Royal College of Obstetricians & Gynaecologists

RCOG Differential Attainment Report

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Background

Differential attainment (DA) is a term used to describe differences in the average performance of different groups with and without protected characteristics[1]. The General Medical Council (GMC) defines differential attainment as 'the gap between attainment levels of different groups of doctors'. There is growing awareness that these differences are not only harmful for the workforce but also detrimental to patient care.

There is also growing understanding about the significance of intersectionality – a term coined by Kimberlé Crenshaw[2]. People with multiple protected characteristics can experience overlapping discrimination, with negative synergy between, for example, racism, sexism and homophobia, meaning that the harm encountered is significantly greater than for any one factor alone.

DA may be evident in all stages of training and working – it can be seen in ARCP outcomes, exam results as well as access to academic opportunities. It is evident in undergraduate and postgraduate training, but beyond training in Clinical Excellence Awards and the composition of Medical Boards. This, our second TEF DA report, seeks to begin to understand the scope of this issue within the Royal College of Obstetricians & Gynaecologists – but focusing on trainees.

The report presented here uses data from the GMC National Training Survey (NTS) and the RCOG TEF 2022 and RCOG training data sets 2019 and 2018. We looked first at the diversity of the current cohort of doctors-in-training, particularly focusing on gender, ethnicity and place of primary medical qualification (PMQ). We then looked at distribution among these groups of those enrolled in sub-specialty training (SST) and those that are working Less Than Full Time (LTFT) . Other outcomes used include support during a serious incident and whether trainees were subjected to persistent bullying behaviour.

Analysis of the data is made more complex due to the use of self-identification and also differences in questions asked and responses allowed. Additionally, the two sources of data often captured the same information differently. There were also several gaps where no data was entered. We briefly reviewed the free text data but it not included within the scope of this report.

Additionally, the TEF is an extensive questionnaire – future reports may include analysis of further relevant outcomes. Questions including those exploring whether the trainees felt valued, whether they had sufficient access to academic opportunities and appropriate supervision were not examined in this report. More work is needed in these areas. This report is intended as a snapshot understanding the differences of experience through various demographics.

Basic demographics

The following data is from the TEF 2021.

<u>Gender</u>

There were 1543 responses to the question relating to gender. The breakdown is seen below.

Breakdown of TEF repsonses by gender (%)

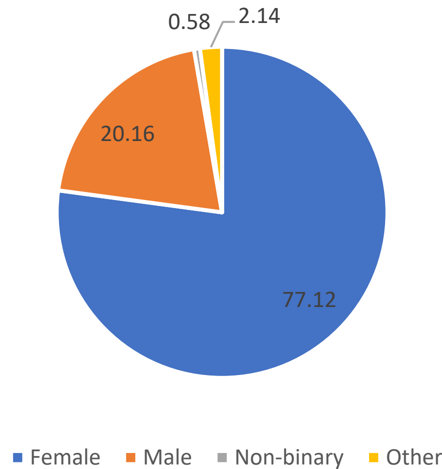

Figure 1. Breakdown of TEF responses by gender

<u>Ethnicity</u>

There were 1500 responses to the question related to ethnicity. Trainees were also able to self-identify. Their responses have been grouped to aid analysis. See figure below.

Breakdown of TEF responses by grouped ethnicity (%)

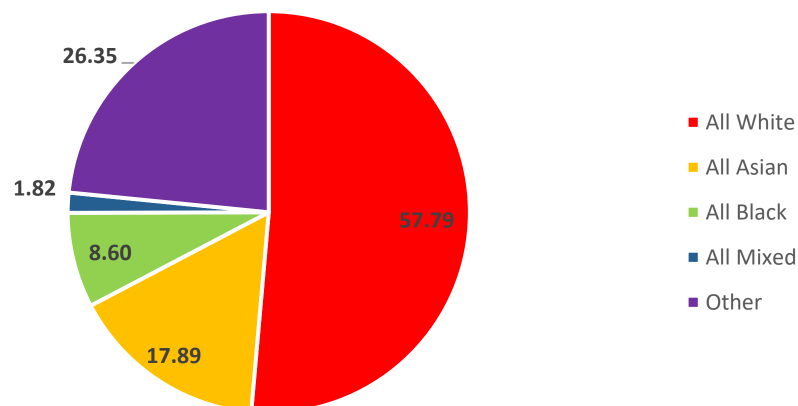

Figure 2. Breakdown of TEF by grouped ethnicity

<u>Location of Primary Medical Qualification (PMQ)</u>

There were 1543 responses to the question related to PMQ. Doctors from the UK, the European Economic Area (EEA) or where International Medical Graduates (IMG). The breakdown is shown in the figure below.

