DIFFERENTIAL ATTAINMENT OF BLACK BRITISH DOCTORS IN MINORITY ETHNIC REPRESENTATION OF SENIOR LEADERSHIP IN THE NHS:

INDIVIDUAL PERSPECTIVES & IMPLICATIONS AT MICRO LEVEL

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ABSTRACT

Differential attainment (DA) in UK postgraduate medical training is a persistent challenge, particularly in the career progression of the NHS's diverse minority ethnic doctors. Its effects extend beyond career outcomes to staff wellbeing, organisational trust and retention. Disparities are greatest at senior leadership level, where minority ethnic doctors remain under-represented. Increasing recognition of differential attainment within minority ethnic groups has also raised questions about whether gains in representation have been shared equally, particularly as leadership data continue to homogenise distinct groups under broad categories such as BAME/BME, masking important differences in attainment and advancement both inter and intra-minority ethnic.

Using combination of narrative inquiry and reflexive thematic analysis, this qualitative study examines these issues from a unique angle: through the narrative accounts of British NHS doctors who have attained senior leadership positions with strategic responsibilities. An additional layer of insight arises from including participants from three distinct ethnic groups—the White majority, Asian minority ethnic, and Black minority ethnic—allowing exploration of how relational representation influences healthcare outcomes for minority doctors and communities.

This study contributes a nuanced understanding of DA beyond meritocratic explanations. Drawing on Pierre Bourdieu's concepts of capital, habitus and field, it suggest that differential attainment in senior NHS leadership between Black and Asian minority ethnic doctors arise not from differences in merit or demographics alone, but from unequal access to and recognition of valued social, cultural and symbolic capital within the NHS leadership field, including unequal thresholds for Black doctors. The longer-established presence of Asian minority ethnic senior leaders appears to facilitate the accumulation and transmission

of these forms of capital through networks, sponsorship and intergenerational achievement, fostering dispositions that align with expectation of the field. DA in senior NHS leadership is therefore better understood as a product of structurally uneven opportunities for capital acquisition and conversion rather individual deficit.

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GLOSSARY OF TERMS

ARCP	Annual Review of Competence Progression
BAME	Black Asian Minority Ethnic
BMA	British Medical Association
BME	Black Minority Ethnic
Consultant	A senior doctor, specialist on GMC register
DA	Differential Attainment
EDI	Equality, Diversity, and Inclusion
GMC	General Medical Council
IMG	International Medical Graduate
ME	Minority Ethnic
NHS	National Health Service
PPE	Personal Protective Equipment
VSM	Very Senior Managers
WRES	Workforce Race Equality Standard

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PART I: BACKGROUND TO STUDY

CHAPTER 1: INTRODUCTION

Overview

In this chapter, I begin with an introduction to the research, including the research question and an explanation of why I believe this study is unique and likely to make a significant contribution to the discourse on the subject, before moving on to the next chapter—the literature review.

1.1 Introduction

At the height of the COVID-19 pandemic, I was working as an NHS consultant in the Emergency Department during a time of significant uncertainty, anxiety, and cautious hope for respite. When the COVID-19 vaccine became available, I observed a notably low uptake among Black and minority ethnic (ME) staff within my department. This prompted me to explore the issue further. Following discussions with my line manager, I was tasked with engaging ME staff to better understand and help address their concerns regarding vaccination. During my preparation, I was struck by the limited availability of COVID-19 vaccine literature tailored to the needs of minority ethnic groups. Key considerations—such as halal compliance, vaccine safety, and culturally relevant concerns for Black and other minority communities—were largely absent. This raised important questions for me about the representation of minority voices at senior levels within the NHS, as the initial communication materials did not reflect either my needs or those of the communities I serve.

Historical context also seemed highly relevant. There is documented evidence that minority ethnic groups may exhibit greater scepticism towards healthcare interventions, including vaccination, often as a result of past injustices and a perception that their perspectives have not been adequately centred in decision-making processes (Paul et al.,

2022, Kamal et al. 2021; Corbie-Smith, 1999). At the same time, I recognised the immense pressure on senior leadership during this period, with their capacity significantly stretched. In response, I developed a culturally appropriate, ME-centred information leaflet. I then engaged directly with a range of ME staff, including cleaners and porters—colleagues who played a crucial yet often under-recognised frontline role in maintaining safe clinical environments. Many shared that they felt overlooked, noting that existing materials were primarily targeted towards a White audience and did not resonate with their concerns. As a result, some had turned to social media, where they encountered both misinformation and disinformation.

What I found particularly striking was the impact of representation and trust. My presence as a Black doctor who had received the vaccine appeared to make a significant difference; for some individuals, this alone was sufficient to influence their decision to be vaccinated. This led to a ripple effect, extending beyond the workplace into families and communities, as staff members shared accurate information and culturally relevant materials with their loved ones. This experience marked the beginning of my deeper exploration into the issue. I came to believe that the lack of adequate minority ethnic representation at senior levels within the NHS may have unintended but detrimental effects on the health and wellbeing of its ME workforce. This is not to suggest that omissions in early communication were deliberate or driven by malice. Rather, they reflect a broader structural imbalance in leadership composition, which remains disproportionately White (Kline, 2025). Despite the absence of malicious intent—and acknowledging the pressures faced by leadership—the consequences were both real and significant. Given that approximately 43% of the NHS workforce is from minority ethnic backgrounds, the implications for morbidity, mortality, and wider community impact cannot be overlooked. These experiences highlight the urgent need

for transformational change and more inclusive thinking at the highest levels of NHS leadership and was key motivation for my research.

1.2 Context and Background

Differential attainment (DA) is evident across many educational and professional settings in the UK (Li, 2021), and the NHS is no exception (Woolf et al. 2020). In postgraduate medical training, DA refers to unexplained differences in achievement between groups that are unrelated to skill or ability (GMC, n.d.) but instead associated with protected characteristics such as ethnicity, gender, or disability (Equality Act, 2010). While the General Medical Council (GMC) acknowledges that attainment differences based on ability are expected, it asserts that those associated with ethnicity are unjust and require investigation (GMC, n.d.). DA encompasses both overt and subtle discriminatory practices, as well as structural and institutional influences that are more insidious and difficult to quantify (Kline, 2014).

This terminology, DA, first reported in 1995 (Dillner, 1995), was chosen as for this study and is preferable to other terms such as Awarding or Attainment Gap (AG)—a term commonly used in undergraduate education assessments to describe differences in achievement between groups—shifting the focus from students to institutions and structural contributors such as curriculum design (Cramer, 2021). Though these terms are often used interchangeably—as they all refer to differences in outcomes not based on ability but on protected characteristics—there are notable distinctions. DA encompasses AG (as described above) but goes further by examining the complexities of inequities beyond the undergraduate assessment context, particularly within workplace environments. Finally, DA was chosen as it aligns with the terminology used by the GMC and contemporary researchers in this field as it is more entrenched in UK medical education research (Woolf et al., 2020).

The NHS is one of the most ethnically diverse healthcare systems in the world, with minority ethnic staff constituting a substantial proportion of the medical workforce in general (Chakravorty et al., 2021). However, this diversity is not reflected proportionately throughout the career progression of its minority ethnic workforce, including doctors (Goyal et al., 2015), and this disparity appears to become more pronounced at senior leadership levels, where minority ethnic representation declines markedly (Kline, 2014; 2025). While Black and Asian doctors contribute significantly to the NHS workforce, their presence within executive, board-level, and other senior leadership positions remains limited (NHS England, 2026; Kline, 2014), which is problematic and cited as contributory factor to for example differential outcome in morbidity and mortality during COVID-19 pandemic (Association of Directors of Public Health London [ADPH London], 2021). Progression into leadership often relies on access to informal networks, leadership development opportunities, and organisational sponsorship, all of which may be unevenly distributed across the different minority ethnic groups (Chakravorty, 2021). Consequently, leadership pathways may not be equally accessible to all groups. This has important implications for doctors' sense of belonging and psychological well-being (Hussain et al., 2023), the retention of minority ethnic doctors within the NHS (Iacobucci, 2022), and the credibility, legitimacy, and organisational effectiveness of this publicly funded service (Johns et al., 2012).

Research on race and ethnicity in medical careers suggests that these disparities are shaped by broader structural and organisational factors (Kline, 2014). Institutional racism (Iacobucci, 2020), both overt and subtle, continues to influence employment experiences and career progression within healthcare organisations. Workplace cultures may privilege dominant norms and practices, while a hidden curriculum of unwritten rules, expectations, and social networks can advantage some groups over others (Esmail, 2007). These inequities

may be compounded by a lack of granularity in ethnicity data collected and reported by NHS trusts and statutory bodies, which can obscure important differences between minority ethnic groups (Aspinall, 2021; Woolf et al., 2020). Access to mentorship and sponsorship—important mechanisms for career advancement—is also reported to vary by ethnicity, affecting opportunities for leadership development and visibility (Chakravorty et al., 2021; Kline, 2014). Such experiences can influence professional identity formation, perceptions of belonging (Iacobucci, 2022), and aspirations for leadership roles.

Over the past two decades, policy and regulatory bodies, including the NHS Workforce Race Equality Standard (WRES) and, more recently, the General Medical Council (GMC), have introduced initiatives aimed at addressing racial inequalities within the workforce, informed by a growing body of evidence and successive policy recommendations (Woolf et al., 2020; Kline, 2014; 2025; Chakravorty et al., 2021). Despite increased monitoring and reporting of workforce outcomes, concerns remain regarding the persistence of DA and the continued underrepresentation of minority ethnic doctors in senior leadership positions. Understanding the factors contributing to these inequalities, particularly the inter- and intra-minority ethnic differences that shape leadership experiences and outcomes, remains an important area of inquiry and is where this study positions itself.

1.3 Research Problems

This study was therefore undertaken in response to the recognised need for greater granularity in research on minority ethnic representation within the NHS (Aspinall, 2021), which includes senior leadership roles (Kline, 2019; NHS England, 2026). Existing research has historically homogenised minority ethnic groups, leading to a "one size fits all" approach (Woolf et al., 2020; NHS England, 2026) that fails to account for the diverse histories, cultures, and lived realities within these populations (Nandi & Platt, 2020). Disaggregating these groups helps to illuminate meaningful differences and provides more accurate insights into the DA observed between minority ethnic doctors (Woolf et al., 2020) within the NHS—a system often regarded as meritocratic (Johns et al., 2012; Henry, 2007).

Although research has extensively explored DA among minority ethnic doctors at various stages of their careers in the NHS, the experiences and perceptions of DA at senior NHS leadership levels remain underexplored. This is particularly the case with respect to differences between Black and Asian minority ethnic doctors, who constitute a significant proportion of minority ethnic groups within the NHS (Kline, 2025). Prior literature has not adequately examined DA both between and within minority ethnic groups at senior leadership levels in the NHS. As a result, important disparities may be obscured, or DA between these two major minority ethnic groups may be inadequately understood.

While statutory and regulatory bodies, including the Workforce Race Equality Standard (WRES) and the General Medical Council (GMC), have documented patterns of DA over the past two decades, these data have primarily focused on career progression and leadership outcomes using broad, homogenising categories such as BME or BAME (Kline, 2014; NHS England, 2026). Distinguishing between these two major minority ethnic groups in the UK is important for several reasons. There are significant diasporic differences, as well

as distinct historical experiences of Black and Asian communities in Britain, which shape their presence, status, social and cultural capital, and broader societal perceptions (Ross et al., 2020; Hussain et al., 2023). These issues are discussed further in Chapter 2. Such differences are important because they have a relational dimension that may influence the experiences and career trajectories of Black and Asian doctors within the NHS (Iacobucci, 2020; 2022). Moreover, these dynamics may become particularly salient at the highest levels of the organisation and likely contributing to DA in senior leadership positions.

Finally, as there is no agreed convention for ethnicity categorisation in qualitative research (Mauro et al., 2022), nor consensus on whether ethnic categories such as Black and White should be capitalised (while Asian is often capitalised, the others frequently are not), I have chosen to capitalise all ethnicity categories throughout this study: Black, White, and Asian.

1.4 Purpose of Study & Research Questions

Over the past two decades, research has progressed from examining systemic racism at macro and institutional levels (Kline, 2014) to recognising disparities within minority ethnic groups and exploring how these intersect with professional structures, culture, and power (Woof et al., 2020). This study builds on that trajectory but distinguishes itself through its specific focus (inter and intra ME DA at senior leadership) and methodological emphasis. This study is guided by three research questions relating to British and British-trained doctors:

1. What are participants' perspectives on the DA between White majority and minority ethnic doctors in senior leadership positions within the NHS?
2. What are participants' perspectives on the DA between Black and Asian minority ethnic doctors in senior leadership positions within the NHS?
3. What are participants' perspectives on the health implications of DA at senior leadership level in the NHS for minority ethnic communities?

1.5 Research Contributions

This study is unique in its specificity for the following reasons:

- **A 'top-down' focus:** It explores the topic from the perspective of senior leadership and executive—an under-researched group whose influence, decision-making authority, and experiences provide crucial insights—rather than frontline staff or stakeholders, where most previous research has been concentrated. This provides a rare opportunity for leaders to articulate their perspectives on this subject within a protected research environment.
- **A micro-level lens:** The study centres on individual perspectives, lived experiences, and personal narratives, examining how these senior leaders have navigated

macro- and meso-level systemic and institutional structures. This focus is important because participants hold positions of authority in which they are responsible for shaping organisational narratives and have legal and statutory duties to address the issues under investigation (NHS England, 2025). The process is therefore both reflective and reflexive for participants.

- **Disaggregated perspectives across key ethnic groups:** It examines these issues through the perspectives of senior leaders from the three main ethnic groups—White, Asian, and Black. This disaggregation offers insight into differential representation at the highest organisational levels and enables exploration of whether there is "elasticity" at the top of the NHS hierarchy, and for whom.
- **A focus on British/British-trained doctors:** To ensure clarity and granularity, the study focuses on DA among British/British-trained doctors based on ethnicity and excludes International Medical Graduates (IMGs), whose experiences involve additional challenges (Pattinson et al., 2019; Pooja et al., 2023) that may overlap with, but are also distinct from, those of British-trained minority ethnic doctors. This distinction prevents conflation of these different pathways, particularly regarding career progression and trajectory.

Taken together, these four dimensions—leadership focus, micro-level depth, ethnic disaggregation, and careful delineation of the study population—form a unique and integrated approach that differentiates this research from previous studies and likely to contribute new knowledge to the field.

1.6 Rationale for Choosing 'Elite' Participants—Focus at the 'Top' End (Senior Leadership) Versus the 'Bottom' End (Medical Students or Junior Doctors)

Over several decades, numerous studies have examined DA across the NHS workforce, identifying persistent disparities in training progression, career development, and leadership representation (Kline, 2014; Chakravorty et al., 2021). While improvements have been made at the medical school and early-career stages—through widening participation initiatives, contextual admissions, and efforts to increase access—gaps in representation at senior leadership levels remain stark (NHS England, 2025). Importantly, emerging evidence suggests that even within minority ethnic groups, disparities persist at leadership level, with some groups progressing more readily than others despite operating within the same organisational ecosystem (Kline, 2014; Moore, 2026). This study therefore positioned itself at the senior end of the hierarchy to explore these inter and intra-minority differences and interrogate the assumption that minority ethnic groups form a homogenous bloc e.g. BME/BAME (NHS England, 2025), leading to lack of granularity in research and research data which feeds into organisational strategies and policy making (Kline, 2013; Kline 2014).

By centring the perspectives of senior leaders—those who shape organisational culture, strategy, recruitment, and policy—this study engaged those with both the positional authority and institutional responsibility to influence meaningful change. Moreover, senior leaders, an under-researched group, are also gatekeepers of opportunity further down the pipeline; thus, understanding their experiences and perspectives is crucial for addressing the systemic factors that contribute to DA across the entire career trajectory. I believe that if change is to cascade effectively throughout the organisation, it must begin with those who set the tone and direction at the top.

CHAPTER 2: LITERATURE REVIEW

Overview

In this chapter, using literature, I examine the structural, organisational, and systemic factors influencing the DA of minority ethnic doctors in the NHS in general and in senior leadership roles. I begin by exploring the relationship between the immigration history of minority ethnic populations in Britain, the NHS, and the broader societal challenges that different groups have experienced within a racialised British society. I also explore specific systemic, institutional, and socio-cultural processes that have shaped the ambitions of minority ethnic individuals in the NHS. Furthermore, I discuss the homogenisation of minority ethnic doctors in the NHS, which obscures inequalities within these groups and perpetuates DA at institutional levels due to a lack of granular data, alongside other issues related to structural inequality and institutional racism.

The following sections provide an overview of the NHS leadership structure, key terminology, and the groups under study. I then review the literature on DA among NHS doctors, focusing first on differences between White majority and minority ethnic doctors in leadership roles, and then on Black and Asian doctors specifically. This highlights a key gap in the literature that this study addresses.

2.1 Background: Brief Historical Perspective of Black and Asian Minority People in Britain and the NHS

The history of Black British people and the injustices they have faced in Britain is extensive, spanning all facets of British life, from academia and the judiciary to healthcare (Lammy, 2017; MacGregor, 2022; Goring et al., 2020). Notable examples include the post-war period, when the first wave of Caribbean migrants—the Windrush generation, who were British subjects—arrived to help rebuild the 'motherland'. A significant number of these Caribbean Britons filled critical workforce shortages within the NHS, despite facing a hostile reception (Hewitt, 2020; Emmanuel & Rauseo, 2024). Similarly, British subjects from India and other parts of the Asian subcontinent were invited in large numbers during the 1950s and 1960s to help address shortages in medical personnel following the establishment of the NHS in 1947 (Gaind, 2017). These individuals were initially admitted without restriction, with migration further encouraged in subsequent years by policies such as the Commonwealth Immigration Act of 1962, which contributed to a significant increase in the number of Indian doctors working in the NHS (Gaind, 2017). This trend continued, and the NHS has consistently benefited from the contributions of Asian—particularly Indian—doctors, who continue to comprise a substantial proportion of its workforce (Esmail, 2007). This legacy is partly rooted in the fact that doctors from India were trained under a British-influenced medical system, with their qualifications recognised by the General Medical Council (GMC) (Esmail, 2007).

However, similar to the experiences of Caribbean migrants, including nurses who arrived in Britain as part of the Windrush generation (Slaven, 2022), these Asian doctors—despite responding to calls to support the NHS—were met with hostility from the very society that depended on their expertise (Moss, 1991). They experienced racism (Raghuram

et al., 2016) and differential treatment in relation to specialty allocation and job opportunities (Gaind, 2017; Moss, 1991), among other forms of inequality. There is also evidence suggesting that professional bodies such as the British Medical Association (BMA) exhibited racial bias during this period, including through discriminatory policies and explicitly biased job advertisements (Gaind, 2017). Evidence suggests that the ambitions of many of these doctors were significantly constrained, with limited access to posts in their preferred specialties or at levels commensurate with their training (Kyriakides & Virdee, 2003). As a result, many were channelled into so-called 'Cinderella' specialties (Gaind, 2017)—fields that were historically underfunded, undervalued, understaffed, and less prestigious, such as psychiatry and general practice, in contrast to more prestigious surgical specialties. Nevertheless, these doctors adapted by retraining where necessary and dispersing across the UK to meet workforce needs, often serving as primary physicians in smaller towns and rural communities (Raghuram et al., 2016).

While some South Asian migrants from India and Pakistan—particularly those who came to work in the NHS as doctors—can be described as originating from middle-class backgrounds by virtue of their education, skills, and professional status, other Asian groups who migrated to Britain, such as Bangladeshis, had a markedly different migration history in general. A significant wave of Bangladeshi migrants arrived in Britain during the 1970s, fleeing a war-torn country, widespread famine, political unrest and economic inactivity (Peach, 2006). They came to Britain primarily seeking refuge and employment and generally belonged to different socio-economic and social class backgrounds compared to Indian doctors who migrated during the 1950s and 1960s (Kyriakides & Virdee, 2003). These differences in social class and subsequent intergenerational advantage represent an important source of cultural capital (Bourdieu, 2007; Gunn, 2005). Cultural capital, in this context, is arguably a key contributing factor to DA within minority ethnic groups and between racial

groups. These disparities can be traced in part to the varying levels of success and progression observed among different minority ethnic groups in Britain today (Peach, 2006; Kyriakides & Virdee, 2003).

Another important contributor to DA between ME groups in the UK is poverty (Robertson et al., 2021). Several studies, including those conducted by The King's Fund, identify poverty as a significant determinant of health outcomes for minority ethnic communities. This includes factors such as access to healthcare, nutrition, and the quality of geographical areas, which are associated with the availability of good schools, services, and opportunities (Mallorie, 2024). These structural conditions can, in turn, influence the success of minority ethnic individuals in Britain (Robertson et al., 2021; Hayanga et al., 2023; Buck & Jabbal, 2014). According to a study by the Institute for Fiscal Studies (IFS) on wealth distribution among minority ethnic groups in Britain, individuals of Indian background rank second, behind the White majority group, while those of Black African and Bangladeshi backgrounds are positioned at the lower end of the distribution (Mirza et al., 2022). Similarly, Karagiannaki (2023) study on the ethnic wealth divide in the UK highlights disparities in wealth accumulation across different ethnic groups compared to the White majority population. The study found that individuals of Indian background, alongside the White majority, have experienced steady increases in wealth over time, accompanied by higher median incomes. In contrast, Black Caribbean, Black African, and Bangladeshi groups have seen little improvement, with the latter two groups consistently at the bottom of the distribution (Karagiannaki, 2025). This is significant, as group-level wealth is closely related to access to opportunities and trajectories of success.

Within the NHS, the generational advantages of certain groups—particularly doctors of Indian background—along with associated cultural capital, are thought to contribute to

their relative success over recent decades (Cribb et al., 2025). This contrasts with other minority ethnic groups, such as Black populations, who do not hold the same levels of structural power or intergenerational advantage in Britain, despite comparable migration histories (Karagiannaki, 2025). Interestingly, despite Black Caribbeans having a higher median income than Black Africans on average (Stockton & Warner, 2024), evidence suggests that Black Africans achieve better outcomes in professional sectors (Foster & George, 2025). These differences often originate in educational attainment, where Black African pupils tend to outperform their Black Caribbean peers at secondary school level (Demie, 2019; Strand, 2021) and beyond (Robertson et al., 2021). This trend appears to extend into professional careers, including within the NHS, where Black African individuals have been found to have better outcomes compared to Black Caribbean counterparts (Woolf et al., 2011; Moore, 2026).

In the 1980s, Britain witnessed a series of race riots in cities including London, Bristol, Manchester, Nottingham, and others. The 1990s saw the murder of Black teenager Stephen Lawrence, and the subsequent public inquiry concluded that the Metropolitan Police had been institutionally racist in their handling of the case (Macpherson, 1999). Furthermore, people of Black origin remain overrepresented in the British prison system and underrepresented in employment across British society (Lammy, 2017), although some of these injustices are also experienced by other non-White minority ethnic groups, such as Irish Traveller communities (Power, 2003). The NHS is not immune to these broader societal inequalities. Despite senior NHS leaders placing ethnicity and diversity at the centre of organisational priorities, shortcomings in achieving true representation of its heterogeneous minority ethnic workforce persist, with limited material change at executive levels and within the most prestigious roles (Kline, 2025). This concern was highlighted as far back as 2004 by Sir Nigel Crisp, former Chief Executive of the NHS, who stated that *"the NHS must open up*

its workforce to diversity of expertise from the whole community" (Commission for Race Equality, 2004). Trevor Phillips (2003), then Chairman of the Commission for Racial Equality, went further, noting that while Black and minority ethnic individuals comprised approximately 35% of doctors, dentists, and allied health professionals in the NHS workforce, leadership positions at the top remained overwhelmingly White (Carvel, 2003; Carvel & Shifrin, 2004).

Beyond the moral and statutory imperatives for diversity and representation, the business case for diversity across all levels of the NHS is compelling. Evidence suggests that a diverse NHS workforce is associated with greater staff satisfaction, as well as a stronger sense of value and belonging (Klara et al., 2009; Carvel, 2003). Moreover, NHS trusts with more diverse leadership and staffing profiles are more likely to achieve higher ratings from regulatory bodies such as the Care Quality Commission (CQC), exhibit lower rates of infection control issues, reduced absenteeism, and improved patient outcomes (Oskrochi et al., 2023). Conversely, a lack of diversity and inadequate representation can have negative consequences, including poorer patient outcomes, particularly for marginalised communities. For instance, post-COVID-19 analyses indicate that the absence of minority representation in decision-making roles contributed, in part, to health disparities and poorer outcomes among minority ethnic populations (Oskrochi et al., 2023).

2.2 The 'B' in the BAME/BME

The limitations of the reductive acronyms BAME (Black, Asian and Minority Ethnic) or BME (Black and Minority Ethnic) have been extensively documented (Aspinall, 2021; Bunglawala, 2020; Malik et al., 2020), highlighting the risks inherent in using such terms to represent a large and heterogeneous population. These acronyms encompass diverse groups, ranging from Black populations (including African, Caribbean, and mixed heritages) to 'Asian' populations, which may refer to individuals from South Asia through to East Asia (Danso & Danso, 2021; Aspinall, 2021).

