IMPROVING FEEDBACK IN THE CONTEXT OF DIFFERENTIAL ATTAINMENT

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Contents

Glossary and abbreviations

CT: Core Trainee, usually followed by number to indicate the year of training.

DA: Differential attainment (DA) is what we call the unexplained gap between attainment levels of different groups of doctors. External factors including the quality of their relationships with trainers can affect trainees' access to resources and slows their progress through training. It occurs across many professions.

EQiT: Embedding Compassionate, Courageous, Cross-cultural Conversations into Training workshop.

FY: Foundation Year, usually followed by number to indicate the year of training. Sometimes referred to F1/F2.

GMC: General Medical Council.

IMG: International Medical Graduate. A doctor who completed their primary medical qualification (PMQ) outside the UK. In our research and in this report, we have included doctors with a PMQ from the European Economic Area (EEA) in the IMG group.

LED: Locally Employed Doctor. Doctors employed by trusts on local terms and conditions.

MED: Medical Education Development team of the GMC

MSF: Multisource feedback (MSF), or 360-degree evaluation, is a questionnaire-based assessment method in which rates are evaluated by peers, patients, and co-workers on key performance behaviours.

NHS: National Health Service.

QAMI: Quality Assurance Monitoring and Improvement team of the GMC.

SAS doctor: Specialist, Associate specialist and Specialty doctors with at least four years of postgraduate training, two of which are in a relevant specialty.

ST: Specialty Trainee, usually followed by number to indicate the year of training.

UK BME: A doctor who completed their primary medical qualification (PMQ) in the UK and is from a Black and Minority Ethnic Background (BME). In this report, we have decided to continue using this term as opposed to others e.g. 'minority ethnic', as UK BME is used in data reports which were the basis of this project.

UK White: A doctor who completed their primary medical qualification (PMQ) in the UK and is from a White background.

WPBA: Workplace based assessments (WPBA) are the assessment of a trainee's professional skills and attitude and they provide evidence of appropriate everyday clinical competences.

Executive summary

International medical graduates (IMG) and UK Black and minority ethnic (BME) doctors are frequently disadvantaged in their career progression when compared to their UK White counterparts (GMC, 2020). This phenomenon is called differential attainment (DA) where there is variation between different demographic groups. One of the possible driving factors of DA is a lack of feedback, which is an important area to explore further (Woolf et al, 2017).

One of the organisational priorities in the equality, diversity and inclusion strategy of the GMC is to embed fair training cultures in postgraduate training environments (GMC, 2023). We therefore conducted a qualitative study to further understand the day-to-day feedback experiences of doctors in training from different demographic groups. We ran three focus groups in January and February of 2023. In total, 17 doctors in training attended the focus groups: five IMGs, six UK BME, and six UK White. Each focus group had doctors from a variety of specialties, training grades, and deaneries. The focus group transcripts were analysed using a thematic framework analysis method. We discussed the outcomes of our analysis with internal and external stakeholder roundtables in May 2023.

Through our analysis and roundtable discussions, we identified priority areas and recommendations to improve feedback experiences for IMG and UK BME learners. Across all the focus groups, there were numerous suggestions on how formative feedback can be improved in the workplace. The recommendations focus on three main areas:

- Standards
- Training for learners and educators
- Removing barriers such as lack of awareness, time, and blame

For the full summary of the recommendations, please see here.

Our research also highlighted areas that should be researched further, such as UK BME trainees feeling less confident in asking for feedback with increased seniority, educator's experiences of feedback, and experiences of feedback for Locally Employed Doctors (LEDs).

Introduction and background

One of the organisational priorities in the equality, diversity and inclusion strategy of the GMC is to embed fair training cultures in postgraduate training environments (GMC, 2023). We therefore conducted a qualitative study to further understand the day-to-day feedback experiences of doctors in training from different demographic groups.

What is DA*?

Doctors joining the UK medical workforce are ethnically diverse. Over half identify as BME, and the number of IMGs continues to grow. BME doctors make up 42% of fully licenced doctors (GMC, 2022). As a result, these groups of doctors are an integral part of the NHS and it is important they are supported in their career pathways.

IMG and UK BME doctors are on average disadvantaged in their career progression when compared to their UK White counterparts (GMC, 2020). This phenomenon is called DA where there is variation between different demographic groups. This phenomenon has since been highlighted across different specialties, and it is now well established in the literature that IMG and UK BME doctors have poorer outcomes with exams and training progression (Woolf, 2020).

DA is a complex multifactorial phenomenon. The Fair Training Pathways report summarised the risks to progression of IMG and UK BME doctors, listed below (Woolf et al, 2017).

* In this report, we use the term differential attainment to refer to the phenomenon of UK BME and IMG learners underperforming in medical education and training. We recognise that academic definitions of differential attainment highlight the unexplainable difference in attainment which does not apply to IMGs as this difference can be explained by taking into considerations factors such as language and cultural barriers, lack of prior knowledge and experience of systems and exam formats. We have purposely decided to continue using the term differential attainment as opposed to other terminology as this is most widely recognised across the current literature. Differential attainment affects many different demographic groups, in this report we are focussing on IMG and UK BME doctors in training.

Risks to the progression of UK BME and IMG doctors in training:

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

Risks to the progression of IMG trainees only:

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

Whilst work has been undertaken to tackle DA over the past few years, inequalities continue to persist. Tackling discrimination and inequality in medicine is an urgent priority for everyone supporting the health services. It is also vital in helping retain doctors working in the UK and to support high quality patient care. We must do more to provide the necessary support to IMG and UK BME doctors. It is the right and fair thing to do.

Feedback

One of the possible driving factors of DA is a lack of feedback.

Feedback is defined as 'information describing performance in a given activity that is intended to guide future performance in that same or related activity' (Ende, 1983) and helps doctors to achieve the desired performance. Both formative and summative types of feedback are important in medical education. Formative feedback focuses on the importance of delivering constructive feedback in a timely manner after a specific experience and allows learners to improve their performance at the time. Whereas summative feedback is provided more infrequently and typically delivered as a means of final assessment of a learner at the end of a course of study (Kelly, 2019). Formative feedback is considered more relevant on a regular basis where feedback is being provided in a timely manner on a specific clinical task or behaviour (Burgess, 2015).

Feedback is very important for the development of doctors and patient safety. Without high quality feedback, 'good performance may not be reinforced, poor performance might remain uncorrected, and learners may rely on hearsay from colleagues, guesswork, and trial and error at the expense of patients' (Kelly, 2019). Feedback allows doctors to address educational needs as part of their professional and career development (Kamali, 2018). Additionally, receiving useful feedback is linked to increased job satisfaction (Cowan, 2001), and contributes to the wellbeing of doctors. This in turn can affect patient safety as poor-quality feedback can contribute to workplace stress and retention of doctors. It is important that doctors receive timely, supportive and constructive feedback (Coia, 2019), and individual relationships with supervisors are crucial in delivering and responding to feedback (Woolf et al, 2017).

IMG and UK BME doctors are at risk of not receiving high quality feedback. IMG doctors are 2.5 times and BME doctors are 2 times as likely to be referred compared to their White counterparts for fitness to practise concerns, and one key factor identified is the lack of direct and honest feedback in the 'fair to refer?' report (Atewologun, 2019). A common reason leading to a lack of feedback is avoiding difficult conversations, therefore concerns related to a doctor's practice are not revealed. The importance of honest feedback and trust in a trainee-trainer relationship has been highlighted further, where poorly delivered feedback could lead to trainees withdrawing from training opportunities and impact on their self-confidence (Rutter and Walton, 2020).

We wanted to further explore feedback experiences across different demographic groups of

doctors in training, and in turn gain further insight into how we can improve feedback in the context of DA. We have conducted a qualitative study exploring formative feedback experiences between UK White, UK BME, and IMG doctors in training.

Aims

- To understand differences in formative feedback experiences between IMG, UK BME, and UK White doctors in training.
- To understand how we can improve these formative feedback experiences.
- To engage with different stakeholders and share our findings.

Methods

Design

Semi-structured focus groups were undertaken with trainees from different demographic backgrounds via Microsoft Teams. Focus groups were recorded and conversational in style to allow the facilitator to address themes relevant to the study, whilst allowing them to follow relevant avenues of inquiry opened by the participants. Each focus group lasted 1 hour and 30 minutes. We decided to split the trainees in different demographic groups (IMG, UK BME, and UK White) to provide a safe space for sharing experiences and to allow us to observe differences in answers across the groups. All the groups were structured in the same way and we asked the same questions to all the focus groups (Appendix 1).

Process

Recordings of the focus groups were only accessed by the transcriber. All information collected during the focus groups was only accessed by the research team. None of the stored material contained any details that breached confidentiality or anonymity of participants.

Recruitment to participate in a qualitative study

We approached participants from a group of doctors in training that declared interest through the national training survey. We had an initial list of 332 trainees and we sent an email asking to declare interest in taking part in the project together with an information sheet (see Appendix 2). A total of 97 trainees expressed interest and researchers selected 30 participants based on their specialty and training level. We selected 12 IMG trainees, 11 UK BME trainees, and seven UK White trainees. We have decided to have focus groups of this size to allow for free-flowing conversations. Given the narrow and specific objectives of this study and the homogeneity of the group (doctors in training in the UK) we feel that this sample size was enough to elicit and understand difference experiences of feedback.

All the selected trainees confirmed their attendance via email and returned a consent form (see Appendix 3), but not all were able to attend the focus group. We had a total of five IMG trainees, six UK BME trainees and six UK White trainees. At the start of each focus group the wording of the consent form was talked through by the facilitator and the participants gave their consent to proceed and be recorded.

Analysis

The focus group transcripts were analysed using a Thematic Framework Analysis method (Ritchie, Spencer and O'Connor, 2003). We read the transcripts in their entirety to remind the analyst of the interview's content. Two of the authors independently established a thematic framework according to the codes they identified and focussed on identifying key quotations within each theme. After the independent review stage, the two authors came together to reach consensus, validate and summarise data, and present it to the third researcher.

Engagement with stakeholders

Following analysis of the transcripts, we wanted to engage with stakeholders to help us formulate recommendations. We ran three roundtable discussions with internal and external stakeholders to the GMC to present the interim findings of the focus groups and identify how formative feedback could be improved in the context of DA. These roundtables were run in the week of the 8 of May 2023.

