Exploring Racialised Barriers Affecting Early-Career Clinical Scholars in UK Academic Gastroenterology & Hepatology:

A Critical (Race) Pragmatism Study in Medical Education

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ABSTRACT

Introduction: Despite recent growth in gastroenterology and hepatology speciality in the UK, unresolved questions remain about access to academic opportunities, support systems, and career development for ethnic minority groups. This study examines how racialised barriers and facilitators influence the progression of early-career clinical scholars (ECCSs) in this speciality. The study's conceptual framework was guided by Critical Race Pragmatism (CRP), aiming to integrate structured critique with pragmatic interventions. The framework incorporates critical race theory, an intersectional and bystander theory perspective, and uses Engeström's activity system model as a linking mechanism to avoid contradictions and identify leverage points and feasible avenues for reform.

Methods: A predominantly qualitative mixed-methods design was used in this study. The initial component involved analysis of publicly available speciality workforce reports, regulatory policies, equality, diversity, and inclusion (EDI) reports, and funding documents published between 2018 and 2025. Seven documents were examined using descriptive synthesis of numerical evidence and qualitative thematic analyses to assess workforce numbers, retention, differential attainment, fairness, accountability, and transparency. The second component was a semi-structured interview with ten ECCSs within this speciality, which was analysed thematically using an inductive and deductive approach to capture participants' lived experience and build the study's CRP framework. Integration of the two strands was achieved through a policy-practice matrix to identify instances in which formal commitments aligned with or diverged from lived experience.

Results: The document analysis revealed considerable service pressure despite an expanding workforce. Disparities were evident in access to training and in funding outcomes. Policy documents strongly endorsed principles of equity and transparency; however, they frequently lacked details on how these principles are monitored or achieved. Interviews similarly highlighted that progression within academia is contingent upon a ''hidden curriculum,'' informal knowledge, and access to senior academic networks. Sponsorship was identified as a key determinant of advancement, functioning as a gatekeeping mechanism. Participants also described intersectional barriers, notably where race intersected with accent, the origin of primary medical qualifications, gender, and geographic location. Moreover, speaking up was often constrained by hierarchical structures and fears of repercussions. Data analysis pinpointed several practical levers for reform, including the establishment of transparent opportunity pathways, structured sponsorship schemes, equitable selection procedures, constructive feedback on funding applications, and safer systems to facilitate speaking out.

Conclusion: This study showed that inequity in academic gastroenterology and hepatology is not attributable to individual prejudice or isolated experiences. Rather, it depends on how opportunities are structured, distributed, and safeguarded. By linking policy evidence to lived experiences, the study provides an evidence-based pathway to actionable change within medical education and the clinical-academic pipeline in this speciality.

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ABBREVIATIONS

Abbreviation	Meaning in the study
ACF	Academic Clinical Fellow
BASL	British Association for the Study of Liver
BSG	British Society of Gastroenterology
CRP	Critical Race Pragmatism
CRT	Critical Race Theory
CRF	Clinical Research Fellow
ECCS	Early Career Clinical Scholar
EDI	Equality/equity, diversity and inclusion
GMC	General Medical Council
IBD	Inflammatory Bowel Disease
IMG	International Medical Graduate
MD	Medical Doctorate
PA	Programmed Activity
PhD	Doctor of Philosophy
PMQ	Primary Medical Qualification
RCP	Royal College of Physicians
UK	United Kingdom
UKMG	UK Medical Graduate
UKRI	UK Research Institute
US	United States of America

CHAPTER 1 INTRODUCTION

I came to this study as a scholar and as someone whose professional trajectory has been significantly shaped by the lived realities under examination. As a Black African migrant and a clinical academic, I found that moving to the UK was more than a change of setting; it reshaped my understanding of race. This shift became evident in my everyday experiences and emerged as a defining feature of how I was perceived, sometimes explicitly acknowledged, often subtly influential, and frequently regarded as self-evident without rigorous scrutiny. Within clinical and academic domains, I observed a recurring pattern of being both hypervisible and overlooked, perceived as different yet not consistently recognised as a member of the community or acknowledged as a potential leader in my field.

My interest in academic gastroenterology and hepatology began early in my career, as this speciality sits at the intersection of high service demand and intense academic competition, where advancement depends on both merit and access to opportunities. As I progressed, I observed disparities in the distribution of these opportunities and the difficulties of safely challenging such decisions. This prompted a question: what kind of racialised barriers affect early-career clinical scholars (ECCSs) in UK academic gastroenterology and hepatology, and what pragmatic changes are achievable? Consequently, this study was driven by a desire to move beyond merely documenting inequities towards generating evidence that can inform practical reforms, whilst maintaining an honest engagement with how race, migration status, and educational background intersect to shape academic trajectories.

1.1 Gastroenterology and hepatology speciality in the UK

UK gastroenterology and hepatology speciality sits at the intersection of high-volume acute and elective care as well as interventional medicine with endoscopic procedures, long-term management of chronic digestive and liver disease, and a growing research agenda spanning inflammatory bowel disease, liver cancer, viral hepatitis, fatty liver disease and alcohol-related liver disease. Gastroenterology

and liver disease have been observed to impact the underrepresented and ethnic minority population, from hepatitis B infection to genetically inherited diseases (Kramvis and Kew, 2007; Rich et al., 2018; Devick et al., 2022; Adams et al., 2005; Luisetti and Seersholm, 2004).

The British Society of Gastroenterology (BSG) workforce report 2024 notes that the substantive consultant workforce has expanded substantially over the past decade (Samji, 2024). However, this growth has not resolved service fragility; the training pipeline remains sizeable (611 higher speciality trainees at the end of 2023), but gender disparity persists, with women comprising 26% of consultants (Samji, 2024). There have also been explicit concerns about representation: Verma and Bhala (2023) argue that, despite a diverse workforce, diversity is not fully reflected in leadership across hospitals, regional bodies, and national organisations. They propose measurable thresholds and annual monitoring to address this gap (Verma and Bhala, 2023).

1.2 Race, medical education and academic gastroenterology & hepatology

Race is a conceptually complex and methodologically contested construct across disciplines, including medical education research. Historically framed through biological essentialism, race has been used to categorise and differentiate humans based on distinct visible biological traits such as skin colour (Richard and Schaefer, 2008). At the same time, ethnicity has been used to classify humans based on culture, language, religion or shared history and geography (Amutah et al., 2021). However, advances in genomics have challenged these assumptions and confirmed that biologically, humans are nearly genetically identical (Collins, 2004; Yudell et al., 2016). Therefore, contemporary scholars have begun to recognise race and ethnicity as social constructs with profound structural consequences rather than biological determinants. As Lynn and Dixson (2021) argue, race is ‘’more than just a variable’’ (Lynn and Dixson, 2021, p. 3); race and ethnic diversity remain embedded within institutions, culture, policy frameworks, and everyday interactions that shape future opportunities and access to opportunities for those

considered from minority groups. Crozier (2023) argued that the term “ethnic minority” is “vague” and doesn’t differentiate among ethnicities (Crozier, 2023, p. 11). Despite the tremendous effort over decades to improve racial and ethnic diversity, racial and ethnic disparities remain within medical education and academic medicine (Ross et al., 2020; Mahmud and Gagnon, 2023).

The differential attainment across the UK has been evident in the GMC (2025) workforce report, affecting career progression and specialist examinations. This was also highlighted by Crozier (2023), suggesting possible structural barriers in higher education, with only 1% of the overall professoriate being Black ethnicities (Crozier, 2023). Within the fields of gastroenterology and hepatology specifically, workforce data from the BSG demonstrated numerical diversity across all clinical roles, a topic that will be examined in more detail later (see figure 4). In the report’s conclusion, BSG emphasises that evidence highlights several key priorities: increasing training capacity while ensuring retention; creating sustainable service models; adopting flexible working arrangements; and prioritising diversity in recruitment and leadership development (Samji, 2024, pp. 8–9). However, leadership and national academic bodies remain markedly less representative (Verma and Bhala 2023). This suggests that, despite workforce growth, it does not translate into equitable academic progression. This is echoed in the literature and available research data (Verma and Bhala 2023), yet it remains under-explained. How workforce pressure is experienced and managed within the academic pipeline also remains under-explained. GMC and BSG reports provide numbers, vacancy rates and strategic imperatives (GMC, 2024b; GMC, 2025; Rutter, 2022; Samji, 2024); however, they don’t show who benefits from growth in academic opportunities or how departments distribute the scarce resources that matter for ECCSs.

The persistence of racial inequity is not solely structural but also interpersonal and cultural. Jones (2000) highlighted how power hierarchies and everyday interactions can reproduce disadvantages and lead to institutional, personal and internalised racism. In medical education, these processes operate through what

Beagan (2003) called the ‘’hidden curriculum’’, suggesting informal messages of who belongs and whose knowledge counts. Many reports highlighted the heightened scrutiny, exclusion, and microaggressions of students and junior faculty from ethnic and racial minority groups (Acosta and Ackerman-Barger, 2017). This was mentioned by Crozier (2023) in his work on personal experience and professional identity: “racism is no longer an issue but a part of general inequity and prejudice against perceived differences” (Crozier, 2023, p. 24).

1.3 Progression, institutional mechanisms and policy making in the UK medical labour market

While past research and policy reporting have usefully demonstrated persistent racial inequities across the UK labour market, studies of hiring and employment have repeatedly shown that applicants from racial minority backgrounds can hold a significant disadvantage, even when they hold equivalent qualifications or experience to their white counterparts (Hammond et al., 2017; Hammond et al., 2022; McKeigue et al., 1990). This was highlighted by Zwysen and colleagues (2021) in their studies, which found that ethnic minorities in the UK must submit significantly more applications than white British counterparts to receive a comparable number of callbacks, suggesting that discrimination can occur even before selection for interview (Zwysen et al., 2021). This wider evidence is crucial to note because it challenges the assumption that formal equality policies necessarily produce equal outcomes. However, the reality is that neutral systems may produce unequal opportunities through informal judgments about credibility.

Within medicine, similar concerns have been identified across medical education, training outcomes, funding success, and workforce progression. Katherine Woolf has done tremendous work studying the differential attainment within medical education in the UK. Her work showed that medical students and doctors from ethnic minorities and doctors who qualified outside the UK (IMGs) experience poorer outcomes across a range of assessment and progression measures (Woolf, 2009, Woolf, 2020). GMC reports over the years similarly showed persistent gaps in medical education and training outcomes by ethnicity and primary medical

qualification (see Figure 4) (GMC, 2024b; GMC, 2025; GMC, 2021; GMC, 2024a). That said, less is known about how these inequities are produced and sustained within specific clinical-academic speciality pipelines. The academic pathway within UK gastroenterology and hepatology remains underexamined, despite the high level of competition and the informal processes that shape progression. Although Verma and Bhala (2023) touched on this, showing that inequity does exist within this speciality, there is insufficient explanation of how these inequities shape who progresses and at what stage of their career. Therefore, analysis of policies is crucial to understand how institutions define and interpret problems and to foresee solutions. It provides insight into whether institutional formal commitments to equity align with the lived experiences of those affected.

This study uses a critical race pragmatism lens to explore how barriers exist across this speciality and where feasible change can be made. This is integral to ensuring equitable opportunities and progression as the workforce continues to expand. The reason for combining documents with interviews is to identify the gap between institutional equity commitments and lived experience through these mechanisms

The next section, therefore, sets out the conceptual framework that guides the design of this study, explaining how you draw on Critical (Race) Pragmatism (CRP), alongside an intersectional perspective, and embed bystander theory and Engeström's activity-system model to connect early career clinical scholars' (ECCS) narratives to specific institutional levers for reform.

1.4 Critical (Race) Pragmatism in Medical Education

In this study, my concern is not with the existence of racial inequity in UK academic gastroenterology and hepatology, but rather with how it is produced and sustained, and, critically, what measures can be taken to effect change. To produce such change, this study will require a methodological 'toolkit' that can: 1) name structural racism without reducing it to an individual problem, 2) keep individuals' lived experiences central to the study, and 3) find leverage and translate findings into feasible reforms within real institutions. The subsequent section of this introduction elucidates the principal theories and methodologies utilised in this study,

emphasising the historical context of each theory and its pertinence in informing critical race pragmatism.

1.4.1 Critical Race Theory (CRT)

Critical race theory (CRT) emerged in the late 1970s through US legal scholars such as Derrick Bell, Kimberlé Crenshaw, Richard Delgado, and Mari Matsuda, who were concerned that civil rights gains were being stalled or rolled back despite the implementation of ‘’race-neutral’’ laws and they argued that racism is not an occasional aberration but a normal, systemic feature of society reproduced through institutions, policies and professional norms (Bell, 1992, Crenshaw and Fletcher, 1989, Delgado et al., 2023). Their work foregrounds how racial power operates, whose stories become dominant, what is treated as legitimate knowledge, and how a 'neutral' process can produce unequal outcomes.

Three concepts of CRT are particularly relevant to this study: 1- **structural racism**: inequity is built into systems, from selection criteria to informal networks and assessment cultures. 2- **counter-storytelling**: how the lived experiences of ethnic minority individuals are not ‘anecdotes’ but vital evidence that can expose hidden mechanisms of exclusion (Delgado et al., 2023, Lynn and Dixson, 2021). 3- **interest convergence**: how institutional change is more likely to happen when equity aligns with organisational interests like funding compliance, reputation and sustainability (Delgado et al., 2023). These concepts can raise questions about where institutional commitments redistribute power and where they remain symbolic.

In the context of medical education, race was always considered a variable for describing a particular demographic. However, many medical education scholars have challenged this, arguing that utilising biological race as a variable masks the mechanisms by which institutions create differential attainment (Tsai et al., 2016; Ross et al., 2020). Gillborn (2006) created a conceptual map that translates CRT into a tool for analysing systemic educational inequity (see Figure 1), structuring it by defining elements such as racism as endemic and interest convergence as a methodological tool to support these arguments. This serves as an analytical tool

to deconstruct institutional practices within medical education and to show how concepts such as meritocracy and colour blindness sustain structural inequities. That's why utilising CRT is crucial in this study, as it focuses on the processes affecting ECCSs rather than on individuals' "problems" (Gillborn, 2006).