Moreover, these terms are increasingly regarded as unfit for purpose (DaCosta et al., 2021). There is concern that their continued use reinforces the centrality of the White majority, implicitly positioning it as the normative, unmarked category (Danso & Danso, 2021). There is increasing recognition that the acronym is not innocuous (Aspinall, 2021); rather, it obscures deep inequalities within and between groups. These issues are further compounded by inconsistent usage across organisations and institutions—including bodies such as the British Medical Association (BMA report, 2021), Public Health England (PHE, 2020), and academic research (Szczepura, 2005)—where definitions and applications vary considerably (Kline, 2014). Such homogenisation risks distorting policy development, research findings, and subsequent interventions—or lack thereof—potentially reinforcing inequalities affecting marginalised groups (Gill, 2024; Commission for Race and Ethnic Disparities, 2021). In this sense, the continued reliance on such aggregated terminology can be likened to "fruit from a poisonous tree" (Gill, 2024). Despite these concerns, it remains difficult to conduct UK-based research on ethnic inequalities without engaging with these acronyms, particularly during literature reviews, given their widespread historical use. Excluding them altogether would likely omit significant bodies of work relevant to minority

ethnic experiences in the UK and the NHS. As such, it is essential to critically interrogate studies that group all minority ethnic populations under these umbrella terms when reviewing findings and recommendations.

In recent years, there have been efforts to move away from such terminology, which is often seen as a convenient shorthand for policymakers that inadequately captures the complexity of the populations it seeks to describe (DaCosta et al., 2021). Alternative terms have been proposed, including racialised, minoritised, racially minoritised, global majority, people of colour, and minority ethnic. While each has its strengths and limitations, the term minority ethnic (or ethnic minority) has gained traction, particularly because it encourages a move away from overly aggregated categories such as BAME/BME and towards a more nuanced understanding of disparities and outcomes across specific ethnic groups (DaCosta et al., 2021). However, despite these shifts, the NHS and some of its regulatory frameworks—such as the Workforce Race Equality Standard (WRES)—continue to use the BAME acronym. For example, in its 2026 report, WRES still employs this terminology to describe (homogenise) minority ethnic staff within the NHS. This continues to contribute to a lack of granularity in understanding disparities and DA among NHS staff, which in turn may have implications for strategic planning and policy development at local levels across NHS trusts.

During the COVID-19 pandemic, early research indicating that minority ethnic groups were disproportionately affected led to the implementation of policies and recommendations—often adopting a "one-size-fits-all" approach—to mitigate these impacts (Kursumovic et al., 2020; Oskrochi et al., 2023). However, closer scrutiny of the data revealed that, particularly in the early stages of the pandemic, the 'B' (Black) group, for example, within the BAME category experienced significantly worse outcomes in certain contexts (Oskrochi et al., 2023). This initial lack of granularity and insufficient attention to

subgroup differences meant that targeted interventions for these communities were either not adequately considered or were delayed—effectively becoming lost within the broader acronym. This is not to suggest that Black and Asian populations in the UK are the most disadvantaged minority groups overall; indeed, there is evidence indicating that, on several metrics, they perform relatively well compared to counterparts in other European countries (Thalhammer et al., 2001). Other minority groups in Britain, such as Irish Travellers, experience significantly poorer outcomes across many indicators (Powell et al., 2020; Loxley & Finnegan, 2021; Kirby & Cullinane, 2016). Similarly, White working-class groups are also likely to experience forms of social and economic disenfranchisement (Stones, 2016; Lewis & Demie, 2015). That said, the experiences of those who are visibly 'other', particularly Black and Asian individuals, remain marked by persistent everyday challenges, ranging from microaggressions to overt forms of racism (DeCuir-Gunby & Gunby Jr, 2016; Naqvi et al., 2022). More importantly, treating these communities as homogenous groups may obscure important differences in experiences and needs, with potential implications for health outcomes and wellbeing.

2.3 DA within the Black Community in the UK

Evidence suggests that DA exists within Black communities across various sectors of UK society, including academia and the justice system (Mirza & Warwick, 2022; Mirza & Platt, 2022). Black populations in the UK, despite often being grouped under a shared British identity, are not homogeneous. Rather, they comprise diverse groups—including Black African (East, West, South, and North African) and Black Caribbean communities—with distinct cultures, histories, and experiences that shape attainment outcomes (Demie, 2019; Demie & McLean, 2007), as is the case for other minority ethnic groups. There is evidence that within this group, patterns of DA emerge early in life and persist into adulthood (Tomlin et al., 2014; Gillborn et al., 2016; Sait et al., 2020). For example, in Lambeth, London—an area with a high proportion of Black residents (approximately 30%)—a report on GCSE attainment revealed significant disparities within Black ethnic groups, pupils of Black African background outperformed many other groups, including some White and Asian groups, whereas pupils of Caribbean heritage had the lowest levels of attainment (Demie, 2019). Concerningly, there is also evidence that the attainment gap between Black African and Black Caribbean students is widening (Strand, 2021). Demie (2019) found that these disparities persist despite broadly comparable socio-economic backgrounds among the pupils. Furthermore, this trend appears to continue into further and higher education, where individuals of Black African origin are disproportionately represented compared to those of Caribbean origin, relative to their population size in the UK (2.0% African background compared to 1.0% Caribbean background) (Office for National Statistics [ONS], 2021). Within UK medical schools, this disparity is particularly pronounced: Black medical students are far more likely to be of African origin than Caribbean (Stockton & Warner, 2024). Therefore, by extension, it is plausible that Black individuals occupying senior leadership

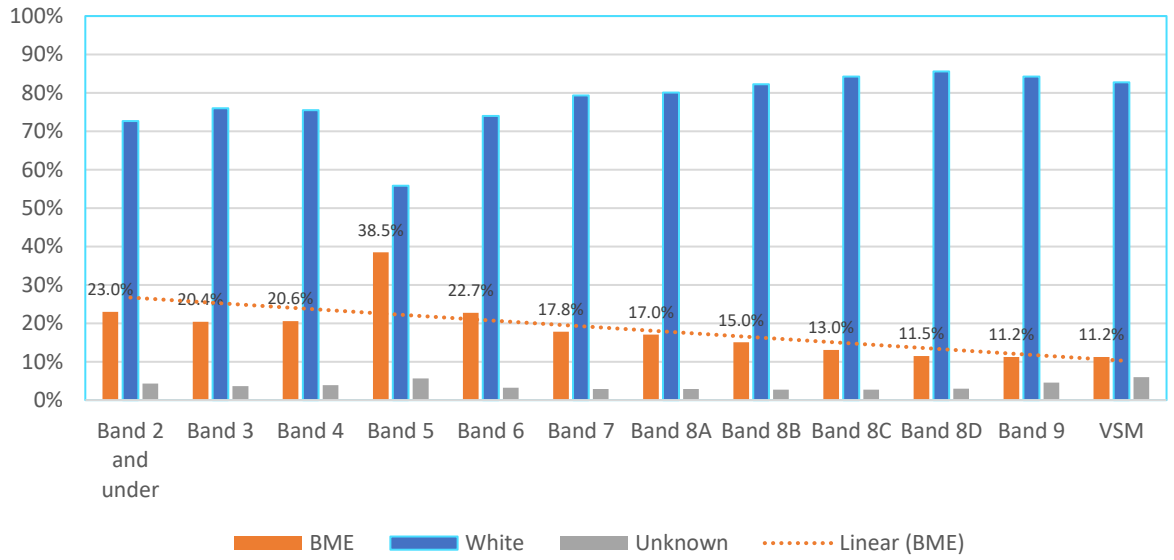
roles within the NHS are more likely to be of African origin, although there is currently limited available data to substantiate this claim which suggest further need for granular data.

The causes of DA between Black African and Black Caribbean populations are multifactorial. These include differing historical experiences in Britain, varying degrees of exposure to structural disadvantages such as institutional racism, differences in family legacies (including parental educational attainment), and cultural values related to education (Demie, 2019). For example, Demie and McLean (2007) highlight the role of strong parental support and close community networks within African communities in promoting educational success. In contrast, these forms of support were found to be less consistently present among some Caribbean communities. Additionally, African parents were more likely to have higher levels of education themselves and to place a strong emphasis on educational achievement, further contributing to improved outcomes among children of African heritage (Demie & McLean, 2007).

2.4 THE NHS: Workforce, Leadership Structure, and Senior Leadership/Very Senior Managers (VSM)

NHS England (NHSE), the body responsible for overseeing NHS trusts, sets out the pay structure for the NHS workforce in England. One such framework is the Agenda for Change (AfC), a national pay system that applies to most NHS staff, excluding doctors, dentists, and senior managers, who are covered by separate arrangements. Band 2 staff are very junior staff including admin team; Bands 4 to 7 are for example nursing staff from junior to senior grades. Although doctors and dentists operate under a separate pay structure, senior medical staff—particularly those at consultant level—have remuneration broadly comparable to AfC Band 8. Senior clinicians and nurses (typically Band 8 and above) are also those most likely to transition into VSM and other senior leadership roles, in contrast to more junior staff. These pay bands are important not only for ensuring transparency in remuneration but also as proxy indicators of seniority and leadership within the NHS. Furthermore, because information on these roles, their occupants, and corresponding salaries is publicly available, they provide a useful source of data for research examining leadership structures and DA within the NHS. Very Senior Management (VSM), a category that replaced the previous Executive Senior Manager (ESM) designation, refers to those occupying the most senior leadership roles within NHS organisations. Individuals in these roles are typically positioned at the highest levels of the pay structure—often aligned with Band 9 in the NHS framework **(Figure 1).**

FIGURE 1: The percentage representation by ethnicity of AfC staff within each pay band, national, March 2023



Source: NHS Workforce Race Equality (WRES) data collection portal. NHS Workforce Race Equality Standard 2023 data analysis report for NHS trusts. Available at: https://www.england.nhs.uk/publication/nhs-workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts

VSM roles include senior leadership positions such as chief executive, deputy chief executive, medical or clinical director, finance director, chief operating officer, executive director of strategy, and chief digital information officer. These individuals are responsible for leading organisational strategy, sitting on executive boards, or reporting directly to the chief executive of the trust (NHS England, 2023). Figure 1 above illustrates a drop-off in minority ethnic staff at higher organisational levels, extending to the most senior VSM and senior leadership positions. However, interpretation of these data is limited by the lack of detailed breakdown within the broad 'BME' category. This may obscure DA both within and between minority ethnic groups. Some evidence suggests that doctors from Asian backgrounds—particularly those of Indian origin—are more frequently represented in these positions (Kline, 2014). However, it should also be noted that doctors of Indian background constitute the largest proportion of minority ethnic doctors within the NHS. Therefore, their

higher representation at VSM and senior leadership levels may, in part, reflect this underlying workforce distribution.

From this point forward, the term VSM (Very Senior Managers) will be replaced with 'senior leaders' or 'senior leadership' to ensure clarity, as these terms are used synonymously.

2.5 DA of Minority Ethnic Doctors in the Medical Profession in General

Hammond et al. (2022), in their study on racial equality in job appointments and career opportunities in the NHS, found that nearly all NHS organisations fail in their duty under UK equality law to appoint ethnically diverse candidates, even when those candidates possess skills and qualifications comparable to White applicants. They further suggest that this inequality in employment has far-reaching consequences, including the potential for poorer patient outcomes (Hammond et al., 2022). Other studies have similarly demonstrated improved quality of care and higher patient satisfaction in NHS organisations with more ethnically diverse workforces (Seeleman et al., 2015). While NHS organisations are attempting to address these issues, some of the mechanisms introduced—such as increased objectivity and standardisation in recruitment processes—may have unintended consequences. Specifically, they may constrain managers from recognising ethnicity itself as an important factor in promoting workforce diversity during recruitment (Hammond et al., 2022).

Ross et al. (2020) suggest that discrimination within the NHS begins much earlier, during professional training, and continues into postgraduate careers. This persistent exposure to disadvantage is likely to contribute, at the individual level, to insecurities and imposter syndrome, and at the collective level to poorer wellbeing, reduced sense of belonging, and perceptions of being undervalued within organisations (Qureshi et al., 2022). Research on recruitment outcomes indicates that Black British doctors are the least likely ethnic group to secure hospital doctor positions, with lower success rates compared to other British minority groups (Sarfo-Annin, 2020; Hammond et al., 2022; GMC Report, March 2023; Woolf et al., 2023).

A key concern is whether these disparities extend into recruitment for senior leadership roles in the NHS, which appears a plausible continuation of existing patterns. Even in London, where a significant proportion of the UK's Black population resides, senior management and executive positions do not reflect the diversity of the population. For example, only around 2.5% of chief executives are from minority ethnic backgrounds, with none identified as Black (Oskrochi et al., 2023). This underrepresentation has tangible implications. As noted by Sir Nigel Crisp, former Chief Executive of the NHS, in the NHS Race Equality Plan (2004), *"under-representation affected staff morale and this in turn inevitably affected the care of patients and outcomes."* He further emphasised that *"this is a health issue and not just an equal opportunity one"* (Commission for Race Equality, 2004).

Beyond recruitment and leadership, there are broader patterns of DA affecting minority ethnic doctors through their interactions with regulatory bodies and professional institutions, such as the Royal Colleges and the General Medical Council (GMC). These organisations play a critical role in postgraduate training, examinations, licensing, and certification. A substantial body of evidence over several decades demonstrates that minority ethnic doctors are more likely to be referred to the GMC for disciplinary action (Atewologun et al., 2019; Ataullah & Livesey, 2020), more likely to have complaints investigated and upheld (Sait et al., 2020), and are perceived to receive more severe penalties (Bridges et al., 2017; Rimmer, 2014). Similarly, minority ethnic doctors are less likely to be shortlisted for postgraduate training programmes, which are essential for progression to specialist and consultant roles—and, by extension, to senior leadership positions (Saif et al., 2020). Among those who do enter training, within the minority ethnic group of doctors, Black doctors specifically are more likely to encounter difficulties progressing, including lower pass rates in postgraduate examinations (Esmail & Roberts, 2013; Woolf, 2020). They are also less likely

to receive favourable outcomes in Annual Review of Competence Progression (ARCP) assessments, which determine advancement within training pathways (Woolf et al., 2011).

In addition, minority ethnic doctors are more likely to receive patient complaints (Moberly, 2014), which are also more likely to be upheld by NHS trusts (Dave et al., 2021). A recent report by the GMC on DA among Black British doctors highlighted significant disparities across the entire career trajectory when compared to White and Asian doctors. The report concluded that *"there is no evidence yet that the attainment gap between doctors of different ethnicities is significantly narrowing over time"* (GMC Report, March 2023, pp. 2–3), underscoring the entrenched and persistent nature of the issue. Collectively, these patterns contribute to the DA experienced by minority ethnic doctors within the NHS, creating a complex and often challenging professional environment that can negatively affect both wellbeing and career progression.

2.6 DA of Minority Ethnic doctors in NHS Senior Leadership

The underrepresentation of Black and other minority ethnic staff at the leadership level within the NHS has been well documented in research over the past two decades (Esmail, 2007; Kline, 2013). Various initiatives have been introduced to address this DA, yet these have achieved limited success (Kline, 2014). Some studies have even suggested a rollback of the modest progress made in earlier years (Department of Health, Race Equality Action Plan, 2004; Kline, 2013).

Kline's (2014) seminal report, *"The snowy white peaks"* of the NHS: A survey of governance and leadership and the potential impact on patient care in London and England", highlighted the extent of DA and systemic inequities between minority ethnic and White staff

in relation to professional progression and access to senior management positions. The report concluded that despite multiple initiatives—such as targeted recruitment strategies, mentorship programmes, and diversity targets—the overall investment, urgency, and prioritisation of these efforts have been insufficient, particularly among senior leadership and institutional gatekeepers. Moreover, the report identified a correlation between the lack of ethnic diversity at senior leadership levels and poorer patient outcomes (Kline, 2014). This association has been supported by subsequent research (Sait et al., 2020; Milner et al., 2020; Ross et al., 2020; Beech et al., 2019). More recent WRES 2025 data (NHS England, 2026), indicate a continued increase in minority ethnic representation across most NHS trusts. However, disparities in career progression remain persistent, particularly in relation to leadership and senior leadership roles (NHS England, 2026).

Chakravorty et al. (2021) published a comprehensive report on tackling DA within the medical profession, focusing primarily on doctors. The report examined the entire career trajectory of a doctor, from recruitment through to progression into leadership roles. It identified five principal drivers of DA: bias, social class and deprivation, immigration status, geographical factors, and individual factors, all of which influence outcomes at every stage of a medical career (Chakravorty et al., 2021). These factors may help explain patterns of DA within minority ethnic groups, particularly in relation to intergenerational advantage, wealth, and cultural capital. Such differences are evident, for example, between third- or fourth-generation doctors of Indian or Pakistani heritage and first-generation doctors from Black or Bangladeshi backgrounds (Kyriakides & Virdee, 2003).

The NHS Workforce Race Equality Standard (WRES) is a key body tasked with monitoring disparities and DA within the NHS workforce through a range of predefined indicators. It also provides recommendations aimed at addressing structural inequalities.

Broadly, WRES findings align with those of Chakravorty et al. (2021). One of its key metrics—Indicator 9—focuses on the representation of minority ethnic staff in senior management, including board and executive roles. Notably, WRES continues to use the BAME acronym to describe minority ethnic staff (NHS England, 2026). WRES reports have consistently demonstrated that minority ethnic staff are disproportionately concentrated in lower pay bands—the least remunerated positions—while their representation declines significantly at higher levels, including senior leadership roles. However, longitudinal data from WRES (2015–2023), alongside earlier work such as Kline (2014), suggest some improvement in minority ethnic representation within senior leadership over time, although these data lack sufficient granularity within minority groups. For example, the 2023 WRES report highlighted that minority ethnic representation at board level stood at approximately 16%, compared to 26% representation within the overall NHS workforce, suggesting an improvement in representation. However, the inter-minority ethnic composition of the 16% was unclear. Moreover, the gap in representation widened—from 9.7% in 2021 to nearly 11% in 2023—underscoring the persistence of structural inequalities despite incremental improvements. Current evidence indicates that Black staff, in particular, remain underrepresented at senior leadership levels and experience significant DA compared to other minority ethnic groups (Office for National Statistics, 2021). However, there remains a notable lack of disaggregated data within broader ethnic categories—especially among Asian groups—despite clear evidence of internal disparities (NHS England, 2026; Kline, 2014; Srinivas et al., 2021).

2.7 DA of Black Doctors Within Minority Ethnic Group in Senior Leadership Roles in the NHS

Concerted efforts by successive UK governments and medical educationalists to widen participation have led to increased representation of students from minority ethnic backgrounds in medical schools (Dowell et al., 2015; James et al., 2008; Mathers et al., 2002). The overall UK population comprises approximately 18% minority ethnic groups—9% Asian, 4% Black, 2.9% mixed, and 2.1% other (Office for National Statistics [ONS], Census 2021). In contrast, around 40% of UK medical students identify as belonging to minority ethnic groups. Within this cohort, 68% identify as Asian, 12% as mixed, and 12% as Black (Morrison et al., 2024). This suggests an overrepresentation of minority ethnic groups among those gaining entry to medical school relative to their proportion in the overall population in Britain. While this overall trend represents progress, there remains a notable disparity in the representation of Black students entering medical school compared to other minority groups.

This is significant, as these students constitute the future medical workforce and potential leaders within the NHS. If entry-level representation is skewed towards particular minority ethnic groups, this imbalance is likely to persist at senior levels over time. Data from the Institute for Fiscal Studies (Stockton &Warner, 2024) indicate that doctors of Asian background make up approximately 33% of the workforce, compared to around 8% from Black backgrounds. These figures suggest that minority ethnic groups, as a whole, are successful within the NHS. Alternatively, they highlight that the NHS benefits from a substantial number of highly skilled minority ethnic professionals. However, disparities persist through career progression and worse at senior levels (Kline, 2014). A government report on diversity in NHS leadership found that minority ethnic staff represent approximately 11.3% of senior managerial positions. However, this representation is largely

composed of Asian and mixed ethnic groups, with Black doctors accounting for approximately 3.4% of combined junior and senior managerial roles. Notably, the report did not provide a further breakdown of this figure to determine the presence of Black professionals specifically within senior leadership positions. It did, however, acknowledge that minority ethnic staff are disproportionately represented in junior managerial roles, while White staff are more likely to occupy senior positions. On one hand, the NHS may be viewed as exemplary in terms of its diverse workforce. On the other hand, systemic shortcomings remain in achieving equitable representation across all levels, particularly within senior leadership. A substantial body of research (Kline, 2014; Calkin, 2013; Dawson, 2009; Delamothe, 2008; Dent, 2006) and recent reports (NHS England, 2026; Stockton & Warner, 2024) highlight the persistence of these challenges. These issues are especially pronounced in relation to Black leadership, alongside concerns about limited transparency and inadequate data granularity—both of which are essential for identifying and addressing inequalities effectively.

2.8 Gaps in Literature

Existing literature on differential attainment and leadership progression among minority ethnic doctors in the NHS reveals several important gaps (Kline, 2024). First, much of the research focuses broadly on workforce inequality without specifically examining progression into senior leadership roles (Wolf et al., 2020). Second, minority ethnic groups are often treated as a homogeneous category, thereby overlooking important inter-group differences and the distinct experiences of specific communities (Aspinall, 2021). Third, the literature tends to emphasise individual-level explanations for differential attainment while giving insufficient attention to structural and organisational mechanisms, such as informal networks, sponsorship, intergenerational advantages and culture capital (Chakravorty et al., 2021). Additionally, there is limited exploration of the relational and intersectional nature of inequality within leadership contexts. Finally, much of the existing research is quantitative and outcome-focused, with comparatively little qualitative work examining the lived experiences of in particular Black minority ethnic doctors navigating senior leadership pathways within the NHS. Collectively, these gaps highlight the need for deeper investigation into the structural and organisational processes at individual level shaping leadership opportunities and differential attainment.

2.9 Theoretical Frameworks

Thus far, this literature review has highlighted the importance of the historical experiences of minority ethnic communities in Britain and their relationship with the NHS. The migration history of the past six decades has been central to the development of the NHS workforce, and its legacy continues to shape and influence the career opportunities available to minority ethnic doctors within the organisation. The literature review has also explored the inter- and intra-minority ethnic challenges experienced by doctors in the NHS, many of which are rooted in systemic and structural inequalities. These include unequal access to career advancement opportunities, barriers to leadership progression, and the ways in which DA is conceptualised, monitored, and reported.

To interpret these issues analytically, this study draws on Pierre Bourdieu's theory of cultural capital, habitus and field alongside the transformative worldview framework. Bourdieu's concept of cultural capital provides a means of understanding how access to valued knowledge e.g. system awareness and EDI (NHS England, 2024), social norms, networks, and organisational practices may facilitate or constrain career progression within senior NHS leadership structures. The transformative worldview, meanwhile, foregrounds issues of power, social justice, inequality, and marginalised voices, enabling a critical examination of how DA is experienced and sustained within organisational contexts. Together, these perspectives provide a robust theoretical lens through which to explore DA among Black and Asian doctors in senior NHS leadership positions.

2.9.1 Cultural Capital, Habitus & Field – Bourdieu

Bourdieu proposed that cultural capital operates alongside economic, social, and symbolic capital to shape life chances and access to power, explaining how social inequalities are

reproduced through education, professional, and social institutions (Bourdieu, 1977, 1986). This framework is built on three central concepts: *capital*, *habitus*, and *field*.

Within Bourdieu's theoretical framework, *capital* constitutes the resources, assets and forms of value that actors compete for within specific social fields. As a form of power, *capital* structures social relations by conferring differential capacities to act, influence outcomes and secure advantageous positions. Bourdieu conceptualises society as organised through the unequal distribution of *capital*, while also recognising the active role of agents in seeking to accumulate and convert different forms of *capital* in pursuit of strategic advantage. *Capital* therefore serves as a key mechanism linking individual agency with broader social structures. *Capital* can be further categorised into economic (material resources), social (resources derived from networks and relationships), and cultural (knowledge, skills, behaviours, credentials, and dispositions recognised by dominant groups). More recent scholarship has extended Bourdieu's work to include analysis of race as a relational dimension within these concepts (Carter, 2003; Rollock et al., 2014).

Processes of *capital* accumulation are deeply embedded within the class *habitus*, which shapes individuals' dispositions, aspirations and perceptions of attainable opportunities. *Habitus* both constrains and motivates action, influencing the extent to which actors can recognise, access and mobilise *capital* within a given *field.* Consequently, individuals' social trajectories and life chances are largely determined by the volume and configuration of *capital* available to them. These processes not only shape individual outcomes but also contribute to the intergenerational reproduction of class relations and enduring social inequalities (Bourdieu & Passeron, 1990).

Bourdieu (1977) describes forms of *capital* as *habitus*, a system of internalised dispositions shaped by social and cultural experiences that influence how individuals perceive opportunities and navigate institutions. Within an organisation, *habitus* can shape perceptions of opportunity in relation to career progression, leadership pathways, credibility, and professional legitimacy or identity (Bourdieu, 1986). Sullivan (2017) argues that these competencies—cultural knowledge, linguistic fluency, and social awareness—are often developed through everyday exposure to language, discussion, and knowledge within families and social environments. They are subsequently rewarded within institutional structures such as education systems and professional organisations (Sullivan, 2017). These forms of cultural knowledge and linguistic competence are associated with institutional success because they enable individuals to interpret expectations, articulate ideas effectively, and engage confidently with authority structures (Sullivan, 2017).

Field refers to a structured social arena or site of struggle, such as education, medicine, academia, politics, or the arts. Each *field* operates according to its own rules, values, and forms of *capital* that are recognised as legitimate and valuable. Individuals occupy different positions within a *field* depending on the volume and composition of *capital* they possess. Bourdieu argues that social practice emerges from the interaction between *habitus* and *field*, mediated by *capital. Habitus* provides individuals with the dispositions that guide their actions, while the *field* constitutes the social environment in which those actions take place. *Capital* determines an individual's position within the *field* and influences the extent to which they can act effectively within it. Consequently, individuals draw upon their available *capital* through the dispositions of their *habitus* to navigate, compete, and gain advantage within particular *fields* (Bourdieu, 1986).