The first roundtable (see Appendix 4) lasted for 1 hour and 30 minutes and included GMC staff members from the Education and Standards directorate. The teams that were represented at the roundtables were:

- Quality Assurance Monitoring and Improvement (QAMI)
- Medical Education Development (MED)
- Education Policy
- Education Operations

The second roundtable (see Appendix 5) lasted 2 hours and included external stakeholders:

- Medical royal colleges
- Deaneries
- Doctors in training
- Researchers in the field of DA
- Med Ed Leaders

The third roundtable (see Appendix 6) lasted 1 hour and 30 minutes and included GMC staff members:

- Outreach team
- GMC National Offices

Results

In total, 17 doctors in training attended the focus groups: five IMGs, six UK BME, and six UK White. Each focus group had a variety of specialties, training grades, and deaneries (see Appendix 7).

We discuss the key emerging themes and findings from our analysis below.

Awareness of DA

The doctors in training were asked if they were aware of DA prior to joining the focus groups. All the IMGs were aware of this phenomenon, compared to a minority of UK White and UK BME doctors in training.

This raises the question of the need to further increase awareness of DA across the workforce. Due to time limitations, we were only able to explore whether raising awareness of DA would be useful within the UK White focus group.

Participant 12:

'I think that would be useful, but it's gotta be framed really positively, you know, so. I guess that obviously just needs to be training that doesn't compound people's assumptions and about why that might be happening and make sure that it's addressing the things that we can do about it. Like giving good feedback and good training and there being a lack of that behind that.'

Specialty differences on feedback

Across the focus groups, key differences arose between specialties in the amount of regular day-to-day feedback. In general, a lack of regular feedback was mentioned more in ward and clinic based activities.

Participant 8:

'My gut response to what you said [experience of feedback on a day-to-day basis] was non-existent.'

'we have MSFs and getting anonymous feedback from a group of colleagues is probably the only time to get formative feedback'

Participant 16:

'I was gonna say on a day-to-day basis I get very little feedback I would say, except for if I'm in the clinic or something, just the consultant saying yes, that's fine or yeah, I agree, but not really much more than that.'

In surgery, there was a more mixed response, where feedback was regular and one-to-one during theatre sessions, but again not as regular with respect to ward and clinic work.

Participant 6:

'I think perhaps maybe it's slightly different in surgery. I mean we do different things on a daily basis. So if I'm in theatre, I will get feedback about how I've operated, if I am on call, particularly if you've been on nights and you're running the trauma meeting in the morning, you have to go through all those patients and you have to tell them what you've done or what your plan is and they will give you direct feedback straight away on it. Sometimes it's not always constructive, but you do get feedback on that.'

Conversely, in other specialties with less ward and clinic work, such as radiology and pathology, participants suggested they received more regular one-to-one feedback.

Participant 13:

'So nearly all of the training and feedback we get will be one to one… immediate response from the consultant as to whether you've got that right or not'

Participant 1:

'I appreciate when my consultants, even though they are not my supervisor, they call and ask me to come and chat with them and then go through the patients and tell me about what was wrong. So that was kind of like kind of quite formative feedback that I've received so that I know what I have done wrong. So that's really helpful'

Valuable ways to receive feedback

Across the focus groups, there was a consensus that feedback is more valuable when given in a timely manner following direct observation of an interaction. Furthermore, building a relationship with a supervisor is important to allow for more individualised feedback.

Participant 3:

'I found that when through supervisors like been observing me taking a history examination and then giving feedback on that, that's been very helpful.'

Participant 9:

'They're giving you direct feedback as the event is taking place. So not after a few weeks. And it's based on their own observation. So you can agree on it rather than someone say like hearsay from someone else….. all direct and instant'

Participant 7

'when feedback happens as close to possible to the event, it's a lot more useful both for myself and also the consultant remembering, you know, things. But then when it's further down the line, it's a bit less useful for me.'

Participant 17:

'it's a bit of a two way discussion'

'it's a face to face meeting with someone that knows me, someone that knows what my goals, my agenda, what my plans are. Someone that cares not just about. And like sort of me, but also what I'm trying to achieve and then is able to say the things that are weak as well as the things that could be improved, how they could be improved.'

Participant 10:

'She [the supervisor] gave me real time feedback and also gave me the space to challenge it as well if I wanted to. And I found that the feedback that is in real time that is consistent and from really the same person who's seeing you develop that was really, really beneficial'

Participant 1:

'It is very important to know the behaviour or the attitude of that particular trainee whether, what kind of like feedback that they would like to have? And so I think it is if we can have the idea beforehand, then I think delivering feedback and receiving feedback would be kind of more helpful so. For me personally, I would like to have an open feedback. Just tell me straight, like if I'm doing wrong I would just correct it and I'm not gonna take it like personally and so these kind of thing.'

Workplace based assessments

When first asked in a polling question about the usefulness of work-place based assessments (WPBAs), most participants seemed to think that they were either somewhat useful or useful.

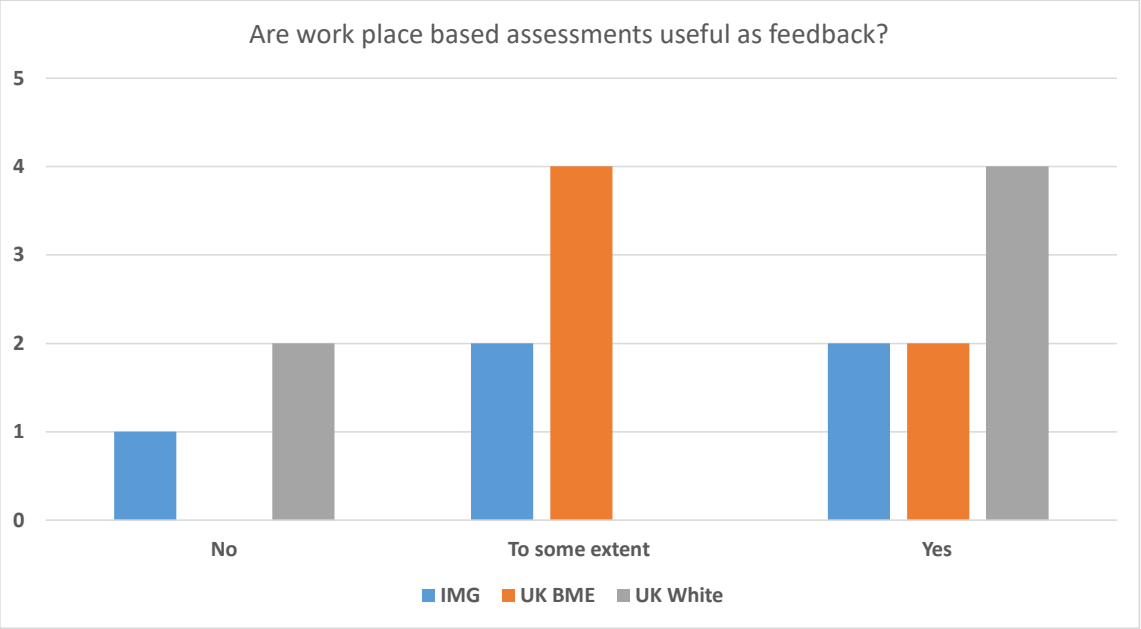

Figure 1 – Are WPBAs useful as feedback? Answers from polling questions across the focus groups

However, more in-depth conversations showed a consensus that WPBAs are not very useful except in scenarios where feedback was otherwise not being provided day-to-day and being used as a reason to observe a clinical interaction and delivery timely constructive feedback.

Participant 5:

'I think in my experience they [work place based assessments] are absolutely useless. The only thing I'm told is like I need to do this and they were like, yeah, yeah. Can you just send it to me? Ohh, fill it in because I don't have time to do all that and it's just me with. I think you can write anything you want, it's not like anybody's checking it. I think in the last 20 that I did, I think 2 actually were checked.'

Participant 9:

'you're doing it for the sake of just completing a ePortfolio so that you can move on to the next step and I think that's detrimental to training in general'

Participant 16:

'I was gonna say on a day-to-day basis I get very little feedback…..Which is why I think within medicine, the more formalised workplace based assessment sometimes prompt your seniors to give you a bit more feedback.'

Barriers to feedback

No participant in the UK White group felt they received less feedback than their colleagues whereas a few in the UK BME and IMG group did feel this way.

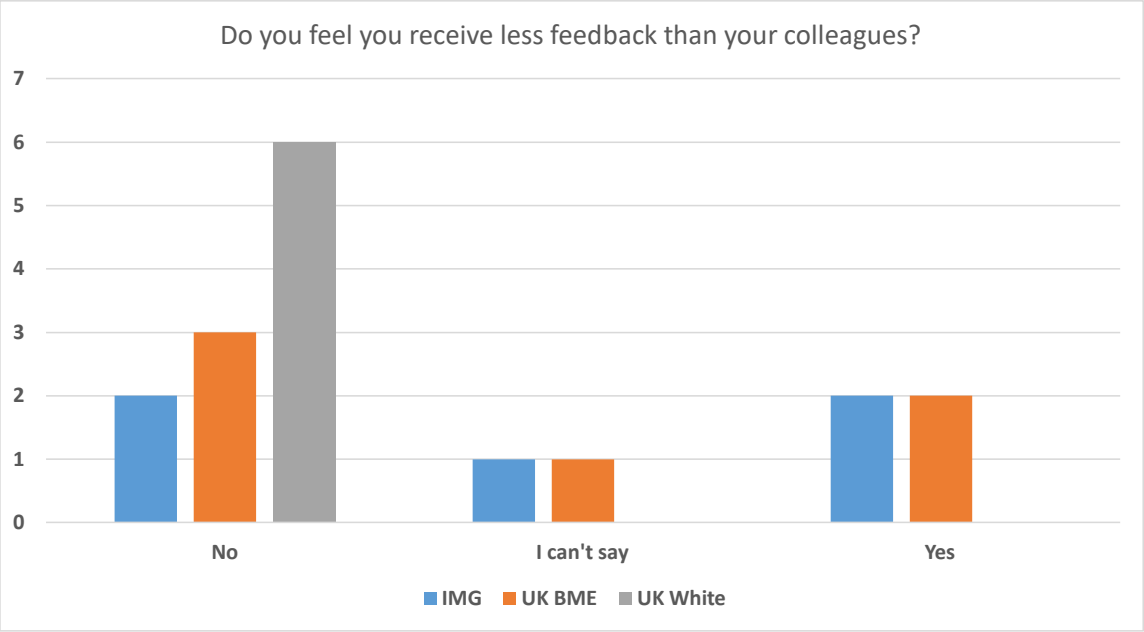

Figure 2 – Do you feel you receive less feedback than your colleagues? Answers from poll questions across the focus groups

Several barriers to feedback were highlighted across the three focus groups during a polling word cloud question.