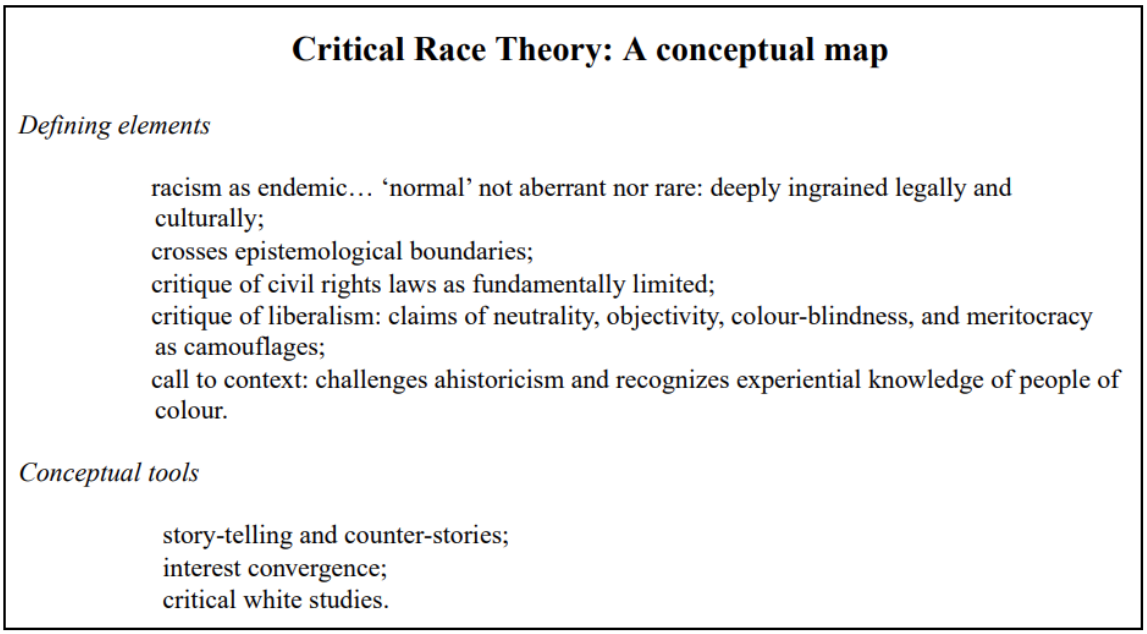

Figure 1: Conceptual map of CRT (Gillborn, 2006)

1.4.2 Intersectionality and ''intersectional thinker'' lens

Intersectionality, first introduced by Kimberlé Crenshaw, argues that social positions such as race and gender are mutually shaping and producing distinct experiences at their intersection (Crenshaw and Fletcher, 1989). She critiques 'single-axis' approaches to discrimination, suggesting that legal and organisational frameworks often recognise discrimination only in one dimension at a time, making some experiences, especially those of black women, systemically invisible within policy practices (Crenshaw and Fletcher, 1989; Crenshaw, 1991). Over time, intersectionality expanded beyond legal scholarship into other sectors, including educational research. The concept that one variable cannot be assessed in isolation, but must intersect with other variables to create a particular individual as perceived by the community (Bešić, 2020). This has been perfectly visualised by Sophie Bright and colleagues (2005), who adapted intersectional theory into a

public health tool for analysing disparities in health outcomes. The model expands the traditional health model to capture how overlapping social identities generate distinct pathways of inequity leading to harm (see Figure 2).

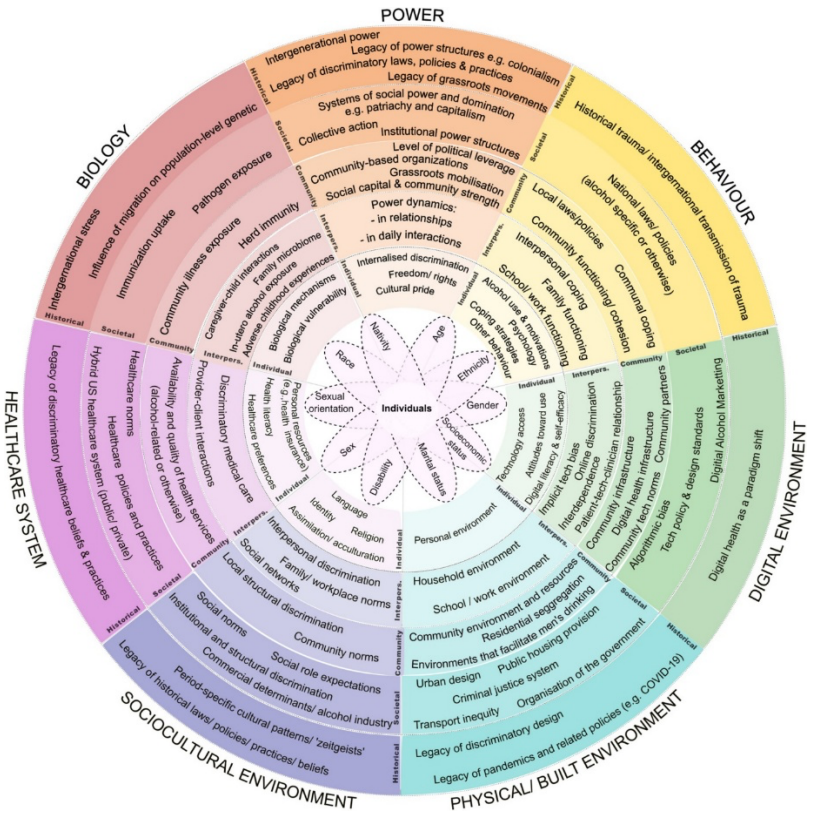

Figure 2: The intersectional inequity framework (Bright et al., 2025)

Employing an intersectional thinker's lens in this study shapes how to describe experience without forcing exclusion and how to interpret patterns in narratives that can intersect and influence experience. The key insight in the context of this study is not simply that ECCS could experience multiple forms of racial disadvantage, but that it is important to examine how these disadvantages interact to produce distinct, non-additive forms of exclusion, and to understand how institutions classify, evaluate, and allocate opportunity through categories that overlap and compound. It avoids flattening ethnic and racial minority ECCSs into a single narrative; it helps identify the specific mechanisms that shape differential progression at key career junctions.

1.4.3 Bystander theory and how it aligns with critical (race) pragmatism

Bystander theory originates in social psychology, particularly in the work on the bystander effect, which, as described by Latané (1970), has shown that people are less likely to intervene when others are present due to diffusion of responsibility, ambiguity, and fear of doing the wrong thing (Latané and Darley, 1970). This has been further extended by the contemporary bystander model, which examines how individuals interpret and experience an event, and how they act based on their experience and understanding of it, with each action shaped by situational pressure and perceived cost (Hortensius and de Gelder, 2018). In the context of academic medicine, these steps unfold within steep hierarchies, a high-stakes evaluation culture, and professional norms that can discourage 'making a fuss' and becoming a 'troublemaker'. This is particularly salient for ECCSs whose progression depends on reputation, references and informal sponsorship, and for whom speaking up may carry unequal and dangerous risks for their future.

The bystander lens provides another dimension that complements critical race theory by moving beyond asking whether ECCSs from ethnic minorities experienced racism to include narratives of critical episodes and probe the bystander pathway by asking who noticed, what happened to people who acted, what action or inaction followed, and what consequences resulted. This captures the practical constraints ECCSs face and identifies the conditions that enable effective allyship. It shifts attention towards how colleagues, supervisors, committees and institutions participate, whether passively or actively, in reproducing or challenging inequity.

1.4.4 Critical (Race) Pragmatism (CRP):

Critical (Race) Pragmatism (CRP) integrates two distinct contextual frameworks within medical education research. It strengthens the focus on race and prevents it from being absorbed into tokenistic exercises and “what’s feasible”. Rather, it focuses on asking who this is feasible for and at what cost. It works to ensure that levers for reform are meaningful for both institutions and those affected (Lawson and Koch, 2004). Creating such a fusion is necessary for researching race in

medical education to avoid treating race as an individual attribute or an isolated barrier. Therefore, the phrase ‘’race is more than just a variable’’ keeps resonating with me (Lynn and Dixson, 2021, p. 3). In this study, CRP is strengthened by explicitly integrating an intersectional lens and bystander theory, as they both clarify how structural barriers are lived, seen and maintained in the clinical academic environment. This is crucial in interracial clinical-academic teams, where reputational risk and reliance on supervisory recommendations can make selection a rational strategy for ECCSs.

CRP therefore fits well within academic settings in gastroenterology and hepatology speciality, as it enables a dual stance on lived experience and counter-stories through CRT, reveals the hidden mechanisms of exclusion, and intersects with other factors within a work culture. This can be used as a leverage point to achieve a feasible solution.

1.5 The current knowledge gaps in race-related research and differential attainment evidence within the UK academic Gastroenterology and Hepatology

The available UK workforce reports in medicine, gastroenterology, and hepatology are strong at describing the landscape; however, they are weak at explaining the mechanisms through which racial inequity is produced and sustained within ECCSs in gastroenterology and hepatology. The BSG workforce, while robust in providing statistics on headcounts, vacancy rates and pipeline indicators, does not tell us how departments allocate scarce resources that matter for academic progression, such as protected research time or access to grants and high-value projects. In simpler terms, these reports provide the ‘what’ of workforce conditions but not the ‘how’ of the distribution of academic opportunity under those conditions. (Samji, 2024). While a recent review by Verma and Bhala (2023) argues that gastroenterology leadership and national bodies do not reflect workforce diversity and identifies policy levers, it does not provide empirical evidence on whether ECCSs experience them, nor does it examine how these processes intersect with

primary medical qualification (PMQ) origin (i.e., being an IMG or UKMG) at earlier stages when trajectories and interest in academia are formed.

1.6 Aims and objectives

1.6.1 Aims of this study

This study aims to understand how under-representation and differential progression among racially minoritised early-career clinical scholars (ECCS) in UK academic gastroenterology and hepatology are reflected in relevant workforce, policy and equality/equity, diversity and inclusion (EDI) documents, and how ECCSs experience and interpret the racialised barriers, enablers and opportunity structures that shape progression across the academic pipeline.

1.6.2 Objectives of this study:

This study has three main objectives: (1) to explore the lived experiences of ECCSs at key progression points, from before, during and after their postgraduate studies; (2) to examine unspoken rules or the “hidden curriculum” within academia and how they create or hinder opportunities; (3) to identify factors that support progression and coping, and to develop a clear, practical recommendation for reform.

1.6.3 Research questions

I. How do race, ethnicity, primary medical qualification origin and, where relevant, gender and geography shape the lived day-to-day experience of ECCSs?
II. What processes and informal practices within institutions mitigate inequity across key progression points?
III. How do ECCSs experience racialised exclusion or discrimination of their colleagues, and what factors enable or prevent safe and effective speaking up or intervention?
IV. To what extent do organisations' commitments to equity align with lived experiences of ECCSs, and where do gaps persist?

This introductory chapter outlined the rationale for exploring this subject within academic UK gastroenterology and hepatology. Despite workforce expansion in this speciality, there remains significant strain due to vacancies and retention concerns (Rutter, 2022; Samji, 2024). Recent studies have shown a representation gap in this speciality, particularly in leadership, and have suggested measurable thresholds and accountability to tackle these issues (Verma and Bhala, 2023, p. 209).

These lessons framed this study by looking beyond outcomes to the mechanisms by which opportunities are allocated and the culture in which unspoken rules normalise racial inequities within this speciality. Therefore, this study adopts a Critical (Race) Pragmatism framework and a mixed-methods design to integrate the lived experiences and narratives of ECCSs with publicly available policy and EDI documents from regulatory and organisational bodies, exploring levers for feasible reform.

CHAPTER 2 METHODS

Methodologically, researching race poses an epistemological dilemma. In medical academia, the dominance of positivist paradigms has often resulted in race being treated as a neutral independent variable without critically examining racism as a structural force (Park et al., 2020; Tsai et al., 2016). Quantitative methods, on the other hand, can identify disparities but may obscure the underlying mechanisms responsible for them. While a quantitative approach to race can capture lived experience, it is sometimes regarded as limited in its generalisability. Gillborn and colleagues (2018), in their article ‘’QuantCrit’’, argued for a critically reflective use of quantitative data and insisted that statistical methods be guided by qualitative theory, such as critical race theory, to avoid deficit narratives (Gillborn et al., 2018).

From an ethical standpoint, challenges in researching race are equally complex. Fricker (2008) concept of epistemic injustice warns that racially minoritised scholars may be dismissed and their testimony might be undervalued within the academic hierarchy. This was further highlighted by Belluigi (2024), who argued that knowledge production itself can reproduce racialised power dynamics, with scholars from ethnic minorities positioned as research subjects rather than epistemic agents for change. Without robust reflexivity and structural critique, researching race carries a risk of reifying categories that it seeks to dismantle (Morning, 2009; Ross et al., 2020).

Due to these methodological challenges, particularly treating race as a neutral variable, there are limitations to decontextualised quantitative comparisons. It is also essential to centre lived experiences without losing sight of structural factors. Many scholars increasingly advocate approaches that can critically engage with change (Bell, 1980; Gillborn et al., 2018). CRT conceptual framework offers an opportunity to strengthen counter-stories as credible evidence and describe how inequity operates through ordinary processes within institutions (Gillborn, 2008). Adding an intersectional lens, along with a bystander angle, pragmatically can provide a coherent basis for this study to identify structural inequity and produce clear, feasible levers for reform (Harris et al., 2022; Lucey et al., 2020).

This chapter therefore sets out to detail the ontological, epistemological, and methodological assumptions, the research design, and the methodological framework grounded in CRP. It explains the procedures by which data are collected and analysed. It also discusses ethical considerations and reflexivity to consolidate the rigorous process in which this study was conducted.

2.1 Paradigm and underlying assumptions

2.1.1 Critical (Race) pragmatism as a research paradigm

The overarching framework of this study is Critical Race Pragmatism (CRP). CRP critically examines everyday practices within institutions, rather than perceiving them as isolated interpersonal experiences, and assesses knowledge based on its capacity to facilitate informed action and practical reform within the realistic constraints of organisational settings. Consequently, CRP aligns closely with the study's objective to translate ECCSs' experiences and policy evidence into a set of actionable leverage points.

2.1.2 Study assumptions

The ontological assumption of this study is that race and ethnicity are social constructs with material effects, and that racism is a durable feature of institutional life. It recognises that access to opportunities is both socially produced and unevenly distributed across society, which aligns with the medical education view that racial inequity is both structural and experiential in shaping progression.

Epistemologically, this study adopts a critical and constructivist stance. It rejects the interpretation of experiences as neutral or self-evident and instead promotes context-dependent interpretation of experiences, policies and practices. Therefore, exploring the lived experiences of ECCSs provides evidence that can highlight mechanisms of inequity that might otherwise be invisible.

Axiologically, this study recognises the researcher’s positionality as part of the analysis process and provides reflexive remarks throughout the study to ensure transparency in data interpretation and presentation.

2.2 Study context

This study is situated within the UK clinical academic environment, which integrates clinical training and academic research. This includes the National Health Service (NHS), universities, research institutes, and regulatory and funding agencies such as the General Medical Council (GMC), the British Society of Gastroenterology (BSG), and the National Institute for Health Research (NIHR).

2.3 Research methodology

This study adopts a mixed-methods design, combining descriptive quantitative data with a methodologically dominant qualitative approach to provide depth, narratives, and contextual interpretation of the results. The study will employ document and policy analysis of data using descriptive statistics, followed by a thematic analysis based on CRP to identify procedural mechanisms and institutional stance. This will be followed by semi-structured interviews with ECCSs from different backgrounds and at different career stages to elicit narratives and specific experiences of facilitators and barriers. Integrating all this together will produce a systematic, comprehensive assessment of points of divergence and alignment to highlight levers for reform.

CRP was operationalised through three analytic lenses that structure this study (see Figure 3). The first is Critical Race Theory (CRT) as a sensitising framework to identify structural mechanisms, counter-stories, and institutional power dynamics. The second lens adopts an intersectional perspective to examine the interplay between race/ethnicity and factors such as migration, primary medical qualification origin, geographical location, and gender, where relevant. The third lens utilises contemporary Bystander Theory to analyse workplace culture, silencing, and speak-up behaviours, and their effects on ECCSs. To link these conceptual frameworks together and avoid contradiction within those theories, Engeström's activity-system model was utilised to integrate them and link ECCSs' lived experience to institutional structures and rules, identifying levers for potential reform and meaningful change (Engeström et al., 1999).