Breakdown of TEF repsonses by PMQ (%)

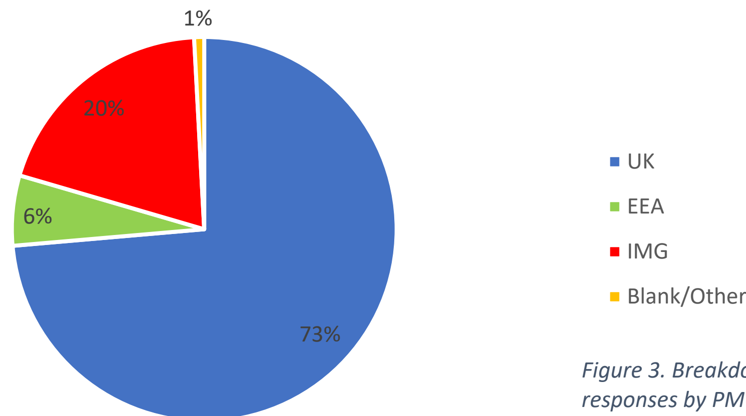

Figure 3. Breakdown of TEF responses by PMQ

<u>Subspeciality training (SST)</u>

There were 61 respondents enrolled in SST. Male trainees were slightly more likely to be in SST programmes (4.5%) than female trainees (3.95%). See fig below.

Proportion of trainees in SST by gender (%)

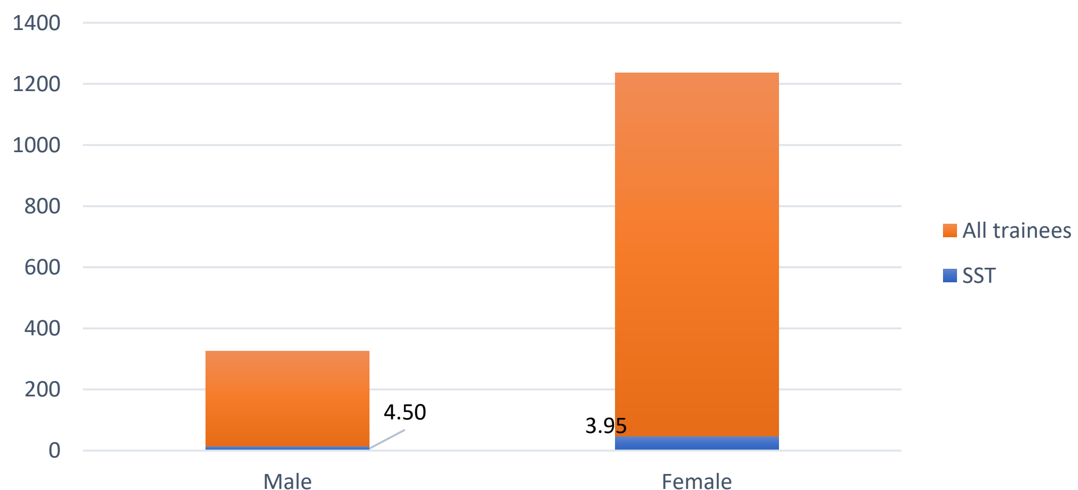

Figure 4. Proportion of trainees in SST by gender

The proportion of trainees from different ethnic backgrounds also revealed differences. 5.08% of Asian trainees were enrolled in SST, double the proportion of black trainees at 2.44%. 4.34% of White trainees were in SST and 3.36% of mixed/other trainees. See both figures below. Additionally although black trainees make up 8.1% of the trainee workforce, they are underrepresented within SST as they only make up 4.9% of these posts. See figures below