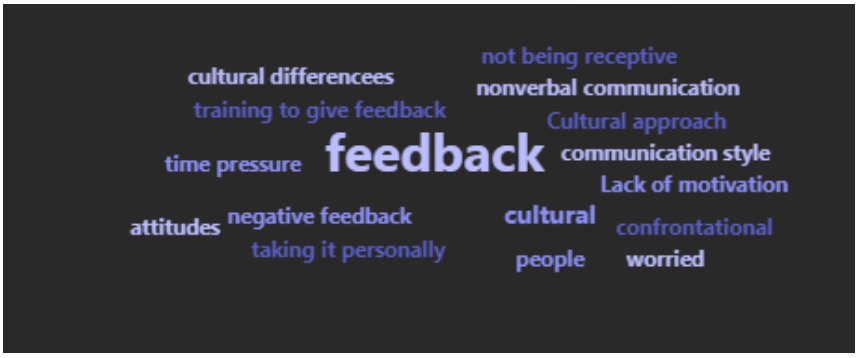

Figure 3 – What do you think are the barriers to feedback? IMG word cloud

Figure 4 – What do you think are the barriers to feedback? UK BME word cloud

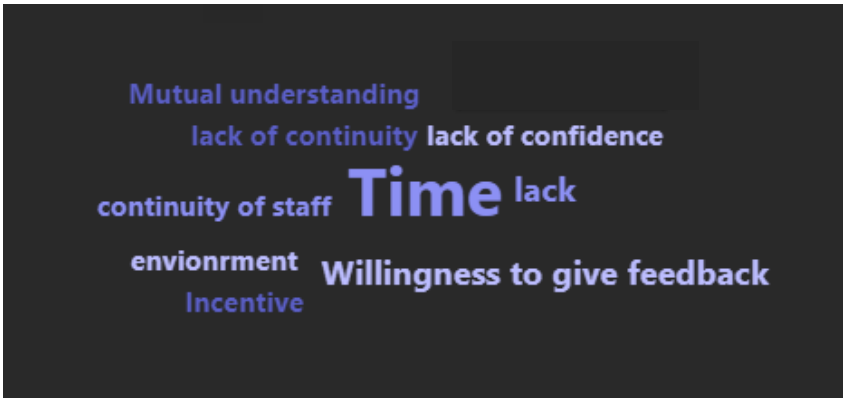

Figure 5 – What do you think are the barriers to feedback? UK White word cloud

One of the barriers mentioned among all trainees was time.

Participant 3:

'sometimes if you're too busy, you know, people might not bother with feedback'

Participant 7:

'If you actually want some form of assessment doing you have to flag it up at the start you know to someone and just hope for the best. Umm, that they're not very time pressured that day'

Participant 8:

'obviously I'm sure you're all aware of how busy everything is at the minute that a lot of the time the formality of any sort of feedback just kind of disappears and doesn't really happen'

Participant 16:

'we're so busy and pressured in our day-to-day job…. I don't often get sort of off the cuff valuable feedback you might get the odd comment, but not really something I can use ongoing for sort of self development.'

When comparing the demographic groups, UK BME and IMG groups specifically mentioned themes relating to 'culture' and 'fear' to be barriers to feedback, which were not mentioned in the UK White focus group.

Facilitator 1: (In the UK BME focus group, responding to word cloud on barriers to feedback)

'I can see that 'fear' is highlighted there and it's really interesting to also see the word 'culture' amongst there as well'

Facilitator 1: (In the IMG focus group, responding to word cloud on barriers to feedback)

'I can see that some words are really striking and repeated, which is on cultural differences and also sort of not being receptive, nonverbal communication, attitudes, negative feedback'

Facilitator 1: (In the UK White focus group, responding to word cloud on barriers to feedback)

'I can see that time seems to be a really big factor. As well as some other points that have been raised environment, lack of contact, confidence, mutual understanding, interesting that culture hasn't been mentioned in this.'

The UK BME and IMG focus groups mentioned about anonymous blame cultures on their ePortfolio.

Participant 8

'I would say there's a big amount of fear culture around that and are giving it and asking for it. And then also you don't want it again put in your portfolio without you knowing about it.'

Participant 9

'[talking about being in negative environments where feedback is not provided] I think it's made me more guarded in and I try and think about how to phrase it better. This, particularly when filling in the portfolio forms and giving feedback. Because you just don't want it to come back and hurt you later on.'

Participant 10

'some nonspecific comments which were anonymous and very, very unhelpful. I had not asked for this feedback and […] I felt that if after 18 months you couldn't tell me this feedback to my face and you decided to anonymize this. How is this gonna help me in the future?'

Participant 2:

'It's a trap that everybody can fall in under stress. We tend to not really provide feedback but provide more of a blame, blaming and which is not helpful at all. And I've been in that situation where most of the feedback is all about blaming'

Asking for feedback

The IMG doctors in training discussed feeling more comfortable in asking a senior who is an IMG for feedback, as the feedback would feel more individualised.

Participant 4:

'Any IMG consultant [to ask for feedback], but definitely more helpful if from same cultural background or same country sometimes'.

'I usually get like a follow up when I ask feedback from an IMG. Other than when I asked from a non IMG consultant they would never dismiss you but I felt they just sign posted me to do this one and that's all.'

Participant 1:

'When I joined the NHS initially […] I feel more comfortable to ask for feedback from IMG consultants because I was not actually sure about what I will be thought of or being seen as if I was not knowing what I should be knowing'

Participant 2:

'I'm under the impression that generally speaking IMGs will seek advice from other IMGs'

The IMG and UK BME focus groups discussed issues around the fear of being labelled incompetent if they asked for feedback. This feeling was raised in the UK White group by two trainees who had returned to work after time off.

Participant 8:

'The person is interpreting that as you can't. You're not good enough to do that job, or you're struggling doing something and then you don't want them to lose confidence in you and your ability so.'

Participant 10:

'it's very hard to work in an environment where you feel fearful of making a mistake'

Participant 6:

'…it does rely on those supervisors having adequate education and knowing why you're asking for feedback. It's not because you're struggling. It's because you want to make sure that you are doing the best that you can so that you can progress to get to, you know, a point where you're a consultant and you can then teach the next generation'

Participant 14:

'when I came back after long term sick. I was not only it was a confidence issue, but it was. Well, if I go seeking feedback. Will they think I'm not coping with being back at work. Will they think the workloads too much. And actually what I was more looking for was. I want to know how to improve. And to be better.'

The UK White and IMG groups mentioned how their confidence to ask for feedback increased with seniority.

Participant 4:

'They don't know me yet or doesn't understand how I work or what my knowledge base is or my experience are, so they might not take that into account while giving feedback. That was my reflection after I got feedback immediately when I came after a few months or so, then the feedback changed with in the similar circumstances by similar people, but. Getting after knowing you better.'

Participant 16:

'I would say that it's something I definitely feel much better about now that I'm more senior and in my sort of early training years, I'd be very reluctant to ask for feedback and you felt like you were almost stepping over a line which you're definitely not.'

Participant 15:

'as you get more senior you want more feedback and you maybe become a bit more confident and just say ask for it because you're like, well, I'll need to know because I want to improve and I want to continue. But when you're more junior, you really don't want to cause much of a fuss. So you don't maybe want to ask.'

Whereas, the confidence to ask for feedback seemed to go down with increased seniority in the UK BME group.

Participant 10:

'it's very hard to work in an environment where you feel fearful of making a mistake'

Participant 8:

'The more senior you get, the more hesitant you are to ask for feedback because you feel like you are asking for feedback or feels like when you're asking for feedback. The person is interpreting that as you can't. You're not good enough to do that job, or you're struggling doing something and then you don't want them to lose confidence in you and your ability so.'

'I have actually had friends and it's happened to myself where I've asked for feedback about a

patient or a management thing. And then I've had that sit on my ePortfolio on a reflection from the consultants as is unable to manage a paediatric sedation independently. Needs to work on that. When an actual fact it was. I've done the paediatric sedation, I've turned around and said oh would you have maybe done can I just ask for some feedback do you think that went well and so I think when I was much more junior[…] I would ask all the time for feedback and I was really kind of wanting that […] then as I've become more and more senior I realized that the subtleties of the environment that I work in that If you ask for it, that's sometimes it's can be quite negative.'

Participant 6:

'On the whole, asking for feedback, I think people see that as a you engaging in your training, you wanting to, you know, try and better yourself. So I think perhaps I've had a slightly different experience and to some of some other people, but I also think that it does rely on those supervisors having adequate education and knowing why you're asking for feedback. It's not because you're struggling. It's because you want to make sure that you are doing the best that you can so that you can progress to get to, you know, a point where you're a consultant and you can then teach the next generation'

IMG and UK BME groups were also worried about being labelled a 'troublemaker' if they raised concerns on lack of feedback.

Participant 11:

'Being comfortable raising concerns. There's a massive problem at the moment for all healthcare professionals.'

'I have had a general bad experience of trying to raise concerns in general, not just specific to feedback, and that doesn't necessarily stop me from raising concerns, but it does make me decide. What concern am I going to prioritize raising? And to be honest? Lack of feedback is not one of the ones that I have prioritised in my career so far'

Participant 8:

'There's no one you can really go to. I think the only opportunity we get is the GMC survey…. even when you fill in the GMC survey, there's only one person that's a full-time training that is giving that feedback and they know exactly who it is. So I would say there's a big amount of fear

culture around that and are giving it and asking for it. And then also you don't want it again put in your portfolio without you knowing about it.'

Participant 9:

'it's still creating that friction between and the consultants in that department are more likely to be friends with each other than they are to look out for you….. it's more likely gonna harm your career progression than doing it. Have any benefit if you raise something like that.'

Participant 5:

'Somebody said that I was a troublemaker just for raising this issue.'

'I'm really worried to say anything because I'm operating with all these consultants that are either never with me or don't mind what I'm doing. I'm really worried to say anything'

The IMGs discussed how they would be more inclined to raise concerns on lack of feedback if this could be done anonymously.

Participant 2:

'I would do it anonymously on the survey, but not with my name on it, yeah, I would be concerned about how it I would be seen. And how would that be interpreted? The struggling trainee not doing well, etcetera?'

Participant 3:

'from what I've seen, experiences of some other colleagues that when they have actually brought it up, it's not really helped and just get in trouble with the Deanery or the trust and. So yeah, as Participant 2 said, probably anonymously, I would,'

Whereas the UK White group discussed the logistics of how to practically raise concerns, rather than the fear of doing so.

Participant 17:

'I don't know who I would say that to, It's the truth. I don't know how I'd report a concern.'