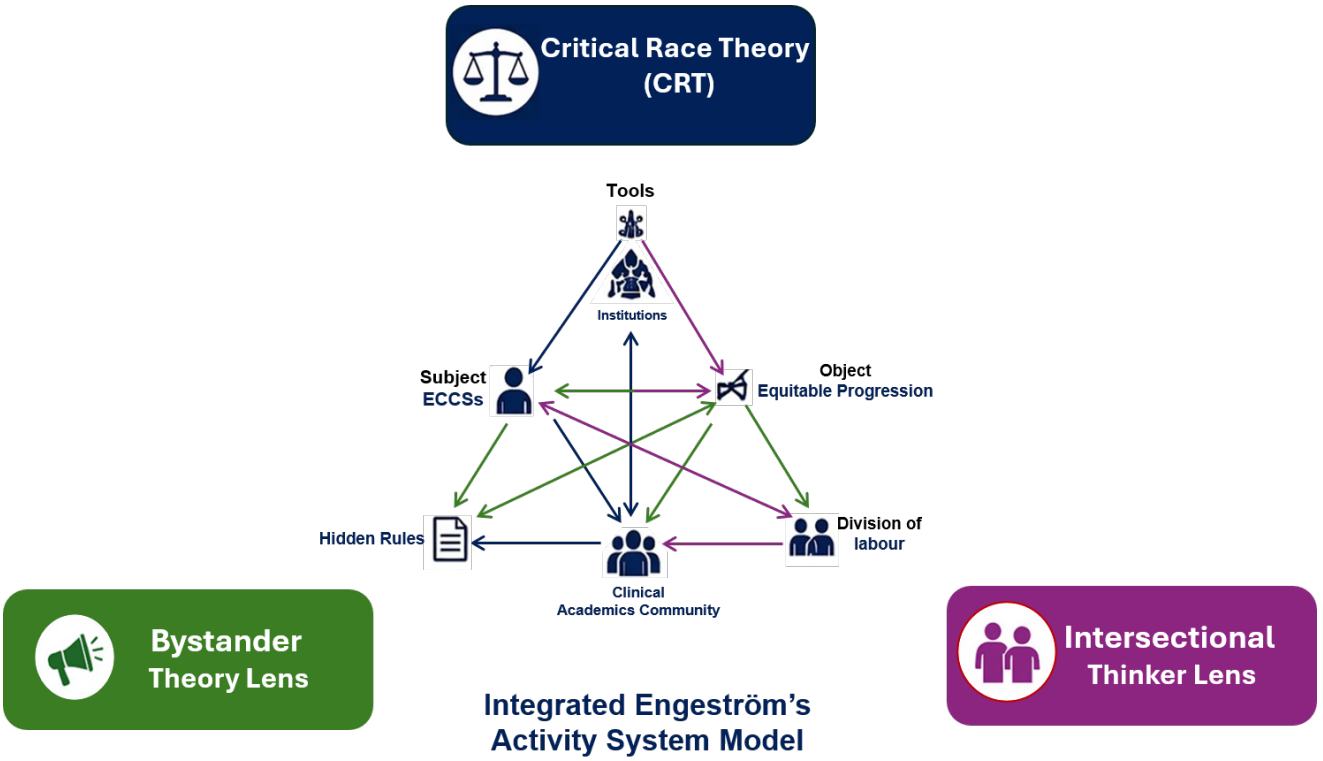

Figure 3: The conceptual framework of CRP in this study, adopted from Engeström's activity system model (created by the author)

2.4 Documents and policies

The main purpose of document analysis is to examine organisational commitments to equity and identify the procedures in place to achieve this. It complements the interviews by supporting the evidence provided by the lived experiences of those affected. The corpus was limited to publicly available documents involving the UK gastroenterology and hepatology speciality.

2.4.1 Documents Inclusion/Exclusion Criteria

I. ***Inclusion criteria****:*

- Workforce reports by societies and regulatory bodies
- EDI policies by regulatory bodies, societies and funding bodies
- Open access and publicly available documents

II. ***Exclusion criteria:***

- Non-public documents related to this study
- Unofficial documents (e.g. news articles and promotional materials)
- Duplicate documents
- Documents lacking procedural content

2.4.2 Documents analysis

Document data were analysed using a mixed-methods approach. A descriptive synthesis of numerical evidence was used to contextualise, rather than statistically test, patterns of workforce pressure, retention, and differential attainment relevant to ECCSs. Numerical indicators were extracted from the included reports using a structured data-extraction template. Variables extracted included: consultant and trainee workforce numbers; vacancy rates; retirement or retention rates; demographics; PMQ origin; training application and offer rates; assessment or progression gaps; funding application and success rates; and representation on funding or governance committees. This approach allowed the numerical document data to serve as contextual evidence, highlighting areas where inequities are identified, where they remain unmeasured, and where further exploration may be warranted. The documents were then qualitatively analysed. After becoming familiar with each document, relevant sections were extracted and coded to clarify how they addressed issues such as workforce pressure, racial inequity, differential attainment, functioning, access, and fairness. The initial coding was conducted using a hybrid approach: partly inductive, to identify recurrent themes within the documents, and partly deductive, guided by CRP. Themes were refined through cross-comparison of codes across documents, allowing the analysis to identify principal themes that revealed what was made visible in the policy and workforce reporting, as well as what remained absent or underspecified.

2.5 Semi-structured interviews

Interviews were designed to capture individuals' lived experiences of mechanisms that policy documents cannot convey. Each participant took part in a semi-structured interview via Microsoft Teams, lasting approximately 60 minutes. The interview was based on the CRP conceptual framework and covered career trajectory and background; workplace culture and relationships with colleagues and seniors; barriers and their impact; coping mechanisms; and reform suggestions (see Appendix A). Narrative prompts were used to elicit detailed episodes, providing rich data for analysis. Interviews were video- and audio-recorded; audio recordings were transcribed and used for integrity checks before deletion. All transcripts were pseudonymised and analysed using NVivo version 14 software. Optional demographic data was requested to support intersectional interpretation while avoiding compelled disclosure.

2.5.1 Participant Inclusion/Exclusion Criteria

I. Inclusion criteria:

- Age > 18 years
- Able to provide informed consent
- ECCSs as defined by the researcher (ACFs, CRFs, PhD students, MD(Res) students, early post-docs, early consultants)
- Self-identified as an ethnic minority background
- Working within UK gastroenterology and hepatology specialities

II. Exclusion criteria:

- Age < 18 years
- Do not self-identify as an ethnic minority background
- Works outside gastroenterology and hepatology
- Not residing in the UK

2.5.2 Sampling strategy and sample size

Sampling was purposive to achieve variation across ethnicity, IMG/UKMG status, and current academic level. The target sample was 10 ECCSs to achieve thematic sufficiency, as the study is qualitatively focused on prioritising insight into mechanisms and lived experiences based on CRP rather than numerical and statistical representation.

2.5.3 Recruitment approach

Participants were recruited using an opt-in purposive sampling strategy. Invitations were distributed through institutions and society mailing lists (BSG, BASL, institutional leads). Interested participants were asked to contact the research team directly to express interest or inquire about this study.

The recruitment strategy was designed to promote heterogeneity within the interview sample while maintaining balance to meet the objective of including ECCSs at various stages of their academic development and with diverse experiences across focal areas, academic roles, PMQ origins, gender, ethnicity, and geography. Such variation is essential for examining different intersectionalities related to experiences of racial barriers and the enabling factors encountered at various career stages and within different institutional contexts.

2.5.4 Semi-structured interview thematic analysis

Interviews were analysed using a hybrid inductive–deductive thematic coding, informed by Braun and Clarke's reflexive thematic analysis (Braun and Clarke, 2012; Braun and Clarke, 2019; Byrne, 2022). Analysis was conducted in thematic stages, beginning with familiarisation, during which transcripts were read and reread, cross-checked against recordings where necessary. Initial analytical notes documented participants' career trajectories, key milestones, and recurring experiences. Inductive open coding was employed to code meaningful segments of text without imposing a predetermined framework, allowing participants' narratives to guide the early coding process. Following this initial inductive phase, codes were reviewed and synthesised into a provisional coding framework.

Informed by CRP, deductive coding was then applied to examine how participants' experiences aligned with CRP concepts such as structural racism, meritocracy, racialised credibility, intersectional positioning, and speaking-up risk. Narrative trajectories were used to describe participants' career journeys across interconnected progression points, rather than isolated incidents.

Themes were generated through comparative analysis of codes across participants using NVivo. These themes were subsequently reviewed, refined, merged, or separated as necessary, and articulated in relation to the study's research questions. The analysis aimed to show plausible mechanisms and patterned processes through which barriers and enablers appeared to influence the progression of ECCS.

2.6 Integration analysis and system mapping

A policy-practice matrix was used to identify convergence, divergence, and leverage points. Engeström's activity-system mapping was then used to reveal contradictions in rules, tools, community, and division of labour, thereby enabling identification of leverage points to inform reform recommendations.

2.7 Ethical considerations and data management

2.7.1 Ethical approval

Ethical approval for this study was granted by the University of Oxford Education Departmental Research Ethics Committee (Education (Educ) DREC - 2478633) on 17 December 2025. Ethics approval was valid until 31 August 2026. All procedures were conducted in accordance with the University of Oxford policies and relevant ethical standards. Participants were provided with information about the study and gave informed consent before participating. Data were handled confidentially and stored securely in accordance with the University's data protection and research data requirements.

2.7.2 Data management process

All data were stored on the University of Oxford Nexus365 OneDrive for Business file storage service. Video recordings of the semi-structured interviews were obtained via Microsoft Teams. The recordings were transcribed under pseudonyms and subsequently permanently deleted. Transcripts were stored on OneDrive for Business. Any paper copies were immediately shredded. Digitised consent forms were saved to OneDrive for Business separately from other data. Identifiable information, including consent forms, was stored on the university's secure servers. Other research data were stored in Microsoft SharePoint and will be retained for 3 years after publication or public release. Data will be kept until the end of the study and subsequent research.

CHAPTER 3 RESULTS

This chapter presents findings from document analysis and semi-structured interviews with ECCSs in UK academic gastroenterology and hepatology. Consistent with the study's Critical Race Pragmatism (CRP) framework, the chapter eschews a purely neutral presentation and interprets the findings as clear mechanisms by which power is enacted. The analysis consequently oscillates between documentary evidence and participant narratives, interrogating not only the existence of barriers but also their genesis, normalisation, resistance, and prospects for reform.

The findings are organised into three linked sections. First, the document corpus analysis examines how workforce, funder and regulators' texts frame inequity, progression and institutional responsibility. Second, the semi-structured interview analysis explores how ECCSs describe the lived and practical mechanisms that shape academic progression. Lastly, the chapter integrates both strands to identify CRP-aligned reform levers: points within the system where critique can be translated into feasible institutional action. Therefore, this chapter is structured around three main themes: policy recognition without full operationalisation; academic progression as hidden work; and racialised credibility, cultural fluency and safety.

3.1 Document analysis:

The documents were selected to provide contextual and policy-relevant evidence on racialised progression in gastroenterology and hepatology speciality in the United Kingdom. The document corpus included publicly accessible reports on speciality workforce trends, national regulatory documents, and diversity reports issued by funding bodies. Table 1 summarises the included documents and their relevance to the study, followed by descriptive synthesis and qualitative findings from the document corpus analysis.

Table 1: Summary of main documents included in the document analysis

Document name	Organisation	Year	Type of document	Relevance to the study
British Society of Gastroenterology Workforce Report 2021 (Rutter, 2022)	British Society of Gastroenterology (BSG)	2022	Speciality workforce report	Provides baseline workforce, vacancy, gender, ethnicity and PMQ context for UK gastroenterology and hepatology.
British Society of Gastroenterology Workforce Report 2024 (Samji, 2024)	British Society of Gastroenterology (BSG)	2024	Speciality workforce report	Provides updated indicators of workforce pressure, trainee and post-CCT retention.
Diversity Data Report 2022 (NIHR, 2022)	National Institute for Health and Care Research (NIHR)	2022	Funder's diversity report	Provides evidence on funding applications, award holders and committee representation by ethnicity, sex, disability and age.
Equality, Diversity and Inclusion Policy (GMC, 2021)	General Medical Council (GMC)	2021	Regulator's policy document	Provides formal policy language on fairness, bias mitigation, equality duties, decision-making, and accountability.
Equality, Diversity and Inclusion: Targets, Progress and Priorities (GMC, 2024a)	General Medical Council (GMC)	2024	Regulator's EDI progress report	Provides national context on differential attainment, PMQ-related inequalities, referral disproportionality and on fair training cultures.
The State of Medical Education and Practice in the UK: Workforce Report 2024 (GMC, 2024b)	General Medical Council (GMC)	2024	National medical workforce report	Provides workforce context on international doctors, PMQ, and access to and retention in postgraduate training.

The State of Medical Education and Practice in the UK: Workforce Report 2025 (GMC, 2025)	General Medical Council (GMC)	2025	National medical workforce report	Provides current workforce context on international doctors, PMQ, and access to and retention in postgraduate training.

3.1.1 Document Analysis and Policy Context

The document corpus establishes a speciality context marked by workforce expansion but persistent strain. The 2021 BSG Workforce Report reported 1,700 substantive consultant gastroenterologists and hepatologists in the UK as of 30 September 2020, representing a 5.8% increase from 2019 (Rutter, 2022, p. 1). By the 2024 report, this had increased to 2,097 consultant gastroenterologists and hepatologists, an 8% increase from 2022 (Samji, 2024, p. 1). On the surface, this appears to be a positive story of speciality growth. However, both reports position this expansion against a backdrop of unmet demand, retirements, vacancy pressure and service burden.

The 2021 report noted that nearly half of advertised consultant posts (48%) remained unfilled in 2020, indicating that expansion was “less than it could be” (Rutter, 2022, p.1). The 2024 report found that 74% of respondents to the Royal College of Physicians (RCP) Census reported consultant vacancies in their departments, up from 59% the previous year (Samji, 2024, p. 1). The same report noted that only 28% of newly qualified consultant respondents intended to apply for a substantive post (Samji, 2024, p.1). These figures are essential to this study since they show that ECCSs are pursuing academic careers in a speciality where service demand is high and academic time is likely to be vulnerable.

The document corpus perceives workforce strain as a background issue. However, through a CRP lens, it can be the mechanism by which inequity is reproduced. When departments are understaffed, protected academic time becomes harder to defend, and research must be fitted around clinical work. When progression depends on discretionary support, those already closest to senior networks may be best positioned to access opportunities.