Within Bourdieu's relational framework, *field, habitus* and *capital* are mutually constitutive concepts. A *field* represents a structured social space in which actors compete for valued resources and positions. The forms of *capital* recognised within a *field* determine an individual's relative position and influence, whilst *habitus* provides the dispositions through which actors perceive, interpret and respond to the opportunities and constraints present within that *field* (Bourdieu, 1986). *Habitus* therefore shapes the strategies through which *capital* is accumulated and deployed, while the *field* determines which forms of *capital* are valued and rewarded. Social practices emerge through the dynamic interaction of these elements, as individuals mobilise their *capital* according to their *habitus* within the objective structures of the *field*. Through this process, social hierarchies are both reproduced and, at times, transformed (Bourdieu, 1986; Bourdieu & Wacquant, 1992).

Within healthcare organisations such as the National Health Service, leadership progression often depends not only on technical competence but also on alignment with implicit organisational norms and expectations (Srinavas et al., 2021). These may include preferred communication styles, forms of professional confidence, and familiarity with institutional processes and networks. Individuals who possess cultural capital aligned with these expectations may therefore recognise each other or be more readily recognised as potential leaders and gain greater access to mentorship, sponsorship, and leadership opportunities by others. Drawing on Bourdieu's theory of cultural capital, the legacy advantages and intergenerational differences that exist between some Black and Asian British doctors within the NHS may contribute to DA in senior leadership roles. Access to forms of embodied and institutionalised cultural capital—including networks, familiarity with leadership norms, and tacit knowledge of organisational culture—may advantage some groups over others, particularly at senior levels where these intangible attributes are highly

valued and prioritised within leadership selection and progression processes (Mills & Reeves, 2024).

The concept of institutional habitus further explains how organisational cultures can reinforce patterns of leadership attainment. Institutional habitus refers to the collective norms, values and expectations embedded within organisations that shape how individuals are evaluated and supported (Reay et al., 2001). These norms may privilege particular leadership styles, professional behaviours and forms of cultural capital that have become established within the organisation over time. Where certain ethnic groups have historically achieved greater representation in senior leadership positions, these norms and expectations may become more familiar and accessible to individuals from similar professional and social backgrounds. As a result, individuals whose cultural dispositions more closely align with these expectations may experience smoother progression through leadership pathways, whereas others may encounter subtle barriers to recognition and advancement (Shah & Ahluwalia, 2019).

From a Bourdieusian perspective, race (McKnight & Chandler, 2012) and ethnicity (Gezgin & Greenfields, 2017) can be understood as relational dimensions, whereby the meaning and value attached to racial and ethnic identities are produced through social relations and power structures rather than residing within groups themselves. Consequently, differences observed between minority ethnic groups should be interpreted in relation to the unequal distribution and recognition of economic, social, cultural, and symbolic capital, rather than as intrinsic characteristics of those groups (Wallace, 2017).

In this study, I applied this theoretical framework throughout my interpretive analysis and reflexive practice, examining how participants' narratives and professional trajectories

may be shaped not only by formal criteria such as qualifications and experience, but also by differential access to cultural, economic and social resources recognised and valued within organisational leadership structures. This perspective is particularly useful for exploring how variations in access to professional networks, mentorship opportunities, sponsorship, and informal organisational knowledge may contribute to differential leadership attainment among doctors from different ethnic backgrounds.

2.9.2 Transformative Worldview Framework

The transformative worldview provides an important philosophical and methodological framework for research concerned with inequality, power, and social justice (Sweetman et al., 2010). Transformative research approaches are grounded in the belief that knowledge production should not only describe social realities but also contribute to challenging structural inequities and improving outcomes for marginalised groups (Mertens, 2014). Central to this perspective is the view that research is inherently political and that scholars have a responsibility to critically examine the systems of power, privilege, and exclusion that shape social experiences and opportunities (Mertens, 2014). This worldview also focuses on "*the needs of the marginalised and disenfranchised"* (Creswell & Creswell, 2017, p. 9).

The transformative worldview is particularly relevant to research on race and ethnicity because it recognises that inequalities are not simply the result of individual characteristics or actions but are embedded within wider social, historical, and institutional structures (Mertens, 2014). This perspective draws attention to how structural inequalities shape access to opportunities, resources, influence, and representation, while simultaneously privileging the experiences and voices of groups that have historically been marginalised. Consequently, it provides a valuable framework for exploring how race and ethnicity

influence career progression and leadership attainment within organisations such as the NHS. Furthermore, this worldview acknowledges that this type of research inquiry cannot be wholly divorced from the political environment in which it sits; the NHS is political (Fabre, 2017). This is partly due to the value of the NHS in British society, but also its economic footprint (Stewart, 2023). Therefore, this transformative framework helps focus on how institutional structures and cultural norms shape career opportunities of its workers with the transformative perspective encouraging critical examination of systemic barriers (Mertens, 2014) rather than attributing disparities solely to individual factors. Furthermore, it supports research that seeks not only to understand differential outcomes but also to inform organisational change and promote more equitable leadership practices (Kline, 2013).

Within this study, a transformative worldview provides a framework for critically examining and interpreting the lived experiences of Black and Asian doctors in senior NHS leadership roles. It facilitates the exploration of how organisational cultures, institutional practices, leadership norms, and power relations may shape DA and contribute to the persistent underrepresentation of minority ethnic groups in senior leadership positions. Importantly, this worldview also supports an examination of how race and ethnicity intersect with access to leadership opportunities, mentorship, sponsorship, professional networks, and decision-making spaces. By foregrounding issues of equity, representation, and social justice, this perspective allows the study to move beyond individualised explanations of career progression and instead focus on the structural and systemic factors that shape leadership experiences and outcomes. Furthermore, the transformative worldview aligns with the study's focus on both inter- and intra-minority ethnic differences—an under researched area (Kline, 2014). It recognises that minority ethnic groups are not homogeneous and that the

experiences of Black and Asian doctors may be shaped by distinct historical, social, cultural, and organisational contexts (Shah & Ahluwalia, 2019).

In this research I considered Critical Race Theory (CRT) as an alternative theoretical lens, given the study's focus on structural racism and racial inequities. I acknowledge that CRT resonates strongly with the study's focus on the experiences of minority ethnic doctors and could have offered powerful explanatory tools for understanding how racial inequalities are reproduced and normalised within organisations such as the NHS (Adegoke et al., 2025). However, the study sought to explore not only the impact of race but also how broader social, historical, cultural, and organisational processes shape career progression and attainment of senior leadership positions within the NHS for minority ethnic doctors. As such, a transformative worldview was selected because of its commitment to equity and social change, while Bourdieu's concepts of habitus, capital, and field provided a broader analytical framework for understanding how inequalities are reproduced and sustained within NHS leadership pathways. Together, these offered a more comprehensive means of addressing the study's research questions.

2.10 Summary & Conclusion

This literature review critically examined the existing evidence relating to DA, leadership progression, and structural inequality affecting minority ethnic doctors within the NHS. The chapter also considered the role of structural and institutional racism, alongside concepts such as social and cultural capital, and inter-minority ethnic differences, in shaping unequal professional trajectories within senior leadership contexts in the NHS. The literature demonstrates that DA cannot be adequately understood through individualistic explanations alone; rather, it reflects broader organisational and structural mechanisms embedded within healthcare institutions as well as wide societal influences and negative stereotyping of minority ethnic people. It explored how organisational culture, institutional processes, informal networks, sponsorship, visibility, and systemic power structures shape access to leadership opportunities and career advancement between White majority and minority ethnic, and within minority ethnic groups. Although diversity and inclusion initiatives have increased the visibility of these issues, the evidence suggests that inequalities in progression, representation, and access to leadership persist for many minority ethnic doctors, particularly at senior levels. The review also identified key gaps in the literature, including the under exploration of lived experiences within senior leadership, limited examination of inter-minority ethnic dynamics, and insufficient focus on the relational and systemic nature of exclusion and opportunity.

Overall, this chapter establishes the conceptual and empirical foundation for the present study by identifying key debates, theoretical perspectives, and gaps in the literature. In doing so, I believe it provides a clear rationale for a more nuanced exploration of the experiences of Black and Asian minority ethnic doctors in NHS senior leadership, positioning this research as a contribution to a deeper understanding of structural inequality, DA, and

organisational exclusion within healthcare leadership systems, through individual lived experiences of decades in the organisation including how their formative years in a racialised Britian continues to shape these experiences.

In the next chapter, I discuss the methodological approach underpinning this qualitative study. The study comprises a narrative inquiry involving participants from diverse ethnic backgrounds—White, Black, and Asian—who hold senior leadership positions within the NHS. It also employs a reflective thematic analysis (RTA) across all participants, which is central to addressing the three research questions guiding this study. By combining these two methodological approaches, I believe moves this qualitative research beyond descriptive analysis and rather engage interpretive and theoretically informed inquiry.

PART II: METHODOLOGY

CHAPTER 3: METHODOLOGY

Overview

The chapter begins with a reminder of the research questions and the rationale for the study. I then discuss the philosophical approach underpinning the research, including the theoretical frameworks used for analysis and justification. The research methodology—narrative inquiry—is presented, along with the rationale for its use and related components such as the analytical approach. Full details of participant recruitment and selection follow, including the data collection process, interview structure and procedures, as well as the challenges encountered when conducting this study with elite participants, accompanied by my reflections and reflexivity. The chapter concludes with a comprehensive description of the data analysis process employed in this study, including its justification and the measures taken to ensure the trustworthiness and dependability of the data.

3.1 Rationale, Research Aims, & Research Questions

The research questions for this study arose from two primary considerations. First, they were informed by my personal perspective and lived experience as a doctor in the NHS with nearly two decades of practice and having reached a significant professional milestone as a consultant. This milestone is not achieved by a substantial proportion of doctors in the NHS for several reasons, including bottlenecks at the top of the organisational hierarchy, individual career preferences, and workforce structures that require relatively fewer consultants as organisational leaders overall (Martin et al., 2015). Although attaining this milestone was personally significant, it prompted a broader exploration of career progression into senior leadership and executive roles. In doing so, I observed patterns of DA that appeared to be aligned along racial or ethnic lines.

Second, the existing literature has documented ethnic disparities in senior leadership within the NHS over several decades, consistently highlighting the underrepresentation of minority ethnic individuals at senior levels despite substantial minority ethnic representation at the lower tiers of the organisation. Moreover, this issue appears to be pervasive and persistent. In addition, a gap I identified in the literature relates to the lack of granularity and disaggregation within analyses of minority ethnic senior leadership. In particular, there appears to be inter- and intra-minority ethnic variation that most data sets and studies have failed to capture adequately. This is largely due to the homogenisation of minority ethnic groups through the use of broad acronyms—such as BAME or BME (Black, Asian and Minority Ethnic; Black and Minority Ethnic)—commonly employed in NHS ethnicity data collection.

Therefore, using narrative inquiry, this research aims to explore the following research questions from the perspective of senior leadership (elite individuals), British and/or British-trained doctors, from different ethnic groups, including majority White group:

1. What are participants' perspectives on the differential attainment (DA) between White majority and minority ethnic doctors in senior leadership positions within the NHS?
2. What are participants' perspectives on the DA between Black and Asian minority ethnic doctors in senior leadership positions within the NHS?
3. What are participants' perspectives on the health implications of DA at senior leadership level in the NHS for minority ethnic communities?

3.2 Philosophical Underpinnings, Ontology & Epistemology

This study is situated within a social constructivist paradigm, which assumes that knowledge and reality are shaped through social interactions, interpretation, and context (Thomas, 2013; Lincoln & Guba, 1985). Through this lens, I investigate DA between different minority ethnic doctors in NHS senior leadership. This paradigm enables me to conceptualise the phenomenon of DA and how knowledge about it is generated, including the ways in which I interpret the subsequent findings. Epistemologically, this constructivist approach—which assumes that knowledge is co-created between researchers and participants through interaction and interpretation (Mertens, 2014; Thomas, 2013)—is central to the narrative inquiry methodology I have chosen. Within this approach, participants are understood not simply as reporting objective facts, but as providing narratives that reflect how they interpret and make sense of their experiences within the NHS, including their journeys into senior leadership roles and their perspectives on the future. This will sit alongside an interpretivist approach, which emphasises understanding subjective meaning and lived experience. This is particularly important in the context of a narrative study, where attention is given to participants' experiences as they navigate their career journeys—from their formative years in the NHS through to senior leadership positions.

In this research, I also adopt a relativist ontology, which assumes that reality is multiple, subjective, and socially constructed rather than singular and objective (Thomas, 2013). Ontology concerns the nature of reality and what is considered real or knowable within a research study. In this context, I investigate the research questions through the lived experiences and perceptions—*that is, the realities*—of the participants, who were carefully selected on the basis of their positions, experiences, and stories, alongside the relational factors of race and ethnicity. A relativist ontological perspective recognises the multifaceted

nature of leadership and career progression at the elite level, which cannot be separated from socio-cultural, historical, and institutional considerations. These dimensions are experienced differently by participants and are therefore likely to be interpreted differently (Lincoln & Guba, 1985). Furthermore, knowledge produced through narrative inquiry emerges through the dialogue between participants and the researcher, and through the interpretive process of analysing narratives (Thomas, 2011). My role as the researcher is therefore to understand the experiences of the participants in relation to the research questions and to interpret their stories—*the meaning-making process*—within the wider societal and institutional context of the NHS.

Social constructivism is particularly well suited to narrative inquiry, especially when the data are drawn from lived experiences, as I attempt to provide insight into how these elite individuals construct their identities and interpret their experiences over time within the NHS (Reissman, 2008). Narrative accounts also allow participants to explain how particular events—such as formative experiences during medical training, relationships with colleagues, mentors or advocates, and organisational practices including recruitment policies, selection processes, or postgraduate examination biases—have shaped their leadership journeys and career trajectories (Elliott, 2005). The justification for adopting a social constructivist paradigm as the main methodological approach for this study is threefold. First, narrative inquiry enables a deep understanding of lived experiences through participants' stories rather than through the measurement of predefined variables (Reissman, 2008). Second, it recognises the importance of contextual interpretation, acknowledging how the experiences of for example these elite individuals in senior leadership roles are shaped by institutional cultures within the NHS and the wider society, as well as by interpersonal and professional relationships (Daiute, 2014). Third, the reflexive approach inherent in narrative inquiry aligns

with the recognition that I, as the researcher—with my role, ambitions, ethnicity, and positionality—also influence the interpretation and analysis of participants' narratives (Elliott, 2005).

3.3 Research Methodology: Narrative Inquiry

3.3.1 Definition, Key Aspects & Rationale for Narrative Inquiry

Narrative inquiry can be defined as the study of experience as story, suggesting that human experience is inherently storied and therefore best explored through narrative accounts (Clandinin & Connelly, 2000). It also has the ability to elevate the voices of individuals, particularly those from marginalised communities (Daiute, 2014). Clandinin and Connelly (2000) propose that people organise and make sense of their lives narratively by linking events across time and interpreting them within social and cultural contexts. This recognises that experiences are built over time (Dewey, 1981) and shaped by the environments in which individuals live and work (Clandinin & Rosiek, 2019). Furthermore, narrative inquiry seeks to explore how experiences are lived, told, retold, and interpreted through narrative forms. As such, narrative inquiry functions as an overarching research methodology, encompassing philosophical assumptions about knowledge and experience, research design, methods of data collection, approaches to data analysis, and the interpretation of narratives (Holstein & Gubrium, 2012). It is situated within interpretivist and constructivist epistemologies, which assume that knowledge is socially constructed and that individuals interpret their experiences through processes of meaning-making (Creswell & Poth, 2016; Andrews et al., 2013). Bruner (1991) further argues that narrative is a fundamental way in which humans organise and interpret reality, as individuals construct meaning by linking events into stories that explain actions, intentions, and outcomes. Similarly, Ricoeur (1984) notes that narrative enables individuals to interpret past experiences and integrate them into coherent life stories. Together, these perspectives underpin narrative inquiry's focus on meaning-making, temporality, and identity construction.

Clandinin and Connelly (2000) developed and described the central concept of the *three-dimensional narrative inquiry space*, which provides a framework for analysing lived experience. The framework emphasises three interrelated dimensions: temporality, which situates experiences across time by examining past events, present interpretations, and future expectations; social context and interactions, which asserts that narratives are shaped through interactions with others and within broader social structures, including relationships, institutional cultures, social norms, and power relations (Riessman, 2008); and place, which acknowledges that experiences occur within specific physical and institutional settings such as workplaces—the NHS, communities, educational environments, and organisations. Together, these three dimensions—temporality, social context, and place—form the analytic framework known as the three-dimensional narrative inquiry space (Clandinin & Connelly, 2000).

Narrative inquiry focuses on lived experience and typically involves in-depth engagement with participants' stories to obtain narrative data through interviews in which participants are encouraged to tell extended accounts of their experiences rather than respond to structured questions. However, in this study, and in order to meet the research aims and objectives, participants were invited to structure their stories around the research questions, in ways unique to their experiences, cultural backgrounds, and societal and institutional contexts. This approach enabled me to better understand how identities and career trajectories within the organisation—and into senior leadership—evolve over time (Goodson & Sikes, 2001). This process afforded me, as the researcher, a unique opportunity to make meaning from and reconstruct narratives using interview transcripts and my field notes. Wherever possible, I identified key events, temporal sequences, significant turning points, and constructed coherent narrative accounts through which participants explained their

experiences (Polkinghorne, 1995). Alongside this analytic work, I engaged in reflexive interpretation—central to narrative inquiry—where I acknowledge that narratives are co-constructed between participant and researcher. This required recognising my positionality (discussed later in the chapter), reflecting on interpretive choices, and acknowledging the influence of context on narrative production, thereby distinguishing narrative inquiry from more positivist research approaches (Andrews et al., 2013).

Relevant to this study, narrative inquiry can also help address the issue of ethnic homogeneity—a key aspect of this research—by exploring the individual experiences of participants and the extent to which ethnicity, alongside the factors mentioned above, shaped their journeys, as perceived by them. Furthermore, this approach allows for an exploration of the collective and community-level implications of DA at senior leadership level in the NHS, which forms one of the research questions. These participants occupy unique positions with strategic and social responsibilities that extend to the health outcomes of their communities. Their reflections on senior leadership—both generally and through the lens of their racial identities—I believe will provide valuable insights into how leadership representation influences the aspirations, perceptions, and opportunities available to others.

3.3.2 Summary of Methodology

1. **Ontology**

   I adopt a **relativist ontology**, recognising that reality is not singular or objective but multiple, constructed, and context dependent. This is particularly important in a study where participants—although holding comparable senior positions within the NHS—have experiences shaped by intersecting factors such as race, identity, organisational culture, and power structures. These dynamics profoundly influence DA across the organisation, especially at senior leadership levels as confirmed by the participants.

2. **Epistemology**

   My epistemological position is **interpretivist/social constructivism**. While distinct, I believe these perspectives complement each other: interpretivism emphasises understanding subjective meaning and lived experience, while social constructivism focuses on how such meanings are co-constructed and shaped by wider structures, such as those internally in the NHS, and externally in a racialised Britain. Both are relevant to this research; I am interpretivist in stance—foregrounding meaning-making in the lived experiences of these elite participants—and social constructivism in analysis, examining how meaning is shaped by culture, power, and institutional and societal systems at a micro level for participants. I also acknowledge my own role in co-constructing meaning throughout the research process.

3. **Theoretical Frameworks**

   This study draws upon two theoretical frameworks: The transformative worldview (Mertens, 2014) and Bourdieu's (1977) concepts of culture and capital, which were discussed in the previous chapter. The transformative paradigm centres issues of inequality and marginalisation and seeks to challenge inequitable systems—an

essential lens given persistent disparities in career progression for minority ethnic doctors in the NHS. It also foregrounds the voices of underrepresented groups, aligning with my decision to interview Black and Asian senior clinicians to highlight systemic barriers and generate practice-relevant recommendations.

I believe Bourdieu's framework offers an additional analytic lens, particularly in relation to class, social capital, and legacy, especially when considering the migration histories of minority ethnic populations in Britain. These themes were prominent in participants' narratives, especially among minority ethnic doctors, who described generational class-based barriers that continue to shape career opportunities within the NHS today, and living in a class based British society.

4. **Methodology**

   The overarching methodology for this study is **narrative inquiry.** It supported participants in articulating and positioning themselves in relation to inequality and DA as they have lived or perceived it, facilitating deeper meaning-making.

5. **Method: Reflexive Thematic Analysis (RTA)**

   As a secondary analytic layer, I used **reflexive thematic analysis (RTA)** to conduct cross-case interpretation. This helped identify shared patterns, points of divergence, and higher-order themes across the narratives, enabling me to answer the research questions and generate recommendations, which is important for my DPhil. Further justification for this approach is provided later in this chapter and in the findings chapter – Part B.

3.4 METHOD

Overview

Having provided a comprehensive overview of narrative inquiry and its rationale, the chapter now moves on to a detailed explanation of the study design. This includes, but is not limited to, the recruitment and selection of participants—alongside justification for the participant groups—and pertinent definitions such as ethnicity and senior leadership within the NHS. This is followed by sections on data collection, the interview process, and researcher reflections, before proceeding to the data analysis. I then outline the ethical considerations and associated issues, together with a discussion of positionality.

3.4.1 Study Design

This research uses narrative inquiry with multiple participants across three different racial groups to gain a comprehensive understanding of their experiences in senior leadership within the NHS, as well as their perceptions of the DA that exists across racial groups and between minority ethnic groups.

3.4.2 Narrative Interview Process

In this narrative interviewing, participants were encouraged to tell their stories by drawing on their lived experiences related to a subject or research topic, in a conversational manner with me the researcher (Elliott, 2005), rather than purely responding to structured interview questions (Murray, 2015). This approach I believe allowed participants to shape both the structure and the meaning of their narratives in ways that reflect their own perceived realities (Riessman, 2008). Consequently, as a researcher conducting narrative interviews, I took care not to impose fixed structures or rigid interview schedules. Instead, I adopted a flexible format that allowed participants' unfolding stories to guide the interview process. This

absence of a predetermined order enabled me to become more fully immersed in participants' narratives (Riessman, 2008).

Jovchelovitch and Bauer (2000) describe four basic phases of the narrative interview, following an initial preparation phase in which the researcher familiarises themselves with the purpose of the study and the relevant gaps in the literature. The first phase is initiation, during which I explained the general aims of the study and the narrative interview process, emphasising the preference for largely uninterrupted storytelling. This phase also included procedural elements such as obtaining consent, arranging audio-recording, and clarifying the anticipated duration and structure of the interview. The second phase is narration, in which participants told their stories without interruption, unless they signalled a need for input or reached a natural pause. I asked the participants – "how would you describe your career journey in the NHS as related to the research questions?" During this phase, I maintained active listening and provided non-verbal encouragement, while mentally noting areas for probing and asking questions primarily for clarification where necessary. The third phase, questioning, began once participants had completed their main narrative, at which point I asked follow-up and clarifying questions e.g. "can you tell me more about these external factors outside of the organisation that impacted your career journey?" The fourth and final phase is concluding talk, during which the interview ended, and participants were invited to offer any additional contextual information. I used this material later to assist with the interpretation of the narratives and in addressing the research questions.

The strengths and limitations of narrative interviews relate largely to interview technique. One challenge arises from participants' potentially uncontrollable assumptions about what the researcher knows or expects, which may lead them to shape their narrative in ways intended to please, persuade, or achieve another aim (Murray, 2015). I remained

mindful of this throughout the research process, allowing participants to tell their stories without unnecessary interruption. Where participants made assumptions about me or my positionality, I sought to refocus the discussion on their experiences in order to minimise undue influence. A second challenge concerns the unrealistic notion that I as the researcher is entirely passive; in practice, I recognised that I had influences on the interview which I acknowledged through reflexive practice (Jovchelovitch & Bauer, 2000).

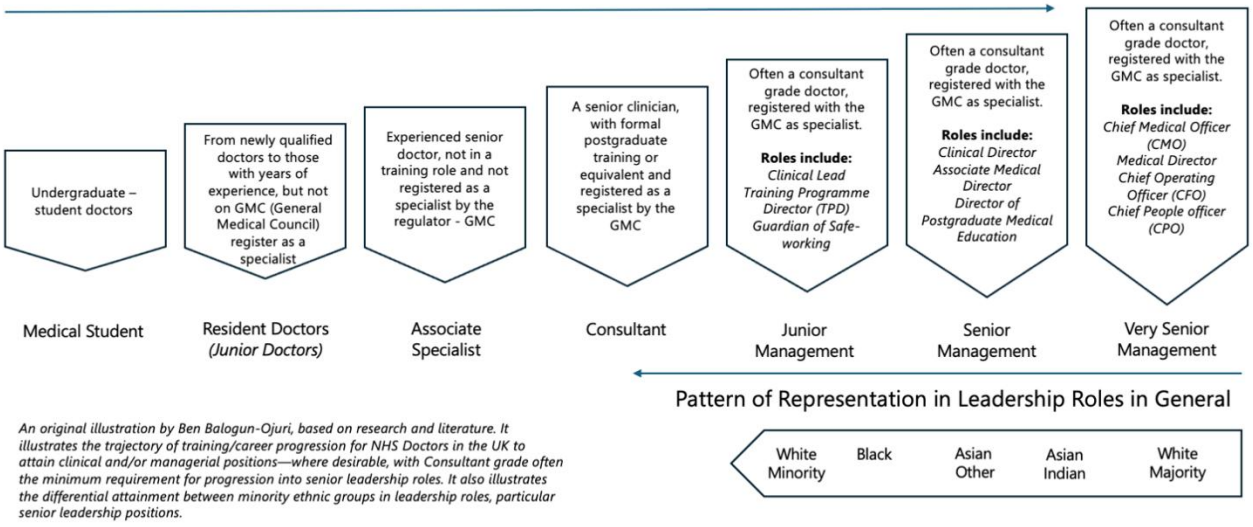
In practice, for this study, while I sought the richness of participants' stories shaped by their lived experiences, I also encouraged them to reflect on the three research questions—both to meet the objectives of the DPhil and to explore the complexities of the subject across participants from different ethnic backgrounds and varied life trajectories who nonetheless occupy similar senior leadership roles within the same organisational ecosystem, the NHS. Within this flexible structure, participants were still free to tell their stories rather than merely answer questions (Bold, 2012). Any additional questions I asked were primarily intended to clarify participants' assertions or probe more deeply for meaning.