Participant 13:

'We would speak to the training lead and say could we have more of this or more of that and that's usually fairly well received'

Participant 16:

'I don't actually know what they would do about it apart from personally delivering feedback. […] And I don't really know how they would make that happen and therefore probably would just moan about it to my friends that no one was giving feedback or replying to my assessments that I sent.'

Delivering feedback

All trainees agreed that it is easier to deliver feedback when directly observing and when the feedback is positive. It is more challenging to deliver negative feedback, particularly if this is on professionalism or cultural behaviours.

Participant 4:

'I think all doctors. All consultants or senior trainees because it differs if, like the feedback given by a person who is directly observing you. […] Their feedback is much more constructive and rather than, uh, getting it through someone else who is not directly in contact with you about that particular feedback'

Participant 5:

'I'm looking like the ST1s and ST2s that are showing up late for ward round, showing up late for work, and the minute you try to say something you're the bad guy in the room. It's very difficult. Because having had a one of my consultants, actually, told a trainee, if you're late, you are not operating, and the trainee automatically put a complaint against him.'

Participant 8:

'more difficult to explain when there's a communication when there's sometimes a language barrier just because people's communication is different from different cultures and different areas of society and so they may not use the same language that we would use or that we would feel is best for the patient.'

Participant 9:

'depending on where the person's background or their past experiences when you, especially when you want to give them negative feedback, they sometimes take this as it's like a personal insult to their work'

Participant 17:

'I'm working with them for one shift. And you're like, well, you know, we'll just see how it is and then and then you then for several shifts. And you're like, oh, now I worked with them too much. And like, this is now our normal behaviour and it's now difficult for me to say that that whole time I thought their behaviour wasn't very good.'

Participant 16:

'I was just gonna say they get completely depends on whether it's positive or negative feedback. You know, I find it very easy to give out positive feedback if I think something's been particularly good. I'll quite openly talk about it.'

Participant 12:

'I suppose more about maybe a behaviour or some or something that feels a little bit more awkward to talk about'

It is more comfortable to deliver negative feedback in a private space away from others. Trainees have felt that when delivering negative feedback, the recipient may no longer want to listen to them.

Participant 3:

'you're in a private setting. Comfortable. I am giving them feedback on something specific in a group I would struggle either giving positive or negative feedback. Sometimes when a situation where there's more than one trainee. So I find it difficult to give in front of other trainees.'

Participant 1:

'they were just like a bit a kind of like resistant. They were not kind of like rude, but just like there was the wall between me and them like.'

UK White trainees mentioned that they find it easier to give feedback to UK trainees as there is already an awareness and mutual understanding of the medical system and training.

Participant 16:

'I would definitely feel more confident giving feedback to a colleague who has also sort of trained in the UK where I trained just because I have a better understanding of what the training involves and what their experienced to date would be'

'we have a lot of sort of trust grade doctors who have trained all over the world and it can be unclear you know exactly what training they've done to date and you don't want to give. And I'm gonna give feedback that seems like offensive because they already know that or, you know, it's sometimes quite hard to pitch the level where if I'm presented with, say, for example, someone who graduated from the university I graduated from, I know exactly what they've done to get to that point and know what kind of feedback is most appropriate.'

Participant 17:

'for example, I was a medical student in Bristol several years ago and if you come across a Bristol medical student as a student, I'm often like, oh, I remember being that. And I'm much more inclined to give them feedback because I'd like I remember that situation and I wish someone had told me this. Then if I were to come across someone in a different context. And there is a sense of like familiarity and freedom to be able to speak in that situation.'

Participant 15:

'I was working with a lot F1s never did cannulas bloods, that sort of thing before. So it's supposed to be mindful of that… important to be mindful of the different sort of way that the universities work.'

Feedback training

There was a general trend that most trainees have not been given training in how to receive feedback, and only a few more trainees have received training on how to deliver feedback. None of the feedback training has included an awareness of cross-cultural communication.

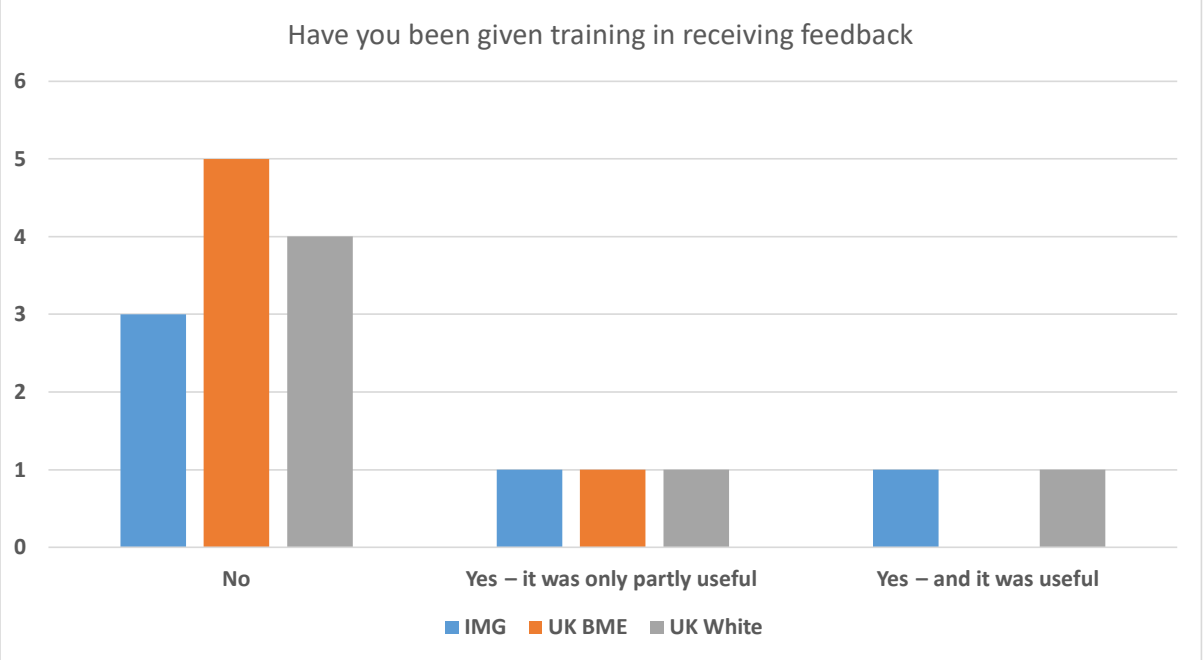

Figure 6 – Have you been given training in receiving feedback? Answers from polling questions across the focus groups

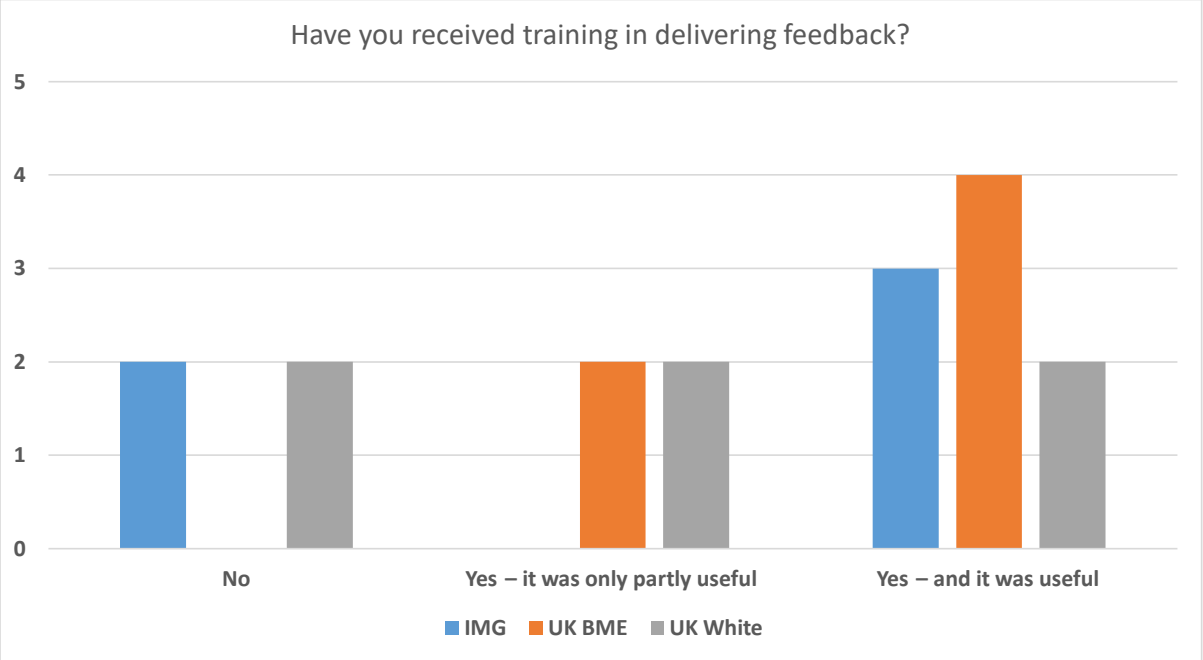

Figure 7 – Have you received training in delivering feedback? Answers from polling questions across the focus groups

Improving feedback

There was a consensus across focus groups that providing general training on feedback would be useful. More specifically, training on cross-cultural communication would be particularly useful in the context of DA.

Participant 15

'really useful to have training in in how best to approach sort of constructive criticism. You know how best to approach it in a useful way without things sounding negative or being taken away as a negative thing.'

Participant 4:

'everyone should have that training to give feedback.'

Participant 12:

'hearing different people's experience or feedback is useful as well in that training and thinking about the culture differences that we were talking about and hearing from some of my friends of different cultures actually that's really useful within that training as well'

Participant 16:

'if you had that training, you feel way more confident in, you know, approaching people from different backgrounds, different training programs and being able to give and receive feedback.'

Participant 17:

'the best session are the sessions where people of different backgrounds are in the same session with you have participants and that's when you get the best experience like definitely from my previous experiences'

Participant 7:

'I guess I'll awareness and educating the masses about it so that it's something that is. And. You know that people sort of bear in mind when they are giving feedback'

Participant 8:

'I think that 10 minute PowerPoint you do as part of your 50 tick boxes on induction to join a trust might need to be extended a little bit and become more part of our curriculum'

Participant 2:

'I like it when people use the word, the term IMG literacy. Which would mean that the NHS becoming more and more of an international workplace than the senior clinicians need to be more IMG aware, aware of the needs of IMGs and how they can adapt more and efforts like putting on just together or body angle, whatever they it's called I believe this is very helpful. I'm hoping that helps.'

Participant 1:

'I will definitely want for my trainers to be aware about the cultural differences and that people might perceive the feedback differently'

The focus groups mentioned that it is important this cross-cultural feedback training is provided in an interactive way e.g. video scenarios, first hand accounts, role-play practice.