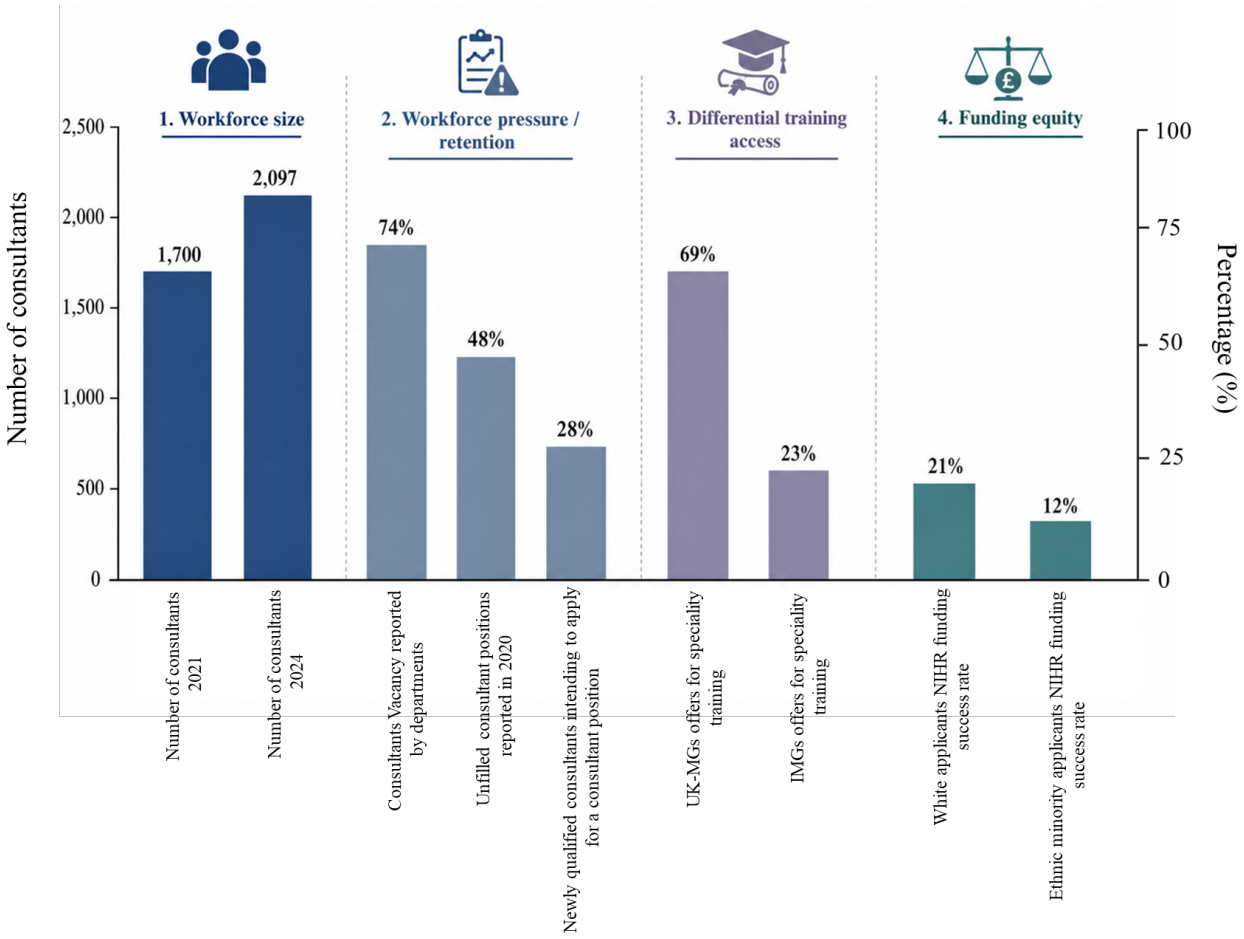

Figure 4: Document-derived descriptive synthesis indicators

3.1.2 Qualitative document analysis, Theme A: Policy recognition without full operationalisation

The qualitative thematic analysis of corpus documents initially identified a theme of policy recognition without full operationalisation. This was subsequently subdivided into three subthemes:

- Subtheme A1: Documents recognise inequity but often frame it procedurally
- Subtheme A2: Measurement is present, but what matters most is not always measured
- Subtheme A3: Interest convergence: equity becomes urgent when linked to workforce sustainability

3.1.3 Subtheme A1: Documents recognise inequity, but often frame it procedurally

Across the document corpus, there is clear recognition of inequity. The GMC EDI progress update explicitly states that *"deep-rooted inequalities continue to shape careers, distort opportunity and weaken the culture of healthcare"* (GMC, 2024a, p. 2). It also frames fairness as a matter of productivity, retention and patient care, arguing that unfairness risks losing talent from a workforce under pressure (GMC, 2024a, p. 2). This is significant because it moves beyond a purely moral argument and links equity to the sustainability of the healthcare system.

However, the documents often operationalise fairness through procedural language, such as monitoring, KPIs, decision-making principles, training, assurance frameworks, and reporting. For example, the GMC (2021) EDI Policy states that fairness should underpin regulatory functions and that processes should be designed to be *"free from bias and discrimination"* (GMC, 2021, pp. 1–2). It describes equality impact assessment, monitoring, auditing, and decision-making principles such as transparency, proportionality and objectivity (GMC, 2021, pp. 2–4). These are important tools. Yet, from a CRP perspective, procedural fairness is not enough unless it reaches the informal mechanisms that distribute opportunity.

Within the framework of this study, the primary issue is that documents most effectively describe formal processes, but provide less comprehensive coverage of informal academic opportunity structures. There is a notable lack of operational details on how institutions should monitor access to funding, authorship, protected academic time, grant development support, and informal invitations to leadership and research opportunities.

3.1.4 Subtheme A2: Measurement is present, but what matters most is not always measured

The NIHR (2022) Diversity Data Report provides one of the clearest examples of measurement as an equity strategy. It reports that *"applicants from ethnic minority groups are less likely to be successful than White applicants"* and that *"ethnic minority groups are underrepresented on our funding committees"* (NIHR, 2022, p. 1). It also identifies limitations in its own reporting, including the aggregation of ethnic categories and the risk that combining categories can mask differences between groups *"This approach can mask the specific differences experienced by each ethnic group and severely limit the insight we can gather from the data."* (NIHR, 2022, p. 5). This reflexivity recognises that data practices can both reveal and conceal inequity.

However, documents measure outcomes more than mechanisms. They identify gaps in funding success, training access, referrals, and assessment outcomes, but less often measure the processes that build academic capital before these outcomes occur. For ECCSs, academic progression depends on being invited to projects, receiving feedback on unsuccessful applications, maintaining protected academic time, and securing sponsorship from senior academics. These mechanisms are often not visible in the formal metrics provided by the assessed documents.

This emerges as a key finding within the CRP framework: institutions that do not measure informal mechanisms for academic progression may precisely be the sites where racialised inequities are perpetuated.

3.1.5 Subtheme A3: Interest convergence: equity becomes urgent when linked to workforce sustainability

A recurring theme across the documents is that equity is framed as important not only because it is morally right, but because it supports workforce sustainability. The GMC (2025) workforce report warns that IMG doctors are central to UK healthcare and that workforce policy must avoid demoralising or driving them out

(GMC, 2025, pp. 4–5). It also shows that more IMG doctors applied for speciality training, but their UKMG counterparts received far more offers *"UK graduates continue to have far higher rates of being offered places"* (GMC, 2025, pp. 11–13).

Within Critical Race Theory, this resonates with the concept of interest convergence: equity gains institutional traction when it aligns with dominant institutional interests (Delgado et al., 2023). In this context, inclusion is closely linked to retention, productivity, patient safety, and workforce sustainability. From a CRP perspective, this presents a pragmatic opportunity. If service sustainability depends on retaining a diverse medical workforce and supporting their progression into senior roles, equity reforms can be appropriately positioned as vital components of workforce planning rather than optional elements of EDI initiatives.

3.2 Semi-structured interview analysis: Overview of themes

The interviews reveal aspects that document analysis cannot fully capture. Participants described formal systems as well as the informal and relational dimensions of progression: identifying appropriate contacts, establishing credibility, understanding unspoken expectations, and securing protection when speaking out.

Before presenting the interview results and their thematic analysis, I outline the key characteristics of the ten ECCSs interviewed across career stages. The level of academic engagement varied; some participants held full-time doctoral research positions, while others combined academic duties with clinical responsibilities and lacked protected academic time. To preserve anonymity, detailed demographic data that could identify participants were omitted. Table 2 summarises relevant characteristics to aid interpretation of the findings. Gender and ethnicity were recorded for their relevance to intersectional analysis. Descriptors were intentionally broad to minimise the risk of deductive disclosure, especially given the small sample size.

Table 2: Summary of broad characteristics of interview participants

Participant	Gender	Race/Ethnicity	Career Stage	Training/Academic Level
ECCS1	Male	Asian	New consultant	UKMG/ Postdoc
ECCS2	Female	Hispanic	New consultant	IMG/ Postdoc
ECCS3	Female	Asian	Speciality trainee	UKMG/ PhD student
ECCS4	Male	Asian	New consultant	UKMG/ MD-Res
ECCS5	Male	Asian	Speciality trainee	UKMG/ Postdoc
ECCS6	Female	Middle Eastern	Speciality trainee	IMG/ PhD student
ECCS7	Female	Black	Speciality trainee	UKMG/ PhD student
ECCS8	Female	Black	Speciality trainee	UKMG/ PhD student
ECCS9	Female	Asian	New consultant	IMG/ Postdoc
ECCS10	Male	Asian	Speciality trainee	UKMG/ Postdoc

The findings from the interviews were organised into two principal themes:

- **Theme B: Academic progression as hidden work**
    - Subtheme B1: Academic pathways are opportunistic and poorly signposted
    - Subtheme B2: Sponsorship, not only mentorship, opens doors
    - Subtheme B3: Protected time determines who can remain academic

- **Theme C: Racialised credibility, cultural fluency, and safety**
    - Subtheme C1: Accent, PMQ, and cultural fluency shape credibility
    - Subtheme C2: Subjective “Fit” reproduces advantage
    - Subtheme C3: Speaking up is constrained by hierarchy and complaint anxiety

3.3 Theme B: Academic progression as hidden work

3.3.1 Subtheme B1: Academic pathways are opportunistic and poorly signposted

ECCSs consistently emphasised that academic progression requires active self-navigation; even when formal pathways are available, they are often perceived as opaque, leading to frustration and uncertainty. ECCS5 described their successful ACF journey as highly strategic, yet noted that success depends on a nuanced understanding of the “game”, highlighting the emotional effort required to navigate complex systems.

> *“With all these things… it’s about, it’s a game… then I approached [the supervisor] before the interview and said, ‘Look, I’m really interested… Can I come to visit your lab?’” (ECCS5)*

This highlights the importance of recognising that the formal application process does not encompass the entire journey. Success often depends on pre-interview contact, supervisor familiarity, and an understanding that such engagement is acceptable. For those well acquainted with academic norms, this may be seen as an initiative. For applicants outside these networks, it reveals an unseen aspect of the process, adding nuanced and sometimes hidden pathways to opportunity. ECCS3 similarly described research access as opportunistic:

> *“So much of research is quite opportunistic… trying to find something that is fully funded and which lines up with the timing that you want to go out of programme, it can be quite challenging.” (ECCS3)*

ECCS3 highlights the importance of opportunity architecture over individual motivation. The core concern is no longer whether ECCSs are interested in

academia, but whether they can clearly see the pathway, access the necessary resources and build a network while navigating it with confidence and support.

ECCS10 offers a valuable post-PhD perspective. Having completed his doctoral studies and remained actively engaged in academia, he expressed concerns about the pathway from PhD to subsequent academic roles, calling it unclear and fragile. This echoes earlier accounts from other participants, who noted that opportunities such as the ACF, MD(Res), PhD, or grant routes are often inconsistently advertised, vary by local centers, or depend on insider knowledge. These insights underscore the importance of fostering clearer, more equitable pathways to support their aspirations.

> *"The lack of clarity and the lack of opportunities to progress from one stage to another, how difficult it is to find funding in this country… I think you can get a PhD, but post a PhD on to the next phase!"* (ECCS10)

This demonstrates that the "pipeline" takes the form of a series of fragmented thresholds rather than a seamless progression. Achieving a doctoral degree is often within reach, especially with a dedicated supervisor's support; however, the postdoctoral journey toward clinical lecturer or consultant academic positions is often uncertain and challenging. ECCS10 further clarified that the traditional pathway appears to be from PhD to clinical lecturer to academic consultant. Yet the initial step after the PhD remains particularly arduous because of scarce posts and limited funding, highlighting the emotional and practical struggles faced by emerging scholars.

> *"That path from PhD to clinical lecturer is really difficult. There's not that many posts… getting onto that Clinical Lecturer post is really difficult."* (ECCS10)

This account reinforces the understanding that barriers to progression extend beyond entry into academia. There is also a critical post-PhD juncture, where scholars face the challenge of translating their doctoral work into independent funding and an academic identity, all while returning to a demanding full-time

clinical training position. Recognising these hurdles is essential to supporting aspiring academics through an often overwhelming transition, fostering a more compassionate and inclusive academic environment.

> *"Everybody just says, oh, try and secure a higher grant. But how do you do that if you haven't secured higher grants before and you have no time to build your own area of research?"* (ECCS10)

3.3.2 Subtheme B2: Sponsorship, not only mentorship, opens doors

Mentorship has long been recognised as a foundational element of professional development (Sambunjak et al., 2006). However, the interview results showed that sponsorship may be even more transformative. Mentorship cultivates understanding and guidance, empowering participants to navigate their careers. In contrast, sponsorship provides vital access to influential networks and meaningful projects, fostering a sense of inclusion and support that can profoundly impact ECCS's confidence and sense of belonging. ECCS4 described how mentors influenced progression:

> *"The things that encouraged me were mentors that I had… they were often people of colour… seeing them and having their encouragement and support, that's what really helped me." (ECCS4)*

This highlights the vital role of representation and relational encouragement in fostering growth. Nevertheless, ECCS4 also described how a senior professor later guided an initial fellowship application, opening doors to research networks. Therefore, it is crucial to distinguish between mentorship and sponsorship in this study: while mentorship nurtures confidence and provides direction, sponsorship actively expands access and offers additional support and opportunities to aspiring scholars. ECCS3 went further by connecting academic opportunities with the supervisor's network:

> *"I feel like sometimes I do suspect there's quite a bit of nepotism… people will select you, or you'll get selected because your supervisor is friends with other people." (ECCS3)*

Rather than treating this as a straightforward allegation of corruption, it should be seen as an insightful portrayal of how reputation spreads within academic networks. Supervisor capital thereby becomes candidate capital, underscoring the subtle dynamics underpinning scholarly trust and personal integrity.

Nevertheless, while sponsorship can create opportunities, it also reveals the exclusivity inherent in academic networks. ECCS10 described how research opportunities often favour individuals already integrated into established centres, or those recommended by trusted colleagues.

> *"The people that often I know who have done research or got research opportunities are often either because they've already been embedded in that centre… or they've been a recommendation." (ECCS10)*

His personal experience highlights the persistent barriers faced by aspiring researchers, such as being recommended to a research group only after a previous member has left.

> *"Somebody who came into my group after I left was purely based on my recommendation… that is less likely to happen if you're coming from an international background." (ECCS10)*

This data offers nuanced insight: sponsorship is essential, yet when informal and untracked, it risks perpetuating exclusion. For UKMG participants in research-active centres, sponsorship may be perceived as an advantage. Conversely, for IMGs, trainees outside tertiary centres, or those without elite institutional connections, the same mechanism can be a barrier, leading to exclusion. Through a CRP lens, the critical question is: how can institutions ensure that sponsorship is transparent, fair, and accountable to promote genuine opportunity and inclusivity for everyone?

3.3.3 Subtheme B3: Protected time determines who can remain academic

Participants identified academic time and its protection as a crucial barrier distinguishing sustainable from unsustainable academic progress. ECCS3

contrasted this with the challenge of pursuing research alongside demanding clinical work, highlighting the emotional strain and frustration clinicians experience as they strive to balance these essential duties.

> *"It's really nice to be able to be full-time in research because I generally feel like it's very hard to do anything when you're split between clinical and academic roles… it's hard to achieve anything significant." (ECCS3)*

ECCS4, now a consultant, articulated the opposite perspective while discussing his programmed activity (PA) time as a consultant.