3.4.3 Definition of Senior Leadership Positions in the NHS as Applied in this Research

This research focuses on the career progression of doctors at the highest levels of the NHS organisation. The figure below (**Figure M1**), illustrates the progression of doctors through the NHS and into leadership roles. It is important to note that not all doctors choose a leadership trajectory, and those who do may do so for a range of reasons. For the purposes of this research, senior leadership is defined in line with NHS England's definition (NHS England, 2025). This includes doctors in roles ranging from clinical directors (as the minimum entry requirement) to chief medical officers or executive-level positions—senior management and senior leadership, as highlighted in **Figure M1**. These individuals hold

strategic responsibilities, organisational oversight, and legal duties, all of which influence the staff population, career pathways, and their wider communities, particularly with regard to health outcomes. **Figure M1** illustrates the progression of doctors within the NHS through to senior leadership. The junior doctor stage begins following graduation from medical school and extends to staff grade positions, encompassing doctors from the first day of training to those with decades of service who do not attain consultant status. Senior doctors represent a smaller group and include associate specialists and consultants listed on the GMC Specialist Register. Senior leadership positions extend beyond this level, with the attainment of consultant status typically serving as a minimum entry requirement.

Figure M1: NHS Doctors Progression to Clinical Leadership and Management



An original illustration by Ben Balogun-Ojuri, based on research and literature. It illustrates the trajectory of training/career progression for NHS Doctors in the UK to attain clinical and/or managerial positions—where desirable, with Consultant grade often the minimum requirement for progression into senior leadership roles. It also illustrates the differential attainment between minority ethnic groups in leadership roles, particular senior leadership positions.

3.5 Study Participants

3.5.1 Sampling & Strategies

A non-probability sampling strategy was used in this qualitative study. Unlike probability sampling—which aligns more closely with quantitative research—non-probability sampling places less emphasis on random or representative selection and instead prioritises the generation of rich, meaningful data through the purposeful selection of participants from the target group (Patton, 2015). In this study, I used three forms of non-probability sampling used: **purposive**, **convenience**, and **snowball sampling**. All three became essential as the study progressed, particularly given the elite nature of the participant group—senior NHS leaders—and my own positionality as the researcher within the same professional environment.

3.5.1a Purposive

Purposive (or selective) sampling involves the deliberate selection of participants (e.g., NHS doctors) based on specific characteristics or qualities (Moser & Korstjens, 2018)— being an NHS doctor, holding a senior leadership position, belonging to one of the three broad ethnic groups (Black, Asian, White), and being British or British-trained, all of which directly align with the research objectives. As Patton (2015) notes, purposive sampling enables the selection of individuals who can provide rich, relevant, and insightful information. Its main strengths lie in depth, relevance, and efficiency, as it ensures that only those with meaningful insights are included. However, limitations include the potential for selection bias, given the reliance on the researcher's judgement in choosing participants, which can impact transferability, which must be acknowledged and contextualised (Patton, 2015; Cohen, 2018).

3.5.1b Convenience

In this study, convenience sampling was used at the initial recruitment stage. This refers to the opportunistic selection of participants who are readily accessible to the researcher due to proximity or existing professional relationships (Patton, 2015). This does not imply that such participants are unsuitable for the study. On the contrary, for this research, these individuals were exactly the group required; their convenience simply reflected my relatively easy access to them, given that we worked within the same organisational environment as a senior doctors in the NHS. Thus, this sampling method concerns *how* participants are reached rather than the *quality* or relevance of the participants themselves (Patton, 2015). It reflects the practical realities of reaching elite individuals whose time is limited and whose availability is often constrained by organisational responsibilities and gatekeepers.

Although purposive sampling constituted the principal sampling design for this study, it became clear that, for practical reasons of efficiency and expediency, the initial participants would be recruited primarily through convenience sampling—specifically, through established or tangential relationships held by me as an NHS consultant. This was significant for several reasons: access to elite individuals within the NHS is challenging for outsiders and typically requires navigating multiple gatekeepers; the research topic itself carries political sensitivities, which may make participants reluctant to engage with an unfamiliar researcher, and even an insider without equivalent seniority—such as a junior doctor—may struggle to secure interviews with leaders at this level. However, I note that convenience sampling carries risks of homogeneity and bias (Cohen, 2018), I attempted mitigating this by later expanding recruitment beyond my immediate network.

3.5.1c Snowball

Thirdly, a snowball sampling effect played a crucial role in participant recruitment, particularly in reaching senior leaders across different NHS organisations. Several initial participants voluntarily used their networks—for example, WhatsApp groups—to support recruitment, while others sent introductory emails on my behalf to colleagues. Although not all contacts were able to participate due to for example bandwidth or competing commitments, almost all responded, making the recruitment process more efficient and far-reaching.

An additional advantage of using convenience sampling followed by snowball sampling relates to the study's limited resources—time, funding, and access. For instance, travelling across the country to recruit suitable participants would have been prohibitively expensive as an unfunded DPhil student, and unsolicited cold-emailing without a trusted intermediary would likely have been inefficient or unsuccessful given the sensitive nature of the research topic. Concerns about trust are understandable, and I observed that both insider status and trusted introductions which took place in this research recruitment process enhanced participants' openness and willingness to engage during interviews. This underscores the importance of relational access in research involving elite participants (Niu, 2024). This is not to suggest that the study could not be conducted by an outsider; however, doing so would likely require substantially more time to build relationships, establish credibility, and secure access to individuals who are typically protected by gatekeepers. Nevertheless, a significant limitation of snowball sampling is the potential introduction of bias, due to the lack of randomisation, which can reduce the credibility and transferability of findings (Etikan et al., 2016). Snowball sampling may also perpetuate network bias (Noy, 2008), as participants may recommend colleagues who share similar worldviews or

experiences. This can constrain the breadth and diversity of the data sample and must be acknowledged when interpreting the findings.

In this study, I believe the combination of the first two sampling strategies—purposive and convenience sampling—worked effectively in tandem for this study, ensuring balance, depth, and reach in identifying the required participants. This combination enabled the collection of rich data, further enhanced by the addition of snowball sampling. Snowball sampling, in particular, was valuable for gaining access to hard-to-reach individuals, including marginalised groups (Patton, 2015), which was especially relevant in this study despite my initial success in recruiting the first few participants. This represents one of the main strengths of snowball sampling.

Across all three sampling methods used in this study, there are inherent common limitations that must be acknowledged: low to very low transferability (Noy, 2008; Patton, 2015), moderate to high sampling bias, and the possibility that the sample may not be fully representative—as is often the case with convenience sampling (Patton, 2015)—nor fully transferable due to the subjective nature of purposive sampling (Etikan et al., 2016).

3.5.5 Participant selection – Recruitment Strategies

The process of participant recruitment followed several stages, each shaped by both the methodological needs of the study and the practical realities of accessing elite NHS leaders. All participants who responded positively to the initial invitation were offered interviews. In total, 32 individuals expressed interest; however, 7 were unable to proceed due to scheduling constraints linked to the substantial responsibilities associated with their senior roles. Ultimately, 25 interviews were conducted. To further preserve the anonymity of these elite

individuals—whose roles sit at the top of the NHS and are therefore fewer in number than most positions in the organisation—I decided not to list participants' roles by ethnicity or geography. Doing so could potentially lead to their identification through triangulation, particularly as they also have publicly accessible online profiles.

Recruitment unfolded across several distinct stages:

Stage 1: Direct Outreach (Local)

The first involved direct outreach to suitable participants—specifically senior NHS leaders within the researcher's organisation—using my NHS email address. This approach served multiple purposes: it fostered immediate trust through shared professional identity, enabled potential participants to express interest informally, and created opportunities for early recommendations that supported subsequent snowball sampling. All follow-up correspondence, including participant information sheets, consent forms, and ethics documentation, was issued via my University of Oxford email address, in line with ethical protocol. Once participants confirmed their interest, formal invitations were issued, along with the consent form, study information, and potential interview dates. A Microsoft Teams invitation was then sent from the university account, and participants were asked to confirm attendance and return a signed consent form electronically. For those who had not done so in advance, verbal confirmation and digital signing of the consent form took place immediately before the interview.

Stage 2: Formal Invitation

The second stage of recruitment involved recommendations from the initial group of participants, who suggested additional senior leaders who might be interested in taking part. This stage proved particularly important because the individuals targeted for this study hold

highly demanding leadership roles with significant clinical, managerial, and strategic responsibilities. Their diaries are often heavily oversubscribed, and their capacity to engage in research is limited. Consequently, the willingness of the first wave of participants not only to participate but also to facilitate introductions to colleagues was invaluable. Their endorsements functioned as a form of social proof, providing reassurance about the legitimacy, confidentiality, and purpose of the study. This expedited recruitment and helped secure participation from highly senior individuals who may otherwise have been difficult to access. Despite these efforts, several recommended participants declined due to scheduling constraints or insufficient bandwidth, underscoring both the scarcity of time available at this leadership level and the challenges inherent in undertaking research of this nature. Nevertheless, the network-mediated recruitment process significantly enhanced the breadth and quality of the participant pool.

Stage 3: National Outreach

The third stage of recruitment focused on identifying senior leaders across England using publicly available online information. Many individuals in very senior NHS roles maintain an online presence—typically through their Trust websites—which often includes professional biographies and contact details. This stage aimed to diversify the sample geographically and reduce over-representation of participants from London and the Southeast, where the initial recruitment activity naturally concentrated due to the researcher's professional base. The decision on who to approach was based on the available online information. A similar approach to the first stage was used: an initial expression-of-interest email was sent via the researcher's NHS account to establish legitimacy and collegiality, followed by formal correspondence through the University of Oxford account upon response. Although only three participants were ultimately recruited through this national outreach, several additional

senior leaders replied to decline participation due to diary pressures and limited bandwidth. These responses nonetheless underscored an important finding: gaining access to senior NHS executives for research purposes—particularly for a politically sensitive topic—is challenging, regardless of method. This stage therefore highlighted both the practical barriers to elite recruitment and the value of personal networks in enabling participation.

Stage 4: Targeted Minority Ethnic Recruitment

The fourth and final stage of recruitment focused on increasing participation among minority ethnic leaders—particularly Black minority ethnic senior leaders—who met the study criteria. This proved especially challenging for several reasons. Senior leadership roles in the NHS are highly competitive, with relatively few positions available nationwide in general. Existing literature also demonstrates that Black doctors face significant barriers to career progression (Kline, 2014; Woolf et al., 2020), including reduced likelihood of appointment to senior leadership roles compared to their White counterparts (Kline, 2014). As a result, the pool of Black senior leaders is already small, making recruitment inherently difficult. Furthermore, proportionally, there were fewer Black doctors in the NHS compared to the Asian doctors, which is relative to the UK population. To address this, support was sought from the initial Black participants, who used their personal and professional networks to facilitate introductions to other eligible individuals. Their involvement was critical, as it helped overcome structural access barriers and issues of trust that may arise when researching sensitive topics such as race, equity, and leadership. In contrast, recruiting Asian minority ethnic leaders proved less challenging, partly due to recommendations from both early minority participants and several White participants.

This multi-layered recruitment strategy ensured representation across the three main ethnic groups while acknowledging the disproportionate structural constraints faced by some groups in reaching senior NHS leadership.

3.5.6 Limitation & Mitigation of Sampling Range

A significant proportion of participants were recruited from London and the Southeast – total of 20. This was partly because the researcher lives and works in London, and partly due to the sampling strategies employed, as discussed above. While London and the Southeast represent a substantial portion of England population wise, this regional concentration may further limit the transferability of the study's findings. Additionally, it is widely recognised that securing training posts, consultant posts, and senior leadership positions in London and the Southeast is more competitive than in other regions of the country. This may suggest that the lower representation of minority ethnic groups in senior positions is, in part, influenced by these regional dynamics. However, paradoxically, the successful recruitment of minority ethnic senior leaders—particularly Black minority ethnic leaders—from this region may indicate proportional representation within the local context. This is supported by demographic patterns: although Black people constitute approximately 4% of England's overall population, around 46% of the Black population resides in Greater London. As such, it is reasonable to expect that Black professionals in London ought to have equitable access to career progression opportunities within their region of domicile.

The main mitigation employed here was that, during the third and fourth phases of recruitment, I made a concerted effort to expand recruitment nationwide beyond London and the Southeast. This successfully added several additional participants to the study.

3.5.7 Sampling – Ethnicity Definition

For this research, participants were categorised into three broad ethnic groups: Black, Asian, and White (majority). The classification system used was based on the UK Government Census, 2021, updated on 26 October 2023. The census provides several levels of ethnic group categorisation, including classifications 20b, 8a, and 6a. For example, classification *20b* contains 20 categories, *8a* contains eight, and *6a* contains six. All three systems share five overarching categories: Asian, Black, Mixed, White, and Other; the primary differences lie in the granularity of subgroup breakdowns.

For this study, I chose to select the most compact system—Ethnic Group Classification 6a—mainly because it provided a manageable but sufficiently detailed categorisation, similar to other related studies (Woolf et al., 2020). The categories within classification **6a** are as follows:

> **Ethnic Group Classification 6a** *(Ons.gov.uk/census/census2021)*
> *Total number of categories: 6*
>
> 1. *Asian, Asian British or Asian Welsh*
> 2. *Black, Black British, Black Welsh, Caribbean or African*
> 3. *Mixed or Multiple ethnic groups*
> 4. *White*
> 5. *Other ethnic groups*
> 6. *Does not apply**
>
> * *Refers to students and schoolchildren living away from home during term time.*

This study focused on the Asian and Black minority ethnic groups, as they represent the largest minority populations in Britain—9.3% and 4%, respectively (Office for National Statistics, 2022). The White majority group was included as a comparator being the largest group in the NHS workforce in general. These classifications formed the primary basis for participant selection. However, at the beginning of each interview, participants were also asked to self-identify their ethnicity to align and compare two processes: my categorisation

using the UK Government Census classifications, and participants' own self-identification. While several participants provided more specific descriptors—such as Black African Nigerian, White Irish, Asian Korean, or Asian Pakistani—these more detailed self-definitions still corresponded to the broader census-based categories used in the study. In all cases, there was no discrepancy between participants' self-identification and the wider census classification employed.

3.5.8 Further Ethnicity Considerations

A key consideration in this research is the interpretation of ethnic categories, particularly the distinction between Black African and Black Caribbean groups, and how these relate to the Asian category. According to the UK Government Census (2021), Asian British includes individuals of Indian, Pakistani, Bangladeshi, Chinese, or any other Asian background; Black, Black British, Caribbean or African includes those of Caribbean, African, or any other Black or Black British background; the White category encompasses English, Welsh, Scottish, Northern Irish or British, Irish, Gypsy or Irish Traveller, Roma, or any other White background; Mixed or Multiple ethnic groups includes combinations such as White and Black Caribbean, White and Black African, White and Asian, or any other mixed background; and Other ethnic groups includes Arab or any other category not captured elsewhere (Office for National Statistics, 2022).

However, these categories are not always discrete or fixed in practice. For example, individuals who are visibly "Black" may self-identify using categories such as "Any Other," rather than "Black African," based on historical, cultural, or diasporic identities. For example, this can be observed within Somali communities: although individuals may appear visually Black and have African origins, some may self-identify culturally as Arab (Sannoh, 2025). Regardless of this self-identification, they may still be socially perceived as Black by the

White majority and may therefore experience similar racialised inequalities to other Black minority groups for example (Brown & Carpenter, 2018). I felt it was important to distinguish between race—commonly understood as a social construct rooted primarily in visible or phenotypic characteristics)—and ethnicity**,** which centres on shared cultural, linguistic, or ancestral heritage (Juang et al., 2021; Umana-Taylor et al., 2014). While these concepts often overlap, they are not synonymous. For instance, as described above, a British Somali individual may identify ethnically as Arab, while appearing visibly Black and originating from the African continent (Sannoh, 2025). This research acknowledges these complexities and nuances. As such, while initial participant selection necessarily relied on outward appearance—reflecting how society at large often perceives ethnicity—participants were also asked, as mentioned above, to self-identify their ethnicity at the outset of the interview. This I believe ensured that individuals were not placed into predetermined categories without their own input and that the study remained sensitive to the fluid, multidimensional nature of ethnic identity.

3.5.9 Sampling – Participant Numbers and Demographics

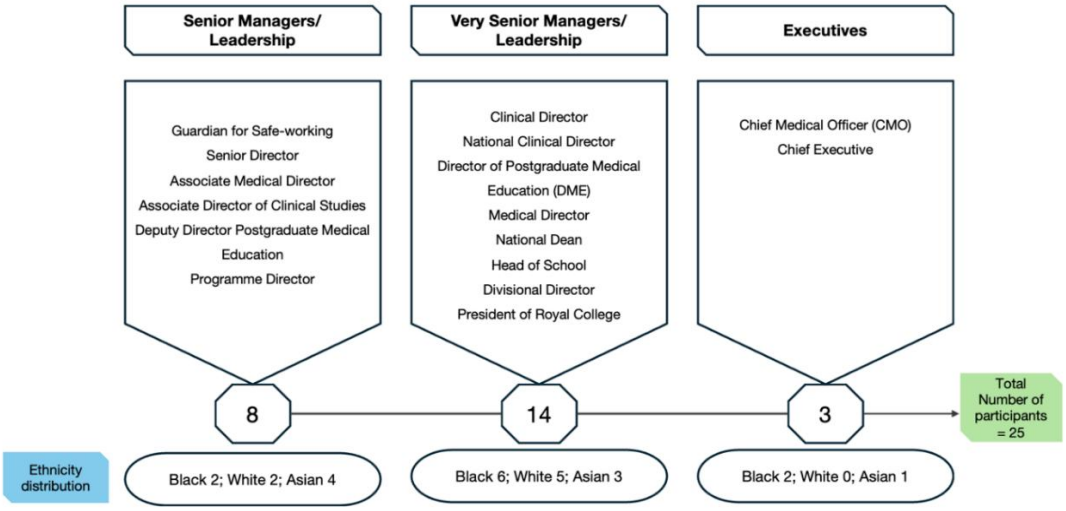
There was no predetermined number of participants required for this study. Although the study proposal outlined a minimum target and aimed to recruit approximately 30 participants, literature indicates that there is no firm consensus regarding an appropriate sample size for PhD/DPhil-level qualitative research (Vasileiou et al., 2018). Vasileiou et al. (2018) systematic review of 15 years of qualitative health research found that justifications for sample size are often limited and vary considerably depending on journal expectations and disciplinary norms. Other scholars have suggested that sample size may be guided by what

researchers can feasibly manage, given the depth and complexity of qualitative data collection and analysis (Ritchie et al., 2003; Britten, 1995).

In total, 32 participants were initially recruited, of whom 25 ultimately completed the interview process. The seven participants who did not take part withdrew primarily due to scheduling challenges rather than a decision to disengage from the study. The final ethnic composition of the interview sample, based on broad UK census categories, comprised 10 Black, 8 Asian, and 7 White participants. **Figures P1 and P2** (below) present participants by role, gender, and ethnicity. Each interview lasted approximately one hour. All interviews were completed in full, and every participant discussed the research questions within their narratives to varying extent. No participant has since requested withdrawal from the study.

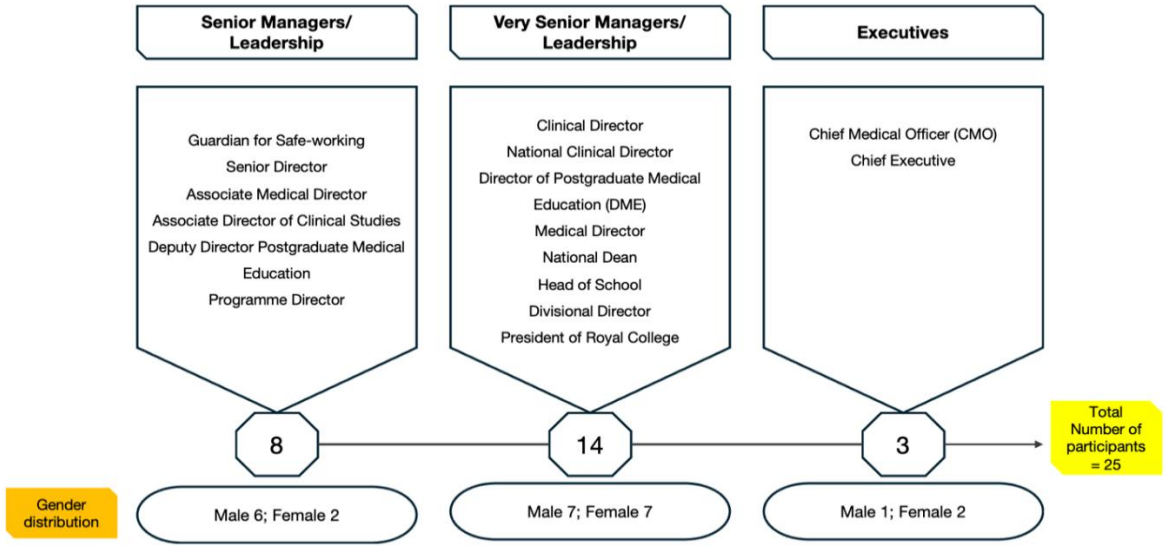
This narrative study, comprising 25 interviews, generated a substantial volume of data that could not feasibly be analysed in full within the scope of this DPhil research, given time constraints and the requirement to complete the programme within a specified timeframe. Consequently, I made the methodological decision to conduct in-depth narrative analysis of 9 of the 25 participants. The rationale for selecting these nine participants is detailed in the findings chapter and was primarily informed by two key criteria: (1) formative or seminal years spent in Britain leading to medical training, and (2) attainment of a primary medical qualification in the UK. However, all 25 participants were included in the subsequent RTA (Chapter 5, Part B).

Figure P2: Study Participants NHS Senior Leadership Roles by Ethnicity



Original Illustration by Ben Balogun-Ojuri. Showing total number of study participants by roles (senior leadership) and by ethnicity

Figure P1: Study Participants NHS Senior Leadership Roles by Gender



Original Illustration by Ben Balogun-Ojuri. Showing total number of study participants by roles (senior leadership) and by gender

3.6 Data Collection

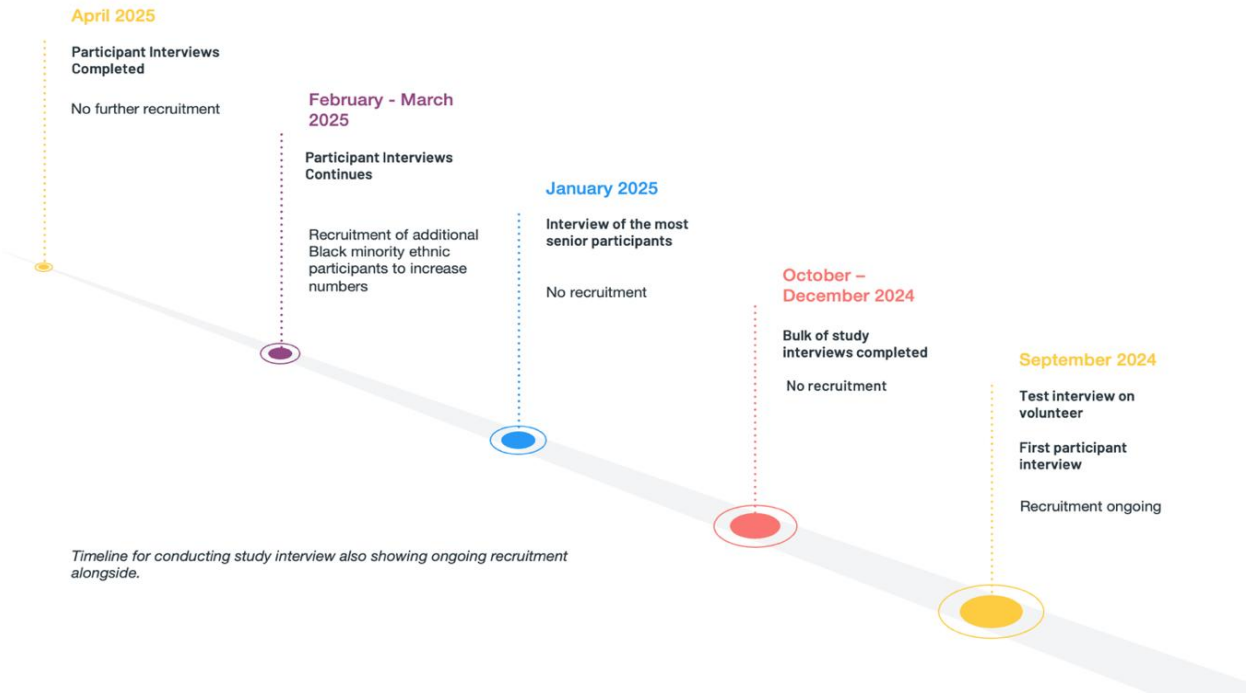
3.6.1 Study Setting

All interviews were conducted online via Microsoft Teams and were recorded in line with the research protocol. Participants selected a suitable date from an extensive list of options, in recognition of the demanding schedules and competing responsibilities typical of senior NHS leaders. Each interview therefore took place in a setting of the participant's choosing. It was noted that almost all of participants chose to participate from their workplace—usually their offices—within their organisations.