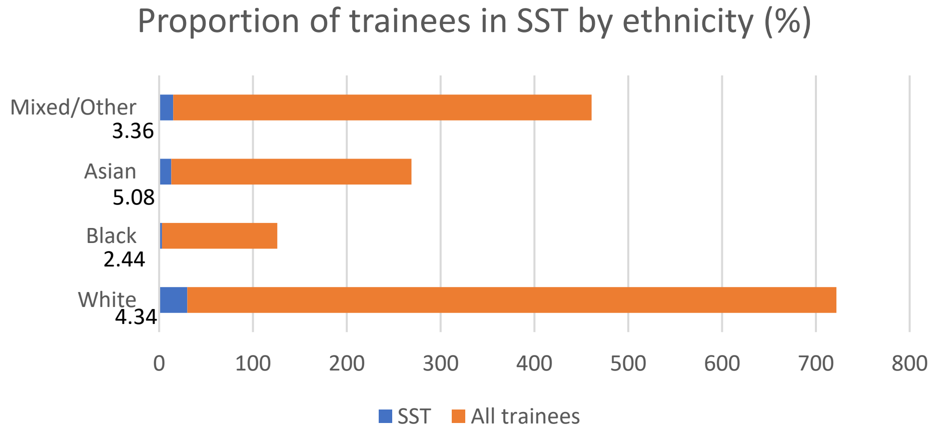

Figure 5. Proportion of trainees in SST by ethnicity

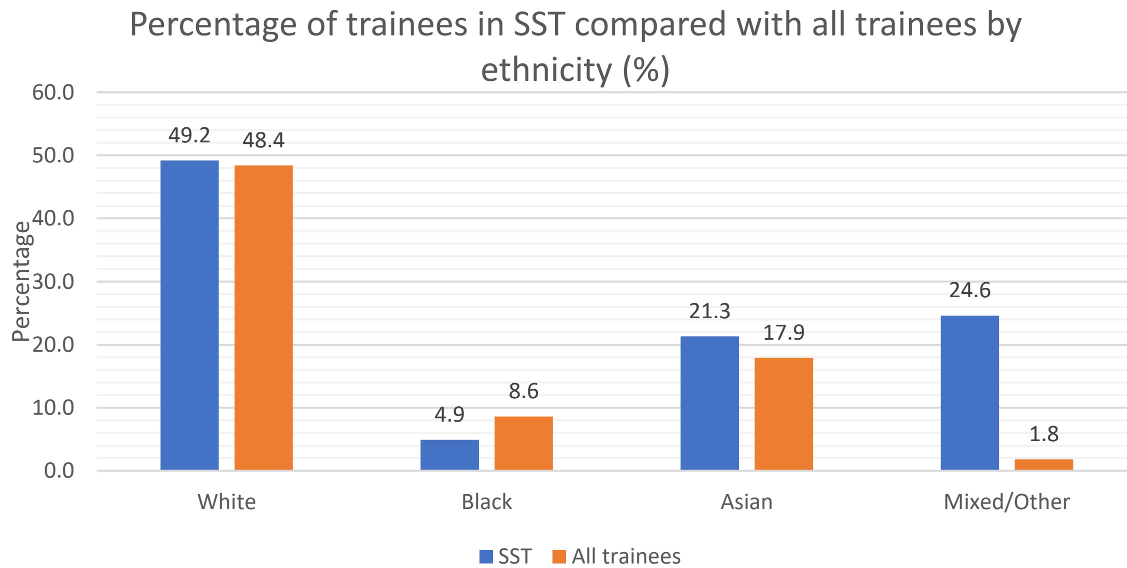

Figure 6 Proportion of trainees in SST compared to all trainees by ethnicity

IMG graduates were least likely to be enrolled in SST at (3.30%) whilst EEA graduates were most likely at 4.40%. See figure below.

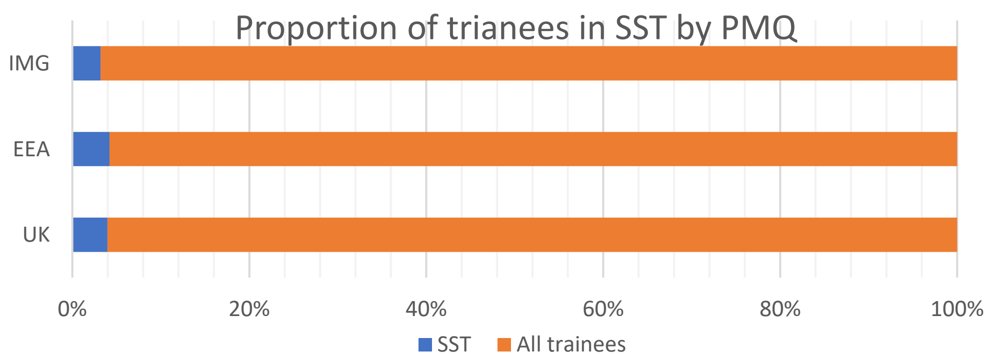

Figure 7. Proportion of trainees in SST by PMQ

Less than full time (LTFT)

There were 1473 responses related to the questions related to working the LTFT. Most LTFT trainees were Category 1 LTFT.

See fig below.

