team were reported:

> I remember working in one place that was more remote, and there was… another 'brown doctor' for want of a better way to describe it, working there too. Staff would always get us confused with one another, even though we're very, very different… It doesn't make me feel great. You don't feel like an individual really. You're just 'the brown doctor'. (Participant 14)

These experiences directly and negatively impacted their sense of belonging. The perceived sense of 'not belonging' was pronounced in those doctors who also had a disability. Other ME doctors spoke about changing or adapting aspects of their identity to try and 'fit in':

> It's something around, I guess, as a minority how you're expected to join the majority and…….to be able to fit in there's a need to lose a bit of your (own) identity. (Participant 1)

Understanding about differences across diverse cultures

Doctors who had initially trained or had lived overseas described adapting towards understanding new cultures when they moved to working in Scotland. Being understood and understanding others is linked to feeling part of a community and a sense of belonging. Doctors identified differences in interacting with seniors and the perceptions of hierarchy in the workplace:

> …there's no hierarchy in the team, which I was very, very surprised to see…(whereas in my previous country of work), consultants were like Gods walking on earth. (Participant 1)

ME doctors felt that they were sometimes left with a degree of ambiguity around their performance and highlighted a lack of helpful feedback around some aspects of their training. Doctors reported having received no effective feedback from trainers and supervisors after examination failures, nor any adequate support for learning and development for future examination attempts. Doctors received disproportionately more harsh feedback from senior colleagues compared with their non-ME peers. Interestingly, many doctors from ME backgrounds reported receiving comparatively more strict or harsh negative feedback from seniors who were also from a ME background.

Feeling pre-judged (by patients and colleagues)

ME doctors felt pre-judged by patients and colleagues. These pre-judgements were exclusively described as having negative connotations, such as assumptions around their level of ability and competence in their work. Doctors who identified as being Muslim and female particularly identified as being negatively pre-judged by others. Doctors felt that they did not have the 'privilege' of being accepted into the learning environment without any preconceived negative assumptions, as their non-ME peers did:

> When I was wearing the hijab, it automatically makes me more evident that I'm different, and the colour of my skin, I'm a woman… I would say that the perception is that you're not good, and you have to prove them wrong. You have to work extra hard to prove people wrong, rather than what we call white privilege. We see it when we see a male colleague who's white, who's been here forever, whatever they do is fine, until they do something wrong. Whereas for us, everything is wrong until we do something very good. (Participant 8)

Having a non-UK accent meant that doctors were negatively pre-judged as being less competent in comparison to their UK peers. Socio-economic backgrounds also influenced how others interacted and perceived them in the workplace, and in turn impacted on sense of belonging:

> I just don't feel that with (the) background that I (have), I don't think I naturally fit into the whole sort of…I don't want to make assumptions, but I do feel medicine is, you know, naturally you could say… middle-class. (Participant 2)

ME doctors who were IMGs reported having been offered 'blanket' support when taking up their posts, such as specific induction for those new to the UK, but for some these were not suited to their own specific needs when they had already been working in the UK for some years.

Identity and concealing parts of identity to assimilate

ME doctors felt a need to lose or conceal parts of their own personal identity in an effort to 'fit in' and belong in the workplace. These included changing their name to 'a more English sounding name'; ceasing to wear their headscarf and adapting their accents. Some felt they needed to take these steps for the sake of their own safety. This process of assimilating was linked to success in the workplace and in postgraduate training:

> …(I stopped wearing my headscarf because) I'd rather be safe and blend in and just put my head down and try and get through the last year of core training… I think that is maybe a factor of… how I managed to be where I am today, because I try so hard to blend in. In the process, maybe yes, maybe no… I've lost a bit of where I'm from. (Participant 8)

Another doctor reported that where their unique differences were not perceived as being valued (e.g., being bi-lingual), then this added to their tendency to want to assimilate or conceal parts of their identity.