> *"At the moment, I have no research PAs, no research PAs!" (ECCS4)*

Repetition carries significant analytical weight. It signals underlying frustration. While academic identity may endure, the lack of dedicated time renders research efforts increasingly marginal and disheartening. ECCS7 made a similar point about Academic Clinical Fellowship (ACF) work extending beyond the allotted time:

> *"The cliche answer you're supposed to give is that you find these dedicated pathways… but it's never quite true… You continue to do academic work in the evenings, the weekends." (ECCS7)*

Other participants described research in the evenings, on weekends, or without research PAs. However, ECCS10 recognises a crucial dimension: academic work may be constrained by service obligations, yet it is intimately intertwined with home life and parenting responsibilities. This acknowledgement highlights the emotional toll and personal sacrifices involved, and the importance of maintaining work-life balance. It also emphasises the challenge of re-engaging with academic careers if momentum is lost after completing a PhD, and the potential difficulties of returning to the field later in life.

> *"If you take your foot off the pedal now, post PhD and don't keep the momentum going, it's hard to see how you can come back to it later."* (ECCS10)

Together, these quotes show that protected time extends beyond employment conditions; it is a vital mechanism for achieving equity. Those with fewer family caregiving responsibilities, greater financial stability, robust sponsorship, and higher confidence may find it easier to undertake unpaid academic labour. Conversely, individuals lacking these resources may feel compelled to leave academic pathways despite their evident ability and motivation.

3.4 Theme C: Racialised credibility, cultural fluency and safety

3.4.1 Subtheme C1: Accent, primary medical qualification origin and cultural fluency shape credibility

Participants consistently distinguished between explicit acts of racism and the more nuanced, often unnoticed, forms of racial judgement. These subtle biases frequently manifested as judgements about accent, medical educational background, and familiarity with NHS norms, revealing the persistent challenges faced by those navigating complex social landscapes. ECCS3 reflected on why they personally had not felt strongly disadvantaged, while recognising the vulnerability of friends with stronger accents:

> *"It definitely helps that… I did medical school here… a lot of the prejudice that you see is from when you have a potentially really strong accent and people struggle to understand you, or they think you were trained somewhere they've not really heard of." (ECCS3)*

ECCS4 made a similar observation:

> *"I'm lucky I don't have an accent… people who I've worked with who are incredibly smart, incredibly talented… have been met with scepticism… because they are not white and they don't sound like everyone from the UK." (ECCS4)*

These narratives suggest that accent functions as a racialised proxy, subtly shaping perceptions of trust, credibility, and competence. Although not explicitly identified as race, such biases can profoundly affect individuals' experiences and

self-confidence. ECCS6 described this starkly in relation to their early NHS experience:

> *“Sometimes with the way you’re wording things and how you’re talking to me, I can tell that you’re seeing me inferior to you. I was a trust grade SHO and my first month in the NHS.” (ECCS6)*

Despite the relative protection of not having an accent, ECCS10 still recalled subtle racialised interactions, particularly during training in predominantly white settings, highlighting the emotional toll of these experiences.

> *“It’s not explicit racist comments, but you notice the subtle, implicit, you know, like, “where are you from?” And it’s like, well, I told you where I’m from. It’s like, “no, but where are you really from?”” (ECCS10)*

He then contrasted his own experience with that of colleagues with different accents. This bystander perspective is particularly valuable because it shows that credibility is unevenly assigned even when clinical competence is not in question.

> *“I do see people sometimes, not even patients, I think sometimes even colleagues being shorter, less pleasant in their interactions with colleagues because their English isn’t as good.” (ECCS10)*

This quotation illustrates the complex interplay among hierarchy, PMQ origin, and newness to the UK system. ECCSs observed a pattern in which an accent position can unjustly lead others to perceive an individual as less competent. Recognising these subtle dynamics is crucial, as policy measures that focus solely on formal discrimination or on broad outcomes may overlook such nuanced mechanisms.

ECCS9 added further nuance. She described being a native English speaker yet still experiencing a cultural shock in the NHS:

> *“There is an internal hierarchy within the NHS that quite possibly matches the hierarchy of social class as well… it can be hard for an outsider, even with perfect English, to navigate.” (ECCS9)*

This suggests that simply mastering language skills does not eliminate the influence of the hidden curriculum. Cultural fluency in the UK, along with class norms, hierarchies, and an understanding of "how to get things done", plays a crucial role in shaping belonging and establishing credibility.

3.4.2 Subtheme C2: Subjective "fit" reproduces advantage

Participants often characterised the selection and progression procedures as formally organised yet influenced by personal judgment, reflecting the inherently subjective nature of these processes. ECCS3 noted that candidates from Top universities seemed to evoke greater interest from potential supervisors, underscoring the importance of understanding individual contexts and fostering a supportive, equitable environment for all applicants.

> *"The fact… I went to Cambridge… people immediately were just more interested if I said I went to Cambridge." (ECCS3)*

She then linked this to similarity and power:

> *"A lot of the senior professors are from Oxbridge. So immediately they see someone who is potentially similar to them… people who are in positions of power… naturally gravitate towards people who are more similar to them." (ECCS3)*

This counter-story offers an essential perspective that challenges purely meritocratic accounts of academic progression. The participant affirms their competence yet acknowledges that institutional prestige and similarity can inadvertently influence opportunities. This perspective resonates with CRT's critique of the illusion of neutrality: institutional processes may appear fair but can subtly reward proximity to dominant norms, creating barriers for many (Delgado et al., 2023; Ladson-Billings and Tate, 1995).

ECCS5 similarly described successful navigation of the process as relying on strategic self-presentation and proactive pre-interview engagement. While ECCS5 viewed this as a necessary aspect of due diligence, CRP analysis encourages reflection on who is aware of these expectations, who feels confident about

undertaking them, and who may fear being judged differently for demonstrating the same behaviours. That is, understanding the emotional and social complexities involved.

ECCS8 highlighted the profound emotional distress she experienced as she grappled with questions about identity and status:

> *"There's a little, 'Oh, you're a doctor? Okay.' It's not even in the words… it's their body language sometimes." (ECCS8)*

This shows how credibility judgements are conveyed through tone, body language, and subtle cues, such as moments of hesitation, which can be difficult to capture. Yet over time, these cues accumulate and profoundly shape one's professional identity.

ECCS10 also expands on opaque selection processes. When asked about the transparency of funding and progression criteria, he noted that while obvious elements, such as preliminary data and publications, were evident, the more nuanced criteria, specifically the qualities sought by funders, remained unclear.

> *"No, I didn't think it's that transparent… the exact criteria of what they're looking for and who they're looking for, I don't think it's that clear." (ECCS10)*

This aligns with the document analysis. Policies may set out transparent selection criteria, but interview participants report ongoing uncertainty about how those criteria are applied, what counts as a fundable promise, and how much weight is given to informal recommendations. ECCS10 also described job advertisements that appear formally open but are effectively designed around known candidates.

> *"It was created for me and then they were like, "oh, you will have to do an interview though"… they put the job out… then I got a message being like, can you apply because someone else has applied." (ECCS10)*

This finding holds significant analytical importance, as it illustrates the coexistence of formal transparency and informal pre-selection processes. From a CRP perspective, this phenomenon should be regarded as a structural characteristic

inherent in the functioning of academic labour markets. Such dynamics tend to advantage those already visible to senior academics while disadvantaging those outside these networks.

3.4.3 Subtheme C3: Speaking up is constrained by hierarchy and complaint anxiety

Participants described speaking up as risky, particularly in cases involving subtle incidents or when involving a junior, an IMG, or someone in another vulnerable position. ECCS7 noted that racialised hostility was difficult to articulate.

> *"It's always really hard… you gently arrive at the conclusion that, okay, maybe actually this has played a part, my race has played a part in this interaction." (ECCS7)*

This phrase, "gently arrive," carries particular weight. It highlights the interpretive effort required to identify racism in contexts where explicit acknowledgement may be discouraged. ECCS7 subsequently outlined the corresponding response strategy:

> *"Medicine is a very hierarchical system, so I don't know how you do anything about it"* talking about speaking up *" … maybe if I work harder, then they will realise how much I care." (ECCS7)*

This reflects a key bystander and speaking-up dynamic. The burden is placed on the affected individual to exert additional effort, demonstrate care, and avoid conflict, rather than on the system to intervene.

ECCS9 described witnessing public criticism of IMG colleagues:

> *"My first reaction was outrage… there is some degree of emotional violence within a person's choice of words or delivery." (ECCS9)*

They also noted that the words themselves were often polished:

> *"It wouldn't be based on words alone… it is in the implied manner in which the words are delivered… feedback of that nature being public… making that particular person feel uncomfortable and inadequate." (ECCS9)*

This is highly relevant, as harm may be visible to observers yet difficult to challenge because it is expressed in professional language. Such behaviour can be denied on the grounds that it is not overtly offensive, even when its impact is humiliating.

ECCS8 described a related bystander experience:

> *"It's the tone in which they're spoken to sometimes… condescending, impatient, less grace to them trying to get up to speed." (ECCS8)*

They described wanting to help the colleague navigate the system:

> *"I'd want to take that person… and be like, okay, this is how you're going to navigate, this is how we're going to get you through this." (ECCS8)*

The silence was not due to indifference; rather, it represented a calculated risk. ECCS10 explained that future job allocation, informal references and consultant-to-consultant conversations remain important. This creates a rational fear that speaking up may damage one's career.

> *"Ultimately, a lot of these posts are still to people like you. They'll call around… you don't want to jeopardise that when you're looking for jobs. We've seen that with people when they've tried to talk out… it hasn't ended well for them generally." (ECCS10)*

This exemplifies a form of informal bystander intervention through private support rather than public confrontation. While potentially protective for the individual involved, it does not necessarily change the system. A CRP response, therefore, would ask how institutions might transform private acts of rescue into mechanisms for public accountability.

3.5 Cross-cutting theme: Intersectional positioning shapes exposure and protection

Throughout the interviews, race intersected with PMQ origin, accent, gender, UK training, class, geography, and institutional prestige. For instance, ECCS4 explicitly acknowledged a relative advantage:

> *"I'm lucky enough to be a man… I think I've been quite lucky because I've trained in this country and because I was born in this country. I think that my disadvantages from my race are much less than someone who hasn't had those things." (ECCS4)*

ECCS5 similarly described London as protective:

> *"Because I've always been in London… medical school is very, very mixed… I've not seen any or experienced any sort of discrimination." (ECCS5)*

These accounts should not be interpreted as contradicting participants' descriptions of racism. Instead, they show that context matters. London's diversity, the UK educational system, native English proficiency, and access to elite institutional capital may buffer some racialised scholars whilst rendering others more vulnerable. ECCS8 brought gender into the conversation:

> *"Maybe definitely like the female thing… there's that undertone when you're like about starting a family, taking time out of training, go less than full time." (ECCS8)*

This may indicate that gendered assumptions operate alongside racialised and migration-related biases. Consequently, intersectional analysis ensures that the study does not treat "racialised ECCSs" as a uniform group.

3.6 Integration of document and interview findings

This section was designed to integrate themes from document analysis and interviews, identifying areas of convergence, where the document corpus and interview strands align, and divergence, where policy documents recognise an issue but interviews reveal further hidden details of informal and complex processes. This underpins the study's CRP-grounded framework, thereby helping the study move beyond problem identification to identify leverage points that can facilitate actionable change (see Table 3).

Table 3: Policy-practice Matrix showing areas of convergence, divergence and reform levers.

Studied area	Documents	Interviews	Convergence	Divergence	Reform lever
Equity becomes more urgent when linked to workforce sustainability	GMC and BSG reports link fairness to productivity, retention and workforce pressures.	Academic work is difficult to sustain because service pressure leaves little protected time for it.	Sustainability matters.	Equity gains urgency when it is linked to retention, staffing and service delivery.	Using interest convergence without losing the equity argument
Fairness recognised without equitable opportunity	GMC, NIHR and BSG documents strongly endorse fairness, transparency, diversity and mitigation of bias.	Academic routes were described as difficult to access unless individuals already knew the system or had early sponsorship.	Fairness is integral and important.	Policy states fairness in principle, but opportunities remain informal and uneven.	Transparent academic opportunity infrastructure
Key workforce measurement is present, but not the mechanisms	The documents quantify workforce size, funding outcomes and broad diversity data.	Participants repeatedly described sponsorship, time and access to academic networks as central to their progression.	Inequity can be identified and observed	The most important processes for progress are not always the ones most clearly measured.	Structured sponsorship rather than informal goodwill
Hidden curriculum, credibility and subjectivity shape progression	Support transparency and accountability,	Described the hidden curriculum, “fit”, accent and familiarity as shaping credibility and access.	Recognise exclusion as a problem within speciality	Interviews reveal everyday mechanisms that are only weakly visible in formal policy language.	Fair selection, feedback and panel practices

Speaking up remains risky in hierarchical settings	Policies support inclusion, accountability and speaking up.	Described hierarchy, silence and fear of consequences when exclusion or racism was noticed.	Recognise the importance of speaking up.	A reporting route is not the same as feeling safe enough to use it.	Safer speaking-up and bystander systems

Integrating findings from both documents and the semi-structured interviews reveals areas of both alignment and divergence between documents and lived experience. Alignment is evident in the documents' recognition of differential attainment, workforce pressures, EDI priorities, and the necessity for inclusive environments. Divergence is evident in the discrepancy between formal policy mechanisms and the informal academic practices described by participants.

For example, GMC documents call for fairer training cultures, support for doctors new to the UK, improved exam feedback, educator training, and reform of recruitment processes (GMC, 2024a, pp. 11–12). These align with interviews highlighting unclear career pathways, IMGs' vulnerabilities, and the need for improved induction procedures. Nonetheless, interview data further show that inequity extends beyond formal training structures to include sponsorship practices, credibility assessments, public feedback mechanisms, and informal introductions.

Similarly, NIHR diversity reports reveal ethnic disparities in funding success (NIHR, 2022, p. 9). However, interview analysis suggests that factors influencing funding success are determined well before submission, including whether a participant has a supportive supervisor, sufficient time to prepare, feedback on previous applications, institutional support, and confidence in the application process. This has revealed several critical junctures and leverage points to address: using interest convergence without losing the equity argument; transparent academic opportunity infrastructure; structured sponsorship rather than informal goodwill; fair

selection, feedback and panel practices; and safer speaking-up and bystander systems.

3.7 Reflexive analytic remarks

I acknowledge that some interview accounts felt personally familiar, given my background as an IMG from an ethnic minority. Descriptions of navigating hidden rules in everyday UK academic and clinical settings, interpreting tone, working harder to prove legitimacy, and assessing the risks of speaking up resonated with aspects of my own professional experience. This proximity should be regarded as an analytical condition to be made visible rather than as a bias to be eliminated. It enhanced my awareness of subtle mechanisms that might otherwise be dismissed as interpersonal misunderstandings or personal insecurities (see Supplementary Appendix B).

Reflexivity, however, requires caution. Not all participants interpreted their experiences through a racial lens; several highlighted factors such as training in London, being a UKMG, native English proficiency, or supportive supervision as protective. I therefore avoided imposing a single narrative across all accounts. Instead, my analysis was attentive to variation, identifying who perceived protection, who perceived vulnerability, and which institutional arrangements produced these differences.

CHAPTER 4 DISCUSSION

This chapter discusses findings from the document corpus and interviews in relation to the existing literature on racial inequity in medical education and academic medicine, and on differential clinical academic progression. It explores how these findings contribute to current understanding, explains the disconnect between policies and lived experiences, and examines opportunities for reform that are both critically justified and pragmatically feasible. The central argument of this chapter is that inequity within UK academic gastroenterology and hepatology speciality is reproduced through routine academic processes and should not be viewed solely as a matter of individual prejudice or isolated acts of discrimination. The chapter also addresses the climate of safety amid exclusion. These points build on the results highlighted in the previous chapter, where the document analysis showed strong institutional commitments to fairness, monitoring, and transparency, while interview data indicated that key mechanisms of academic progression often remain informal, relational, and unevenly accessible.