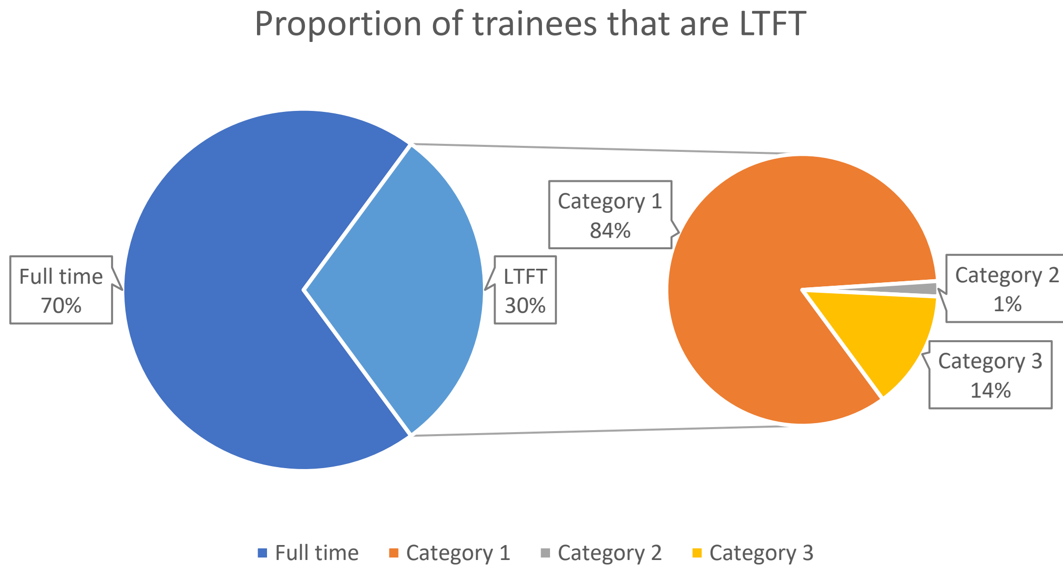

Figure 8. Breakdown of trainees working pattern

Female trainees were more likely to be LTFT 35.5% compared to 7.5% of males. See figure below.

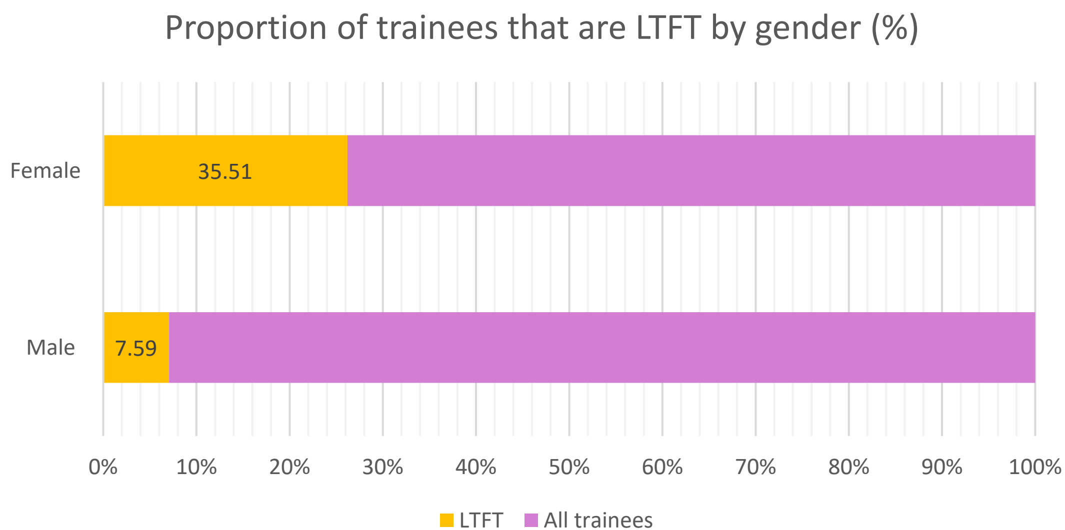

Figure 9 Proportion of trainees that are LTFT by gender

Black trainees had the lowest proportion of LTFT trainees (13.8%). See figure below