Unjust systems—a playing field that is not level

ME doctors reported a lack of useful systems for challenging discrimination; making appropriate adjustments to their learning environment and providing equitable

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Table 3 Unjust systems—a playing field that is not level

Sub-theme	Quote
Challenging discrimination	*"my take from what's going on to minority is there are a lot of things that are going underground—body language, you see micro-aggressions. Things that are very difficult for someone… English is my fifth language: I speak another four languages, you see, therefore it's very difficult to find someone who is ethnic minority who'll put into words what's going on every day. This is very difficult. That has big impact."* *"I wouldn't (report discrimination). I think it takes a lot of a very supportive environment to make me open up or raise it, so no, I wouldn't. Even when I know I've been there, and I've wished that someone fought my corner harder, but even now I'm maybe more in a position to actually fight for someone's corner, I would need a lot more support from maybe the majority …. or just me to actually raise that concern."* *"You would think so many times before doing something like that because I think it will backfire, it will not be in my best interest."*
Lack of appropriate adjustments to learning environment	*" in our country we go from high school, medical school, foundation year, or intern year, and then straight into specialty … and then we do Masters degree and then PhD and that's how we specialise. Different to the UK. We don't do audits, we don't do QIPs (quality improvement projects), we have no idea what these are. Presentations, not at all. Teaching, never."*
Inequitable processes	(*Challenges in getting visas as an IMG*) *"For me, it felt very unsupportive and not understanding of my needs as a foreign trainee. I felt… like there was some discrimination there because nobody did anything to help me."* *"we don't even stand a chance because I didn't train here and the chances of getting the speciality I want to do are very slim, so already that's based on the colour of my skin and my passport."* *"aware of the GMC and the current cases of IMG doctor…, I would say, targeted(?) with loads of other referrals to the GMC. It made me feel, "Well, I may not be able actually to stay in the UK for a longer period of time"… it's the whole acceptance, or the whole situation around the IMG in the UK at the moment. I don't feel they are fairly treated with… starting from visa fees, NHS job description sometimes, long training post. Even the current problem… the consultant who's involved… with the GMC because she asked for a laptop to work"* *"Yes, I found it very, very difficult with a visa to do any academic progression."* *"I also think the principle where we have to beg and scrape to be able to get more than a week of annual leave together that has to change because a lot of us have family elsewhere. If we can't see our family we can't sustain work here in this country, it's just not feasible. I've had to work insane shifts so that I can just see my family for three weeks"* (No support / help with my visa… I tried extensively to) *"explore what was going on and nothing was done and I lost my visa, and I almost had to leave the UK."* *"I do firmly believe that we shouldn't have to be paying out of pocket for our visa fees because this is an expense that is not optional."*

processes, for example, recruitment processes and visas (sub-themes and quotes—table 3).

Challenging discrimination

ME doctors felt they could not trust the organisational mechanisms for reporting racial bullying/discrimination that they faced or witnessed in the workplace:

> I don't trust… the organisations that we have. I don't trust on the bullying hotline, or the Trust bullying machinery. (Participant 4)

Many communicated fears around their career opportunities should they raise any concerns around discrimination in the workplace. ME doctors questioned whether any useful outcomes would emerge from reporting discrimination. Doctors who were themselves parents expressed concerns about how their children would cope with the personal and professional effects of experiencing exclusion in UK social environments. Negative effects on retention of ME doctors were seen:

> Honestly, the experiences I've had have made me want to move. If not now, in the future, when I'm done training. (Participant 5)

Lack of appropriate adjustments to learning environment

ME doctors highlighted the marked differences in UK education systems in comparison to parallel programmes overseas. There was no access to more comprehensive, fuller induction/orientation or networking programmes for doctors or students new to the UK. Consequently, they needed time to understand and navigate new educational pathways in combination with factors around settling into a new country of residence:

> …some of the medical students that I went to school with, had their CVs all lined up, their posters, their research, all lined up… and I wasn't one of them. I was a kid… who came all the way, thousands of miles, and just wanted to get through medical school…. You have a lot of, not just education

to think about, you have like real life; rent, bills … (Participant 8)

An IMG doctor shared:

We don't have e-portfolio in our countries ….It took me six months into training to know that I have to have e-portfolio access…. It's just no one takes the time to explain what is a CBD (case-based discussion), what is an SLE (supervised learning event). (Participant 10)

Inequitable processes

Doctors requiring visas perceived they were systematically disadvantaged around the jobs or specialties they could apply for, or whether they could undertake research programmes whilst in training. These challenges pertained to immigration rules and visa status, which then directly impacted on career opportunity and training:

I didn't even try to get surgical post because I wouldn't have got it because I wasn't UK or EU citizen. Immigration rules is … that a (UK) citizen needs to get a post first (with priority), (then an) EU citizen, before those requiring visa sponsorship would be considered. (Participant 5)

ME doctors (including those from overseas with a UK PMQ) faced additional financial burdens such as those related to visa fees and insufficient leave allowances to visit their family overseas. Academic opportunities were not open to some doctors because of visa rules, and this was inequitable in comparison to their other UK trained peers:

… It's not that we can't overcome these obstacles, but I think we shouldn't (have to), we should be on equal footing with everybody else (Participant 13)

DISCUSSION

Key messages from this study were around ME doctors experiencing barriers to authentic interpersonal connections; impacts on identity including sense of belonging; and perceived unjust systems. We draw on social learning theories to frame the discussion of the findings in this study.

Garrison's self-directed learning models[11] propose that learners seek learning and professional development opportunities from teachers, mentors and peers, facilitated by positive social and interpersonal connections in the broader learning environment. Due to the barriers to authentic interpersonal connections experienced by ME doctors, seeking out others who can support learning in this environment can be suboptimal for this group.

Lave and Wenger[12] articulated that shared and collective learning occurs among a group that shares a particular purpose, constituting a 'community of practice'. This model lends itself to the learning community for doctors in postgraduate medical training. By highlighting the role of the 'community', this model emphasises the importance of belonging to and engaging within a group/community. ME doctors felt socially isolated/excluded in the workplace leading to suboptimal engagement and belonging in the community of practice, and learning and development can therefore be impaired.

ME doctors highlighted experiences impacting their own personal identity, leading to some feeling they needed to change or conceal parts of their identity in order to assimilate. We heard of doctors feeling negatively pre-judged.

Cultural intelligence is the ability to relate to others and interact effectively across cultures.[13] To work most effectively in culturally diverse teams, cultural differences need to be better understood to allow us to interpret each other accurately without forming incorrect assumptions based on our own familiar cultural 'norms'. Developing cultural intelligence/awareness among staff has therefore widely been adopted in many global business sectors.[13] Such training and educational schemes are not currently available or widely accessible for NHS staff. Meyer describes eight 'scales' to describe different cultures, two of which may be of direct relevance to ME doctors: *Feedback style* (direct vs indirect) and *Deciding* (decision-making—often related to hierarchy perceptions), both of which emerged within this study. Individual ethnic/demographic differences could pose barriers to effective feedback conversations.[14] Mutual cultural understanding and developing cultural intelligence, particularly around feedback styles and hierarchy, may therefore help facilitate more effective feedback conversations as well as better working relationships between those from diverse cultures.