Participant 3:

'instead of just sort of giving like theoretical sort of information about the cultural differences actually, like if they could have, let's say, like video scenarios of like a trainer or supervisor, different feedbacks and then giving examples of like good and bad feedback and how it looks different depending on who like the who the trainer is who the supervisor is. So just showing you know like these two people present from country X and person here how good feedback looks when they're doing it'

Participant 15:

'I had worked in Australia for a few years and we had actually a lot of teaching on Aboriginal background, and there was an officer and in the hospital and we got a lot of very valuable and you know from that Aboriginal community themselves would come in…. me coming from the UK across had no real understanding. So things like that I think would be very valuable.'

Participant 17:

'training sort of face to face. Almost like communication skills that you do in medical school, practicing giving people feedback. Would actually be really quite informative.'

Participant 12:

'needs to be training that doesn't compound people's assumptions and about why that might be happening and make sure that that's addressing the things that we can do about it. Like giving good feedback and good training and there being a lack of maybe a lack of that behind that.'

'we get so much equality and diversity training that I just think is a tick box exercise of getting through mandatory training and that's not that that's my attitude.'

Participant 8:

'I think that 10 minute PowerPoint you do as part of your 50 tick boxes on induction to join a trust might need to be extended a little bit and become more part of our curriculum'

The focus groups suggested that mentoring, particularly by those from similar backgrounds is useful. Additionally, enhanced induction can be helpful to settle IMGs into the environment.

Participant 11:

'somebody to just talk to, like appreciating that often these are people who are coming to a completely new country, leaving their family behind and just having somebody who knows the ropes of the NHS and the area that they're working in as both a professional and a like a general supportive person'

Participant 4:

'Getting feedback from people who have similar difficulties. Similar background might be helpful. Then having generic feedback which might not be like useful for you might not be constructive for you'

Participant 7:

'as part of their induction into UK system or into like a UK trust or whatever job there and when they come into this country to sort of like add bits in there about. This is the way things happen

here. Just so it doesn't come as a surprise or as a shock to the system when things when they encounter sort of instances which may be different from what they used to.'

The UK White group explored how encouraging more socialising as a team helps to create a more supportive environment. Furthermore, having wellbeing sessions to encourage conversations within a safe space can further help to create a supportive atmosphere.

Participant 16:

'Even in like a social aspect would be good and I think some of that is lost in their the breakdown of communal spaces at work where people can just mix and all sit and have lunch together…. I think make a huge difference to the cohesiveness of the team, and therefore if you're comfortable with someone you're more comfortable giving feedback as well and you understand, perhaps their culture better.'

'be more included in those more social activities that mean you make the connections and feel more confident'

Participant 17:

'days or weekends where people do sort of activities like a walk or something. And my understanding is from these experiences that people really enjoy them, but most of all, they feel like they can talk to each other a lot more and share things a lot more and then able to feedback in a way that they never would have beforehand. It just changes that it just breaks down that barrier.'

Participant 13:

'when a new trainees join the department, they take us all out for a dinner.'

Participant 8:

'we had like kind of these sessions that were like, well-being sessions where there are completely open forum, so people could just go and talk kind of like we're talking here but with less structured questions and I think maybe integrating that into a training system would be useful so that people can give feedback about how they feel about the feedback that they're getting, because I think this is probably one of the only times they've ever thought about it in any great depth and kind of reflected on it from a cultural perspective'

All focus groups had agreed that time is a barrier to feedback, and being able to create allocated time will be helpful.

Participant 16:

'Having more time. I think that feels like the big barrier to everything'

Participant 3:

'something like it will get done for sometimes if you're too busy, you know, people might not bother with feedback. But if it's [time] kind of like officially allocated, then they'll have to make an effort to actually use that time to give feedback to trainees.'

There were conversations about making sure feedback is a more fluid process between the educator and recipient.

Participant 6:

'it being fluid will give you the best constructive feedback those corridor conversations are often some of the best feedback that I've had as opposed to right, we're gonna sit down.'

Participant 8:

'It needs to be more fluid in nature, and I've done a PGC in medical education and there's very little fluidity on the structure models that you're given to give and take feedback. So allowing it to be both relevant on the shop floor as well as relevant when you're in theatre for some of those people here or whether you're in a formal feedback situation'

Discussion

Our results demonstrate the similarities and differences on feedback experiences between different demographic groups. Aside from exploring feedback, our results have shown how many UK White and UK BME doctors are not even aware of DA as a phenomenon. We explored how useful it would be to raise awareness of DA in our internal and external roundtables. Highlighting DA as a multifactorial process will help to deepen understanding and compassion within the workforce, and avoid any increasing stigma. Raising the awareness should not be thought of as a direct solution to improving feedback experiences, but rather as an underlying issue that helps to improve appreciation of the context between different demographics.

Across the focus groups, there was a consensus that formative feedback is more valuable when given in a timely manner, allowing recipients to reflect on their clinical interaction and if needed make improvements at the time. Feedback is also more valuable following direct observation of an interaction, allowing feedback to be relevant and specific compared to this being performed by a third-party individual. Building a strong relationship with a supervisor is important to allow for more individualised feedback, as the educator will be aware of their past experiences and skillset. These findings are unsurprising and reaffirm the importance of individualised feedback conversations that have been highlighted in previous literature (Kornegay JG et al, 2017) and in the Good Conversations, Fairer Feedback report.

Across the focus groups there was a consensus that WPBAs are not useful and often thought of as a 'tick-box' exercise rather than a means of providing meaningful and constructive feedback. It was raised that in situations where there has been limited feedback due to workplace time pressures, WBPAs could be useful in prompting supervisors to provide some feedback.

None of the UK White trainees felt they received less feedback than their colleagues. Whereas some trainees from the IMG and UK BME groups did feel they were in this position. This partly aligns with the national training survey results where IMGs reported receiving less feedback as shown by the graph below (red demonstrates less feedback being received).

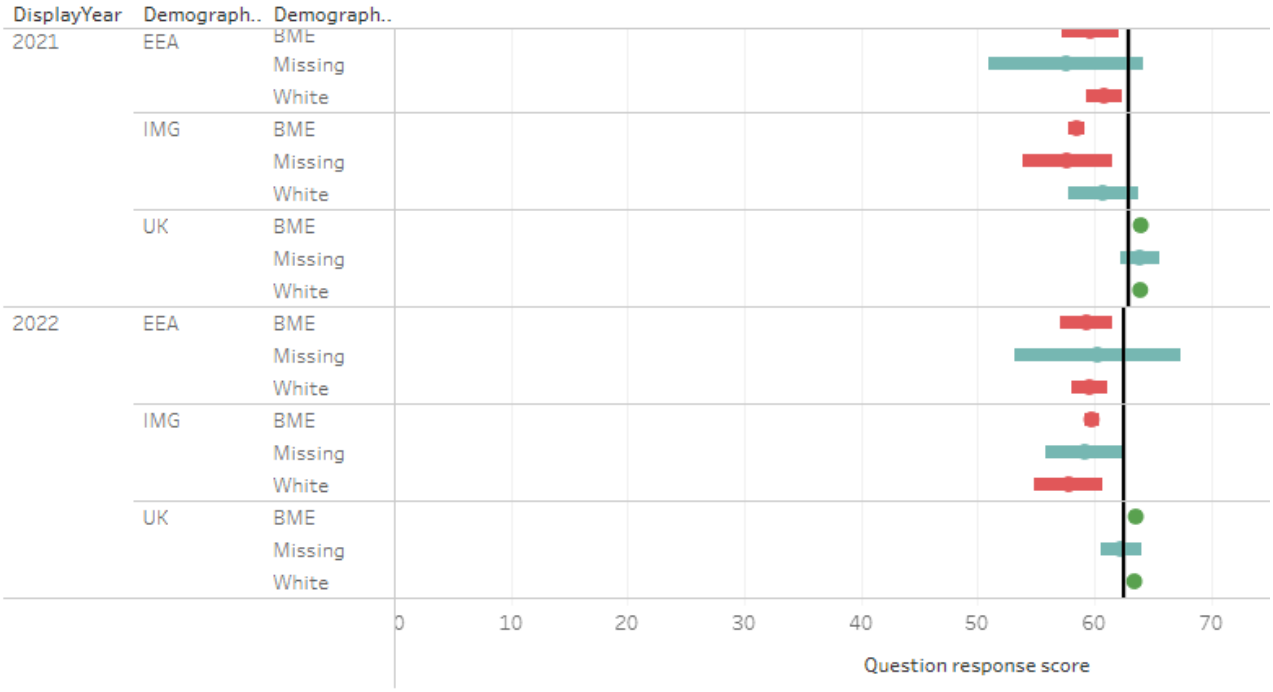

Figure 8 – National training survey data. Question GENHQ178 In this post, how often (if at all) do you receive informal feedback from senior colleagues about your performance?

Several barriers to feedback were highlighted across the three focus groups. One of the key barriers mentioned among all trainees was 'time'. Healthcare staff are working in pressurised environments resulting in a lack of time for training and feedback. We also observed specialty differences that were common across the focus groups. There seems to be a greater lack of feedback in ward and clinic-based activities, compared to supervision in a theatre setting or reporting alongside a senior radiologist or pathologist. It would be beneficial for educators to have allocated protected time to feedback to trainees on a regular basis.

When comparing the demographic groups, UK BME and IMG groups specifically mentioned 'culture' and 'fear' to be barriers to feedback, which were not mentioned in the UK White focus group. These findings suggest a lack of psychological safety amongst this cohort of doctors. Psychological safety is defined as 'a shared belief held by members of a team that the team is safe for interpersonal risk-taking' (Edmondson, 2002 as cited in NHS England, 2022). One factor contributing to a lack of psychological safety in the IMG and UK BME groups was that of blames cultures in ePortfolio, where negative feedback comments had been written anonymously and without having been discussed with the trainee beforehand. To give an example, one trainee had asked for feedback which resulted in a negative feedback comment on their ePortfolio suggesting

the trainee must not be confident in their skillset if asking for feedback.

We explored trainee confidence in asking for feedback amongst the focus groups, and there were key differences that emerged between the demographics. Firstly, trainees in the IMG and UK BME focus groups discussed issues around the fear of being labelled incompetent if they asked for feedback. This was also raised by trainees in the UK White group who had returned to work following a lengthy period of time off.