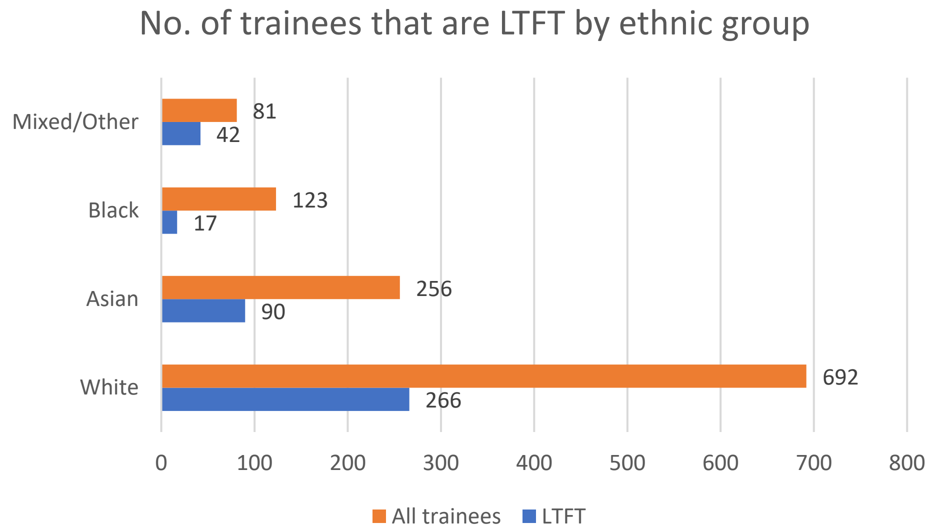

Figure 10. No of trainees that are LTFT by ethnic group

Support during serious incidents

There were 110 trainees who felt disagreed or strongly disagreed with the statement 'When involved in a serious clinical incident or poor outcome, I felt well supported by this unit'.

Of the 110 that disagreed, 97 respondents recorded an ethnicity. No trainees from the mixed ethnic grouping reported poor support. Asian trainees had the highest proportion of trainees that disagreed with the statement. See figure below

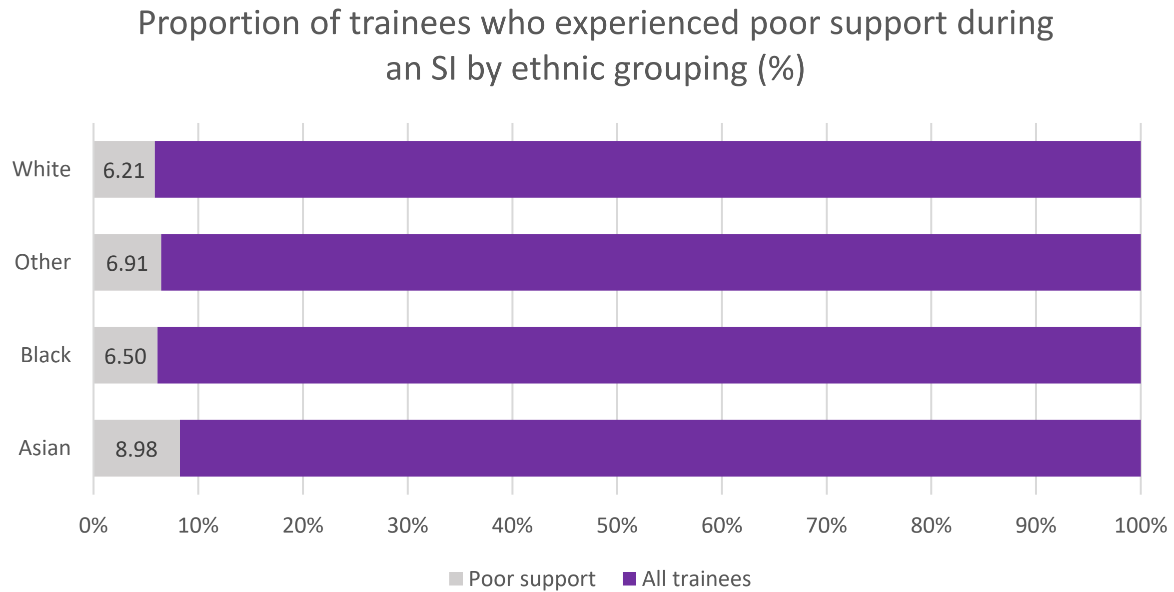

Figure 11 Proportion of trainees who disagreed or strongly disagreed with the statement 'When involved in a serious clinical incident or poor outcome, I felt well supported by this unit' by ethnic grouping

Of the 110 that disagreed, 108 had recorded a gender.

Female trainees were more likely to disagree with the statement than male trainees. See figure.