Throughout this discussion, a personal and reflexive voice was used where appropriate, reflecting my recognition that the project is inherently connected to my position as an ECCS seeking to understand the system from within. Reflexivity was used to identify aspects that might otherwise be normalised, while claims remained grounded in interview data, published literature, and policy documents. The value of this approach lies in explaining how inequity is reinforced through the daily organisation of academic careers within this speciality, and how such durability might be challenged.

4.1 Summary of Key findings from the study

The document corpus analysis indicates that differential progression extends beyond the gastroenterology and hepatology speciality. The GMC Workforce Report 2025 highlighted notable disparities in access to specialist training between UKMGs and IMGs (GMC, 2025, pp. 11–13). Furthermore, NIHR diversity reporting revealed lower funding success rates among ethnic minority applicants compared

with their white counterparts and identified under-representation of ethnic minority groups on funding committees (NIHR, 2022, pp. 1, 9). While these documents do not conclusively demonstrate that identical mechanisms operate at every stage of the academic pipeline within the gastroenterology and hepatology speciality, they provide a credible context in which race/ethnicity and PMQ origin can influence progression. Qualitative analysis showed an increased use of language related to equality/equity, diversity, fairness, and transparency. For example, the GMC EDI progress report explicitly identified fairness as a core challenge in healthcare and linked the development of fairer cultures to improvements in retention and productivity (GMC, 2024a, p. 2). However, a key finding of this study is that, although these documents excel at identifying issues and making broad commitments, they are less effective at outlining specific reforms. This represents the first identified policy-practice gap.

The semi-structured interviews, on the other hand, explained how this disparity is experienced. ECCSs described academic progression as dependent on the hidden curriculum and informal knowledge. They emphasised the importance of supervisors, sponsors, and senior advocates, whilst acknowledging that access to these relationships is often unequal. This is not a unique phenomenon; rather, it reflects a broader pattern within academia, where informal networks and reputation reproduce inequity across all early-career researchers, whether they are women in male-dominated workplaces or working-class scholars in privileged settings (Schwartz et al., 2024; Farkas et al., 2019; Bonifacino et al., 2021; Thompson and Taylor, 2023). In this study, several participating ECCSs noted that academic pathways may be transparent to insiders but remain opaque to those outside established centres or networks, particularly IMGs and trainees who have not rotated through tertiary academic environments or in big cities such as London. A notable indicator of progression identified was protected time allocated for academic and research activities; in its absence, these pursuits tend to encroach on evenings and weekends, thereby conflicting with personal and family commitments. Speaking out against racism or exclusion was viewed as a risky

undertaking, given the hierarchical structure of academic medicine and its reliance on reputation. These findings are discussed below in relation to existing literature.

4.2 How this study relates to existing research and literature

4.2.1 Racial inequity and differential attainment in medical education

This study highlights the uneven career progression experienced by ECCSs from ethnic minority groups, a finding consistent with a substantial body of medical education literature (Woolf et al., 2016; Morrison et al., 2024; Salem et al., 2023). Research into differential attainment has repeatedly identified disparities in examination and recruitment outcomes, as well as in career progression, by ethnicity and by the country of primary medical qualification. Katherine Woolf and colleagues have been particularly influential in showing that differential attainment extends beyond individual ability. Woolf's investigation into ethnic minority medical students highlighted how stereotypes, a sense of belonging, assessment cultures, and institutional expectations can influence the performance and experience of this group (Woolf et al., 2008; Woolf et al., 2011). In postgraduate clinical education, policy reviews have similarly argued that attainment gaps arise from complex interactions among learners' experience, assessment systems, workplace culture, feedback mechanisms, support structures, and biases (GMC, 2024a, pp. 9-12).

While those findings align with the broader literature, they redirect attention to an under-investigated speciality pipeline. Much existing evidence focuses on undergraduate medical education, postgraduate examination outcomes, or recruitment into training programmes (McKeigue et al., 1990; Woolf et al., 2016; Ellis et al., 2025; Davoudi et al., 2023). This study specifically examined the clinical academic pipeline in gastroenterology and hepatology speciality. It therefore extends debates on differential attainment by showing how inequities may be embedded before formal outcomes are measured. By the time individuals apply for academic posts, pre-existing disparities in access to funding opportunities, sponsorship, protected academic time, and visibility may already have shaped their competitive success.

A key contribution of this study is showing how racial inequity manifests in ECCSs' lived experiences rather than distinguishing racial inequity from explicit discrimination, since the latter has already been well documented and theorised (Woolf et al., 2016; Carr et al., 2007; Bonifacino et al., 2021; Schwartz et al., 2024). Some ECCSs reported overt or subtle racist encounters, including microaggressions from patients and assumptions by colleagues about language or competence. Nonetheless, the predominant theme was not always explicit discriminatory intent; more often, ECCSs described mechanisms perceived as routine, such as supervisors recommending familiar colleagues, projects offered to ECCSs already embedded within organisations, roles advertised but effectively tailored to known candidates, or candidates with familiar accents and UKMG deemed more credible. This contextualises the term “racialised barriers”, encapsulating processes in which race, ethnicity, accent, migration status, and institutional familiarity are implicated in judgements of merit, safety, and suitability, even when racism is not explicitly acknowledged.

4.2.2 Academic medicine, sponsorship and the ‘’hidden curriculum’’

The significance of the hidden curriculum and informal sponsorship in this study aligns with the broader literature on academic medicine. The term "hidden curriculum" generally refers to the implicit rules, expectations, and values that shape professional socialisation but are not explicitly taught (Hafferty, 1998). In a clinical academic setting, the hidden curriculum encompasses understanding when to engage with a supervisor, how to identify projects with funding potential, which fellowships are attainable, how to interpret rejections, how to negotiate authorship, and how to maintain visibility among senior academics. Participating ECCSs consistently described these forms of knowledge as crucial determinants of success. The issue is not the existence of informal learning itself; all professions depend on it to some degree, but rather its inequitable distribution. When access to such informal learning occurs early for some groups but not others, disparities are reinforced.

Mentorship and sponsorship are closely related yet contextually different. Mentorship support involves advice and guidance, whereas sponsorship entails active advocacy, such as putting someone forward, introducing them to networks, inviting them to projects, recommending them for positions, or lending senior credibility. Interviews suggest that sponsorship is one of the most influential mechanisms driving career progression. This observation aligns with the available literature in academic medicine, which shows that mentorship alone may be insufficient to overcome structural barriers without the complement of sponsorship, accountability, and access to opportunities (Sambunjak et al., 2006; Beech et al., 2013). From a perspective rooted in racial equity, sponsorship assumes particular importance, as informal advocacy can reproduce similarity bias; senior individuals may favour sponsoring those who resemble them, are part of their networks, or share similar communication styles and institutional backgrounds.

This study further enriches existing literature by offering a nuanced, speciality-specific perspective. Participants highlighted that academic gastroenterology and hepatology are primarily centred within tertiary institutions and research centres. Access to these environments was often perceived as contingent on geographical location, rotation schedules, and early networking. ECCS10 provided a compelling example, noting that research opportunities often favour individuals already embedded within a centre or those recommended through trusted connections. While such gatekeeping is often driven by legitimate concerns, with supervisors preferring to employ known or vouched-for candidates, the implications for equity are clear. Trust rooted in prior familiarity requires greater effort for those outside established networks to gain visibility. In this context, sponsorship can serve as both an enabler and a potential barrier to equitable access.

4.2.3 Racialised perception of competence and credibility

My findings also support seminal scholarship on meritocracy within medical education. Razack and colleagues have argued that medical education often presents itself as meritocratic while neglecting the influence of social position on access to the resources required to demonstrate merit (Razack et al., 2015).

Similar critiques were identified in my study regarding selection and assessment processes, and the development of professional identity, with seemingly neutral criteria often reinforcing dominant cultural norms. In this context, ECCSs rarely challenged the notion of merit; many regarded academic excellence, clinical competence, and diligent effort as important. Nonetheless, they expressed concern that the conditions under which merit is produced and recognised may not be equally accessible to all.

This was particularly evident in discussions about accent, the origins of PMQ, and perceptions of credibility. Several participants noted that a mainstream British accent and a UK PMQ could serve as protective factors. Conversely, colleagues with pronounced foreign accents or overseas qualifications were sometimes perceived as less competent. This observation aligns with existing research, which suggests that IMGs frequently face challenges related to clinical expertise but also encompassing workplace culture, communication standards, supervision, a sense of belonging, and divergent expectations (GMC, 2025, pp. 4-5; Slowther et al., 2012). My perception is that accent functions as a racialised proxy. Although rarely framed explicitly as race within formal systems, it influences judgements of competence and trustworthiness. This is particularly crucial for academic advancement, as interviews, presentations, networking, and grant panels all depend critically on communication skills and clarity.

This study extends the existing body of literature by showing that credibility is not solely determined by publications and academic qualifications. Instead, it is also constructed through relational factors. A candidate is deemed credible when senior academics acknowledge their potential, their institutional background is transparent, their accent is easily intelligible, their supervisor is known, and their career narrative aligns with widely accepted academic norms. This does not imply that all successful candidates are undeserving; instead, it indicates that acts of deservingness are more readily acknowledged when presented in familiar and recognisable forms.

4.2.4 Speaking up, bystanders and institutional cultures

A common theme in the interviews was the recognition of racism or exclusion without necessarily being challenged. Viewing this observation through a bystander-theory lens suggests that intervention involves multiple stages: noticing an event, interpreting it as problematic, assuming responsibility, knowing how to respond, and feeling safe to act (Latané and Darley, 1970). Within hierarchical clinical academic environments, each of these steps is often hindered. Participants described subtle interactions, such as tone of voice, body language, public criticism, or varying standards of patience towards IMGs, that may be observed yet are difficult to articulate. Such incidents can be perceived as problematic but are often not sufficiently clear to justify challenging. Even when a sense of responsibility emerges, ECCSs may hesitate to intervene, fearing they might be perceived as difficult or that their future career prospects could be compromised.

The GMC has emphasised the importance of fostering inclusive cultures, establishing transparent channels for speaking up, and implementing equitable local processes (GMC, 2024a, pp. 11-12). However, my findings suggest that formal channels alone are insufficient when reputational risk remains significant. In a small speciality such as gastroenterology and hepatology, where supervisors, trainers, and prospective employers are often interconnected, speaking up is not only a moral duty but also a strategic career consideration. The interview data complement existing policy frameworks; whilst policies explicitly condemn racism, individuals remain caught between the ethical imperative to raise concerns and the potential impact of speaking up on their career progression and future opportunities. This reveals a significant dissonance between policy aims and real-world practice.

That is why Verma and Bhala (2023) have argued that UK gastroenterology and hepatology require transparent monitoring, implementation of diversity benchmarks, and annual reporting to promote EDI within leadership and professional structures.

4.2.5 Interpretation through a Critical (Race) Pragmatism lens

Critical Race Pragmatism (CRP) offers a valuable conceptual framework for this study, as it addresses two common limitations in equity research. The first is 'inequity normalisation': the repeated documentation of inequity without suggesting pathways for remediation (Bell, 1980). The second is 'superficial pragmatism': the suggestion of generic interventions without interrogating underlying power structures (Ladson-Billings and Tate, 1995). CRP encompasses both approaches by recognising the persistence of structural racism and racialised disparities in access to opportunities, whilst also identifying feasible points of intervention within existing institutional frameworks. Applying a critical race theory (CRT) perspective reveals how seemingly neutral academic systems can reproduce inequities. Formal procedures such as recruitment and job descriptions often appear transparent; however, participants report informal pre-selection and subjective assessments of suitability. An intersectional analysis indicates that these processes are experienced unevenly across racialised groups. UKMG participants, who possess British accents, frequently perceive a degree of protection. Conversely, their IMG counterparts, with foreign accents, female gender, or a geographical location outside known academic centres, may face heightened scrutiny of their credibility or a greater risk of exclusion. Applying a Bystander perspective reveals how hierarchical systems hinder intervention, even when exclusion is acknowledged. Utilising Engeström's activity system framework uncovers contradictions: institutions assert a commitment to fairness, yet the tools, rules, and opportunities surrounding sponsorship and protected time remain informal.

This represents the most significant contribution of my study. It clarifies that racialised inequity often stems from the gap between formal concepts of fairness and informal opportunities. Recognising this distinction is critical, as institutional responses frequently focus on policy drafting and public declarations, yet these measures alone are inadequate if the mechanisms underlying academic advancement remain informal and unquantifiable.

4.3 Leveraging findings to achieve change and reform

4.3.1 Using interest convergence without losing the equity argument

Interest convergence, as described by Bell (1980), offers a valuable conceptual framework for considering reform. In my study, the primary institutional concern was workforce sustainability. The disciplines of gastroenterology and hepatology require robust recruitment, retention, and development of skilled clinicians. Analyses of the BSG workforce reports reveal consultant vacancies, retention challenges, and mounting pressures on departments (Rutter, 2022, p. 1; (Samji, 2024, p. 1). Furthermore, the GMC emphasises the importance of fairness in staff retention, productivity, and patient care (GMC, 2024a, p. 2). This presents a pragmatic case for viewing equity reforms as essential to the long-term sustainability of the specialities. Nonetheless, there is an inherent risk. When equity is justified solely on the grounds of enhancing workforce supply or institutional reputation, reforms may become superficial and transactional. Therefore, my position is that interest convergence should be employed strategically, not uncritically. The moral imperative remains that scholars from racialised backgrounds are entitled to equitable access to opportunities. Pragmatically, it is essential that this specialised field avoid wasting talent through obscure pathways, informal gatekeeping, or preventable attrition. These arguments should be presented together.

4.3.2 Transparent academic opportunity infrastructure

A key conclusion from the interviews is the need for a transparent academic pathway map for gastroenterology and hepatology. Participants noted that access to such opportunities often depends on personal networks, rotations through appropriate centres, or encouragement from senior academics. A national or speciality-specific portal could help disseminate projects, opportunities, fellowships, academic posts, research networks, supervisors willing to support initiatives, and relevant funding deadlines. Such a resource should help reduce reliance on these connections as the primary route into academia.

This reform is attainable because it aligns with existing institutional interests. Bodies such as BSG, academic training leads, universities, and the NIHR infrastructure already have incentives to attract talented candidates and support specialist research. Implementing a central portal would further enhance the pipeline's visibility for trainees outside London and those based at major tertiary centres. For the initiative to be effective, it would require regular maintenance, clear ownership, transparent explanations of the various career pathways, and strategic planning for consultant academic roles.

4.3.3 Structured sponsorship rather than informal goodwill

A fundamental aspect of academic progression is structured sponsorship rather than informal mentorship based solely on goodwill. While mentorship initiatives are common, evidence from this study suggests that sponsorship has greater influence as a form of professional currency. Establishing a formal sponsorship scheme could strategically pair ECCSs with senior academics explicitly tasked with identifying opportunities, facilitating introductions to useful networks, reviewing fellowship applications, nominating candidates for speaking engagements, and enhancing authorship visibility. Notably, such sponsorship activities should be systematically documented and regularly assessed to prevent them from becoming informal arrangements that primarily benefit those already prominent in the academic sphere.