3.6.2 Interview Period & Process

Recruitment commenced in September 2024 and continued until the end of April 2025, running in parallel with the interview phase (see timeline below for details). Conducting recruitment and interviews concurrently provided flexibility, allowed efficient scheduling with elite participants, and supported iterative refinement of the interview approach based on early insights. However, the timeline changed from the initial proposal in the DPhil Transfer of Status (ToS) report, extending this stage of the research by several months. The main reason for this was the challenges I encountered during recruitment after I had exhausted my initial contacts through convenience sampling. I also felt it was important to recruit more widely by expanding the geographical area of participants, which had been limited to London and the Southeast. This approach was intended to help mitigate the low transferability associated with the sampling strategy—particularly snowball sampling, where participants are more likely to recommend individuals with similar worldviews. Furthermore, some

recruited participants were lost due to scheduling conflict, necessitating further recruitment drive.



Timeline for conducting study interview also showing ongoing recruitment alongside.

3.6.3 Conducting & Coding Elite Interviews

Conducting and coding elite interviews presents unique methodological considerations. There is no clear definition of an elite in the literature. Richards (1996) defined the notion of an elite individual as *"group of individuals, who hold, or have held, a privileged position in society and, as such… are likely to have had more influence on political outcomes than general members of the public"* (Richard, 1996, p. 199). This was echoed by Dexter (2006) who added that these individuals are *"the influential, the prominent, and the well informed"* (Dexter, 2006, p. 19). In context of research and conducting interviews, Welch et al. (2002) defined elite as *"an informant… who occupied a senior or middle management position; has functional responsibility in an area which enjoys high status in accordance with corporate*

values…" (Littig, 2009, p. 99). Niu (2024) suggest that these individuals provide *"invaluable access to the perspective and decision-making process that shape policy and societal trends",* with the information obtained from them described as *"often distinct, invaluable and provides insights that may not be accessible through other means of data collection*" (Niu, 2024, p. 3).

In this study, elite individuals refer to the senior leaders i.e. doctors in senior leadership positions in the NHS. These senior leaders occupy positions of authority, influence, and responsibility, which can shape both the content and tone of their responses. Some participants may be accustomed to controlling narratives or engaging strategically in politically sensitive discussions, while others may be more guarded due to public visibility or organisational constraints. In this study, a number of participants openly acknowledged these dynamics during the interviews. To ensure the integrity of the data collection process, it was important that I was aware of and able to manage these interactions—maintaining a conversational and respectful style while employing careful, targeted probing to elicit depth, nuance, and candour (Harvey, 2011). This approach I believe helped build trust, reduce defensiveness, and foster meaningful engagement with the study's complex issues.

There are also important considerations during the coding of elite interview data. Some senior leaders, particularly those whose roles include a political or public-facing dimension, may provide responses that are highly curated, strategically framed, or "pre-packaged." This can make it challenging to access the full depth or nuance of their perspectives (Harvey, 2011). To mitigate this, I combined open-ended interviewing techniques with firm but respectful probing to encourage participants to expand on initial responses, clarify ambiguities, or illustrate points with concrete examples. This approach helped ensure that coding was grounded not only in surface-level statements but also in the

underlying meanings, tensions, and complexities embedded within participants' narratives (Shenton & Hayter, 2004). Maintaining politeness and respect throughout the process was essential for protecting rapport and ensuring that participants remained comfortable speaking candidly, even when addressing sensitive or politically charged topics.

One of the disadvantages of conducting research that relies on Elite Interviews (EIs) is the challenge of gaining access to these individuals in the first place, as this may be controlled by gatekeepers (Shenton & Hayter, 2004; Welch et al., 2002). However, my current position in the profession along with established trust with some of the initial participants through convenience sampling I believe helped mitigate this to an extent. Another consideration relates to power dynamics, which can significantly influence the researcher and may affect the quality of data obtained. Reflexivity offers an important mitigation strategy, particularly through examining and interrogating the dynamics that arise between researchers and participants (Niu, 2024). Within this study, my shared professional identity as a senior doctor within the NHS mitigated these power dynamics to some extent, facilitating a greater degree of rapport and openness during the research process.

3.6.4 Transcription of Interviews

Transcription is central to methods in qualitative research (Bucholtz, 2000). It is commonly understood as a process that is theoretical, selective, interpretive, and representational (Davidson, 2009). Some scholars also emphasise its political dimensions (Green et al., 1997) and the power relations embedded within transcription practices (Davidson, 2009; Jaffe, 2000), while others highlight how researchers' theoretical positions shape the transcription process (Du Bois, 1991). Transparent reporting of transcription procedures is considered essential (Duranti, 2007; Lapadat & Lindsay, 1999), as it contributes to the overall

trustworthiness of qualitative research (Davidson, 2009). Transcription may take various multimodal forms (Davidson, 2009), but across approaches, the overarching principles involve methodological transparency (Lapadat, 2000) and alignment with the research's philosophical orientation—for example, interpretivism (Green et al., 1997; Mischler, 1991). Reflexivity is also a critical component (Ochs, 1979).

For this study, interviews were conducted using Microsoft Teams, which recorded both audio and video in line with the study protocol. The platform provided near accurate, efficient, real-time transcription and generated a transcript for review at the end of each interview. This approach was preferred over traditional methods such as analogue audio recording followed by manual transcription, which are more time-consuming and labour-intensive, even though these traditional approaches have certain advantages (McMullin, 2023; Davidson, 2009). Similarly, automated transcriptions have limitations, such as occasional inaccuracies, lack of contextual nuance, and challenges capturing overlapping speech or emotional tone. However, I was able to mitigate potential transcription inaccuracies through triangulation, revisiting the recordings as frequently as necessary to verify and refine the transcripts. Furthermore, transcriptions are not neutral artefacts (Bucholtz, 2000); it is an interpretive act which speaks to the theoretical underpinning of the research, rather than a purely mechanical act (Point & Baruch, 2023). Therefore, preparing the computer-generated transcripts for analysis was an essential step. This included making minor corrections (e.g., typographical errors), ensuring the transcript reflected participants' words as closely as possible, anonymising identifiable information due to the sensitive and political nature of the research, and adding relevant contextual notes based on reflexive and field notes (Lapadat & Lindsay, 1998). Importantly, for the reflective thematic analysis part of the method, no coding took place during this stage, and I was careful not to begin

interpreting the meaning of the data prematurely. This was my attempt to emphasise the integrity of the transcription process as an important exercise in its own right, separating it from the first stage of RTA— the data familiarisation phase—by treating these two elements as discrete.

The aim was to prepare a faithful, accurate dataset on which the subsequent analytic phases could be rigorously built, while recognising my worldview and philosophical lens is also at play. Although transcription was carried out automatically via Microsoft Teams, it became clear that there were errors on multiple levels. These ranged from simple spelling mistakes to mis-transcriptions and omissions, perhaps due to the volume of speech and/or accent variations. Consequently, I had to listen to all recordings multiple times to ensure accuracy, alongside anonymising the dataset. This anonymisation focused on removing any information that could individually, or in combination, be used to triangulate the identity of any of the elite participants, who, after all, have public profiles.

3.6.5 Reflections on Interviews

I had several reflections in action—both during the interviews and afterwards. I was struck by the differences in candour and openness shown by the participants overall. I attributed this, in part, to my position as an insider–outsider: an insider because I am a fellow consultant in the NHS with some leadership responsibilities (though not at senior-leader level), and an outsider because I am a research student. Many participants expressed feeling comfortable discussing their life experiences with me, particularly in relation to the research questions, which have political dimensions.

However, I noticed slight variations in openness that appeared, to some extent, to align with ethnic background. The Black participants were generally very open and shared

deeply personal experiences, including historical issues of social injustice that they felt had shaped their journeys into senior leadership. Several emphasised how important they felt this research was—particularly the focus on distinguishing between minority ethnic groups—which they described as an under-researched area in senior leadership. Many also described the interviews as cathartic, enabling them to tell their stories through the lens of their unique experiences rather than through the homogenising category of "minority ethnic doctor." There were moments during the interviews when participants paused to reconfirm anonymity before continuing, which reminded me of the potential high stakes involved for them in contributing to a study with political implications, and the sense of insecurity that some minority ethnic participants experience even after reaching very senior positions.

In contrast, the White male participants did not appear to convey the same sense of insecurity when discussing their roles. It is important to note, however, that this does not imply that they experienced complete security in their positions. Rather, this observation reflects my interpretation of how insecurity was articulated and expressed during the interviews. I also observed that in general they tended to be more circumspect and analytical in describing their journeys and experiences within the NHS and their pathways into senior leadership. Their responses around the research questions ranged from more academic discussions to a limited awareness of the scale of ethnicity-based DA. However, the White female participants largely resonated with the Black participants in terms of their general awareness of differential attainment and their openness to discussing it.

The majority of Asian participants, while aware of disparities, tended to focus more on demography, including the historical, cultural, and legacy differences between Black and Asian populations in Britain over the last three to four decades. Many believed these

long-standing contextual factors play a significant role in the leadership differentials observed between minority ethnic groups.

3.7 Data Analysis

Overview

In this section of the methods chapter, I describe the data analysis process for this narrative study. The analysis comprised three stages of narrative analysis: first, the production of narrative summaries of participants' interviews to manage the initial volume of data; second, narrative re-storying to enhance coherence, preserve context, and uncover deeper meanings within the narratives; and third, narrative emplotment to connect participants' experiences and events into a meaningful whole (Hartog et al., 2020). To move beyond idiographic interpretation, interrogate shared patterns across the dataset, and address the interview questions more explicitly, Reflexive Thematic Analysis (RTA) was subsequently conducted. This approach is described in detail in the following section.

3.7.1 Rationale for Data Analysis

The narrative accounts of nine participants from different ethnic backgrounds were selected for detailed narrative analysis. These participants were chosen for two main reasons. The first relates to where participants spent their formative years prior to obtaining their primary medical qualification. Those who completed their schooling and medical education in the UK share socio-cultural, political, historical, and legacy experiences that were reflected in their narratives, adding depth and complexity to their accounts of current positions and future trajectories. This contrasts with participants who completed their schooling and medical training outside the UK before migrating for postgraduate medical careers and who are now in senior leadership roles as British citizens. While this distinction is necessarily somewhat arbitrary, the narratives of the UK-educated group were characterised by different plotlines, turning points, characters, and elements of narrative identity compared with those of

participants who did not share the same historical or socio-cultural context of growing up in a racialised Britain. The second rationale for selecting nine participants was pragmatic. It was not feasible, within the constraints of a DPhil—such as word limits and time to completion—to present detailed narrative analyses for all 25 participants interviewed in this study. The data was substantial.

The demographic characteristics of the nine participants were as follows: three Asian participants (two male and one female), four Black participants (one male and three female), and two White participants (both male). Of the 25 participants interviewed, 15 met the new selection criteria. The final nine participants were selected primarily on the basis that their narratives addressed all aspects of the research questions. However, all 25 participants who took part in the study were included in the Reflexive Thematic Analysis (RTA). This ensured that a range of voices and perspectives were represented in the final cross-case analysis.

3.7.2 Narrative Reconstruction & Interpretation of Narratives - Narrative Analysis

Narrative analysis refers to the process of constructing coherent stories from data such as interview transcripts and organising them into narrative accounts with plot, sequence, and meaning (Clandinin & Connelly, 2000). This analytic approach emphasises temporality and meaning-making, recognising that people understand their experiences through stories (Bruner, 1991). The key characteristics of narrative analysis therefore include a focus on individual cases, an emphasis on temporal sequencing, the preservation of each participant's narrative integrity, and the construction of coherent narrative accounts (Riessman, 2008). Key events within each narrative are interpreted as part of a meaningful plot in which turning points, motivations, and outcomes are highlighted and then assembled into a coherent narrative account (Ricoeur, 1984).

Practically, this process involved the use of restorying and emplotment, which allowed me to preserve the temporal dimension of these senior leaders' experiences as well as the contextual meanings within each account and across ethnic groups. Narrative inquiry emphasises understanding lived experiences through stories, so maintaining narrative coherence during the early stages is essential (Clandinin & Connelly, 2000; Riessman, 2008), and this guided my analytic choices. For the first level of analysis—narrative analysis—I used both restorying and emplotment.

3.7.3 Narrative Restorying

Clandinin and Connelly (2000) describe narrative restorying as an analytical process in which researchers reorganise and reconstruct participants' accounts into coherent chronological stories while preserving the meaning of their lived experiences. They outlined several variations of this process. In this study, restorying involved watching the video recordings multiple times, reading and re-reading the transcripts, cross-referencing them with the recordings, and analysing these materials to develop a deeper understanding of participants lived experiences before re-telling their stories (Clandinin & Connelly, 2000). Restorying is used for three main purposes. First, coherence, which allows researchers to make sense of life stories that are rarely told in perfect linear fashion, thereby improving readability and interpretability. Second, meaning-making**,** where researchers and participants work collaboratively—implicitly or explicitly—to interpret events that might otherwise appear disconnected or random. Third, empowerment**,** as restorying enables participants to regain a sense of agency and control over how their narratives are represented (Clandinin & Connelly, 2000; Squire & Andrews, 2008).

For each of the nine selected participants, I began by immersing myself in the audio recordings and interview transcripts. To manage the substantial volume of data generated by each participant, I produced a narrative summary of each transcript while preserving both the essence and the voice of the participant (Clandinin & Connelly, 2000). I then organised the events described in the interviews chronologically (Ollerenshaw & Creswell, 2002), typically beginning with participants' reflections on their medical school experiences or earlier formative periods, such as significant secondary school events where relevant.

Subsequently, I identified key events or turning points within each narrative, including experiences of mentorship during early clinical training or significant encounters with patients and care-related challenges. Finally, I linked these events to participants' actions, interpretations, and outcomes in order to construct coherent and structured narrative accounts of each participant's experience, as they related to the research questions (Clandinin & Connelly, 2000).

In this study, I was unable to return the re-storied narratives to participants for subsequent co-construction; consequently, member checking was not undertaken. This was partly due to the time constraints of the DPhil, as well as challenges related to re-accessing participants, many of whom had indicated that they were unlikely to be available for follow-up interviews. In light of this limitation, I took particular care to remain faithful to the original interview data and to ensure, as far as possible, that participants' voices were preserved throughout the narrative re-storying process (Lewis & Hildebrandt, 2019).

3.7.4 Emplotment

Emplotment refers to the process of linking events together into a coherent plot so that they form a meaningful narrative rather than a simple chronological list of happenings (Ricoeur,

1984; Polkinghorne, 1995). Configuring narrative events into a plot provides meaning by explaining the relationships between actions, motivations, and outcomes within participants lived stories (Ricoeur, 1984; Bruner, 1990). In this study, I use emplotment to structure participants' career narratives and illustrate how experiences of mentorship, barriers, and institutional dynamics shape leadership trajectories across different ethnic groups. I believe this approach will support the addressing of the research questions through the insights derived from participant narratives, particularly in relation to the challenges they experience, their reflections, and the solutions they may envisage.

3.7.5 Reflexive Thematic Analysis (RTA)

Although this research primarily focuses on presenting the individual narratives of each participant's journey in their roles as senior leaders in the NHS, I also combined the narratives across all participants to identify similarities and differences across groups (Baxter & Jack, 2008). These cross-case insights, based on the research questions, will be presented in the finding chapters. This approach also enables the identification of overarching themes that cut across the different narratives.

I considered RTA appropriate for this research for three reasons. First, it aligns with the interpretivist and constructivist epistemology underpinning narrative inquiry, which recognises that themes do not simply "emerge" from data but are co-constructed through the researcher's engagement with participants' narratives (Braun & Clarke, 2006). Second, RTA allows for interpretive depth through the use of theoretical frameworks and concepts such as cultural capital and the transformative worldview, which inform the analytical lens applied in this study. Third, RTA is a flexible and accessible tool for qualitative researchers, and as a novice researcher, it enabled me to generate themes across the data while preserving the

integrity of participants' stories and addressing the research questions in line with the aims of this DPhil.

I believe this integrated analytical approach—combining narrative analysis, and RTA—enables the development of both rich narrative accounts of this under-researched group, capturing their lived experiences and leadership trajectories in the NHS, and broader thematic insights into organisational dynamics related to leadership progression, particularly at the highest levels.

3.7.6 Data Analysis – Reflexive Thematic Analysis (RTA) in Practice for this Research

RTA acknowledges that themes do not "emerge" objectively from data but are constructed through the researcher's engagement with it—an engagement shaped by theoretical assumptions, positionality, and reflexive awareness. Consequently, different researchers analysing the same dataset may produce different codes or themes (Braun & Clarke, 2013, 2019). While this is sometimes regarded as a limitation in terms of reliability, it is also a strength: it foregrounds interpretive depth, reflexivity, and the situated nature of qualitative knowledge production. Multiple coders—often used to enhance reliability—were not appropriate within a doctoral project focused on developing the researcher's analytic expertise.

The aim of RTA in this study was therefore not neutrality, but rigorous, reflexive, and transparent interpretation, guided by iterative engagement with the data and supported—but never replaced—by analytical tools such as MAXQDA which was used during coding and organisation of the data. The software enhanced efficiency and organisation, but the interpretive labour rested entirely with me, in line with RTA principles (Nowell et al., 2017; Braun & Clarke, 2021).

Braun and Clarke (2021) set out six phases of reflexive thematic analysis:

1. *Familiarisation with the dataset*
2. *Coding*
3. *Generating initial themes*
4. *Developing and reviewing themes*
5. *Refining, defining and naming themes*
6. *Writing up*

Phase 1 - Familiarisation with the dataset

Before beginning these phases, it was essential to ensure that all transcripts were properly prepared, as described earlier. This preparation process fed directly into this phase. Given the size of the dataset, this proved to be the most time-consuming and challenging stage. In total, I conducted 25 interviews—though 9 participants were chosen for the final analysis, each lasting approximately one hour, generating hundreds of pages of raw transcript data.

During familiarisation, I listened back to each recording multiple times, ensuring accuracy between the audio and the autogenerated transcript, and absorbing the broader context of each participant's narrative (Byrne, 2022). This immersion helped me appreciate participants' meanings more fully. After refining the transcripts, they were imported into MAXQDA for coding. Reflexive memos and fieldnotes—capturing my impressions, observations about tone or non-verbal cues, emotional responses, moments of hesitation, and conversational dynamics—were also uploaded into the software. These notes were essential for contextualising the data and informed later stages of coding and theme development.

Phase 2 – Coding

Codes serve as the "building blocks" of thematic analysis—succinct descriptive or interpretive labels that capture pieces of data relevant to the research questions (Byrne, 2022). After repeatedly reading and listening to the transcripts, I decided to organise coding by

research question. This structure enabled direct comparison of my research questions and interpretive coherence when segments overlapped. This allowed for meaningful comparison of responses across all selected participants for each question.

For the coding, I used both semantic and latent approaches to capture the broad range of responses and descriptions which varied between participants. Semantic codes focus on the explicit or surface meanings of the data, providing a descriptive analysis. In contrast, latent coding moves beyond the surface to identify underlying meanings, assumptions, ideas, and ideologies (Byrne, 2022). The latter offered the potential for a more interpretive stance, which was important given the complexities of the research topic, and it also enabled me to integrate my reflexive notes more effectively.

During initial coding, I remained reflexively aware of my interpretations, ensuring that coding captured participants' voices and meanings as closely as possible. To avoid under-coding, I paid particular attention to nuance, often using in vivo codes (Saldana, 2016) to preserve participants' exact language rather than relying solely on descriptive labels. For example, some of the in vivo code used include *"being in the room to make it happen"* and *"representation at decision making table",* which were used by participant to emphasise the importance of representation which encompasses visibility, power and privilege. At this stage, I coded any segment that might later prove relevant to the analysis, understanding that refinement would follow.

I began by manually creating original codes, and then also use the computer software MAXQDA to help organise the data through several iterations of coding. Multiple codes were frequently applied to the same segment to reflect layered meanings for all participants.

As coding progressed, I continually revisited earlier transcripts, adding, merging, or redefining codes where needed (Kuckartz & Radiker, 2019).

Over time, duplicate or synonymous codes emerged, reflecting the iterative nature of the process and my increasing familiarity with the dataset. To maintain transparency, I tracked the evolution of codes using a separate Excel file, documenting refinements and decision-making (Byrne, 2022). I believe this ensured a clear audit trail and supported the rigour of subsequent phases of theme development. I coded the interviews from Black participants first, followed by Asian participants, and then White participants. This sequence was based primarily on the number of participants in each group, which corresponded to the volume of data generated, with Black participants contributing the largest dataset. I also chose to code by ethnicity to examine whether any thematic congruence emerged within or across groups, which could inform my reflexive, interpretive approach. **Appendix 1** contains a coding document showing semantic, latent, in-vivo and interpretive codes.

Phase 3 – Generating Initial Themes

After several iterations of coding, I began to explore patterns of meaning across the dataset to determine whether any initial themes were emerging. Research Question 3, in particular, produced a high degree of consensus among participants, which was reflected in the coding stage—fewer codes were generated for this question, and the emerging themes were more immediately apparent. Using MAXQDA, I grouped related codes into preliminary clusters which allowed me to explore relationships between codes and the broader ideas expressed by participants. This stage included examining how codes with similar sentiments could be combined to form overarching themes and, where necessary, subthemes (Braun & Clarke, 2021), even in cases where codes reflected contradictory or divergent perspectives. The goal

was to ensure that each theme captured the complexity of participants' experiences while remaining meaningfully connected to the research questions (Byrne, 2022).

Initial themes were collated in a structured table, linking each potential theme to its supporting data extracts. This mapping process helped clarify both the breadth and depth of meaning contained within the dataset and served as a foundation for the more detailed refinement and reviewing of themes in the subsequent phase (Braun & Clarke, 2021).

Phase 4 – Developing and Reviewing Themes

During this phase, I evaluated the quality, coherence, and relevance of the initial themes in relation to the dataset and the research questions. Several guiding questions informed this process: *Is this a theme or merely a code? Does the theme capture a meaningful pattern of shared experience or perception? Is it too broad or too narrow? Is it supported by sufficient and credible data across the dataset? Does it align with the analytic goals of the study?* (Byrne, 2022; Braun & Clarke, 2021).

This stage required multiple iterations and frequent movement back and forth between the coded data, the candidate themes, and the full transcripts. Using MAXQDA, I examined whether the codes grouped under each theme genuinely belonged together, or whether they required further separation, reorganisation, or refinement. Themes that overlapped conceptually were reviewed carefully to determine whether they reflected distinct ideas or whether they were better conceptualised as subthemes within a broader, more coherent theme. I also identified themes that were not sufficiently connected to the research questions or were supported by minimal data. Although these codes were meaningful in their own right, they did not contribute substantively to the central analytic aims of the study and were therefore removed or repositioned. Throughout this process, reflexivity remained central. I

paid particular attention to sections of the data that aligned closely with my personal experiences or expectations, ensuring that I did not privilege these at the expense of participants' more nuanced or divergent perspectives. I found this exercise emotionally challenging. However, I understood that this was crucial, as the emotional intensity and clarity of expression differed across participant groups; while some narratives generated strong, easily coded data, others were more guarded or subtle, requiring careful interpretive work to avoid over- or under-representation.

Phase 5 – Refining, Defining and Naming Themes

Having completed the iterative work of reviewing and consolidating themes, this phase focused on refining the thematic structure and ensuring that each theme was analytically robust, clearly articulated, and meaningfully connected to the research questions. By this stage, a coherent thematic framework had emerged—one that I understood intimately through sustained engagement with the data and multiple cycles of iteration. This familiarity made the process of refining and naming themes more straightforward. See **appendix I** for sample thematic structure. The aim here was to develop clear, analytically meaningful theme names that captured the essence of each pattern of meaning, including underlying tensions, variations, and the breadth of experiences expressed across the dataset (Braun & Clarke, 2021). Subthemes were retained where they added conceptual clarity or captured important nuances within the broader theme. MAXQDA was instrumental in facilitating this stage, allowing me to visually arrange codes, themes, and supporting extracts in ways that made it easier to evaluate coherence and contrast across the structure.

By this point, I had a robust set of supporting data extracts that spoke directly to each theme, including nuance, divergence, and complexity. These extracts will be used illustratively in the findings chapter: they support the analytic narrative without being

required for its coherence (Terry et al., 2017). This distinguishes them from *analytically essential* extracts, where removing the quotation would undermine the logic of the argument (Byrne, 2022). My use of extracts was therefore designed to enhance clarity and illustrate meaning, rather than act as the foundation for analysis.

Phase 6 – Writing up

This phase involved using the final themes to construct meaning and develop a coherent narrative grounded in the data. This is discussed in detail in chapters 4 and 5. I incorporated data extracts to illustrate each theme and to support the overall interpretation, including any areas of divergence. Throughout this process, I ensured that the voices of the participants—often expressed through these extracts—remained central. For each research question, I presented the themes alongside explanations and interpretations in relation to the question. I continued to engage reflexively during the writing process, acknowledging my lack of complete neutrality and the ways in which my positionality-highlighted above— 'shaped' the themes and, to some extent, the overall direction of the research (Finlay, 2002). Across all six phases of reflexive thematic analysis, MAXQDA software was used as a tool for efficiency, organisation, and visualisation. However, it did not replace the interpretive work required to ensure rigour and my agency as the researcher (Nowell et al., 2017; Braun & Clarke, 2021).