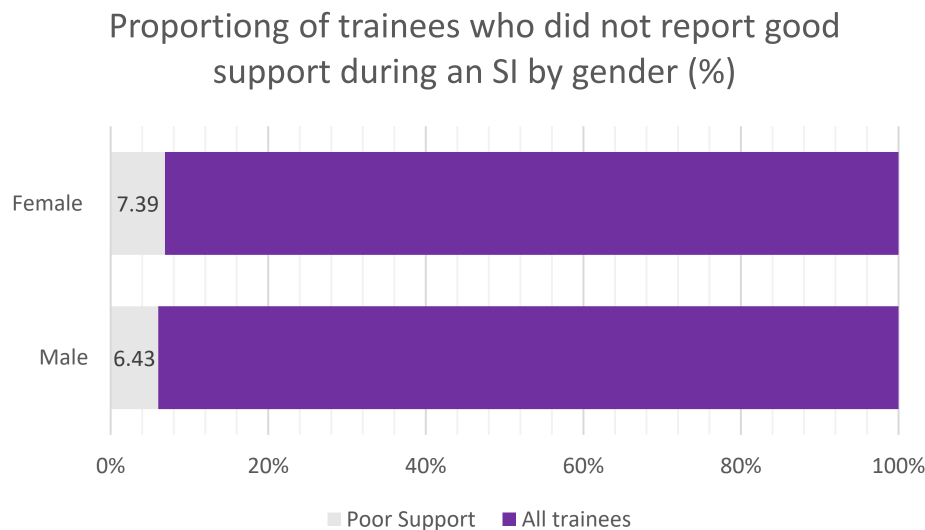

Figure 12 Proportion of trainees who disagreed or strongly disagreed with the statement 'When involved in a serious clinical incident or poor outcome, I felt well supported by this unit' by gender

Persistent behaviours

There were 1140 responses to the statement 'In this post, I was NOT subjected to persistent behaviours by others which have eroded my professional confidence or self esteem'. 223 (15%) of trainees disagreed. See figure below.

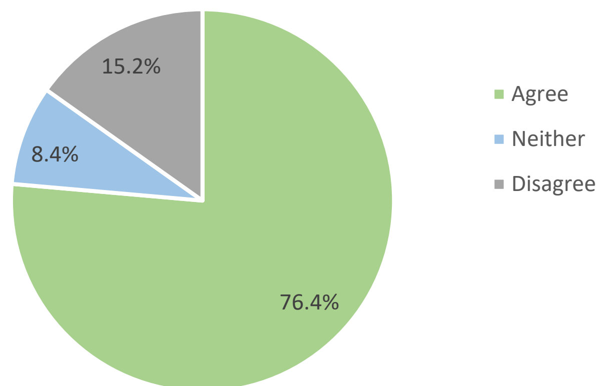

Figure 13 Breakdown of responses to the statement 'I was NOT subjected to persistent behaviours by others which eroded my professional confidence or self-esteem

Trainees from a mixed ethnic background were the most likely to disagree with the statement, with 42% of them reporting being subjected to persistent negative behaviours. White trainees were the least likely, with 15% disagreeing. Due to small numbers, responses marked 'other' has not been included. See figure below.

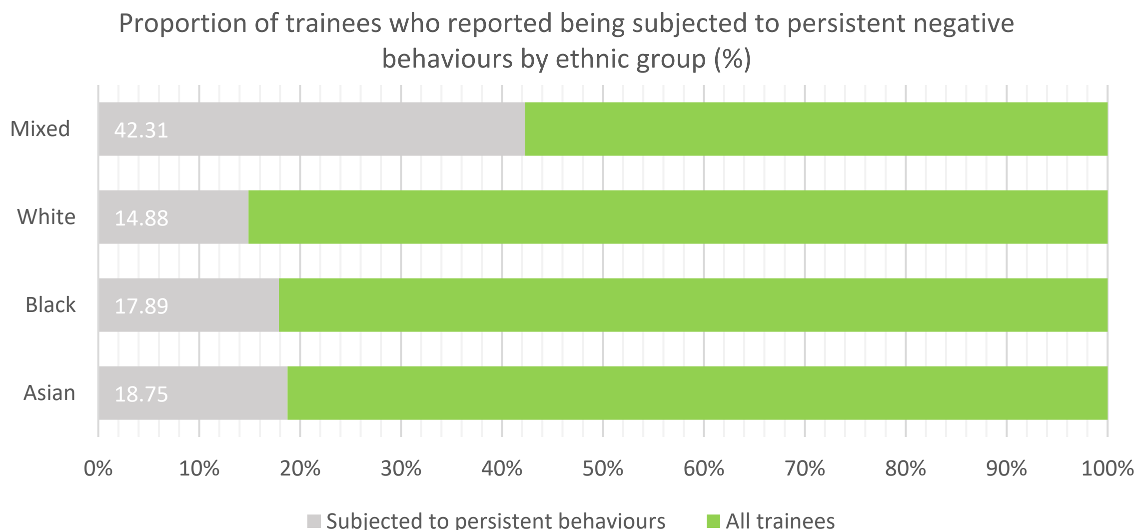

Figure 14 Proportion of trainees who disagreed or strongly disagreed with the statement 'I was NOT subjected to persistent behaviours by others which eroded my professional confidence or self-esteem' by ethnic group