Secondly, we explored whether trainees felt their confidence in asking for feedback changes with seniority. In the IMG and UK White focus groups, confidence in asking for feedback increased with seniority, whereas in the UK BME group this confidence seemed to decrease. The underlying reasoning in the UK BME group was again related to the fear of creating a perception of incompetence, as when trainees are senior they feel their trainers expect more from them. It is not clear as to why the trend in the UK BME group is opposite to that in the IMG and UK White groups. A theory discussed within the external roundtable is that UK BME doctors may have been subject to more negative experiences (compared to UK White doctors) during their training, resulting in a lack of psychological safety to ask for feedback. The reason the IMG cohort have improved in their confidence is likely because they are trying to adapt to a completely different environment right from the start, and so as IMGs become more experienced, their overall confidence improves anyway. Regardless, we recommend further research is conducted to identify whether this is a recurring trend among UK BME doctors and to explore the underlying reasoning.

The trainees were asked whether they are comfortable in raising concerns if feedback is not being provided. The conversations in the IMG and UK BME groups were around the fear of doing this as they do not want to be 'labelled as a troublemaker'. Whereas the UK White group discussed the logistics of being able to raise concerns as they did not know if there was a clear path to do so. This example further illustrates a lack of psychological safety within the IMG and UK BME groups.

When exploring how trainees feel about delivering feedback, all focus groups agreed that delivering feedback is easier when directly observing and when the feedback is positive. It is more challenging to deliver negative feedback, particularly if this is on professionalism or cultural behaviours. Trainees feel worried about the recipient 'putting up a wall of resistance' towards them in these circumstances. If negative feedback is needing to be given, it is more comfortable

to deliver this in a private space away from others. These findings again reaffirm those found in the Good Conversations Fairer Feedback report, where critiquing actions in front of others made trainees feel 'awkward, inadequate, and embarrassed' (Rutter and Walton, 2020).

Between the different demographic groups, the UK White trainees mentioned they generally find it easier to deliver feedback to UK trainees as there is already an awareness and mutual understanding of the medical system and training. This is unsurprising and can be linked to the same way in which IMGs seek advice and mentorship from other IMGs who have gone through similar experiences. Our findings demonstrate the importance of training in delivering feedback across the workforce.

We further explored training experiences in feedback. Across the focus groups, most trainees have not been given training in how to receive feedback, and only a few more trainees have been given training on how to deliver feedback. A particular point to note is that many of the individuals participating in the focus groups mentioned they have a particular interest in medical education with a background of formal clinical education degrees and projects. Yet, even these trainees have not been provided with opportunities on training in feedback. When discussing these findings at the roundtables, participants highlighted the importance of providing training on giving and receiving feedback at undergraduate level. Some trainees mentioned they may have been given training on delivering feedback during medical school, but could not recall specific details, and mentioned feedback training had not been provided during their postgraduate training. Feedback training at both undergraduate and postgraduate levels allows the information to stay more relevant to the context in which trainees are working in. Additionally, if feedback training is only focussed at undergraduate level, then those who are already within their postgraduate training years and beyond will miss out on this opportunity. Another important point from our study is that participants mentioned none of the feedback training provided has included an awareness of cross-cultural communication. It is important that this training is delivered in a meaningful and interactive manner, and several suggestions e.g. videos, role-play practice, in-person first hand accounts, would be helpful in delivering this training. We believe this cross-cultural competence training will help improve feedback experiences between demographic groups. A recent evaluation of the EQiT (Embedding Compassionate, Courageous, Cross-cultural Conversations into Training) workshop showed that training that includes elements of cross-cultural communication can lead to 'development of better relationships and support mechanisms for trainees' (Brown et al, 2023).

Following on from exploring feedback experiences, we asked the focus groups their thoughts on how feedback experiences could be improved, particularly in the context of DA. There were several suggestions raised, which are summarised below. Some of the suggestions support ideas that are already being developed, such as enhanced induction and mentoring. Trainees also suggested how group activities and well-being days are useful in creating a friendly network, allowing for a more supportive environment where feedback can be shared more freely. It is important that such activities are accessible to all so as not to disadvantage and exclude certain demographic groups. A key suggestion for improving feedback experiences is to provide training in feedback, as discussed above.

Suggestions from the focus groups on how to improve experiences of formative feedback in the context of DA:

- Allocated and protected time for feedback
- Cross cultural communication and cultural competence training
- Roleplay practice and video scenarios
- Training in how to best approach constructive feedback maybe with use of a more fluid structure to establish common ground
- Mentoring
- Enhanced induction
- Wellbeing days/group activities
- Increasing awareness of DA

Assumptions to challenge

After each focus group, there were a few tendencies identified and agreed on by all three focus group facilitators during the post-debrief. Firstly, there was a tendency for UK White and UK BME groups to assume that DA only affects IMGs. The conversations on DA would always revert to describing IMGs, with no awareness of this phenomenon also affecting UK BME doctors. Secondly, there was a tendency by the UK BME doctors to associate cultural differences to do with IMGs rather than their own cohort. Lastly, during conversations within the UK White trainee group, there was an assumption that IMGs are locally employed doctors, rather than thinking of IMGs as trainees.

Limitations

We have conducted a qualitative project involving three focus groups to explore feedback experiences in IMG, UK BME, and UK White trainees. Our results may be limited by the smaller number of trainees who attended at the time. Regardless, many of our results reaffirm findings across existing research, suggesting new results from these groups are also valid. The smaller group numbers allowed each trainee to have a chance to speak and for more free-flowing discussion between all trainees.

One of the project facilitators is a UK BME trainee, which could have the potential to introduce bias from participants in the focus groups and during the analysis and interpretation of conversations. We saw no evidence of participant bias in the conversations. The risk of bias from the facilitator was mitigated by ensuring the analysis was first conducted independently by two of the researchers. During the focus groups, all facilitators did not contribute to the conversations themselves.

Next steps

Through the analysis of the focus groups and the stress we placed on improving feedback, we were able to identify potential interventions and changes that may be helpful in improving feedback in the context of DA. We engaged with internal and external stakeholders to seek their views on which of these interventions might be the most impactful and feasible. Below we summarise the recommendations that emerged from the focus groups and the roundtables.

GMC recommendations

GMC standards

Feedback should be considered more carefully in GMC outcomes and standards around training, including future reviews of Outcomes for Graduates, General Professional Capabilities, Excellence by Design, Promoting Excellence. This will enable the GMC to quality assure training environments and curricula against these outcomes and standards. The GMC should also seek examples of good practice and share them with stakeholders.

Quality assurance

The QAMI and MED teams should consider quality of feedback, training in giving and receiving feedback, and cross-cultural communication and cultural competency in their quality assurance processes with key stakeholders, such as deaneries, royal colleges and faculties, and medical schools.

Surveys

The national training survey is a key tool through which training environments can be captured. During our focus groups, we identified how trainees are worried about giving negative feedback about departments they are working in due to the fear of being identified. We have fed this back to the Surveys team who have adapted their messaging to trainees about the systems that are in place to ensure and protect the anonymity of respondents.

As a recommendation to the Surveys team, the future iterations of the national training survey could include more specific questions about the quality of feedback in the context of DA.

System-wide recommendations

Training in giving and receiving feedback

Training in giving and receiving feedback should be more widely available and accessible for trainees and educators across the UK. Access to training can be a 'postcode lottery' and this needs to be addressed to make sure there is equal access to opportunities. Case studies, roleplay, and similar learning tools should be used as part of the learning process. This could support learners in recognising the usefulness of day-to-day feedback and that this comes in various shapes, forms, and settings.

Cross-cultural communication and cultural competency

Feedback training should include elements of cross-cultural communication and cultural competency to enable trainers and trainees to have effective and productive feedback conversations. As mentioned above, case studies, roleplay, and similar learning tools should be used as part of the learning process.

Raising awareness of DA

It would be beneficial to raise awareness of DA while also highlighting the causal factors of DA to make sure that harmful stereotypes are not perpetrated. Educators and supervisors are a key group that should know about DA.

Blame culture

It would be beneficial to add a system that prompts the person giving feedback to specify if the negative feedback has been discussed with the trainee. Where this didn't happen, the system should alert the trainee's educational supervisor who would then be responsible for investigating and handling the matter. Simply having a prompt could be beneficial as a reminder for people providing feedback to make sure they think about discussing negative feedback before documenting it on an ePortfolio. The GMC should ensure that such systems are being monitored in their quality assurance processes.

Allocated protected time for feedback

Educators and supervisors should have allocated protected time for feedback and recognition of the amount of time it takes to deliver feedback effectively. This should be reflected in job plans.

Research

- One of our new key findings was that UK BME trainees feel less confident asking for feedback with increased seniority. This was the opposite in the UK White and IMG groups. We recommend further research takes place to identify if this trend persists in a bigger sample size and explore the underlying reasoning.
- Further funding and research is needed to implement targeted interventions in this field and evaluate their effectiveness.
- Our study has focused on doctors in training in a GMC recognised training programme in the UK. We believe our findings can be extrapolated to wider groups, specifically LEDs and we recommend further research into the experiences of this group.
- It is widely recognised that feedback is a two-way process and conversation. Further research is needed to understand the experiences of educators from different demographic backgrounds.

Conclusion

Our research has deepened our understanding of the differences in feedback experiences between IMG, UK BME and UK White doctors in training.

Our key findings are summarised as follows:

Awareness of DA

There was a higher awareness of DA in the IMG group compared to the UK White and UK BME group. The participants agreed that increasing awareness would help gain a deeper understanding of individual circumstances and could increase compassion in the workplace.

Valuable ways to receive feedback

Across the focus groups, there was a consensus that feedback is more valuable when given in a timely manner following direct observation of an interaction. Furthermore, building a relationship with a supervisor is important to allow for more individualised feedback. These findings reaffirm the importance of individualised feedback conversations within the Good Conversations, Fairer Feedback report.

Barriers to feedback

Several barriers to feedback were highlighted across the three focus groups. One of the key barriers mentioned among all trainees was 'time'. We also observed specialty differences, with lack of feedback being present more in ward and clinic-based activities. When comparing the demographic groups, UK BME and IMG groups specifically mentioned 'culture' and 'fear' to be barriers to feedback, suggesting the lack of psychological safety amongst this cohort of doctors.

Receiving feedback

None of the UK White trainees felt they received less feedback than their colleagues, whereas some trainees from the IMG and UK BME groups did feel they were in this position. This partly aligns with the national training survey results where IMGs consistently report that they receive less feedback.

Asking for feedback

The IMG and UK BME focus groups discussed issues around the fear of being labelled incompetent if they ask for feedback. This feeling was raised in the UK White group by two trainees who had returned to work following time off.

The UK White and IMG groups mentioned how their confidence to ask for feedback increased with seniority, unlike the UK BME group where this declined with time.