3.7.7 Summary of Method and Principles:

- **Research development and research questions:** An interpretivist and social constructivism epistemology was used to explore the perceptions of doctors in senior leadership positions in the NHS from three different minority ethnic groups, drawing on their lived experiences within the organisational setting.
- **Research design:** Narrative inquiry was selected to address the research questions. This approach enabled the co-construction of knowledge and meanings through exploration of participants' multidimensional experiences and stories.
- **Methodological grounding:** The narrative inquiry design chosen for this study is supported by the work of Connelly and Clandinin (2000), who advocate its suitability for exploring lived experience and meaning-making in qualitative research.
- **Sampling:** Purposive sampling—recommended for narrative inquiry—was used alongside convenience and snowball sampling, which were particularly important for reaching this group of elite participants.
- **Data collection:** Data were collected through narrative interviews, guided by the three research questions. Interviews were recorded and transcribed using Microsoft Teams software, allowing participants to shape their own narrative accounts.
- **Data analysis:** A two-level analytic approach was used. First, narrative analysis was conducted for selected participants to construct individual narrative accounts. Second, analysis of narratives was applied across all participants through reflexive thematic analysis to generate themes based on the three research questions.

3.8 Ethical Considerations, Risk and Benefits of Participating in the Study

Ethical approval was obtained prior to commencing this study (appendix II). Approval was granted by the University of Oxford's ethics board following submission of a CUREC application, which included consent forms and a detailed participant information sheet outlining the purpose of the study, the research questions, expectations of participation, and anticipated challenges.

Medical doctors—especially those in patient-facing roles—are familiar with the principles of informed consent, which form a cornerstone of clinical practice (GMC, Good Medical Practice, 2017). Similarly, in research, participants must be provided with sufficient information to offer fully informed consent (Cohen et al., 2018, p.122), including the study's aims, procedures, motivations, intended use, and dissemination pathways (BERA, 2018). Given the sensitive and politically charged nature of this topic, and the seniority of participants involved, it was essential that potential risks and benefits were made clear.

For this study, participants were emailed comprehensive written information outlining all key aspects of the research, including safeguarding and data-security measures (appendix II). These materials were shared after participants expressed initial interest in taking part. Confidentiality was treated as a critical ethical requirement (Cohen et al., 2018, p.115), particularly due to the sensitive subject matter and the identifiable nature of elite NHS roles. Safeguards were therefore implemented throughout—secure storage of recordings, careful preparation and anonymisation of transcripts, secure data handling during analysis (Cohen et al., 2018, p.130), and cautious reporting to avoid inadvertently revealing participant identity through descriptive detail.

3.8.1 Risks, Harm, Benefits and Mitigation

This study involved two main potential risks of harm to participants: emotional burden and the political sensitivity of the subject matter. The emotional burden was most evident among the minority ethnic participants who recounted experiences of overt discrimination—commonplace in earlier decades of British society—as well as the more contemporary forms of subtle discrimination, undermining behaviours, and microaggressions they continue to face. The political nature of the research also required participants to engage in a level of introspection they may not have anticipated. Some White participants, for example, expressed surprise or discomfort upon recognising the scale of DA across the medical career pathway, while others described the interview process as unexpectedly cathartic. These interactions revealed the potential for *moral injury*, as participants reflected on their own roles within systems that may perpetuate inequity, despite their individual intentions. Furthermore, given that I had prior professional connections with some of the participants, there was the possibility of a conflict of interest which I acknowledged at the outset. I declared my personal interest and lived experience in relation to the topic and took care not to conflate these with the participants' accounts or the study findings.

Mitigations included offering participants the option to pause or stop the interview at any time, providing opportunities for further discussion in a confidential and supportive environment, and signposting participants to institutional support services such as Occupational Health (OH) and Professional Support Units (PSU), should they require additional assistance. While the study addresses a significant gap in the literature and holds potential value for informing organisational change, it also places a degree of responsibility on participants to contribute to this endeavour (Kvale & Brinkmann, 2009). Nevertheless,

unsolicited informal feedback after interviews suggested that participants felt comfortable engaging in the process and viewed the research as worthwhile and sensitively conducted.

Other ethical considerations in this research concerned issues of power dynamics and potential imbalances. These dimensions are discussed further in the positionality section, alongside the reflexive strategies used to mitigate them. Power imbalances can arise in qualitative research where participants occupy senior or influential roles, or where the researcher's identity intersects with the subject matter in meaningful ways. In this study, both dynamics were present: participants were elite NHS leaders, and the researcher held a dual insider–outsider position as a senior clinician exploring a topic closely linked to his own lived experience. To manage these complexities, reflexive practice formed a central component of the research process. This included the use of a reflexive journal and analytic memos (Braun & Clarke, 2021), which allowed continuous examination of assumptions, emotional responses, and interpretive decisions. These reflexive strategies helped ensure that interview dynamics, positionality-related influences, and potential power asymmetries were acknowledged and addressed transparently. Ultimately, this reflexive engagement supported the ethical integrity and trustworthiness of the study.

3.8.2 Methodological Approaches to Safeguarding Confidentiality Among Black Minority Ethnic Participants with Limited Senior-Level Representation

The main rationale I adopted was to avoid including any single piece of information, or combination of details, that could be used to triangulate the identity of all participants. This was particularly important given that the interview transcripts often contained rich narratives in which participants drew on their gender, ethnicity and origin, and geographical location to

add depth to the conversation. Proportionally, there are far fewer Black minority ethnic doctors in very senior NHS leadership roles. This was evident during recruitment—particularly the challenges in identifying and accessing suitable participants—which underscores both their underrepresentation and the importance of ensuring their voices were included in this study. As these individuals are highly visible within their organisations and, in some cases, nationally, ensuring their anonymity required exceptional care. To protect participants from direct or inadvertent identification, a rigorous, multi-stage anonymisation process was applied to all transcripts. This included the removal of explicit identifiers such as names, job titles, organisational affiliations, email addresses automatically generated by Microsoft Teams, and any references to specific hospitals, regions, or initiatives. Beyond overt identifiers, further steps were taken to address *indirect* identifiability. This involved modifying or omitting combinations of information—such as ethnicity, gender, and unique leadership roles—that could unintentionally reveal identity (for example, statements like *"as a Black female chief executive in London…").*

This careful anonymisation process continued throughout all phases of coding and reflexive thematic analysis. During analysis and in the final reporting, deliberate decisions were made to avoid presenting excerpts that combined attributes in ways that could be triangulated back to an individual. This included avoiding pairing ethnicity with leadership title, geographical location, or other unique characteristics. In addition, in presenting the narratives of the nine individuals selected for the analysis, I decided to remove gender and pronouns in the report, acknowledge the tension between anonymity and preservation of the storytelling in the narratives. I discuss the rationale for this further in the findings chapter.

I believe these safeguards help ensure that the integrity of participants' narratives was preserved while significantly reducing the risk of identification, thereby maintaining

confidentiality and trust—particularly for Black participants whose demographic visibility made ethical protection both essential and complex.

3.9 Positionality

3.9.1 Researcher's Social Identity and Background

I am a Black minority ethnic individual from a single-parent, working-class household. Although this was where my journey began, I now occupy a very different position as a senior doctor (consultant) in the NHS, working in one of the most prestigious hospitals in the country. I also benefitted from private education—funded by my working-class parent, who placed a strong value on education despite having limited formal schooling herself. This foundation, combined with my aptitude, dedication, and perseverance, has led me to my current position: a middle-class doctor undertaking doctoral study at Oxford. Comparatively, I now occupy position of 'power' and status as demonstrated by the wheel of privilege (Holliman et al., 2024), nevertheless there are immutable characteristic such as race—I am visibly Black—that can at times—in places and situations—negate some of these advantages accrued through social mobility.

3.9.2 Motivation and Interest in the Topic

My initial motivation for undertaking this research was primarily professional. Having reached a significant milestone in my career—becoming a consultant in the NHS, a position that many doctors do not achieve, whether by choice or circumstance—I began exploring pathways into senior leadership. These roles are limited, competitive, and highly sought after. As I considered this next step, it became increasingly apparent that DA exists not only between the White majority and minority ethnic doctors, but also within minority ethnic groups themselves. This observation prompted me to question whether what I was seeing was a local anomaly or reflective of a broader national pattern.

This realisation was reinforced by my own departmental experience: despite working in a highly diverse team, I was the only Black consultant among dozens of consultants. This could be partly explained by factors such as varying specialty preferences among minority ethnic doctors or pipeline issues, such as fewer Black doctors obtaining training grades. However, broader evidence suggests that Black doctors face persistent barriers throughout the medical training continuum (Woolf et al., 2011). These disparities reduce the likelihood of Black doctors reaching consultant level—a pre-requisite for senior NHS position—thereby limiting their representation at this level. This is in contrast to some Asian communities, where medical careers often span multiple generations—creating established pipelines of guidance, support, and cultural familiarity with the profession.

For context, while I am a second-generation Black British individual, I am the first in my family to attend university, let alone pursue medicine. The contrast between my trajectory and the multigenerational professional histories of some other minority ethnic groups prompted deeper reflection. My interest evolved from a professional curiosity into a personal, intellectual, and social justice commitment to understanding why these disparities persist—particularly for Black doctors—and how they manifest at senior levels of NHS leadership.

3.9.3 Assumptions, Beliefs, and Theoretical Stance

Given my background and lived experiences, it is important to acknowledge the worldviews that underpin this research. These perspectives shape how the topic was conceived and developed, and why a qualitative approach—rather than a quantitative or mixed-methods design—was chosen. While quantitative or mixed-methods approaches could have offered a degree of objectivity through measurable data, I selected a qualitative methodology because of its capacity to explore lived experience, meaning-making, and the complex realities embedded within social structures. Epistemologically, the study is grounded in

interpretivism, supplemented by social-constructivist, culture and capital, and transformative perspectives. These frameworks inevitably influence how the research was conducted, how data were interpreted, and how conclusions were drawn. Being explicitly aware of these assumptions and beliefs throughout the research process was essential. Practices such as maintaining a reflexive journal and writing analytic memos I believe helped mitigate the risk of allowing personal worldviews to overshadow participants' voices. These strategies I believe also ensured a deliberate and transparent effort to bracket, interrogate, and reflect on my positionality at each stage of the research.

3.9.4 Relationship to Participants and Field

It is important to acknowledge my existing professional relationships with several of the initial participants—approximately ten in total. These relationships carried both advantages and potential drawbacks for the study. On the positive side, familiarity with this group significantly facilitated recruitment, particularly given the challenges associated with accessing senior NHS leaders. Their willingness to participate, combined with their introductions to colleagues within their professional networks, accelerated the recruitment process and helped build trust with participants who did not previously know me. This trust was crucial given the sensitivity and potential controversy surrounding topics such as race, inequality, and differential treatment. During the interviews, many participants expressed that they felt "safe" speaking openly and candidly because they were talking to someone who understood their professional context and, for minority ethnic participants in particular, shared aspects of their lived experience. However, this familiarity also introduced potential disadvantages, including the emotional complexity of discussing difficult or painful experiences with someone they knew, and the possibility that participants might either moderate or intensify their responses based on our relationship. Similarly, my own

positionality meant that I needed to remain vigilant to avoid letting personal experiences shape the interview process or the interpretation of participants' contributions.

3.9.5 Power, Privilege and Vulnerability

There was no significant power imbalance between me as the researcher and the participants; in fact, the relative proximity of our professional positions—combined with existing relationships in some cases—created a more comfortable interview environment. This familiarity enabled me to ask more direct or probing questions, and to anticipate areas where clarification might be needed due to shared professional context. For example, questions involving intra ethnic nuance and differential, where we observe that Black doctors from West African background appear to feature more than Black doctors from Caribbean background, both within the consultant workforce and at senior leadership levels within the organisation. It also meant that I was less likely to feel intimidated when interviewing senior leaders, an issue that might arise for an external researcher or a junior doctor unfamiliar with navigating hierarchical dynamics. Interestingly, I noticed a marked difference in my comfort levels when interviewing Black participants, including those I had not previously met. These interviews often felt more relaxed, conversational, and fluid, as though there was an unspoken cultural and experiential grounding. In contrast, interviews with some of the White or Asian senior participants who were not known to me felt more formal and structured. I have not fully unpacked the underlying reasons for this difference, but it highlights how shared identity markers—and perceived proximity or distance—shape the relational dynamics within qualitative interviewing.

3.9.6 Influence on Data Collection

I was acutely aware that my presence as a Black consultant—and the nature of the questions being asked—might influence participants' responses, particularly given the sensitive and

political dimensions of the topic. This was especially noticeable when interviewing non-Black participants, where moments of tension or hesitation occasionally arose as individuals appeared to carefully consider how to express their views. This was at times palpable. Some participants seemed cautious about offering counter-perspectives—for instance, suggesting they did not perceive a DA gap affecting Black doctors—as they may have felt uncomfortable voicing such views directly to a Black interviewer. This dynamic was further complicated by the premise of the research itself, which assumes the existence of DA and seeks to explore its drivers rather than question its validity. As a result, some participants may have downplayed or avoided certain opinions, and in a few cases, this may have led to less complete or more guarded responses. A similar dynamic was evident among some Asian participants. While several addressed potential sensitivities directly—such as concerns that the research might imply their senior roles were achieved at the expense of equally capable Black doctors—others navigated the topic more cautiously. In these cases, it occasionally felt as though participants were circumventing aspects of the discussion or their experiences, which may have resulted in partial or constrained data.

3.9.7 Influence on Data Analysis, Interpretation and Reflexive Practices Used

Given the interpretive nature of qualitative research—and my own positionality—it was essential to remain reflexively aware of how my perspectives might shape the analysis. Throughout the analytic process, I consciously acknowledged that complete neutrality is neither possible nor desirable within an interpretivist framework. Instead, I aimed for transparency and reflexive rigor. Using reflexive thematic analysis required me to engage deeply and iteratively with the data, continually questioning how my assumptions, experiences, and theoretical lenses might be influencing the identification of patterns or meanings. To mitigate these risks, I maintained a reflexive journal throughout the analysis,

documenting moments of resonance, discomfort, or surprise, as well as decisions made during coding and theme development. These notes provided a layer of insight and helped ensure that interpretations were grounded in the data rather than driven by personal narrative. Additionally, I revisited transcripts multiple times—both during and after coding—to ensure that emerging themes accurately represented participants' voices, including areas of divergence or contradiction. Even with these measures, I recognise that another researcher might have generated different codes or themes, given the central role of the researcher as the analytic instrument. However, through transparency, reflexive practice, and clearly articulated methodological choices, I sought to uphold the trustworthiness and credibility of the analysis.

3.9.8 Limitation - Researcher as 'Insider-Outsider'

There were clear advantages to my position as an NHS consultant—i.e., a senior clinician and therefore an insider within the system. This facilitated relatively easy recruitment of key participants, as described above. As an insider, I benefitted from existing professional relationships and an informal sense of collegiality or fraternity, even though I was simultaneously operating as an outsider in my role as a research student. This dual positionality proved important and was evident during interviews: several participants explicitly stated that they felt more comfortable speaking openly because they were speaking to me, rather than to an external researcher. Their responses were less guarded, particularly among minority ethnic participants—and especially Black participants. However, this positionality also introduced potential disadvantages. Specifically, there was a risk of over-interpreting data from participants who shared my minority background, and conversely under-interpreting data from White majority participants. Recognising and managing these risks required ongoing reflexivity throughout the research process. I attempt

to mitigate this by keeping a contemporaneous reflexivity journal which was useful, as it helped me remain aware that participants' contributions were subjective experiences—valid and meaningful, yet requiring careful interpretation. It reminded me to be cautious in how I derived themes and meaning from the data and to avoid conflating participants' experiences with my own, whether consciously or unconsciously, during analysis and coding. The use of verbatim quotations and careful contextualisation was paramount in maintaining fidelity to participants' voices and grounding interpretations in the data (Maxwell, 2013; Sandelowski, 1993; Silverman, 2017).

3.10 Chapter Summary

In this chapter, I have detailed the methodology for the research, including the philosophical underpinnings and the methodological framework for this narrative inquiry qualitative study. I have explained the rationale for choosing narrative inquiry and outlined the two-level analytic approach employed—narrative analysis of selected participants, followed reflexive thematic analysis (RTA), which incorporated all selected participants and generated themes across the dataset. The chapter has also comprehensively documented the methods used, including justification for key decisions and reflections on the research process. In addition, I have described the ethical considerations, the benefits and risks for participants, and my positionality as the researcher.

Part III presents the study findings in two chapters: the first provides a narrative analysis of the nine selected participants, while the second presents a cross-case analysis of all participants using reflexive thematic analysis (RTA).

PART III: FINDINGS

Overview of Findings Chapters

Part III of this report, the Findings, is divided into two sections: Part A (Chapter 4) and Part B (Chapter 5). In Part A, I present the narrative summaries and analyses of nine selected participants. I begin by outlining the rationale for selecting these participants from the 25 who took part in the study and provide a reminder of the three research questions. For each participant, I offer a brief introduction while protecting their anonymity, and explain the measures taken to ensure confidentiality and minimise the risk of identification through their rich and detailed narratives. This is followed by a narrative summary and individual narrative analysis, including re-storying, emplotment, and a core summary.

Part B (Chapter 5) presents the cross-case analysis based on a Reflexive Thematic Analysis (RTA) of all 25 participants. This section identifies and explores shared patterns across participants' accounts to address the research questions and inform the study's recommendations. The chapter concludes with a summary and synthesis of the RTA themes and their interrelationships.

CHAPTER 4: PART A - Individual Narratives & Analysis

4.1 Introduction

In this chapter, I present the narrative findings of the nine participants selected based on the criteria outlined in the preceding chapter. These findings consist of individual narratives that trace each participant's life journey and experiences within the NHS, as they relate to the three research questions. Importantly, participants' stories have not been fragmented; rather, they were allowed to narrate their experiences in the way they wished. The individual narrative findings are presented by participants' ethnic grouping and organised alphabetically—Asian, Black, and White. This organisation is not intended to suggest congruence among narratives within the same ethnic group but rather reflects the overall structure of the research and enhances coherence.

For each participant, the findings include a narrative summary supported by selected excerpts from their accounts. Many of the original quotations were long, recursive, and characterised by abrupt transitions. Therefore, I employed a tightening technique (Cristancho et al., 2021) to extract key phrases and integrate them into my own sentences. Ellipses (…) were used to indicate where sections of participants' quotes were removed because they did not add substantive content or consisted of filler words (e.g. "umm, you know"). Where necessary, I also modified the wording of quotations using square brackets (e.g. *[did not]*) to maintain grammatical integrity and clarity, without altering participants' voice, nuance, or meaning (Cristancho et al., 2021). This approach was applied across both parts of the findings chapter.

Each narrative summary is followed by restorying, as outlined in the methodology chapter, and then by an individual narrative analysis. This concludes with an emplotment that

highlights key narrative considerations for each participant, such as turning points. Each participant's narrative concludes with a core meaning that synthesises their overall story.

While narrative analysis offers rich individual accounts, a different methodological approach was required for cross-case analysis; therefore, RTA was selected as it is better suited to addressing the research questions at a collective level. In chapter 5, a Reflexive Thematic Analysis (RTA) of data collected from all 25 participants is presented.

Research Questions (RQ)

- **RQ1:** What are participants' perspectives on the differential attainment (DA) between White majority and minority ethnic doctors in senior leadership positions within the NHS?
- **RQ2:** What are participants' perspectives on the DA between Black and Asian minority ethnic doctors in senior leadership positions within the NHS?
- **RQ3:** What are participants' perspectives on the health implications of DA at senior leadership level in the NHS for minority ethnic communities?

4.2 Rationale for Additional Anonymisation, Confidentiality and Pseudonymisation

I focused on anonymity, a form of confidentiality concerned with keeping participants' identities hidden, as distinct from confidentiality more broadly, which relates to not disclosing what participants have revealed (Saunders et al., 2015). I adopted a "Letter + Number" system (Wang et al., 2026), whereby the letter represents participants' ethnic identity along with an assigned number. For example, A1, B3, and W2, denoting Asian Participant 1, Black Participant 3, and White Participant 2, respectively. This approach was taken to retain participants' ethnicity, as it is central to the research questions and constitutes a key thread running throughout the study. Additionally, this naming strategy invites readers to continually reflect on participants' ethnicity as they engage with the narratives, thereby contextualising the accounts through the lens of ethnic identity. However, this is not intended to suggest congruence among participants of the same ethnicity; rather, the interpretive lens through which the narratives are read is considered important.

Furthermore, I chose not to assign participants pseudonyms, including gender-neutral names such as *Alex* or *Sam*, as this may encourage unfounded generalisations (Bickford & Nisker, 2015) or cultural assumptions (Lange et al., 2016). This is also an acknowledgement that names often carry meaning, history, geography and essence (Lange et al., 2016); they are not just decorative (Bickford & Nisker, 2015). In the context of this research—where ethnicity is a central analytic focus—the use of White Anglo-sounding names, while potentially aiding pronunciation or recall for English-speaking readers (Wang et al., 2026), may undermine the emphasis on ethnic individuality and may be understood as a form of colonising or decolonising practice (Wanjiru & Matsubara, 2017), given the ethnic diversity of the sample. Similarly, I avoided the use of ethnic-sounding names, as these may risk

becoming caricatures of participants. Therefore, I have retained the naming convention described earlier (A1, B1, W1, etc.).

In addition, I removed gender identity and gendered pronouns from all narratives, opting instead for the gender-neutral pronouns *they* and *them*. This decision was intended to further protect anonymity and reduce the risk of triangulating these elite participants, whose senior roles are limited in number and often publicly visible. However, I carefully weighed this decision against the potential loss of narrative nuance, such as differences in male and female experiences within a patriarchal society (Saunders et al., 2015), the possible impact on data integrity (Joseph, 2023), and the loss of contextual detail (Bickford & Nisker, 2015). Ultimately, I placed greater priority on anonymity, acknowledging the ethical and methodological tensions that arise from these competing priorities in qualitative research (Joseph, 2023; Saunders et al., 2015).

4.3 Process of Restorying and Emplotment

For each participant narrative, I focused on establishing a chronological ordering from the narrative interviews to construct a coherent account of their journeys. For some participants, this included experiences prior to entering the NHS, extending as far back as schooling and formative years; for others, the focus was on their time within the NHS, which in many cases spanned several decades. This approach was useful in linking lived experiences across past, present, and anticipated futures. It was also important for addressing the research questions, as it produced rich, detailed, albeit individualised experiences and perspectives. At times, elements of the timeline—particularly issues that continued to affect participants in the

present—were challenging to separate; in such cases, these were presented in the sequence in which participants discussed them.

In restorying the narratives, I consciously removed my own voice in order to preserve the participants' voices and foreground their stories for the reader. Instead, I focused on maintaining narrative flow while remaining faithful to participants' accounts. Throughout this process, I employed 'narrative smoothing' (Spence, 1986), whereby events or aspects that were not directly relevant to the overall story or the research questions were removed. This included ambiguous content or details that could potentially reveal participants' identities or enable triangulation.

Each narrative begins with a narrative summary, drawing on selected excerpts presented in italics to reflect the participant's voice. Within these excerpts, identifying information—such as regions of the country, specific locations, or other potentially revealing details—was removed to further protect participants' anonymity.

4.4 Presentations of Narratives

Below are the participants' narrative analyses, each of which begins with a full narrative summary, followed by restorying—mapping the arc of the story—and then an emplotment analysis. These narratives are presented in alphabetical order by ethnicity (Asian, Black, then White) for the purposes of this report. This ordering does not suggest any hierarchy of importance or narrative congruence; rather, all participants' stories are distinct and grounded in their lived experiences before and within the NHS, as they relate to the study.

4.5 Asian Participants

4.5.1 Asian Participant 1 (A1)

Length of Service in the NHS - >20 years, Current Position – Senior Leadership Role/Director

4.5.1a Narrative Summary – A1

Participant A1 is a British Asian [gender anonymised], UK-trained doctor working at a very senior level in the NHS with over two decades of experience. They presented a measured, reflective, and systems-oriented account of differential attainment. Their narrative is characterised by a tension between acknowledging structural inequality while resisting simplistic or exclusively structural explanations.

A1 begins their narrative by explicitly recognising that differential attainment exists within the NHS generally, and notably in relation to the career progression of doctors, with marked differences between ethnic groups at more senior levels. As A1 stated, *"my thought is that Black numbers drop at consultant level…"* They then attempt to rationalise this disparity by suggesting that attrition at the consultant level—where Black doctors appear less represented than Asian doctors—may relate to career choice i.e. individual factor or preference. Specifically, they suggest that some Black doctors may choose to pursue equivalent roles outside hospital settings, such as becoming General Practitioners (GP) in primary care, a role A1 views as comparable to that of a hospital consultant. As A1 reflects: *"…I assume there are some [Black doctors] lost to primary care… but then I would have expected a reasonable attrition of the Asian population to go off to GP."* In doing so, A1 again acknowledge that differential attainment exists between minority ethnic groups despite their earlier attrition to primary care hypothesis.

A1 situates differential attainment within a broader and more complex socio-cultural context, reflecting on their upbringing in Britain and their family's migration to the UK in the 1960s–70s: *"…it is a complex area…ties into a broader national position…on immigration, and how we adopt cultures."* They described three key influences: their parents' history and legacy; their own experiences of culture, capital, and class; and wider societal narratives about minority ethnic identities. Although A1's parents were immigrants, they were also middle-class professionals from India who arrived in Britain with a middle-class mindset and were able to secure comparable roles, albeit not always in their preferred geographical or specialist areas. A1 recounts how their parents nonetheless faced overt racism: *"…they were told overtly…you're not going to get the position you want…you're Indian and brown, you wear a Sari (a traditional garment worn primarily by South Asian women) …"* A1 contrasts this with contemporary Britain, suggesting such explicit racism would now be considered unacceptable: *"…that would be considered outrageous today."*

They contrast this further with other Asian immigrant groups whose families were not middle-class, suggesting that these differing legacies may help explain variations within minority ethnic groups. A1 notes: *"…a lot of the 1st generation of the Pakistanis came to work in shops and do manual labour…so there is a whole class, cultural, and education status difference which still has some impact today…"* A1 uses this generational comparison to illustrate societal progress over time while implying that discrimination has shifted from overt exclusion to more subtle forms. They highlight how being born abroad can still influence perceptions: *"…not always, but sometimes it's quite easy to tell when someone was born abroad and I do believe consciously or subconsciously, that sometimes works against them…it is reflected in all your conversation and your interview…your application…and the understanding of the softer nuances about communication…"* This framing positions

inequality not as a single phenomenon within the NHS but as embedded within wider societal structures, including migration, culture, and class.