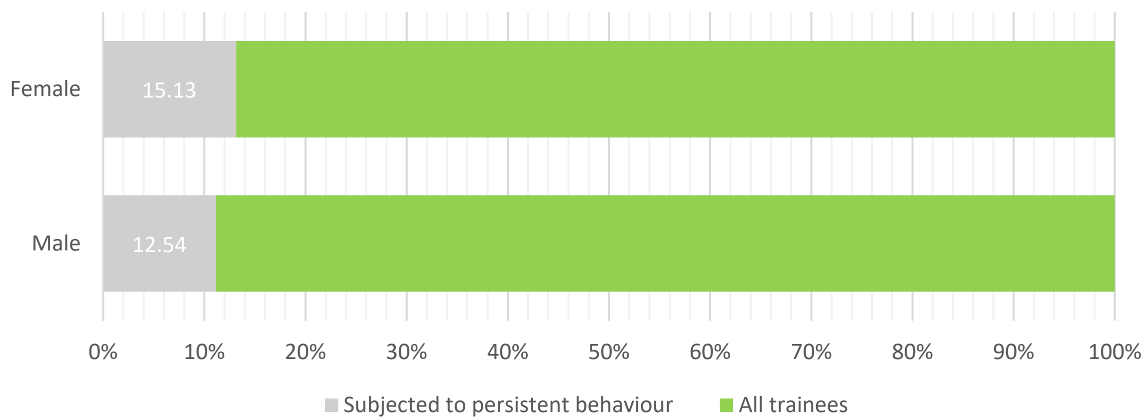

Figure 15 Proportion of trainees who disagreed or strongly disagreed with the statement 'I was NOT subjected to persistent behaviours by others which eroded my professional confidence or self-esteem' by gender

Female trainees were more likely to report being subject to persistent negative behaviours than male trainees, 15% compared to 13% See figure above..

Entry into obstetrics and gynaecology

Female candidates were more likely to apply, be appointable and to accept training positions in Obstetrics & Gynaecology following foundation training according to the GMC data from 2016-2020. See figure below.

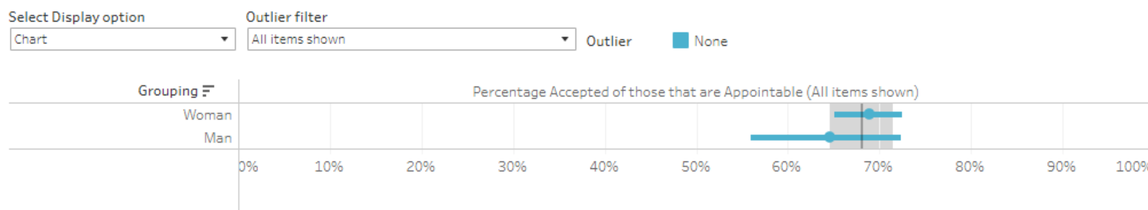

Figure 16. Proportion of candidates who accepted by sex

UK graduates were most likely to be appointable, with UK white graduates being the most appointable candidates. White candidates from the UK, EEA or IMG backgrounds were more appointable than their BME counterparts, although UK BME graduates were the second most appointable in keeping with previous years. See figure below

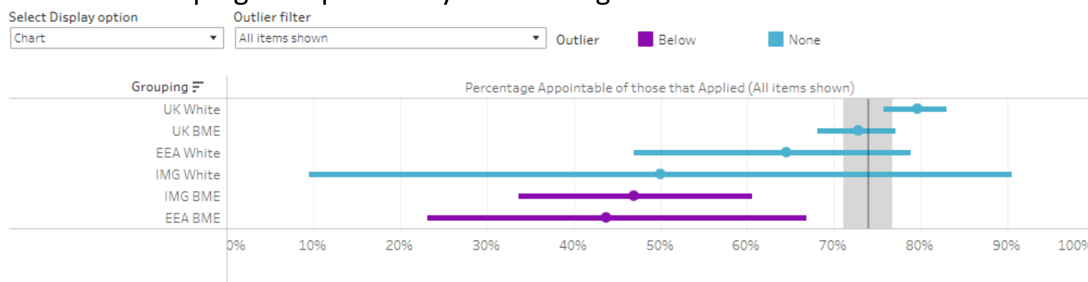

Figure 17. Percentage of candidates who accepted by ethnicity and PMQ

There was no clear association between appointability and deprivation quintile or acceptance of training post and deprivation quintile, although the most deprived quintile was the least likely to be appointable or to accept an offer.

