Chapter one: Differential Attainment

This chapter is an introduction to Differential Attainment (DA) and its causes.

It is intended to stimulate discussion and so could be sent to participants in advance of your session so that they come armed with some knowledge and thoughts.

You can then use the power point slides to:

Define differential attainment (slide 2)	Slide 2
Share the statistics	Slides 3 & 4
Ask the group for their experience of and thoughts about DA	Slide 5
Consider whether our current 'trainee deficit model' is valid	Slide 6
Think about situated learning and how the learning environment contributes to the learning process	Slide 8
Encourage delegates to think more carefully about the possible causes for DA and to consider what actions might be taken to address it within their own setting	Slides 9 - 12
Think about what inclusion means and whether our work places are truly inclusive for everyone	Slides 13 - 14
Consider standard setting and whether we should apply the same standards to all trainees regardless of background	Slide 15
Introduce the idea of cultural humility and appreciative enquiry	Slide 19 - 23
Think about possible solutions	Slides 17 - 18 & 24 - 25

Differential Attainment

To begin any session on differential attainment, the 'local' facilitator will need to provide an explanation of the concept.

Differential attainment (DA) refers to unexplained variation in attainment between groups who share a protected characteristic and those who do not share the same characteristic. For the purposes of this toolkit, we are taking it to mean the difference seen in attainment between white medics and Black Asian Minority Ethnic (BAME) medics.

How much of a problem is DA in medicine?

In broad terms, across Annual Review of Competency Progression (ARCP), recruitment and exams the following groups tend to perform less well

- Male
- Older
- Black, Asian and Minority Ethnic (BAME)
- International Medical Graduates

The average postgraduate exam pass rate overall for UK medical graduates is 71%.

- This rises to 75.8% for those who are **White**
- This falls to 63.2% for UK **BAME** medical graduates
- This falls to 41.4% for **International Medical Graduates** (IMG) (GMC 2015).

Of UK medical graduates, 72% of BAME Foundation doctors applying for a specialty training programme are successful on their first attempt, compared to 81% of white doctors.

These statistics are mirrored in other Higher Education Institutes.

Why does DA exist?

The traditional approach has been to assume that differences in attainment can be explained by deficits in the trainee. Interestingly, there is no evidence that pre-university attainment, examiner bias or economic difference can explain DA.

Recent work by HEIs and the General Medical Council (GMC) suggests that there may be other reasons to explain DA -it seems that factors which might help to explain the differences seen include:

- **Bridging social capital** (the ability to form connections with social groups outside one's own)
- **Identity** (whether learners feel a sense of belonging; whether the learning environment is inclusive, in that it allows individuals to flourish because of their different strengths; and how learners are perceived by their teachers or supervisors)
- **Relationships** (including the effect of unconscious bias; teacher expectations; and which students end up receiving extra time or attention from their supervisor or teacher).

Possible Approaches to DA

The GMC concluded in their 2015 review that simple linear interventions are unlikely to work. There are unlikely to be simple solutions to this very complex problem. However, the material in this toolkit is designed to help facilitate some changes in approach to trainees who find their working environment and its expectations a challenge.

It isn't easy to change the culture of a department sufficiently so that professionals working within it are enabled to move away from a trainee deficit model to a more appreciative approach.

Educational Supervisors might wish to consider the following questions in relation to their individual contexts:

- How might your department be viewed by an outsider?
- What induction programme and support systems would you put in place to ensure IMGs feel included and part of the existing team?
- Are there ways in which individual strengths could be capitalised on more than they are currently? What would be needed for this to happen?
- What could be done differently (in your department) to promote inclusion and belonging?
- How can we address conscious and unconscious bias?

References

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