Regarding class, A1 concludes that Britain is a markedly class-based society, permeating both private and public organisations and particularly visible at senior levels: *"Britain has one of the most class-based societies, I think, internationally. This will likely have a factor [on differential attainment]."* They provide examples of how class dynamics may disadvantage different groups, including minority ethnic individuals who have grown up and been educated in the UK. A1 expressed: *"we like to believe we all look like each other and sound like each other and whatnot, I'm not sure that's strictly true. I think you and I might sound more like each other than someone from Bradford… there are a whole bunch of soft social cues that separate us…"* This suggests that regional factors, such as accents, may act as a source of discrimination even among British doctors seeking senior leadership roles.

A1 further broadens their analytic lens to incorporate intersectionality, where ethnicity interacts with other social markers. They draw on their observations of inequalities linked to visible religious or cultural symbols such as the hijab, which they suggest may negatively affect career progression and disproportionately impact minority ethnic doctors. These intersectional factors, they argue, can conflict with dominant White cultural norms: *"…whilst everyone might be British… there are very overt cultural signs above and beyond the colour of your skin and we should embrace and celebrate them. But we've got to be honest…sometimes that will unconsciously highlight the difference between me and you."*

Despite acknowledging broader inequalities, A1 distances themselves from any direct personal experiences of racism in the workplace: *"…I don't feel that I have ever been discriminated against…. I'm very conscious that others have…"*. This introduces an

important distinction between personal trajectory and collective experience, reinforcing the heterogeneity within minoritised groups.

A1 further argues that greater granularity is required to differentiate between minority ethnic groups in order to meaningfully observe differences in attainment. They frame these differences as multifaceted and compounded by the lack of precise categorisation or recognition of the interplay between ethnicity, country of origin, colour, identity, country of birth, or formative years in Britain—factors that may shape accent, cultural fluency, and navigation of a White-dominant professional culture. As A1 notes: *"…first thing is to understand the data…. what exactly does British African or Caribbean descent mean? How do people identify? Is South Asian British Indian or Pakistani or other…but this makes no reference to my skin tone, but it's sort of an allegiance to a country, which may not be accurate"*. This highlights the complexities of minority ethnic identity and classification, which may not align with how individuals perceive themselves and may vary markedly between people. It also highlights the challenges in exploring intra-minority ethnic differentials.

A1 suggests that ethnicity categories could be simplified by adopting terminology used by minority ethnic people themselves, such as *"Black or Brown",* given that skin tone is often the most immediate and immutable characteristic by which minoritised individuals are appraised. However, A1 recognises the tension for the majority White group in adopting this terminology, where it may be perceived as negative, offensive, or even racist: *"…how the government breaks it down doesn't make sense…"*, A1 remarked in reference to UK census categories, *"…they break it down further…but still doesn't mean much…. there is never a box that just says Brown, why? Because would that seem offensive and racist.... it's a*

descriptor…I would refer to myself as having Brown skin. In the globally perceived shades…. we're all three colours…. you can say Black, but we can't say Brown…"

Finally, A1 reframes diversity as beneficial beyond representation, highlighting the value of proportional representation at senior leadership levels in the NHS for minority ethnic communities: *"I've always thought it's good that we represent our population..."* A1 extends this further, advocating for diversity as an inherent good for any organisation, regardless of the ethnic composition of the population it serves: *"…what we should be saying is that diversity would be a good thing anywhere…. not just in heavy minority area. I'm saying that even in the North of England that's all White…the message has to be diversity in itself. It is a good thing that creates diversity in thought."* A1 ultimately positions diversity not only as an equity imperative but also as a functional and organisational asset.

4.5.1b Narrative Restorying – A1

Participant A1 is a British doctor with more than two decades of NHS experience who has progressed to a senior leadership position. Their account of differential attainment is characterised not by certainty, but by careful reflection, moments of self-questioning, and an appreciation of the issue's complexity. A1's narrative can be restoryed as a journey through generational change, personal positioning, and systemic reflection.

A1 begins from a historical baseline of overt discrimination, illustrated through their parent's experiences, where race, gender, and visible markers of difference directly constrained career opportunities. This earlier context forms the backdrop against which contemporary progress is understood. A1 explains disparities between Black and Asian doctors partly through structural and career-pathway differences—such as the movement of some Black doctors into general practice—which may contribute to lower representation in hospital-based leadership roles. However, they acknowledge that this explanation is speculative and insufficient on its own. In contrast, A1's own career has taken place within a system that feels more inclusive, yet still unequal; they do not perceive having been directly discriminated against, suggesting that while structural barriers have become less overt, they have not disappeared.

As the narrative develops, A1 shifts from overt discrimination to subtler processes of inclusion and exclusion, particularly those relating to cultural alignment. They emphasise how communication style, accent, and behavioural norms influence perceptions of competence and belonging. A central concern is the inadequacy of broad ethnic categories currently used by UK government in census and other terms such as "Black, Asian and Minority Ethnic (BAME)." This leads to a call for greater granularity, as A1 argues that such umbrella terms obscure meaningful within-group differences and may conceal specific forms

of disadvantage. For them, understanding differential attainment demands a more disaggregated and nuanced approach or adopting the simplicity of *'Brown & Black'*, which South Asian and Black communities already use to describe themselves, and speaks to the immutable visible characteristic—skin colour.

A1 then extends their analysis to cultural and social processes more broadly, suggesting that progression into leadership roles depends not only on competence but also on alignment with dominant cultural norms. They highlight subtle yet consequential factors—such as communication, demeanour, and cultural familiarity—that shape how individuals are interpreted in professional contexts. These dynamics, often unconscious, influence recruitment, promotion, and inclusion.

The narrative further widens to consider class and social background, reinforcing that differential attainment is multi-layered and intersectional. A1 distinguishes between international medical graduates (IMGs) and UK-trained minority ethnic doctors. They argue that international graduates may face additional challenges related to cultural adaptation and differing professional norms, particularly in communication. At the same time, UK-born minority doctors are not insulated from disadvantage; class, accent, religion and regional identity may still influence how they are perceived and assessed.

Throughout the account, A1 maintains that differential attainment is shaped not solely by race but by intersecting factors including class, geography, and migration history. They stressed that British society remains highly class-based, and those social cues—such as accent and mannerisms—can affect perceptions of suitability for leadership roles. Although A1 states that they have not personally experienced discrimination, they recognise that others,

including their parent, have done so. This generational lens enables A1 to acknowledge significant progress while also recognising persistent structural inequities.

A recurring theme in A1's narrative is the role of adaptation. They argue that individuals from minority backgrounds may need to adjust their communication, behaviour, and self-presentation to navigate professional settings effectively. A1 frames this not as loss of identity but as a pragmatic social competency that operates across contexts.

When considering solutions, A1 emphasises the need for greater awareness, more robust data, and more nuanced analysis. They argue that both individuals and institutions share responsibility for tackling disparities, and that meaningful progress requires an acceptance of the issue's complexity rather than reliance on simple explanations. They adopt a balanced position: while systems must address structural inequities, individuals may also need to develop strategies to navigate existing cultural expectations. The narrative concludes with a reframing of diversity, moving beyond representation to articulate its broader organisational value. For A1, diversity is not only an equity imperative but a driver of better decision-making and improved organisational performance.

4.5.1c Narrative Emplotment – A1

Emplotted Narrative: "From Assumed Equity to Reflexive Awareness"

Orientation: Assumption of complexity but relative fairness - A1 begins their narrative from a position of believing that disparity exists, but without fully understanding the mechanisms behind it. They also note that they have not personally experienced discrimination during their NHS career or progression into senior leadership. However, A1 acknowledges historical overt racism within the NHS, drawing on their mother's experiences, and recognises that such discrimination has evolved into more subtle contemporary forms.

Complication: Questioning simplified explanations - A1 challenges dominant narratives by rejecting "BAME" as a meaningful or analytically useful category, arguing that broad labels lack granularity and obscure important inequalities. Instead, they refer to terminology used within minority ethnic communities—such as "Black and Brown"—to capture more immediate and recognisable distinctions. A1 also introduces cultural, class-based, and social complexities as important factors influencing differential attainment among minority ethnic doctors, particularly at senior leadership levels. They highlight differences between British-born doctors of varying ethnic backgrounds, shaped by intergenerational factors such as the social class and migration histories of first-generation families. While acknowledging the persistence of differential attainment, A1 emphasises the absence of a clear, singular explanation and underscores the inherent uncertainty surrounding the issue.

Rising tension: Subtle bias and Cultural "fit" - A1's narrative develops around key concepts including unconscious bias, communication norms (such as regional accents), cultural alignment with White majority expectations, and subtle social or cultural biases. They also note intersections of race, class, and identity—such as visibly religious markers—which may

negatively influence perceptions of suitability. These dynamics reframe inequality as soft, embedded, and difficult to detect.

Turning point: Reflexive disruption - A critical moment arises when A1 realises the underrepresentation of Black consultants while reflecting on senior leadership within their local organisation. This moment prompts discomfort, self-reflection, and awareness of their own blind spots. It highlights the systemic and relational nature of inequality and draws attention to the tension between individual adaptation and structural change. This recognition of hidden inequality crystallises a key insight for A1: inequality exists but is not always visible—even to those who consider themselves aware.

Resolution: Awareness as the first intervention - For A1, the narrative resolves with a call for greater recognition of disparities, including more granular data to differentiate between minority ethnic groups and better identify inequalities. They propose a shared responsibility between senior leadership and individuals—who retain agency—while urging leaders to develop greater cultural awareness and an appreciation of the complexity of differential attainment.

Core Narrative Meaning

A1 constructs differential attainment as a complex and evolving phenomenon, shaped by historical inequality and sustained through subtle cultural, social, and structural processes. They argue that differential attainment persists not only because of structural barriers but also due to its partial invisibility. Subtle cultural norms, unconscious bias, and aggregated data obscure meaningful differences, making reflexive awareness an essential first step toward change. Addressing these disparities, A1 suggests, requires both systemic reform and individual navigation, with diversity reframed not merely as an equity imperative but as a

broader organisational strength. Within A1's narrative, there was limited exploration of the wider implications of differential attainment and underrepresentation for the broader minority ethnic community. This is not to suggest that A1 has not experienced these issues throughout their career journey in the NHS or in their role as a senior leader within the organisation; rather, their narrative focused primarily on differential attainment between minority ethnic doctors within NHS leadership.

4.5.2 Asian Participant 2 (A2)

Length of Service in the NHS - >20 years, *Current Position - Senior Leadership Role/Director*

4.5.2a Narrative Summary – A2

Participant A2 is an Asian (other), UK-trained doctor with over two decades of NHS experience. They construct their narrative through a deeply personal, intergenerational lens, linking past racism to present-day structural inequality.

The narrative begins with a family origin story, positioning A2 within a lineage shaped by migration, social mobility, and racism. A2 reflects with both pride and sadness that their father, who came from a deprived community and successfully became a doctor almost against the odds. However, A2 felt that the significance of this achievement was somewhat diminished when their father arrived in the UK to practise medicine and experienced racism: *"…he came in the 70s, he was a doctor…proud…came here and experienced extreme racism, as a doctor, from his colleagues…"* This had a strong influence on how A2 was raised to see the world and what to expect: *"…I was brought up with a very obvious awareness of racism within the NHS…when I went to med school, my dad's advice was 'keep your head down…don't speak too much to the consultants.'"* Here, A2's formative years establish an orientation of cautious separation and mistrust toward the majority White population, who are often the gatekeepers to career attainment and opportunities within the NHS. Interaction with them, therefore, becomes both necessary and fraught for career advancement.

Despite these early experiences, A2 describe themself as resilient, with a positive mindset and strong sense of purpose: *"…I want to make changes. I want things to be better…"* They describe their early years in the NHS with hope—willing into existence a

different experience from that of their parent—only to be confronted with the reality of differential treatment that persists in the organisation: *"…I hoped I could be a bit of a change agent, but certainly in my registrar years [resident doctor], I think White doctors and Asian doctors and Black doctors were treated differently…I knew this growing up in the NHS [referring to their parent's experience]…I think there is just systemic racism, and I think there still is."*

Here, A2 expresses a tone of resignation regarding the structural and systemic factors that allow racism to persist within the organisation. A2 further reflects on conversations with their father about leadership attainment in the NHS, which had highlighted additional challenges for minority ethnic doctors: *"…we talked about the glass ceiling…it's difficult to break through."* This connects to A2's present-day experience in senior leadership and their observations of differential attainment between White and minority ethnic leaders in the NHS: *"…I look at the corridors that we walk around…they are predominantly White men on the walls [referring to pictures of past leaders] …I think we've improved to have White females on the wall, but we don't necessarily have people of colour…at the very senior management level."*

A2 discussed the long-term effects of the pervasive and structural nature of this issue on the psyche of minority ethnic doctors, noting that although the evidence is widely acknowledged, deep systemic problems continue to prevent meaningful change and add layers of complexity that make tangible solutions difficult to identify. As A2 reflects, *"…people are more aware…but there are some endemic systemic issues. Sadly in 2024/2025 [at the time when the study was conducted] …I still feel that the NHS is racist."*

A2 expressed frustration at the absence of clear solutions, underscoring the enormity of the challenge: *"…it's difficult to tease out why they exist and why they're so pervasive."* However, A2 suggested that potential solutions may lie within the problem itself, describing a kind of *'catch-22'*: increased minority ethnic representation—particularly achieving a critical mass in leadership—may be essential to change, yet remains difficult to achieve within a system shaped by majority-White gatekeepers. As A2 notes, *"…if you've not seen Black faces, Brown faces in certain areas…maybe you think that's not a place for you…so it's self-perpetuating…and people [minority ethnic] are not being pushed forward for these positions…even though they are there and able."*

A2 also highlighted the importance of agency on the part of minority ethnic doctors aspiring to leadership roles, suggesting they proactively seek mentors and opportunities both within and beyond their local organisations. They emphasised the value of networks—including social media—in connecting with mentors, advocacy groups, and sources of group power and inspiration: *"…social networks allow you to hear the voices of other people like you… that can inspire."* Returning to their characteristically optimistic outlook, A2 expressed hope for the future of the NHS with regard to minority ethnic representation. They situated this optimism in changes they believe have been occurring over the last decade, which they feel will translate into improved representation at senior levels. These changes include greater minority ethnic representation (indeed, overrepresentation) at the point of entry into medical school, the ubiquity of social media and AI—which they believe reduce local barriers to mentorship, affiliation, advocacy, and access to inspirational figures—and broader societal shifts towards equality and diversity: *"…I'm optimistic…before the end of my career…we would see more Black students, lecturers, professors…than we certainly see today…I'm optimistic that trend will go up…there is a lag."* A2 further attributed this optimism to a

generational shift among gatekeepers, noting that some of those historically occupying the top of the hierarchy may be ageing out, making room for more socially conscious and culturally aware leaders: *"…there is a generation of that kind of public school-educated middle-class…White men…but that room is opening up to others and I think we are seeing that come through."*

Finally, A2 extended their optimism to the emerging critical mass of exemplary minority ethnic doctors progressing through the system, suggesting that their talent, skill, and sheer presence may increasingly challenge institutional and structural barriers: *"…there are good people that I think not for much longer can be overlooked because it's going to be very obvious…they were outstanding…"* A2 added that today's social media landscape may also facilitate greater accountability in cases of perceived injustice. A2 concludes their narrative by powerfully connecting leadership inequality to real-world health outcomes, citing COVID-19 as an example where the lack of representation at senior leadership levels contributed to differential health outcomes for minority ethnic communities, including minority ethnic staff working in the NHS. As they reflected: *"…I think our generation will always use COVID as the great example of failure of leadership due to lack of minority ethnic representation at decision-making level…when I saw faces of colleagues who died…it breaks my heart to think where were the people who were meant to advocate for us [minority ethnic staff]…you know, it's the old expression 'you've got to be in the room where it happens'"* This reframes representation as not merely symbolic, but clinically and socially consequential.

4.5.2b Narrative Restorying – A2

Participant A2 is a second-generation Asian doctor whose professional identity is shaped by a strong intergenerational narrative of migration, social mobility, and racial inequality. Their father, who migrated to the UK in the 1970s as a doctor, experienced overt racism from both patients and colleagues, and this history profoundly influenced A2's early understanding of the NHS as a racialised institution.

Growing up with this awareness, A2 was advised to adopt a strategy of caution—keeping their head down and avoiding confrontation. Over time, however, A2 developed a contrasting orientation, aspiring not only to succeed within the system but also to change it. This tension between inherited caution and personal ambition forms a central thread in their narrative. During their own training in the early stages of their career, A2 perceived differential treatment between White doctors and minority ethnic doctors, reinforcing their belief that systemic inequalities persisted beyond the overt racism experienced by the previous generation. They described the NHS as an institution where racism has evolved rather than disappeared—becoming less overt but still embedded in structures and practices. Rather than dampening A2's optimism, this understanding appears to deepen their awareness of the structural complexities underpinning differential attainment and inequality in the NHS.

A2 identifies a clear pattern of stratification within the workforce, where minority ethnic staff are well represented at junior levels but increasingly absent at senior levels. They interpret this not as a coincidence but as evidence of structural barriers that limit progression. Central to this process is the concept of a "ceiling," which functions both as an external constraint and an internalised expectation shaping career aspirations. This idea had been introduced to A2 during childhood, as their father had cautioned them about the limitations placed on minority ethnic doctors within the NHS.

In their current position as a senior leader, A2 argues that underrepresentation at senior levels is self-perpetuating: when individuals do not see people like themselves in positions of authority, they may question whether such roles are attainable or appropriate for them. This creates a cycle through which inequality is reproduced across generations. However, A2 recognises that the ubiquity of social media and technological advancement has increased visibility of minority ethnic leaders more broadly, allowing aspiring leaders to seek inspiration, support, mentorship, advocacy, and guidance beyond their immediate organisations.

A2 also highlights the role of cultural bias and unfamiliarity in shaping perceptions of competence and suitability. They describe how behaviours such as communication style, tone, and language are interpreted through a racialised lens, leading to unfair assessments of minority ethnic candidates. These biases, often subtle and unconscious, accumulate to produce significant disadvantage. In recruitment and promotion processes, A2 observed that decision-makers frequently favour candidates who resemble themselves in background, experience, or identity. This homophily reinforces existing patterns of representation and limits opportunities for those outside dominant networks. Despite these challenges, A2 remains optimistic about the potential for change. They emphasise the importance of visibility, mentorship, and structural interventions to support progression, and highlight the role of professional networks—including social media—in expanding access to role models and opportunities.

Finally, A2 connects workforce inequality to broader societal consequences, arguing that a lack of representation in leadership can lead to poorer decision-making and worse health outcomes for minority communities. They cite examples from COVID-19 and

women's health to illustrate how the absence of diverse perspectives can lead to systemic failures.

4.5.2c Narrative Emplotment – A2

Emplotted Narrative: "From Inherited Racism to Transformational Agency"

Orientation: Intergenerational Inheritance of Racism - A2's story begins with their father's migration to the UK and his experiences of overt racism within the NHS. The cautionary advice he offered—shaped by these encounters—instilled in A2 an inherited awareness of discrimination. This positions racism as both historical and foundational within A2's narrative.

Development: Persistence Despite Apparent Progress - Throughout their career, A2 maintained an optimistic outlook despite observing discrimination, racism, and differential career trajectories based on ethnicity. Although A2 acknowledges that overt racism has declined, they note that subtle and systemic forms persist, with inequalities continuing to manifest in new and complex ways. This creates tension within the narrative, particularly in relation to the concept of a "glass ceiling" for minority ethnic doctors and the internalised self-limitation that can accompany it. A2's account intensifies around this idea of a persistent "ceiling," ongoing underrepresentation, and reduced aspirations shaped by perceived barriers.

Turning Point: Emergence of Agency - A2 recognises that bias, limited access to networks, and a lack of representation collectively reproduce inequality. However, they diverge from the inherited stance of caution passed down from their father. Rather than "keeping your head down," A2 embraces leadership, visibility, and active change-making. They emphasise that minority ethnic doctors aspiring to leadership roles in the NHS possess agency and can draw on external resources—such as social media and AI—to support their development, rather than relying solely on traditional, locally based mentorship models.

Resolution: Hopeful but Conditional Change - A2's narrative concludes with optimism and a commitment to advocacy. They argue that meaningful progress requires recognition of the structural forces that perpetuate differential attainment, alongside intentional action from senior leadership and organisational gatekeepers.

Core Narrative Meaning

Differential attainment is shaped by an intergenerational cycle of structural racism, internalised ceilings, and institutional bias. Yet A2 suggests that these patterns are not fixed; they can be disrupted through increased visibility, agency, access to mentoring networks, and deliberate systemic reform.

4.5.3 Asian Participant 3 (A3)

Length of Service in the NHS - >20 years, *Current Position – Senior Leadership Role/Director*

4.5.3a Narrative Summary – A3

Participant A3 is a British Asian who is visibly religious, with decades of NHS experience and currently in a senior leadership role. Their narrative is deeply reflective and intersectional, foregrounding race, gender, religion, and visibility as key dimensions shaping leadership trajectories in the NHS. A3 also presents a narrative shaped by structural barriers, particularly during the transition from consultant level to senior leadership.

A3 begins their story by reflecting on how differential attainment was not initially salient during their early training. As with many doctors in training, their attention was focused on immediate progression and the demands of postgraduate medical training—often balancing full-time work with the challenges of examinations required for advancement. At the time, A3 did not view these issues as interconnected, describing them as something they *"did not actively notice"* early in their career: *"...as a trainee, I tended to look at the people in the level below me rather than levels above me."* As they progressed through their career, however, retrospective reflection brought awareness of the absence of minority representation at senior levels: *"...no particular person stands out as having been from a minority ethnic background...who was in that kind of role [senior leadership] or above a consultant level."* Their reflection continued, drawing on concepts of intersectionality and representation in NHS leadership: *"...first thing I would say...I think my other reflection would be as a Muslim person [mentions religion] ...I don't think I have ever seen anybody like me at that level...and I was cognisant of that fact."*

When discussing their broader experience of leadership in the NHS, A3 introduces nuance in their observations of the composition of senior leadership, particularly regarding

gender and race. They also highlight differential attainment between doctors and non-doctors at this level of senior management. A3 notes that doctors are present in both executive and non-executive senior leadership roles but acknowledges that some roles—such as Chief Financial Officer or Chief Technology Officer—require specialist expertise and may not be suited to doctors. However, among roles that are suitable for doctors, A3 observes a disparity in attainment favouring non-doctors. Reflecting on the composition of doctors who do reach senior leadership, A3 suggests that disparities are often more pronounced by gender than by race: *"…what struck me is that those roles [senior leadership] were occupied by men rather than women."* They also acknowledge that race and ethnicity are important factors: *"…the people of colour aspect is equally important, but even that is often male-dominated…when I look across [senior leadership spaces], you do see the colour difference, but you also see the gender difference at that level."*

A key analytical contribution from A3 is their emphasis on intra-ethnic variation, particularly within the Asian minority ethnic group, which they note is a large and diverse diaspora: *"…this extends to people with Chinese, Japanese, Korean origins… and those from other areas of the world."* However, A3 recognises that the largest minority ethnic populations within this broad category in the UK are those from South Asian backgrounds. They suggest that the differences *between* these groups are also significant, and that in their experience one group appears to benefit more than others: *"…I wonder if there's a difference between Pakistani and Indian backgrounds…because for me, I see people from an Indian heritage more in these senior roles."* A3 contrasts this with Black representation, noting the different migration histories of Caribbean and African communities in Britain. While Caribbean heritage communities have a longer history and broader societal representation, this pattern is not reflected in NHS leadership. In A3's experience, doctors of Black African

origin are more represented, particularly in senior NHS leadership roles. Although A3 observes this differential, they express frustration at the difficulty of accessing sufficiently granular data to evidence it. They argue that current data collection practices homogenise minority ethnic groups—often through acronyms such as BAME—and fail to distinguish between, for example, subgroups within the large Asian category or between African and Caribbean groups: *"…if you look at…Caribbean and African heritage as well…we do have this tendency to lump people together… though some are doing better than others."*

A3 attributes differential attainment to a combination of perception, structural barriers, and internalised expectations, where minority ethnic doctors question their authenticity, value, and 'fit' within NHS leadership: *"…do I look right? Am I the right fit?"* They suggest that the lack of minority ethnic representation at senior levels contributes to excessive self-scrutiny, doubt, and self-deselection**,** whereby minority ethnic doctors choose not to apply for leadership roles. This perpetuates existing disparities: *"…some people just don't think they have the face for the role…that may well be because of their colour or being visibly other…so you then choose to stay away…people don't feel these roles are for them, leading to a deterrent effect…why would you want to put yourself through that?"*

A3 also describes the impact of structural and systemic barriers, including unspoken exclusivity within senior leadership, where positions—starting from consultant level—are often locally guarded, with internal candidates more likely to be appointed than external applicants: *"…it is very rare for a new entity to be able to come in…take people by storm… and be put into these positions."* A3's suggested solutions include encouraging and challenging individual trusts to *"recognise people for their talents only"* and to implement visible mechanisms that demonstrate that *"they are welcoming and embracing…and it's actually somewhere you want to be,"* including increased minority ethnic representation at

senior levels. This adds both nuance and complexity to the experience of minority ethnic staff seeking career progression and highlights the barriers that remain unaddressed by organisational gatekeepers.