ARCP outcomes

Female trainees were more likely to obtain a favourable ARCP outcome (2020), although the difference is small. There was no statistical difference in ARCP outcomes between BME and White trainees. This is a change. Previous analyses of GMC data suggested that white trainees were more likely to have a favourable outcome than BME trainees. See figure below.

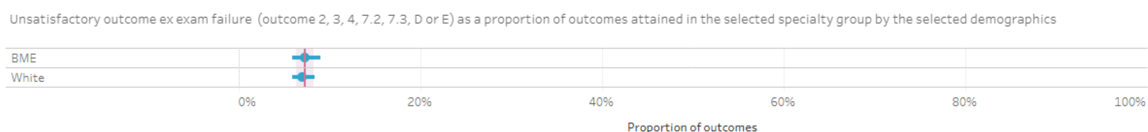

Figure 18. Proportion of unfavourable ARCP outcomes by ethnicity

EEA graduates had the lowest proportion of poor ARCP outcomes, whereas IMG had the highest. See figure below

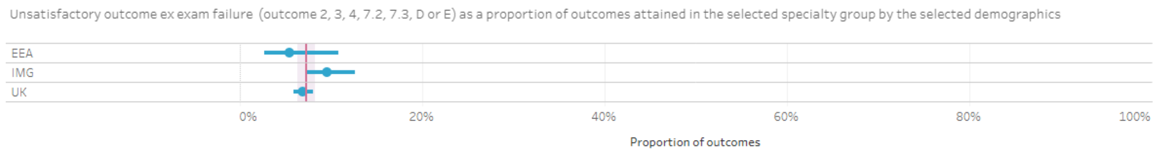

Figure 19. Proportion of unfavourable ARCP outcomes by PMQ

There was no clear association between deprivation quintile and ARCP outcome.

MRCOG pass rates

Women had significantly higher pass rates for MRCOG than men. See figure below.

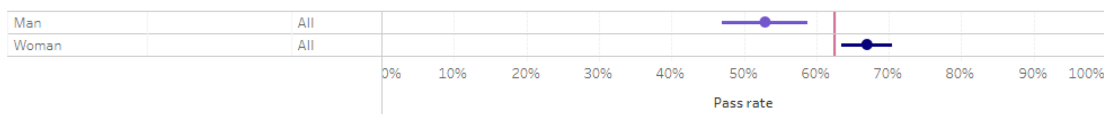

Figure 20. MRCOG pass rates for candidates by sex

UK graduates had higher pass rates than their EEA and IMG counterparts. On average, White trainees were more likely to pass than their BME counterparts. This situation has not changed since previous analysis, in contrast to the situation with ARCP. See figure below.

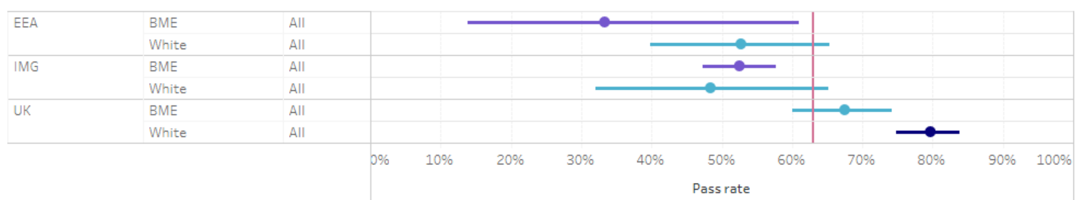

Figure 21. MRCOG pass rates for candidates by PMQ and ethnicity

Summary of findings

This report identified several areas of differential attainment, particularly in regards to exam results, support during serious incidents, experience of persistent bullying behaviours and access to SST.

White trainees are more likely to pass MRCOG than their BME counterparts, with significant differences in pass rates even among UK graduates. Access to SST showed clear differential attainment, with black trainees making up only a tiny proportion of this training grade.

Non-white trainees were the most likely to report experiencing persistent behaviours and Asian trainees were the most likely to report lack of support during serious incidents.

However, one clear improvement is that ARCP outcomes no longer show ethnicity related differences.

References

1. Mountford-Zimdars, A, Sabri, D, Moore, J, Sanders, J, Jones, S & Higham, L 2015, *Causes of Differences in Student Outcomes (HEFCE)*. HEFCE, London.

2. Crenshaw, K., 1991. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, 43(6), p.1241.