This proposal is feasible because it advocates reconsidering the deployment of existing senior staff rather than creating new academic posts across all departments. Speciality societies could launch pilot sponsorship schemes targeting racialised ECCSs, IMGs, women, and scholars outside traditional academic centres. I consider this one of the most transformative reforms because it addresses a mechanism repeatedly emphasised by participants: the need for someone to facilitate access to opportunities rather than merely providing advice.

4.3.4 Fair selection, feedback and panel practices

Another consideration is reforming selection and feedback mechanisms. Participants did not necessarily claim that formal criteria were entirely absent; instead, they described them as insufficiently explicit, open to interpretation, vague, and occasionally influenced by familiarity with candidates. Consequently, reform initiatives should include developing transparent scoring systems, assembling diverse panels, explicitly addressing biases, providing structured feedback to unsuccessful applicants, and declaring any relevant prior relationships. In the context of academic appointments, applicants should be informed of the evidentiary standards considered valuable, including publications, preliminary data, project feasibility, supervisory fit, leadership potential, and institutional backing.

This is achievable because recruitment and funding mechanisms already use established criteria and panels. The proposed reform aims to enhance the accountability of selection processes. Providing detailed feedback is particularly vital; without substantive observations, unsuccessful candidates cannot discern whether deficiencies are addressable or whether exclusions are opaque. This issue is especially relevant to racialised equity, as repeated rejection without clarification may exacerbate imposterism and discourage future submissions.

4.3.5 Safer speaking-up and bystander systems

The final leverage point derived from this study is the safety of speaking up. Participants described situations in which racism or exclusion were acknowledged but not challenged, often due to hierarchical structures, uncertainty, or fears of reputational repercussions. Conventional reporting mechanisms are insufficient. Institutions must implement specialty-specific bystander training, establish explicit escalation pathways, uphold anti-retaliation policies, and develop feedback loops that demonstrate tangible responses to concerns. Senior clinicians and academics require scripted guidance and clear expectations for intervention when supervisors or colleagues make racialised remarks or when feedback is publicly humiliating.

In my view, initiatives that encourage individuals to speak out should avoid imposing the burden on ECCSs from ethnic minority backgrounds to educate the system. A CRP-informed framework would treat bystander intervention as an institutional obligation, aiming to shift from private remediation after harm has occurred to a proactive public approach centred on prevention. This is particularly crucial within small, specialised fields, where future employment prospects and academic collaborations are significantly influenced by reputation and likability.

4.4 Implications for policy, practice and education

There are multiple levels of implications arising from this study's findings for policies, practices, and educational initiatives in gastroenterology and hepatology speciality. At the level of speciality societies, organisations such as the BSG or BASL might develop comprehensive national academic pathway resources, systematically collect data on leadership diversity, and monitor representation. Within university and NHS trust institutions, departments could audit ECCSs' protected research time, clarify pathways for academic career progression, support grant applications, and ensure transparency across all processes. Funding bodies may enhance feedback for unsuccessful applicants, assess diversity within review committees, and investigate whether ethnic disparities in success rates persist at each stage of the review process. At the training programme level, academic-focused careers should be introduced earlier and normalised as a viable option across a broader cohort of trainees, extending beyond those already enrolled in ACF pathways or affiliated with elite universities and centres.

From a medical education perspective, the findings indicate that research literacy and academic career navigation should be regarded as essential components of professional development. Participants reported a general lack of awareness of available pathways or scepticism about their entitlement to pursue them. Early exposure to research pathways, near-peer examples, and explicit guidance on funding opportunities may help reduce these barriers. Nonetheless, education alone is insufficient. Teaching individuals to navigate an inherently biased system risks fostering adaptation rather than systemic reform. Therefore, educational

strategies must be complemented by structural reforms to ensure an equitable distribution of opportunities.

4.5 Limitations of the study

There are several limitations to consider in this study: the document analysis relies on publicly accessible materials that reflect official policies and institutional self-representations. However, these documents may not capture local practices, unpublished data, or internal decision-making processes. This limitation also offers an analytical insight: some of the most critical mechanisms for promoting equity are not formally documented in public resources. Furthermore, the quantitative document analysis is inherently descriptive. Indicators derive from a variety of organisations, reporting periods, denominators, and sampling frameworks. As a result, it is methodologically inappropriate to combine these data statistically or to infer causal relationships. The aim of the quantitative synthesis of the numerical data obtained is therefore primarily to demonstrate contextual patterns of workforce pressure, differential career progression, and funding disparities that underpin the qualitative findings.

A limitation to note about the interview component of this study is that the sample size is relatively small and limited to ECCSs. However, the aim was to conduct a theoretically informed qualitative investigation of underlying mechanisms and experiential narratives. The primary strength of this approach, therefore, arguably lies in its depth of insight rather than in representativeness. It is also important to acknowledge that the sample may not fully capture the heterogeneity of racialised experiences across regions, institutions, subspecialties, career stages, or ethnic groups. Participants self-selected into a study on racial barriers, and those with strong opinions, challenging experiences, or a particular interest in equity may have been more likely to participate. Conversely, some individuals may have declined to participate because of the emotional difficulty or perceived risks associated with the topic. Therefore, the findings should be viewed as detailed accounts of potential mechanisms rather than as indicative of prevalence.

Finally, my own positionality shaped this study. Given my background, I may have been particularly sensitive to certain aspects of racialised exclusion, IMGs' experiences, and the hidden curriculum. This is not merely a limitation but also a source of analytic insight. Nonetheless, I have sought to maintain reflexivity and avoid imposing a singular interpretation on participants. Some individuals recounted experiences of relative protection, support, and belonging; these accounts are particularly significant, as they illustrate that racialised experiences are not uniform.

4.6 Recommendation for future research

This study has examined racialised barriers within a single clinical-academic speciality. The findings suggest that inequity arises from the complex interplay between formal institutional frameworks and informal opportunity structures. Future research should therefore explore two interconnected avenues: first, employ collaborative, mixed-methods, and data-integrated approaches to broaden the scope of inquiry; and second, assess interventions designed to modify opportunity structures rather than merely documenting existing barriers.

4.6.1 Extending the study to other specialities

A priority is to examine whether the mechanisms identified in this study are also present in other clinical-academic specialities. Gastroenterology and hepatology speciality is characterised by distinctive features, including endoscopy, tertiary liver and IBD centres, out-of-programme doctoral training, and significant workforce pressures. Nonetheless, many of the mechanisms reported by participants are unlikely to be exclusive to these disciplines. Fields such as cardiology, oncology, neurology, renal medicine, respiratory medicine, and all surgical specialities, which are regarded as highly competitive, may similarly rely on covert academic pipelines, informal sponsorships, elite institutional networks, and disparities in access to academia. Future research should therefore include comparative analyses across specialities. A multidisciplinary qualitative study could examine how academic opportunities are distributed across procedural, medical, and surgical domains. Participants should include academic clinical

fellows, doctoral fellows, clinical lecturers, postdoctoral clinicians, early-career consultants, senior clinical academics, and those who have left academic pathways. This approach would enable comparisons across stages of the academic pipeline. It would build on the wider medical education literature, which shows that disparities in attainment and progression are driven predominantly by structural and institutional factors rather than by individual deficits alone (Woolf, 2009; GMC, 2024a).

Comparative speciality research would also help avoid treating gastroenterology and hepatology as an isolated case. Instead, it would position this study as a foundation for a broader exploration of how clinical-academic careers are organised, accessed, and sustained across medicine.

4.6.2 Scaling up through mixed-methods and institutional collaborations

Secondary future research should expand this initiative through strategic collaboration. The barriers identified in this study span multiple institutional tiers, including universities, NHS trusts, postgraduate deaneries, royal colleges, funders, speciality societies, and national regulatory bodies. No single entity holds all the necessary data or has the capacity to effect change independently.

Accordingly, future research should adopt a collaborative approach from the outset. The development of a larger study could be facilitated through partnerships with organisations such as the BSG, BASL, NIHR, UKRI, the NHS, the GMC, and the Medical Schools Council. Collaboration with EDI leads within each institution, clinical-academic training coordinators, and ECCS groups would also be crucial. Such an approach would help ensure that future research is not merely conducted with marginalised clinicians but is designed in consultation with those whose careers are affected by the systems under investigation. This collaborative ethos aligns with participatory and action-oriented paradigms in medical education, which position affected groups as knowledge custodians and active agents of change rather than as passive subjects of research (Jagosh et al., 2012; Foreshew and Al-Jawad, 2022). Ultimately, this approach will facilitate future research that integrates national data patterns with local lived experiences and practical reforms.

Furthermore, it embodies the principles of CRP, whereby structural critique is combined with actionable, feasible steps.

4.6.3 Evaluating interventions rather than only describing barriers

A final area to be explored is intervention research. While existing work in medical education has substantially contributed to understanding of issues such as differential attainment, under-representation, and exclusion (Woolf et al., 2011; Woolf et al., 2016; Woolf, 2020), there is now a pressing need to assess whether targeted reforms can alter the distribution of opportunities. Future research should therefore explore interventions targeting the mechanisms identified in this study, and their effectiveness should be assessed by their ability to enhance access to opportunities.

Qualitative research remains indispensable because it shows whether interventions are perceived as meaningful, tokenistic, burdensome, or transformative. This issue has been highlighted in the literature on the “minority tax” in academic medicine, where individuals from underrepresented groups are often assigned disproportionate amounts of diversity work without adequate recognition or reward (Rodríguez et al., 2015; Charles et al., 2024). Future intervention research should therefore examine both outcomes and unintended effects.

In my assessment, supported by this study, the discipline now demands fewer sweeping assertions of institutional commitment and more rigorous analyses of mechanism-specific reforms. It requires integrating lived experiences, institutional data, and practical interventions. Where inequities are sustained by informal sponsorship, obscured criteria, and cultures inhospitable to speaking out, reforms must be scrutinised precisely at these points.

CHAPTER 5 CONCLUSION

This study went beyond asking whether racial inequity exists in the growing fields of gastroenterology and hepatology to explore how such disparities are created and maintained, and how they might be challenged throughout the clinical-academic career pathway. Employing Critical (Race) Pragmatism as the guiding framework, the project combined an awareness of systemic racial barriers in academic institutions with a pragmatic focus on feasible areas for reform. Its aim was not only to describe obstacles but also to pinpoint opportunities for change. The central message was that inequity in academic gastroenterology and hepatology stems from how academic opportunity is structured, distributed and defended, rather than from individual prejudice. When research access depends on informal sponsorship, selection hinges on perceived “fit,” and speaking up entails personal risk, inequity can persist even within systems that formally endorse fairness.

Working on this project as an ECCS from an ethnic minority group has made this study personally meaningful. I recognised some of the tensions described by participants: the need to establish legitimacy, the importance of sponsorship, and the challenge of articulating subtle forms of exclusion. However, this endeavour has also reinforced my conviction that reform remains attainable. Practical measures such as transparent opportunity pathways, structured sponsorship, clarity over authorship, enhanced support for IMGs, and systems that foster safer speaking-up environments are within reach. These do not require compromising excellence; rather, they demand that we take excellence seriously enough to critically assess who has been given the conditions necessary to demonstrate it.

Ultimately, this study argues that racial equity in academic medicine should not remain an aspiration enshrined in policy. It must become visible in the everyday distribution of academic time, trust, credit, opportunity and protection. That is where the academic pipeline is either narrowed or widened, and where meaningful change must begin.

CHAPTER 6 REFERENCES

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SUPPLEMENTARY APPENDICES

A. Ethics approval letter



Education (Educ) DREC
15 Norham Gardens, Oxford, OX2 6PY

Applicant: Almuthana Mohamed
Principal Investigator: Paulina Rodriguez Anaiz
Department: Education

Study title: Exploring racial barriers impacting early-career clinical scholars within UK academic gastroenterology and hepatology: A critical (Race) pragmatism study
(Version: 1.0)

Ethics reference: Education (Educ) DREC - 2478633

Dear Almuthana Mohamed,

On behalf of the Committee, I confirm that the above research study described in the application and other supporting documentation submitted to the committee has been carefully considered by the Education (Educ) DREC in accordance with the University's regulations and policy for ethics approval of research involving human participants, human tissue and/or personal data. The opinion is as follows:

Opinion of Research Ethics Committee: Favourable Opinion
Subject to the following conditions:
Decision Date: 17 Dec 2025, 15:42
Opinion End Date: 31 Aug 2026

If favourable, insurance-provided indemnity arrangements will be in place between the decision date and opinion end date and you may now commence your study activities. Should you plan to continue the research beyond the end date above, it is your responsibility to ensure that you request, and receive, an extension (via amendment) from the committee for indemnity to remain in place. You may be required to provide a justification.

Please note the following:

Amendments: Should there be any subsequent changes to the reviewed study, applications for amendments can be made via the Oxford Ethics Application System (Worktribe Ethics).
Reports: Researchers conducting high risk studies are required to submit a *progress report* on each anniversary of study approval, until the study is completed. An end of study report is also required for applications considered by OxTREC. Other committees should be notified that the research is complete.
Audit: This study may be selected for audit at the discretion of the Research Governance, Ethics and Assurance Team.
Data safety: It is the responsibility of the PI to ensure that all data collected during the course of the study is stored and transferred safely and securely in accordance with University requirements. Further guidance and advice are available from the Research Data Team. Additional information is available at University Research Ethics (Please note that this link will not work in Protected View).

Yours Sincerely
Education Ethics Officers

B. Participant information sheet

DEPARTMENT OF EDUCATION
University of Oxford
15 Norham Gardens
Oxford, OX2 6PY

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

Exploring racial barriers impacting early-career clinical scholars within UK academic gastroenterology & hepatology

Central University Research Ethics Committee Approval Reference: [(Educ) DREC - 2478633]

1. Introductory paragraph

You are invited to participate in this research project investigating Racial Barriers Affecting Early-career Clinical Scholars (ECCS) in UK Academic Gastroenterology & Hepatology. Before deciding, it is important that you understand the purpose of the research and what it involves. Please take the time to read the following information carefully and discuss it with others if you wish. Feel free to ask us if anything is unclear or if you require more information. Take your time to decide whether you want to take part.

2. Why is this research being conducted?

The research explores how ECCS in the gastroenterology and hepatology speciality from ethnic minority backgrounds navigate academia/career progression. What helps them, and what sometimes gets in the way of career progression. The study looks at how race and ethnicity may shape these experiences

3. Why have I been invited to take part?

You have been asked to participate because you are an early-career clinical scholar (ECCS) from a racial and ethnic minority background in the gastroenterology and hepatology speciality, and it will be very helpful to work with you to understand your experiences and views on this research topic.

4. Do I have to take part?

No. It is your decision whether to participate. You can withdraw from the research at any time without providing a reason and without facing negative consequences to your role, simply by informing me of your choice. The deadline to withdraw any information you have contributed is 30-April-2026. In that case, any data already collected will be deleted or destroyed immediately and will not be included in any reports.

5. What will happen to me if I take part in the research?

If you agree to take part, I will invite you to an interview where we will discuss your experiences with racial barriers in your training and career growth, as well as the strategies you find helpful for overcoming them. This will involve questions about your social identity and background, including race/ethnic background, nationality, migration status and origin. Before the session begins, you will have the chance to ask any questions and give your consent to participate.

This interview will be held online at a time convenient for you and should last approximately 60 to 90 minutes.

With your consent, I would like to record the interview audio so I can keep an accurate record of our conversation. You may ask to pause or stop the interview at any point.