IMG and UK BME groups were also worried about being labelled a 'troublemaker' if they raised concerns on lack of feedback, whereas the UK White group discussed the logistics of how to practically raise concerns.

Delivering feedback

All trainees agreed that it is easier to deliver feedback when directly observing and when the feedback is positive. It is more challenging to deliver negative feedback, particularly if this is on professionalism or cultural behaviours. It is more comfortable to deliver negative feedback in a private space away from others. Trainees have felt that when delivering negative feedback, the recipient may 'put up a wall of resistance' towards them.

UK White trainees mentioned that they find it easier to give feedback to UK trainees as there is already an awareness and mutual understanding of the medical system and training.

One foundation trainee mentioned they do not tend to give feedback as they do not want to overstep the mark.

Training in feedback

There was a general trend that most trainees have not been given training on how to receive feedback, and only a few more trainees have received training on how to deliver feedback. None of the feedback training has included an awareness of cross-cultural communication.

Assumptions to challenge

There were several assumptions in the focus groups that should be challenged

- UK BME and UK White: the tendency that DA only affects IMGs.
- UK BME: the tendency that cultural differences are to do with IMGs and not within their own cohort.
- UK White: the tendency that IMGs are SAS doctors rather than trainees.

Improvements in feedback

Across all the focus groups, there were numerous suggestions on how formative feedback can be improved in the workplace. Through the focus groups and roundtables we ran, we were able to define key recommendations and stakeholders. The recommendations focus on three main areas:

- standards
- training for learners and educators
- removing barriers such as lack of awareness, time, and blame

Our research has also highlighted areas that should be researched further, such as UK BME trainees feeling less confident in asking for feedback with seniority, experiences of feedback of educators, and experiences of feedback for LEDs.

Appendices

Appendix 1 – Focus groups questions

Feedback focus group question structure

Intro questions

Were you aware of differences in educational outcomes between different demographic groups before receiving my emails? (Poll Yes/No)

What do you think are the barriers to feedback? (Poll Word cloud)

Point to mention: Interesting you have/have not mentioned culture.

Do you think cultural differences has affected your experience of feedback? (Poll Yes/No)

Theme 1 – Types of feedback *(15 mins)*

What are the most valuable ways in which you receive formative feedback?

If asked what is formative feedback, ask the question back.

Are work place based assessments useful as feedback? (Poll scale yes/no/to some extent)

What is your experience of feedback on a day-to-day basis?

Prompt: Do you think general daily conversations are useful feedback? Why is this feedback useful? How does it support your learning? What do you receive feedback on (e.g. behaviour)?

Theme 2 – Delivering feedback *(15 mins)*

How do you feel about giving feedback to your junior colleagues?

How do cultural differences affect the experience of delivering feedback?

Prompt: Do you ever avoid giving feedback? Is this more often for certain demographic of people? Why? Do you find it challenging to deliver negative feedback?

Theme 3 – Receiving feedback *(15 mins)*

Do you feel you receive less feedback than your colleagues? (Poll scale – Yes/No/I can't say)

How do you feel asking for feedback? *Why?*

Are you able to raise concerns if feedback is not being provided regularly?

Theme 4 – Improving feedback *(25 mins)*

Have you received training in delivering feedback? (Poll scale yes – and it was useful/yes – it was only partly useful/no) **Have you been given training in receiving feedback?** (Poll scale yes – and it was useful/yes – it was only partly useful/no)

If answered NO - if you were to receive training, what would you like this to include? *Prompt: why would you like to include this?*

If answered YES - has this training included an awareness of cross-cultural communication?

How can we overcome any barriers cultural differences create in delivering and receiving feedback?

Can you think of other interventions that would help to improve formative feedback for specific demographic groups?

Additional questions if time

What has been your experience of receiving feedback at medical school and has this changed in post-graduate training?

Who do you receive most of you feedback from?

Prompt: Should all doctors give feedback? Does feedback feel more relevant if delivered by ES/CS?

One of the recommendations of GCFF is to focus more on having a two-way feedback conversation, what are your thoughts on this?

How do you feel you can develop a more meaningful trainer-trainee relationship?

How useful are workplace-based assessments for making up for a general lack of feedback received otherwise?

What do you receive feedback on? (Do you regularly receive feedback on your behaviour?)

Appendix 2 – Information sheet

Information sheet on feedback project

Background

International Medical Graduates (IMG) and UK Black and Minority Ethnic (BME) doctors face disadvantage throughout their careers. It is therefore unsurprising that despite being selected for high academic achievement, trainees from these groups end up performing worse on average than their UK white counterparts during education and training. Nationally, across all specialties, UK ethnic minority trainees have a 12% lower pass rate than UK white trainees. IMG ethnic minority trainees have a 32% lower pass rate than UK white trainees. (GMC Progression data). This phenomenon is called "differential attainment (DA)".

Tackling discrimination and inequality in medicine is an urgent priority for everyone supporting the health services. It's the right and fair thing to do. It's also vital to helping retain doctors working in the UK and to support high quality patient care. To achieve our target of eliminating discrimination and disadvantage in medical education, we're working on projects across the education and training pathway to tackle the root causes, from recruitment and selection into training, and access to educational resources such as mentoring, exam preparation and good quality feedback.

You may wish to refer to the following papers for further information:

Fair Training Pathways for All: Understanding Experiences of Progression - Final Report (gmc-uk.org)

gmc-da-final-report-success-factors-in-training-211119_pdf-80914221.pdf (gmc-uk.org)

Research suggests that IMG and UK BME doctors are at risk of not receiving high quality feedback compared to their white counterparts.

'Good Conversations, Fairer Feedback'

'Fair to Refer'

These reports recommend improving feedback, firstly to enhance the progression of IMG and UK BME doctors, and secondly to help reduce the higher proportion of fitness to practice referrals of

these doctors.

What is the project?

We are conducting a project exploring *what* trainees think of as being *formative* feedback and *how* we can improve *formative* feedback to help reduce the DA gap.

We will be running trainee focus groups involving different grades of doctors and predominantly those who are IMG and UK BME trainees. We would like to use the focus groups to ask questions related to trainee experiences on formative feedback. The information we gain from these focus groups will be fed into a short life working group, where we can combine the expertise of different stakeholders to drive improvements in formative feedback in the context of DA. We may also ask for your interest in joining a short life working group at a later date.

How can you help?

We are looking for volunteers to join our focus groups, **please express your interest by completing these short set of questions (approximate completion time is 1 minute)**. To have a variety of trainees within our focus groups we would like to capture some demographic detail that we have asked for in the survey. We kindly request for the survey to be completed by **21st December.**

Provisional focus group dates and times:

January 31st, 6 -7:30pm - Virtual meeting via Microsoft Teams

February 1st, 6 - 7:30pm – Virtual meeting via Microsoft Teams

Please note you will only need to attend one of the focus groups. If we receive a high volume of interest you may be put on a waiting list.

What happens next?

After the survey completion deadline on **21st December**, we will be in touch with further information on focus group allocation.

Thank you so much for your time, we appreciate this is a very busy part of the year with winter pressures. Participating in the focus group is completely voluntary and you may withdraw consent at any point.

Any questions?

If you have any queries then please email:

da@gmc-uk.org

Thank you

Dr Priyanka Singhal

Marx Fellow, General Medical Council

National Medical Director's Fellow

Appendix 3 – Consent form

Feedback Project

Purpose & approach

The Education and Standards Team are running focus groups exploring what trainees think of as being formative feedback and how we can improve formative feedback to help reduce the Differential Attainment (DA) gap.

We are conducting this research for a number of reasons:

To issue recommendations to drive improvements in formative feedback in the context of DA

To inform future research projects at the GMC.

How your information will be used: We will not pass any of your personal details on to any other companies and all the information we collect will be kept in the strictest confidence and used for research purposes only. If something that you feel is important occurs to you at a later point or you need to check something and get back to us, you can get in touch after the interview. The identity of participants will not be identifiable within any published material.

Right to data: Additionally, under UK data protection law (UK GDPR), you have the right to have a copy of your data, to change your data, or withdraw from this research at any point. Further information about your rights as a data subject are available on our website.

If you wish to confirm the validity of the research or get more information about aims and objectives, you can contact:

DA@gmc-uk.org

Recording: The focus groups will be recorded and transcribed via MS Teams so that we can accurately capture your views, and so researchers can listen back when analysing the data. The recordings will be kept for 3 months after the interview to allow for quality checks to be carried out on the transcripts. The transcripts will be retained in line with our published Records retention and disposal policy.

If you are happy to proceed on this basis of recording, please fill out the below:

Name:

Signature:

Date:

Appendix 4 – Internal Feedback Roundtable Plan (Education)

Introduction (15 min)

Thank you for volunteering your time for this roundtable. Round of introductions.

You should have all received the roundtable information sheet for reading, but I will also now deliver a quick presentation (**for the purpose of the focus group we define IMG and UK BME etc**) to summarise the project and key findings. Share presentation (stop at the assumptions to challenge slide).

We would now like to ask everyone a series of questions and invite your thoughts. We hope by the end of this session we can all take forward key recommendations, practical considerations, action points and ownership of this to take forward.

Questions for Roundtable

1 (10 min)

From our focus groups the results show that only 40% of UK White and UK BME trainees are aware of differential attainment as a phenomenon. In conversation, UK BME trainees did not associate cultural differences to do with their own cohort, and tendency to associate DA with IMGs.

Have you come across this tendency from the UK BME groups?

Do you think raising awareness of differential attainment and the groups affected will be helpful? Should we raise awareness with trainees, any other groups to target as well?

How do we raise the awareness as current ways are still not getting the message across to many doctors?

2 (10 min)

Not all trainees are given training on feedback, even less when it comes to how to receive feedback. A key point we noted is how none of the training delivered has included cross-cultural

communication and competence training. (*A lot of trainees we spoke to already had a great interest in medical education, therefore are already more attune to training and feedback, and even they have not had this training*).

How do we bring this to light?

Should we be making this an integral part of doctors training by bringing this into curricula? Undergraduate and post-graduate?

3 (10 min)

When discussing barriers to feedback, culture and fear were highlighted within the IMG and UK BME groups. These demographic groups also mentioned fear of being labelled a troublemaker if raising concerns on lack of feedback.

How can we quality assure that there is a safe feedback environment? Are we already doing this? Do we need to do more?

4 (10 min)

UK BME reduce confidence with seniority. (For end of discussion/during – could mention our theory. Does this link to FTP if not asking for feedback).

We were surprised with this finding and the difference with the other groups (particularly IMG). Does this come as a surprise to you?

What do you think is causing this?

What can we do to address this?