Some doctors reported that they received more 'harsh' or critical feedback from seniors who were also from a ME background. It may be that this represents internalised racism for some senior ME doctors.[15]

ME doctors who were IMGs and/or were female (in particular those who wore a headscarf) faced unique challenges, as did those who identified as having a disability. This highlights the need to consider each doctor as an individual, whilst being mindful of the potential effects of intersectionality, which as Crenshaw states are not simply 'the sum' of different forms of discrimination.[16] Any supportive interventions need to be sensitive and relevant to the needs of each individual doctor. Indeed, caution is required around whether any generic or untailored interventions may introduce stereotype threat which may exacerbate inequalities in education.[17]

Poor systems for challenging and reporting discrimination and gaining any support from bystanders during or after these situations in the workplace are concerning. Underpinning many aspects around unjust systems was also a sense of fear among ME doctors. Many felt unsafe and concerned about potential unfair referrals to the GMC (as had been highlighted in high profile media reports regarding ME doctors). The GMC's report[18]

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highlights themes (including a lack of effective feedback) related to disproportionate referrals.

Interviews were conducted through a conversational process, allowing in-depth exploration of the participants' views and experiences. In order to mitigate against any perceived power imbalance between the participants and the lead researcher, we maintained openness and honesty, with the lead researcher's name/roles being included in the invitation letter and the participant information sheet.

Potential bias due to the lead researcher identifying as a ME female doctor was acknowledged, reflected on and sense checking with experienced qualitative researchers within the team around the data analysis was maintained; but it was also acknowledged that participants may have been more open while being interviewed by another ME doctor. The iteratively generated codes and themes were seen consistently between participants, with rich data to support these, evidencing credibility and dependability to the study.[19] Some of our findings around experiences of ME doctors around feedback, microaggressions and exclusion/lack of belonging in the workplace are in keeping with previously published work.[4 5 17] Many participants found the areas discussed to be of a personal and sensitive nature and some articulated the challenge they felt in speaking of their experiences.

The GMC's 2022 workforce report[20] indicates a 121% increase in the number of IMG doctors joining the UK NHS workforce since 2017. Furthermore, the National Workforce Strategy for Health and Social Care in Scotland[21] highlights the concerted efforts and allocated resources to increase international recruitment of healthcare staff in coming years. The 2020 medical workforce race equality standard report from NHS England[22] indicates that>40% of doctors in NHS England are from ME backgrounds, and a recent GMC report from 2023 indicates no evidence of the attainment gap improving for ME doctors in the UK.[5]

Doctors feeling negatively pre-judged and unvalued regarding their contribution to the NHS at whatever level is a poor reflection on any working environment, let alone one where compassion is ostensibly at its heart. Yet, it should not be a surprise given recent more generic research.[23] ME doctors, by definition, are not 'majority' and thus are possibly more vulnerable. Perhaps there might be value in wider consideration of how we view colleagues and our presumptions about capability?

Conclusions

ME doctors feel *socially excluded* and *pre-judged* in an *unjust system*. This is a disappointing and concerning conclusion.

Overcoming barriers to authentic interpersonal interactions; providing dedicated, individualised support and learning opportunities; initiatives to develop mutual understanding between those from diverse backgrounds; cross-cultural awareness/cultural intelligence development among all; creating opportunities to develop social capital; and initiatives addressing systemic inequities can all be valuable contributors in creating more inclusive working and learning environments for ME doctors.

Doctors feeling unable to report or access support for any discrimination in the workplace is concerning. Perhaps, we might take time to reflect as organisations the purpose around patient safety initiatives, and how creating a just culture for staff may be more effective than enforcement? There is a need to transform talk about inclusion into genuine inclusivity in NHS workplaces.

Author affiliations
[1]NHS Education for Scotland, Edinburgh, UK
[2]Department of Immunology, NHS Lothian, Edinburgh, UK
[3]Institute of Applied Health Sciences, School of Medicine, Medical Sciences and Nutrition, University of Aberdeen, Aberdeen, UK
[4]University of Aberdeen, Aberdeen, UK
[5]University of Glasgow, Glasgow, UK
[6]Department of Pathology, NHS Grampian, Aberdeen, UK

Twitter Charu Chopra @_DrCharu and Kathrine Gibson Smith @kgibsonsmith7

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ORCID iDs
Charu Chopra http://orcid.org/0000-0003-3798-3605
Kathrine Gibson Smith http://orcid.org/0000-0002-7341-4701
Peter Johnston http://orcid.org/0000-0002-9446-8354

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APPENDIX E – Topic Guide – Version 1 – 30th Oct 2021

The lived experiences of postgraduate medical training of doctors from minority ethnic backgrounds in Scotland – A qualitative study.