6. **What are the possible disadvantages and risks in taking part?**

There are no foreseeable discomforts, disadvantages, or risks that have been identified for this study. You will not be identifiable from the results of this work. None of the information you provide as part of this study will be shared with your employer or clinical/educational supervisor.

7. **Are there any benefits in taking part?**

While there are no immediate benefits for you in participating in this study, it is expected that this work will contribute to practical reforms in training and academic career development in gastroenterology and hepatology. I hope that reflecting on these aspects will also provide some valuable insights for you.

8. **What information will be collected and why is the collection of this information relevant for achieving the research objectives?**

With your permission, we will Video and audio record the interview to ensure an accurate record. Recorded files are deleted after transcription and quality checks; only anonymised transcripts are kept. If the interview is held on Microsoft Teams, the platform automatically records audio and video in a single file. We will not analyse or retain the video. Immediately after the interview, we will extract the audio only and delete the video file.

Your data will be stored securely on password-protected University of Oxford servers and may be used in academic publications, presentations, and my dissertation.

The data collected will be stored as follows:

- All the data will be stored on the University of Oxford Nexus365 OneDrive for business file storage service, which is approved by the University for confidential data storage.
- Audio recordings of the semi-structured interviews will be done on an encrypted PIN-protected audio recorder and stored on the device's hard drive. They will be deleted from the audio recorder on the same day as the interview, after the data has been transferred to OneDrive for Business.
- In the eventuality that the interview will take place remotely, Microsoft Teams will be used, and the interviews will be video recorded.
- The audio recordings of interviews will be transcribed using pseudonyms, and then the recordings will be permanently deleted. Transcripts will be stored on OneDrive for Business. The interviews will be transcribed using Microsoft Office tools approved by the University for this purpose.
- The interview notes will be digitised and stored directly on OneDrive for Business. Any paper copies will be immediately shredded.

- Consent forms will be digitised and saved on OneDrive for Business, separately from the rest of the data collected. The paper copies will be shredded immediately after being digitised.

Only I, my supervisor and authorised admin support staff at the University of Oxford will have access to the data.

Identifiable data (including consent forms) will be stored on the University's secure servers, as described above. Other research data will be stored on Microsoft SharePoint for three years after publication or public release of the work of the research, and kept until the end of the study and subsequent studies.

9. Will the research be published? Could I be identified from any publications or other research outputs?

The findings from the research will be written up in a dissertation for my Masters in Medical Education and will be aim to be presented at national and international conferences as well as publications. This will not contain any identifiable information. A copy of my dissertation will be deposited both in print and online in the Oxford University Research Archive where it will be publicly available to facilitate its use in future research.

I would like your permission to use direct quotations, but without identifying you in any research outputs.

10. Data Protection

The University of Oxford is the data controller with respect to your personal data, and as such will determine how your personal data is used in the research. The University will process your personal data for the purpose of the research outlined above. Research is a task that is performed in the public interest. Further information about your rights with respect to your personal data is available from the University's Information Compliance web site at https://compliance.admin.ox.ac.uk/individual-rights.

11. Who has reviewed this research?

This research has received ethics approval from a subcommittee of the University of Oxford Central University Research Ethics Committee. (Education (Educ) DREC - 2478633)

12. Who do I contact if I have a concern about the research or I wish to complain?

If you have any concerns about any aspect of this research, please contact Dr Almuthana Mohamed at almuthana.mohamed@gtc.ox.ac.uk or Dr Paulina Rodriguez Anaiz at paulina.rodriguezanaiz@education.ox.ac.uk, and we will do our best to address your enquiry. We will acknowledge your concern within 10 working days and provide an update on how it will be handled. If you are still dissatisfied or wish to make a formal complaint, please contact the University of Oxford Research Governance, Ethics & Assurance (RGEA) team at rgea.complaints@admin.ox.ac.uk or on 01865 616480.80.

13. Further Information and Contact Details

If you would like to discuss the study with someone beforehand (or if you have questions afterwards), please contact:

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C. Consent form

DEPARTMENT OF EDUCATION
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CONSENT TO TAKE PART IN THE STUDY PROJECT
Exploring racial barriers impacting early-career clinical scholars within UK academic gastroenterology & hepatology

Central University Research Ethics Committee Approval Reference: [(Educ) DREC - 2478633]

Purpose of Study: The aim of this study is to explore the racial barriers facing early career clinical scholars (ECCS) in academic gastroenterology and hepatology across the UK and to identify pragmatic, context-specific strategies that enhance equity, inclusion, and career development	**Please initial each box if you agree with the statement**
I confirm that I have read and understand the information sheet for the above research. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any point [until 30-Mar-2026] without giving any reason.	
I understand who will have access to personal data provided, how the data will be stored and what will happen to the data at the end of the study.	
I understand that I will not be identifiable from any publications or presentations.	
I consent to being audio recorded for the purpose of this study.	
I consent to my pseudonymised data being stored and reused in future, ethically approved research, provided the risk of re-identification is assessed as low.	
Use of quotations: Please indicate your preference (select *one* option): a) I do not wish to be quoted. **or** b) I agree to the use of quotations in research outputs if I am not identifiable. **or** c) I agree to the use of direct quotations, attributed to my name, in research outputs.	

I understand how to raise a concern or make a complaint.	☐
I agree to take part.	☐

Name of participant	dd / mm / yyyy Date	Signature
Name of person taking consent	dd / mm / yyyy Date	Signature

D. Semi-structured interview

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SEMI-STRUCTURED INTERVIEW
Exploring racial barriers impacting early-career clinical scholars within UK academic gastroenterology & hepatology

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Thank you for volunteering to take part in this research study, which aims to explore the racial barriers affecting early-career clinical scholars within UK academic gastroenterology & hepatology. During this interview, I will ask you a series of questions. There are no right or wrong answers; I simply want to hear about your experiences and opinions.

1) Career story & background (narrative timeline) ~12 min

Q1. Could you tell me a little about yourself?

Prompts:

- How did you come to be in your current post?
- What's your current job?
- Stage of training / academic level?
- How long have you been working in the UK? Are you enjoying your job so far?

Q2. What motivated you to pursue an academic career alongside your clinical one?

2) Everyday workplace culture & relations ~15 min

Q3. What's a typical week like in your clinical-academic role?

Prompts:

- Are you mostly clinical or academic?
- Balance between two?
- Life-work balance?

Q4. If you think back over your journey into medicine, have there been times when you felt your race, ethnicity or cultural background affected how colleagues or patients interacted with you?

Prompts:

- How did you make sense of it at the time? What, if anything, did you do?

- If you saw this happen to someone else, what did you notice others doing or saying?
- How comfortable would you feel speaking up or reporting? What would make it easier?

3) Progression & barriers (walk through key stages) ~20 min

Q5. Can you talk me through a time you were trying to move to the next step, for example, a training post, fellowship, PhD/MD(Res), consultant role, or leadership position?

Prompts:

- Who encouraged or discouraged you?
- Shortlisting, interviews, ranking, or references — how fair did this seem? What feedback did you get?
- Access to sponsorship (being named or placed) versus mentorship (advice).
- Authorship, presentations, high-value clinics or lists, protected academic time.
- Funding experiences (e.g., NIHR, charity schemes, study funding for IMGs).
- In your view, to what extent did race/ethnicity, migration/IMG versus UK grad, and gender influence who advanced and who did not?

Q6. Thinking across stages, where do barriers mostly appear, for you or your peers?

Prompts:

- Entry into training / initial clinical-academic positions
- Advancing within the programme / securing protected research time
- Applying for competitive fellowships / posts / consultant positions
- Gaining access to leadership opportunities and research/teaching roles

Q7. In your view, how do structures or norms in your department/Trust/university shape who progresses and who doesn't?

Prompts: Transparency of criteria, Hidden expectations, Networks/gatekeeping, "Professionalism/neutrality" norms, who can safely challenge.

4) Impacts, coping, enablers & suggestions ~10 min

Q8. What has helped you to cope or progress in your academic career?

Prompts: People/communities/practices (inside or outside academia).

Q9. If you could change three things to make the academic pathway fairer for early-career clinical scholars in gastroenterology and hepatology, what would they be?

Prompt:

- One rule or process to revise (e.g., transparent criteria; safer reporting).
- One tool/resource to ensure (e.g., sponsorship logs; protected time; IMG study-funding bridge).
- One hierarchy practice to reform (e.g., publicly scripted statements; safe challenge norms).

5) Close (2–3 min)

Q10. Is there anything important I didn't ask? Would you like to add anything else or share final thoughts?

Optional Demographics (participant may skip any item)

Please offer each as optional. Record verbatim where open:

Role/grade & training stage: _____
UK graduate or IMG (optional): _____
Racial/ethnic self-description (open): _____
Gender (open): _____
Migration background/visa (optional): _____
Institution type (e.g., Russell Group/other) & region: _____
Clinical–academic split (approx %): _____

Interviewer memo (complete within 30 minutes post-interview)

Key timeline markers (turning points; aids/hindrances).

Bystander sequence: notice → responsibility → options → action/inaction → consequences.

Activity-system nodes involved (Rules/Tools/Community/Division of Labour).

CRP actions proposed by participant (verbatim if possible) for policy/training updates.

E. Reflexive Logs



Project Reflexive log

ECCS-1 Interview 12 MAR 2026

Role: last year PHD – Newly appointed Consultant
UK graduate
Asian male
Working 90% clinical 10% academic
No dedicated research time.

I think the apparent thing is there is a barrier added to ECCS.

- I felt sense of disappointment in the system

- We had different experience as my Background is different. but he noticed the difference as by student He treated as an Insider with good understanding.

Felt He was Cautious when talking about funding & opportunity bias.

He did mention "Once setting your foot on the door"
Ethical Issue with recruitment (transparent on safe but not so much in real life"

Theoradical framework

* CRT/CRP: Gatekeeping, Interpersonal racism
* Intersectional thinking: Being IMG or have an accent affect interview & success in finding gender gap is improving
* Bystander Theory: Can see difficult weather for race in his experience didn't respond or escalate.

Changes for next interview
use more thinking prompts
slow down after sensitive comments

ECCS-2 Interview 17/3/2026

Role: Consultant, finished her PHD
Female, IMG, Hispanic Background
- working 90% clinical 10% research
- Work over weekend so poor life/work balance

Impression: strong emphasis on "IMG dont know the pathway" and no clear academic pathway in UK.

Positionality: Participant reflect on personal experience & compare with previous experience in spain.

Overall negative experience in UK
Intersectionality with being female & IMG.

suggest a clear pathway to academic progression

CRT/CRP: lack of transparency in recruitment & funding
Intersectional Phase: Being female or IMG hinder your academic progression
Bystander: sees defaulted behavior & dont see safe reporting.

ECCS-3

Role: specialty Registrar currently year 1 PHD
Female, Asian Background, Born & raised in
New Zealand but studied in Cambridge (High achieving)
Won a competitive scholarship.
100% research + 10-20% clinical work
difficult to balance life/work but not too Bad

Impressions: decided to do PHD to secure both clinical J.B
prefer to go full clinical in future. Believe "Accent"
has impact on career progression & How people prevent
selection criteria for funding & job security is not as
transparent as advertised. You need to know right people
at the right time

Thematic framework.
CRT: Race might not have huge impact but it
does linguistic in Background / How you sound "Accent"
is what matters
Bystander - seen MGs being unfairly treated, felt
Helpless. Not a fan of system.

Intersectionality. Female & Asian can impact outcomes

ECCS – 4

Role: Consultant, finished an MD-Res in liver
Male, British Born, Parented Immigrants, southeasian BG
Guy.
Working loo' clinical.
Thinks he currently have good life / work Balance
Impressions:
strong opinion on Differential attainment & Impact of
Race on experience in academia
Brought the "Accent" again has huge impact on
experience. Think while selection criteria is transport
On the surface, HS not. & has huge impact on IMG
Do not want to pursue academic career because
dont believe it worth it.

Theoretical frame work.

CRT: Race Might Not Impact as much as Accent.
Expectation is less if you are fun ethic [illegible]

Bystander theory: Huge effect if Accent is [illegible]

Intersectionality: in Background & orientation [illegible]

ECCS-5

Roles: PostDoc speciality trainee currently doing Academic lectureship. Asian Background, was born & raised in UK. Male. have good life work balance 50-60% research & 40-50% clinical (Depends on him)

Impression: felt he is trying to be politically correct
- Not a fan of using race & feels HS has No impact.
- Believe trainees want to be given things on silver platter.
- Feels that No impact of race on career progression However, He was career focussed from early age. & worked hard to reach this level.

* Theoretical framework:-

CRT: Don't feel Race has role on impact on progression
IMGs vs UK MGs "Accent"

Bystander: Not witnessed definitely before ??

Intersectionality: Not mentioned

ECCS - 6

Role: PHD 2nd year ACF
Female
IMG - Middle eastern - Turkey
working too research
wolay extra shifts so weekends.

Impression: strong & persistent, would had to get to this position.
also identified No clear pathway
Had experienced bullying during early career due to being IMG.

Positionality: feels research culture is gatekept by local graduate.
No clear pathway.
- Thematic summary
- CKP: No clear pathway hinder progression
- Intersectionality: Female in Male dominant specialty
- By standby Always seen ongoing bully

ECCS 7.

Role : PHD 2nd year
Female, Black African, UK graduate
ACF
100 research, awarded a competitive scholarship
Feels has good work life Balance
Not doing much research

Impression: expressed alot of racism while outside
London
strong Background in research, still
Feels she is being undermined by
colleagues
- Racism still exist.

Positionality :
Feels the clinical academic
field in gastroenterology is Male/white dominant.
Felt she is always being asked if she will
continue on academia
suggest transparent criterion & clear
Career progression

CRT: Racism exist in academia, However
very settled By studies: seen racism before
Intersectionality: Females affected more. Son IMGs.

ECCS - 8

Role: ST6 Grade, starting PHD in health inequality
Female African background, UK graduate

Impression: Feels the clinical academia is gatekept by certain personality
Feels she had never felt she could succeed in academia. However Mentorship is important
has been seeking Mentorships but Couldn't find always to approach or succeed.

- feels Mentorship should be a main thing in academia
- also feels No clear pathway to become a position

CRP: always felt place been in Background
Intersectionality: Being a female & Not out then personality hinder progress.
Bystander: TMG get significant Backlash for minimum steps.

ECCS-9

Roles: Consultant gastroenterologist
Female, Asian, IMG, Australian training
starting a PHD

Impression: - related to UK to pursue clinical experience & Academic position.
- left after 1 year due to personal reason related to her getting pregnant & also lack of position for PHD.

- Bystander experience of passive aggressive & micro aggressive toward IMGs from Non-english speaking Countries.
- Think Academia is gate kept by local graduates.

CRT: Racism while exist its mostly related to Origin, Accent, culture
Intersectionality: Origin & gender intersect with race & make it difficult to dissect.
Bystander Theory: significant experience as bystander

overall agrees that change need to happen but dont know How with the limited resources available

ECCS-10

Roles Post Doc Registrar finishing training
South asian male, British born & UK [illegible]

Impression:
Strong opinion regarding career progression
Sgate keeping. highlighted the lack of clarity with
post PHD route.
Highlighted racism & bystander experience
speaking up is Difficult as it affect progression &
likability. Seen this happening to someone he knows
Believe No clarity in selection criteria

Transparency

CRP lens.
CRTs: Racism exist within department yet settled
Intersectionality: accent & gender playing role
Bystander: second head hand experience with
racism.

overall he believe that progression is not
clear & Regular options that sometimes impossible