5 (10 min)

In order to encourage Deaneries and Royal Colleges to take action in improving formative feedback experience, can Action Plans include section on how formative feedback is being improved in the context of DA?

6 Reshare presentation from after the assumptions to challenge slide.

7 (15 min)

These are the recommendations that came out of the focus groups. We are looking at prioritising them and would like your views in which ones you would like to see based on feasibility, impact and resources.

Direct Observation
Timely feedback (straight after the clinical encounter/event)
Allocated and protected time for feedback
Building a relationship with supervisors
Individualised feedback
Cross cultural communication and cultural competence training. UK white group especially valued first hand accounts
Roleplay practice and video scenarios
Training in how to best approach constructive feedback maybe with use of a more fluid structure to establish common ground
Mentoring
Enhanced induction
Well-being days/group activities
Increasing awareness of differential attainment

Consensus on which key points to take forward.

Appendix 5 – External Feedback Roundtable Plan Sheet

Introduction (20 min)

Thank you for volunteering your time for this roundtable. Round of introductions.

We will be making use of the recording service on Teams, to help us remember some of the conversation afterwards. This will only be accessible to the project researchers and will be deleted once we have done our write up.

You should have all received the roundtable information sheet for reading, but I will also now deliver a quick presentation (for the purpose of the focus group we define IMG and UK BME etc) to summarise the project and key findings.

We would now like to ask everyone a series of questions and invite your thoughts, your wealth of practical experience in medical education. We also really welcome to be challenged on any ideas as this is very much an open space. We hope by the end of this session we can all take forward key recommendations and action points for this area of work. As a reminder we are specifically wanting to look at formative feedback in the context of IMG and UK BME doctors in training as part of differential attainment.

We have a set of questions to get through exploring each of these themes, with allocated time for each section, apologies if I need to move on from your comments as we do have quite a lot to get through, but please feel free to use the chat function if needed as I really would love to hear your thoughts.

Questions for Roundtable

1 (15 min) 13:50

From our focus groups the results show that only 40% of UK White and UK BME trainees are aware of differential attainment as a phenomenon. In conversation, UK BME trainees did not associate cultural differences to do with their own cohort, and tendency to associate DA with IMGs.

Have you come across this tendency from the UK BME groups?

Do you think raising awareness of differential attainment and the groups affected will be helpful? Should we raise awareness with trainees, any other groups to target as well?

How do we raise the awareness as current ways are still not getting the message across to many doctors?

2 (15 min)

Not all trainees are given training on feedback, even less when it comes to how to receive feedback. A key point we noted is how none of the training delivered has included cross-cultural communication and competence training. (*A lot of trainees we spoke to already had a great interest in medical education, therefore are already more attune to training and feedback, and even they have not had this training*).

How do we bring this to light?

How can we make this training more widespread across the workforce?

Break (5 min) 14:20

3 (15 min) 14:25

The IMG and UK BME groups talked about anonymous blame culture on eportfolios. We propose that negative criticism should be raised and discussed with the trainee in the first instance, and only included in the eportfolio following trainee awareness.

How do we make such a system happen?

Who is responsible for identifying and correcting the issue if this has not been followed?

4 (15 min) 14:40

When discussing barriers to feedback, culture and fear were highlighted within the IMG and UK BME groups. These demographic groups also mentioned fear of being labelled a troublemaker if raising concerns on lack of feedback.

How can we create a safe feedback environment?

Clearer pathway for raising concerns without fear of labelling to encourage psychological safety, culture of learning, and taking away from blame culture. How do we implement this? What are the steps? *Raise the importance of creating a pathway for raising concerns where feedback is not being provided or provided in a non-constructive way with senior leadership e.g. DME*

5 (15 min) 14:55

UK BME reduce confidence with seniority. (For end of discussion/during – could mention our theory. Does this link to FTP if not asking for feedback).

We were surprised with this finding and the difference with the other groups (particularly IMG). Does this come as a surprise to you?

What do you think is causing this?

What can we do to address this?

6 (20 min) 15:10

These are the recommendations that came out of the focus groups. We are looking at prioritising them and would like your views in which ones you would like to see based on **feasibility, impact and resources.**

Direct Observation
Timely feedback (straight after the clinical encounter/event)
Allocated and protected time for feedback
Building a relationship with supervisors
Individualised feedback
Cross cultural communication and cultural competence training. UK white group especially valued first hand accounts
Roleplay practice and video scenarios
Training in how to best approach constructive feedback maybe with use of a more fluid structure to establish common ground
Mentoring
Enhanced induction
Well-being days/group activities
Increasing awareness of differential attainment

Consensus on which key points to take forward.

General feedback for all doctors (if we have enough time):

In terms of barriers to feedback, all groups agreed that time was a barrier and that feedback is most useful when delivered in a timely manner following direct observation, rather than the feedback coming as a second hand account from ES at an end of placement meeting. NHS is currently an overstretched system, is there any power on creating time within job plans?

Appendix 6 – Internal Feedback Roundtable Plan Sheet (Outreach)

Introduction (15/20 min)

Thank you for volunteering your time for this roundtable. Round of introductions.

You should have all received the roundtable information sheet for reading, but I will also now deliver a quick presentation (**for the purpose of the focus group we define IMG and UK BME etc**) to summarise the project and key findings.

We hope by the end of this session we can all take forward key recommendations and action points for this area of work. We would like some practical considerations to take forward and ownership of this to take forward. We would now like to ask everyone a series of questions and invite your thoughts.

Share presentation (stop at the assumptions to challenge slide).

Questions for Roundtable

1 (10 min)

From our focus groups the results show that only 40% of UK White and UK BME trainees are aware of differential attainment as a phenomenon. In conversation, UK BME trainees did not associate cultural differences to do with their own cohort, and tendency to associate DA with IMGs.

Have you come across this tendency from the UK BME groups?

Do you think raising awareness of differential attainment and the groups affected will be helpful? Should we raise awareness with trainees, any other groups to target as well?

How do we raise the awareness as current ways are still not getting the message across to many doctors?

2 (10 min)

Not all trainees are given training on feedback, even less when it comes to how to receive

feedback. A key point we noted is how none of the training delivered has included cross-cultural communication and competence training. (*A lot of trainees we spoke to already had a great interest in medical education, therefore are already more attune to training and feedback, and even they have not had this training*).

How do we bring this to light?

How can we make this training more widespread across the workforce?

3 (10 min)

When discussing barriers to feedback, culture and fear were highlighted within the IMG and UK BME groups. These demographic groups also mentioned fear of being labelled a troublemaker if raising concerns on lack of feedback.

How can we promote safe feedback environment?

4 (10 min)

UK BME reduce confidence with seniority. (For end of discussion/during – could mention our theory. Does this link to FTP if not asking for feedback).

We were surprised with this finding and the difference with the other groups (particularly IMG). Does this come as a surprise to you?

What do you think is causing this?

What can we do to address this?

5 Reshare presentation from after the assumptions to challenge slide

6 (15 min)

These are the recommendations that came out of the focus groups. We are looking at prioritising them and would like your views in which ones you would like to see based on **feasibility, impact and resources.**

Direct Observation
Timely feedback (straight after the clinical encounter/event)
Allocated and protected time for feedback
Building a relationship with supervisors
Individualised feedback
Cross cultural communication and cultural competence training. UK white group especially valued first hand accounts
Roleplay practice and video scenarios
Training in how to best approach constructive feedback maybe with use of a more fluid structure to establish common ground
Mentoring
Enhanced induction
Well-being days/group activities
Increasing awareness of differential attainment

Consensus on which key points to take forward.

Appendix 7 – Focus group participants

IMG group

Training Level	Specialty
ST1	Clinical Radiology
ST3	General Practice
ST5	General Psychiatry
ST5	Paediatrics
ST5	Ophthalmology

UK BME group

Training Level	Specialty
ST4	Trauma and orthopaedic surgery
ST4	Infectious diseases
ST5	Emergency Medicine
ST8	Emergency Medicine
ST8	Obstetrics and Gynaecology

ST4	General Practice

UK White group

Training Level	Specialty
ST3	Anaesthetics
ST5	Histopathology
FY2	Foundation Training
CT3	Internal Medicine Training
ST4	Geriatrics
ST6	Anaesthetics

References

1. Atewologun D, Kline R, Ochieng M. *Fair to refer?* General Medical Council. 2019
2. Brown J, Jenkins L, Sandars J, Bridson J, Patel M. Evaluation of the Impact of the Workshop 'EQiT – Embedding Compassionate, Courageous, Cross-cultural Conversations into Training'. 2023
3. Burgess A, Mellis C. Feedback and assessment for clinical placements: achieving the right balance. Adv Med Educ Pract 2015; 6:373-81
4. Coia, D. and West, M. *Caring for doctors, caring for patients.* General Medical Council. 2019
5. Cowan, G. E. Assessment and appraisal of doctors in training: principles and practice. Royal College of Physicians of London. 2001
6. Edmondson A. Managing the risk of learning: Psychological safety in work teams. International Handbook of Organizational Teamwork, London: Blackwell. 2002. As cited in NHS England. Safety culture: learning from best practice. 2022
7. Ende J. Feedback in clinical medical education. JAMA. 1983
8. General Medical Council. Equality, diversity and inclusion Targets, progress and priorities for 2023. General Medical Council. 2023
9. General Medical Council. *The state of medical education and practice in the UK*. General Medical Council. 2022
10. General Medical Council. *The state of medical education and practice in the UK*. General Medical Council 2020
11. Kamali, D. and Illing, J. How can positive and negative trainer feedback in the operating theatre impact a surgical trainee's confidence and well-being: a qualitative study in the north of England. BMJ Open **8**(2): e017935. 2018
12. Kelly E. Medical education, giving feedback to doctors in training. BMJ 2019

13. Kornegay JG, Kraut A, Manthey D, Omron R, Caretta-Weyer H, Kuhn G, Martin S, Yarris LM. *Feedback in Medical Education: A Critical Appraisal*. AEM Educ Train. 2017 Mar 22;1(2):98-109. doi: 10.1002/aet2.10024. PMID: 30051017; PMCID: PMC6001508.

14. Rutter A, Walton C. *Good conversations, fairer feedback.* General Medical Council. 2020

15. Woolf K, Viney R, Rich A, Jayaweera H, Rigby M, Griffin A. *Fairer Training Pathways for All: Understanding Experience of Progression Part 2*. General Medical Council, 2017.

16. Woolf K, Rich A, Viney R, Rigby M, Needleman S, Griffin A. *Fair Training Pathways for All: Understanding Experiences of Progression.* General Medical Council, 2016.

17. Woolf K, Differential attainment in medical education and training. BMJ. February 2020