INTERVIEW TOPIC GUIDE

Introduction

Thank you for volunteering to take part in this research study, which aims to explore the lived experiences of doctors in training who are from minority ethnic backgrounds.

Thank you also for filling out the short demographics form and signing the consent form. I'd like to audio record this interview and take some notes to help me accurately remember what was said. The recording will be sent to a professional independent transcriber. We will remove any information that would identify you individually, in order to anonymise the interviews. All notes will also be anonymised. The data will be kept confidential and only published in a way that means it cannot be linked to you as an individual. Is that OK? Do you have any questions at this point?

During this interview, I will ask you a series of questions. There are no right or wrong answers, I just want to hear about your experiences and your opinions. May I start recording?

Establishing Rapport / Opening Conversation

1. Could you please tell me a bit about yourself?

Prompts:
-How did you come about to being in your current post?
-What's your current job?
-Stage of training / specialty if appropriate/ region of work in Scotland?
How long have you been working in Scotland? Are you enjoying your current job?

Training Experiences

2. a) Can you tell me about a time when you had a positive learning experience in your current training post?

Prompts:
-What happened?
-What was it about the experience that was positive?
-e.g. Supervision from senior colleagues, other trainees involved?

b) Did the experience change you in any way?

Prompts:
-Affect your motivation
-the direction of your career

APPENDIX E – Topic Guide – Version 1 – 30th Oct 2021

3. a) Can you tell me about a learning experience in your workplace when something happened that was difficult to deal with?

Prompts:
- What happened?
- What was it about the experience that you found challenging?
- Were you able to get any support to help you deal with it?
- What may have helped you? (prompt: supervision / mentorship from senior colleagues, other trainees involved?)

b) Did the experience change you in any way?

prompt: -how motivated you felt?
-the direction of your career?

4. With regards to your own experiences of working as a doctor in training in Scotland:

a) What are the main challenges or hurdles that you have had to deal with professionally to get to where you are today in your career?

prompt: getting through assessments / ARCPs/ exams, getting through selection processes for a ST post`? Was this post your 'first choice'?

b) Did you get any help or support?

-From whom? (prompt: How about outside of work?)
-Did anyone or anything hinder you? (prompt: opportunities provided by the workplace; peers, senior colleagues)

If relevant: Of all the challenges you've talked about, which would you say was the most difficult for you? Why?

c) We are interested in how doctors from ME backgrounds feel they are treated by others in the workplace. What are your experiences?

Prompts: do you feel that you have experienced any discrimination in the workplace? How often? From whom? Why do you think you have experienced discrimination?

d) With regards to your future career aspirations, do you have an idea of where you ultimately want to get to?

- What do you see as your main challenges or hurdles facing you over the next few years?
- Will you need any help or support to deal with those challenges or hurdles? What kind? From whom? (Prompt: other trainees, senior colleagues, anyone outside work?)
- How easy or difficult do you think it will be to get the help and support you need?

5. Thinking about doctors from ME backgrounds in general:

-There is published evidence to indicate that both UK and non-UK trained doctors from ME groups (these are all doctors who identify as being non-white on their ethnicity monitoring data) are less likely to be successful in recruitment and in assessments compared to UK-trained doctors who are

white. What do you think about this? Why do you think this might be the case? What could be done to remedy this?

-UK evidence also shows that doctors from ME backgrounds are three times more likely to experience discrimination in the workplace compared to their white colleagues (17% vs 6%). What do you think about this? What could be done to remedy this?

Wrap Up

6. Is there anything else that you would like to add / say?

Thank you again for your participation in this study.