A3 discusses the interplay between culture, cultural practices, socialisation, and networking in shaping access to leadership roles and the ease or speed of progression. This is particularly relevant for doctors from minority ethnic backgrounds, especially those with visible intersectional identities related to culture or religious belief—both protected characteristics under the UK Equality Act (2010). A3 provides examples of how everyday culture and socialisation, both within and outside the workplace, can influence doctors' opportunities: *"there is an element of networking…and some of those things involve alcohol and going out…having drinks in a particular setting which may not align with your belief or culture…so that naturally puts you at a disadvantage…and if you're not seen in the right place…you're not going to be talked about…"* A3 suggests that this may lead to opportunities being lost by omission rather than malice: *"…people just don't know you in the same way."*

Through A3's journey into management and senior leadership, they noted that leaders can become distanced from some of the everyday concerns that affect their staff, including issues related to career pathways. This, they emphasised, is not due to a lack of care or interest, but rather to the additional requirements placed on senior leaders, who must focus on more strategic elements of their roles, including legal duties. Although these responsibilities do not remove leaders from staff wellbeing concerns, they can reduce day-to-day visibility. A3 provided an example of a monitoring framework requiring senior management to track disparities in career progression by ethnicity and implement measures to address these issues: *"…one of the difficulties is when you get into senior leadership roles, because you're more strategic, you don't have the same visibility that you used to."* However, A3 expressed

frustration that although such frameworks have existed for at least a decade, differential attainment in leadership based on ethnicity remains significant within the NHS. While acknowledging some improvements, A3 argued that real progress requires greater openness, transparency, and intentional engagement with all stakeholders—including junior doctors aspiring to leadership roles. As A3 stated: *"we are not having these conversations openly…we need more transparency and targeted talent development… identifying individuals actively, not by passive invitations."*

Finally, A3 discussed the importance of minority ethnic representation in senior leadership and the positive impact this can have on communities. They referred to examples from the COVID-19 pandemic to illustrate this point: *"…so if you think about the lack of PPE (personal protective equipment) provision and the risk that people from minority ethnic backgrounds were put at…just from a workforce point of view… a more powerful representation at the highest tier would have made a difference to outcomes [for minority ethnic workers]."* A3 argued that insufficient representation contributes to poorer workforce protection and wider health inequalities affecting minority ethnic communities. In considering solutions, A3 recognised that while increasing minority ethnic representation at senior levels is important, the finite number of positions at this level means it cannot be the sole intervention. Even when one or two minority ethnic leaders are present, their ability to influence outcomes may be limited. A3 therefore suggested that meaningful progress requires better relationships with community groups—including smaller, underrepresented communities such as the Somali community: *"we need a sort of marketplace where you invite different groups and charities in the local community to come and tell us [senior management] what they are doing and what is needed…"* A3 concluded their narrative by emphasising that some individuals require "championing", reflecting on their own

experiences of mentorship throughout their career. They highlighted that support from mentors—often White senior colleagues—was instrumental in helping them reach their current leadership position.

4.5.3b Narrative Restorying – A3

Participant A3 is British and visibly religious, with over 25 years of experience in the NHS, and currently holds a senior leadership position. Their narrative provides a nuanced account of differential attainment shaped by intersecting identities, including ethnicity, gender, and religious expression. A3's story unfolds as a gradual shift from limited early awareness to a critical recognition of the structural and intersectional barriers that shape progression within the NHS.

In reflecting on their early career, A3 describes how issues of representation were not initially salient; their focus was primarily on immediate progression rather than the wider architecture of leadership. However, with hindsight, A3 recognised a striking absence of individuals from minority ethnic backgrounds—particularly those who shared their identity as visibly Muslim—within senior leadership roles. A3 identifies that representation within leadership is uneven, not only between White and minority ethnic groups but also within minority ethnic categories. They observe that individuals from Indian backgrounds appear more frequently in senior NHS roles than those from Pakistani backgrounds for example, highlighting the importance of examining intra-ethnic differences. As their narrative develops, A3 begins to interrogate why these disparities persist. They identify perceptions of "fit", shaped by entrenched leadership norms, as a significant factor influencing both opportunities and aspirations. A3's account also emphasises how these barriers operate internally as well as structurally. Narrow expectations about who "looks right" for leadership shape not only organisational behaviour but also the decisions individuals make about whether to pursue such roles at all. These perceptions are reinforced by visible leadership demographics and organisational culture. A3 therefore attributes disparities in leadership attainment to a combination of structural exclusion and internalised

expectations. Minority ethnic individuals may self-select out of leadership pathways due to perceptions of exclusion, anticipated scrutiny, or feelings of not belonging. These dynamics are sustained by the limited diversity within existing leadership structures. A3 emphasises that responsibility for addressing these disparities lies primarily with senior leadership. They argue for proactive talent management strategies that identify, support, and develop individuals from underrepresented backgrounds, rather than relying on passive systems in which individuals must independently navigate opaque and complex pathways.

A3's narrative also highlights the role of informal networks in career progression. Social activities and networking events—often centred around cultural practices such as alcohol consumption—can inadvertently exclude those whose values, beliefs, or preferences differ. Such exclusion limits access to influential relationships and informal learning that often shape leadership opportunities. For A3, Mentorship and sponsorship emerge as critical mechanisms for progression. A3 distinguishes between general mentorship and active advocacy, noting that individuals who are championed by senior leaders are significantly more likely to progress. They reflect on their own experience of being supported by a mentor who intentionally addressed issues of inequality, which had a substantial impact on their development and approach to leadership.

A3 further connects disparities in leadership representation to broader consequences for healthcare delivery. They argue that the absence of diverse voices at decision-making levels contributes to blind spots in service design and policy implementation, as seen during the COVID-19 pandemic, where the needs of minority ethnic communities were not consistently centred in strategic decisions.

A3's personal journey underscores the challenges faced by minority ethnic individuals, including early discouragement and structural barriers that shape access to leadership roles. Despite these challenges, A3 emphasise the importance of resilience, supportive networks, and proactive engagement. Finally, A3 links representation to wider systemic outcomes, arguing that a lack of diversity at senior levels leads to missed opportunities to address persistent inequalities in healthcare delivery. Their narrative portrays differential attainment as a multifaceted issue requiring systemic intervention, cultural change, and intentional leadership practices to achieve equitable representation and opportunity across the NHS.

4.5.3c Narrative Emplotment – A3

Emplotted Narrative: "Negotiating Visibility, Belonging, and Structural Barriers"

Orientation: Early Career Without Awareness - A3's narrative begins with a limited awareness of leadership disparities in the NHS or differential attainment between minority ethnic doctors. This was because A3's focus remained on their training and immediate progression. Consequently, there was no early recognition of minority underrepresentation or the lack of visibility of senior leadership structures.

Development: Realisation of Absence - The plot develops through A3's growing recognition of the limited minority representation at senior levels, including the lack of visible role models and, in particular, the absence of minority ethnic and visibly religious leaders. A3 also noticed a gender imbalance within leadership roles as their career progressed within the NHS. Rising tension is conveyed as A3 describes the intersectional exclusion of race, gender, and religion that shaped their experience in the organisation. They expressed concerns about whether one's "face fits," along with internal questioning of belonging and suitability, which led to self-deselection from leadership pathways due to perceived barriers—creating a growing deterrent effect for aspiring to senior roles. Furthermore, A3 observed exclusion from informal networking spaces conducted under White social norms, and a perception of needing to work harder for the same recognition.

Turning Point: Recognition of Structural Responsibility - A critical change occurred when A3 recognised that inequity was systemic—rather than an individual failure—acknowledging that NHS structures do not adequately support the progression of minority ethnic doctors. This shift prompted A3 to think about strategies for change, including an awareness of how

mentorship, networking, and organisational support shape career progression, and how intersectional disadvantages might be addressed.

Resolution: Advocacy for Structural Change - The narrative resolves with a call to action and a sense of optimism. A3 identified solutions at both the strategic level and the individual doctor level. They emphasised the need for active talent management strategies, the importance of mentorship and sponsorship, increased visibility and representation in leadership, strengthened engagement with diverse communities, and intentional organisational interventions to disrupt inequality.

Core Narrative Meaning

A3 constructs differential attainment as an intersectional and structurally reinforced phenomenon—encompassing perceptions of belonging, exclusion from informal networks, and the absence of active sponsorship—which disproportionately affects minority ethnic individuals. These dynamics arise where a lack of representation, cultural exclusion, and organisational practices converge to shape both access to, and aspiration for, leadership roles. The consequences extend beyond individual careers, influencing wider healthcare systems and the communities they serve. A3 argues that meaningful change requires intentional, top-down interventions supported by culturally intelligent leadership practices and a sustained commitment to equity at every organisational level.

4.6 Black Participants

4.6.1 Black Participant 1 (B1)

Length of Service in the NHS - >25 years, Current Position – Senior Leadership/Executive

4.6.1a Narrative Summary – B1

Participant B1 offers a reflective account of differential attainment grounded in decades of experience in the NHS. They began by describing the overall picture of minority ethnic representation at senior leadership levels as mixed, noting disparities between minority ethnic groups and adding nuance within Black minority ethnic representation. They explained that there were *"...lots of Asian doctors at senior roles… [but] significantly small numbers of doctors who are Black and even smaller numbers of doctors who are Black and British trained,"* highlighting a distinction between Black doctors generally and those who are locally born and trained.

B1 acknowledges having observed a significant improvement in Black minority ethnic representation at senior leadership level over time—an area in which they have personally been involved through local and national programmes—though they recognise that progress remains incomplete: *"...I'm seeing more Black senior leaders… there's been a focus on trying to promote more talent… this is something I'm part of…"* Many of the programmes they describe as vehicles for change were advocacy initiatives established by various minority ethnic groups who recognised long-standing gaps in representation and sought to respond to institutional apathy on the issue. However, B1 offers a note of caution. While acknowledging improvements, they suggest that the main gains for Black doctors have been in lower levels of leadership and management rather than at senior leadership levels: *"...I think there's a significant increase in visibility of non-White clinicians at lower level… it's*

not quite getting there just yet… and it still feels like I'm the only person [Black] in the room…" They lament that, at this stage in their career—after decades of service—they had hoped to see far greater representation and to be *"the rule rather than the exception."*

B1 explains that differential attainment, particularly between minority ethnic groups, is complex, and began with individual ambition "*not every doctor—minority or otherwise—wishes to pursue leadership, and for those who do, there are additional challenges and competencies required, regardless of ethnicity.* However, B1 recognises that the path is smoother for some—namely White doctors—than for others: *"…if you choose to do so [leadership]… the pathway is attritional and requires a lot of hoops to go through… you either start early or you have to do an awful lot of work to build currency in those spaces."* B1 links this to a deeper pattern among Black doctors, who they believe face a different standard of expectation compared with other minority ethnic doctors—specifically, a baseline requirement to be "*exceptional"*. This expectation begins early in both career and leadership journeys: *"...I was being watched as a sort of test subject for all Black doctors… I didn't really want to mess up both for myself and Black doctors to come… it would be bad for everybody else… that kind of thing stuck with me."* A major thread running through B1's narrative is the idea that Black doctors often feel required to be significantly better than their peers to be appointed. B1 argues that when a Black doctor is selected, it is usually because they have outperformed all other candidates, not because they were only marginally stronger: *"…as a Black doctor, when they get to interview panels, what I tend to find is that if a Black candidate is appointed, that means they are clearly the best candidate by a million miles… they're never a punt; they're always by far the best candidate… they're never a marginal choice."*

Furthermore, B1 relates this idea of minority ethnic people—and in particular Black people—having to be exceptional to succeed to B1's own personal experiences, tracing it back to formative years in British society and the values instilled during family upbringing. They describe how parents often reinforce the belief that Black children must significantly outperform their White counterparts in order to be treated as equals: *"...there is an ongoing narrative that sits within a lot of Black British doctors… that they feel they have to be better to get on… they have to be absolutely bulletproof… and people are watching them… there is definitely a vulnerability where they feel that anything that happens to them, that is adverse, relates to their ethnicity… rather than them personally",* suggesting internalised racism.

B1 also draw a subtle distinction between *race* and *ethnicity*, suggesting that the White majority are either unable or unwilling to differentiate between these concepts, despite their significant influence on the cultural identity and self-perception of minority ethnic individuals: *"...sometimes all they see is a race issue… I'm Black rather than an ethnic issue, i.e. Black British… which is different."* B1 goes on to contrast this with their perception of how White doctors navigate their professional careers differently, suggesting the presence of inherent privilege*: "...this is not a conversation that White people have, i.e. 'is it because I'm White that they don't like me?'… I mean for White people, it can be because I'm poor or… a woman or differently abled… but not race."* B1 expresses concern about the mental health impact on Black doctors working in a system where they feel hyper-visible and under scrutiny, with differential attainment often assumed to relate to factors other than competence or talent. They describe how this leads to excessive self-interrogation about setbacks that may simply reflect normal career fluctuations: *"...this perception drives some kind of excess of introspection for Black doctors… a lot of navel gazing happening… tends to cause a lot of over-performance from them in that regard, which is unhelpful…"*

Another key feature of B1's narrative is their insistence on the heterogeneity hidden within broad ethnic categories. They caution against treating "Black" or "Asian" as uniform groups, pointing out differences between Black British Caribbean and Black British African experiences, as well as among Asian subgroups such as Indian, Pakistani, and Bangladeshi doctors. B1 notes the significant differential attainment within these groups—differences that often begin in formative years and continue throughout careers and later life: *"...if you look at Bangladeshi consultants… they are not pushing forward at all."* B1 expands this narrative by drawing on cultural factors and forms of capital linked to the historical legacy of certain Indian subgroups in the UK. These, B1 argues, help explain why differential attainment exists within minority ethnic groups at all levels, including NHS leadership: *"...it goes back generationally of course… Indian doctors are 3rd, 4th generations… they're going to have known the game and the system for ages… Bangladeshi are 1st and 2nd generation or do not have the same lineage advantage or insight."* B1 continues by applying this idea to the confidence displayed by some Indian Asian doctors in the NHS, noting that their significant representation and generational presence confer a legacy advantage: *"...you can see it in the way the 3rd and 4th generation Indian and Pakistani doctors carry themselves with confidence… I've been doing this game for such a long time… I can see it a mile off—somebody who has come from a medical family and someone who has not… and I think there is an expectation around that… there is a set of behaviours which are so non-technical and so non-visible that they inherit."*

B1 also expands on the complexities and an additional strand of challenges facing Black doctors in achieving senior leadership positions. They suggest that even exceptional ability may not be sufficient due to the limited number of Black doctors already in senior roles, and the fact that these positions are largely gatekept by White and a significant number

of Asian senior doctors. They argued that exceptional talent may not be enough because selection criteria can be relational rather than strictly merit-based: *"...at interview panels… it's about the person they want, and they'll skew the marking to accommodate that person… the interview questions won't change, but how they mark it will change… in favour of the preferred candidate."*

B1 then discusses a different perspective, suggesting that the expectation for Black people—and Black doctors in particular—to be exceptional in order to achieve leadership is not only imposed by White or non-Black gatekeepers, but also by other Black doctors who already occupy senior leadership roles, implying little to no respite for Black candidates. B1 suggests that these Black senior leaders may also expect a higher standard from Black candidates, often as a reflection of their own experiences and the need to maintain security in their positions. Having themselves often been exceptional candidates in order to attain senior leadership roles, they may consciously or subconsciously set the bar higher for prospective Black doctors: *"...I tend to find that the exceptional candidate in leadership… take a dim view of the ordinary candidate who shares the same demographic… that's just something I've observed."* B1 expands on this further: *"...you start asking them questions and think to yourself, why are they just ordinary? What have you been doing?"* B1 reflects on real-life situations where Black candidates have lost out on positions even when their competence and skills were comparable to those of non-Black candidates, owing to the different standard applied to them: *"...when we Black senior leaders get to the point where we can appoint another Black doctor… perhaps an average one as a matter of course… we are likely to go with the average White candidate… because we're still saying to the Black candidate that you cannot be like everybody else in there… you've got to be better, and not just a little bit better…",* again speaks to the internalised racism amongst minority ethnic people.

B1 also catalogues and references the challenges faced by Black doctors as they navigate their careers in the NHS, suggesting that there are clear disparities in treatment: *"...as a Black doctor you are more likely to be taken down a formal disciplinary route..."* They noted that these patterns of differential attainment persist throughout postgraduate training and career progression, even when compared with other minority ethnic doctors and international medical graduates—who also experience unique challenges, particularly during their initial years in the NHS due to unfamiliarity with the culture and system, challenges which tend to improve over time. As B1 summarises, *"...our [Black doctors] challenges are more visible, there is no doubt about that."* B1 explains that some elements of this disparity in treatment are not necessarily driven by malicious intent, though the consequences for Black doctors remain disproportionately negative. They highlighted a paradox in which, particularly among White doctors in leadership roles, fear of being accused of racism or appearing biased leads to the formalisation of minor issues or infractions. Crucially, this same standard is not universally applied to non-Black doctors: *"...the rationale for taking a more formal disciplinary route with Black doctors is interesting... previously you would say it was done for pejorative reasons... now I think more often than not, people are scared of being seen as being biased, so rather than just say I'll have a word with you, instead they decide what I'm going to do is be really transparent and write and document everything... so it can be proven everything is OK and I'm above board... whereas the White doctor may be given an informal conversation, with nothing on their record."* Again, this suggests differential treatment along racial lines, with important and often unforeseen consequences for the career trajectories of minority ethnic doctors.

B1 acknowledges significant improvement in the recruitment of doctors from minority ethnic backgrounds, including Black doctors, over the last few decades. However,

they contrast this with wider societal narratives in which minority ethnic people—especially Black people—continue to be viewed negatively: *"…everything dark or Black is seen as a negative thing… everything White is a good thing… that's just ingrained within our culture and society… the fact is that people still perceive people of colour to be a threat."* B1 goes on to contrast differences both between and within minority ethnic groups, noting that although stereotypes are generally negative, some groups benefit from more positive connotations: *"...I think every stereotype has a degree of threat assigned to it… Chinese or Korean people are seen as studious, hardworking and dedicated… South Asians are more entrepreneurial and you're really smart and well connected… and if you're Black, you're either some Nigerian Prince—related to fraud—or you're some hood rat… these mindsets haven't moved on…"* B1 emphasises that such perceptions influence healthcare workers, shaping not only the quality of care received by minority ethnic patients but also the career paths of minority ethnic doctors. Even high-achieving doctors may find themselves navigating or attempting to move beyond these stereotypes, despite their current positions of success.

B1 attributes some of the broader patterns of differential attainment to generational differences within minority ethnic diasporas in the UK—particularly between Asian and Black communities. They suggest that Asian minority groups tend to have a larger population, longer-standing presence, and established histories in the UK, including greater levels of generational wealth, which acts as a significant social determinant of outcomes. By contrast, Black communities are smaller in number and often lack the generational wealth, cultural capital, and structural advantages that facilitate progression: *"...we don't live in a country with a large enough Black middle class that have been there for long enough to make a difference... Asian minority groups already appear to have that... so it's not about*

representation in the sense of having a Black Prime Minister or Black captain of the national Rugby team; those are exceptional people, not ordinary people."

B1 shifts their narrative to a more personal one, reflecting on their current position as a Black senior leader in the NHS—a role they have held for much of the latter part of their career—and the tension between being a doctor and being a Black doctor in leadership: *"…I'm here primarily to be a good doctor. I don't want to be a distraction…I don't want everything to be about my ethnicity."* They describe being highly self-aware in these spaces, often as the only Black person in the room, suggesting that there is no respite from being Black. Much of this is internalised, yet they resist the expectation that Black leaders share monolithic issues or motivations: *"…as a Black person in a senior position, I've got no choice about whether I'm Black or not, that's pretty much obvious… but my cultural nuances and my back story and what I am, motivates what I care about… this might be shared by another Black person, but we are not necessarily the same… I come from a different cultural background [names their cultural background] …"*

B1 also discusses the "cost" of being a Black doctor in senior leadership roles, distinguishing between internal institutional dynamics and external, public-facing challenges, particularly at higher levels where professional profiles are more visible. Internally, they describe the struggle to avoid being seen as a single-issue leader—someone who talks primarily about minority ethnic issues—despite having responsibility for the wider population: *"…there is a price you pay as a minority individual… in that space… my White colleagues can come to work, go home, see their kids, and that's job done. But you're asking me as a Black senior leader in the same position to get on a bandwagon and do all this additional stuff as well and be the target on a bullseye for racist people to have a go at… because I just don't happen to be White… you're asking a lot of people for nothing…"* For

ME leaders, B1 suggests this burden includes criticism and the constant need to justify their position and competence to members of the public who believe they have not earned their role on merit: *"…if you look at my [mentions an online platform], it's just full of abuse right now… I don't bother reading it anymore… I get, 'hey, you know you're only there because you're Black'… it's quite onerous."*

Furthermore, B1 suggests that this burden extends beyond the workplace and into their personal life, noting that their White colleagues do not share a similar burden. They recognise that Black leaders—particularly because they remain underrepresented in senior roles—often feel an obligation toward prospective Black doctors further down the pipeline who may wish to pursue leadership positions in the NHS. However, they stress that a critical mass of Black leaders is required both to share this burden and to advance the wider argument: *"…so numbers are important. If it's just one person doing all this work for the Black community… it's quite a lot of stuff… when you get 50 people saying the same thing, it's a much easier load."*

Finally, B1 links workforce representation to health outcomes for minority ethnic communities. B1 argues that COVID revealed the importance of cultural credibility, drawing on their experience as a Black vaccinator and the difference this made to vaccine uptake among Black patients, who trusted them in ways they might not have trusted others: *"…there is no doubt that being a Black vaccinator was a big deal… Black people let me vaccinate them and not necessarily anybody else because we had the conversation… that is being culturally credible and competent."* Related to this, B1 suggests that the lack of minority ethnic leadership at decision-making tables during the pandemic may have contributed to poorer outcomes for minority ethnic communities. This was due, in part, to the absence of bespoke information targeted towards these groups, leading some individuals to rely on less

credible sources containing misinformation and disinformation, which had adverse consequences. Furthermore, they discussed the advantages that minority ethnic doctors and leaders may have in addressing mistrust in healthcare systems—mistrust rooted in historical traumas experienced by minority ethnic communities within healthcare structures run predominantly by White professionals: *"...I know a lot of people are getting their information from [mentions a specific social media site]… chat rooms… from nonsense stuff from non-credible sources… they didn't trust the credible sources because they were all written in White… and I think that's a problem."* This suggests a failure to produce literature that is relevant to minority ethnic groups, along with the consequential impacts of this omission.

4.6.1b Narrative Restorying – B1

Participant B1 is a Black British doctor, trained in the UK, who has worked in the NHS for decades and attained one of the highest leadership roles in the system. Reflecting on differential attainment, they describe the senior leadership picture as uneven. In their view, Asian doctors are relatively well represented in senior roles, while Black doctors remain markedly underrepresented—especially those who are British-born and British-trained. They observed that although there are senior Black clinicians in the NHS, many trained in the Caribbean or Africa and entered through postgraduate or international routes rather than following their own locally trained pathway.

B1 notes that this pattern has begun to change, particularly in [mentions their region of the country] and over the last five years, as leadership bodies and professional groups have increasingly focused on promoting minority talent and highlighting differential attainment. They have themself been involved in such work, including race-related programmes and professional networks. Even so, they feel that progress remains incomplete. Despite three decades in the NHS, B1 often still feels like the only Black person in senior spaces and had hoped that, by now, their presence would be normal rather than exceptional. When explaining why there are fewer Black senior leaders, B1 describes leadership progression as an attritional pathway. They argue that success in leadership requires starting early or deliberately building leadership capital through courses, programmes, local roles, and credentials. These opportunities are gated at the local level and must typically be accumulated before someone can move into higher-profile leadership spaces. Looking back, they believed they spent much of their career focused primarily on being an excellent doctor and safeguarding their position, rather than actively pursuing leadership as early as they might have. They attribute some of this to a deep preoccupation with simply keeping their job.

B1 then broadens the analysis beyond themself. They argue that many Black and minority ethnic doctors feel an over-dependence on credentialing and are less willing to take risks or pursue roles "on a punt." They recall being told as a junior doctor that they were being watched as a test case for Black doctors, which made them reluctant to fail or draw negative attention. As a result, they pursued extra exams, courses, and qualifications in order to make their applications "bulletproof." They see this overperformance as both a coping strategy and a factor that delays progression. They further reflect that Black male [in general] doctors in particular often monitor how they come across, worrying that they may be perceived as threatening if they are too assertive. More broadly, they see among Black British doctors a narrative that they must work harder, be better, and avoid mistakes because any adverse event may be interpreted through race rather than individuality. B1 contrasts this with White doctors, who do not typically have to wonder whether rejection or criticism occurred because of their Whiteness. B1 believes this sense of needing to be better comes from both home and the NHS. Within Black families, B1 argues, children are often taught that they must work harder than others to get ahead. Within the institution, B1 perceives that when a Black doctor is appointed, it is because they are unmistakably superior—not because they are simply appointable. In their experience, a Black candidate is rarely a marginal or developmental choice; they must be demonstrably stronger than the field.

When comparing Black and Asian doctors, B1 argues that these broad categories conceal major differences. B1 points out that some Asian groups—particularly those with longer-established medical lineages in the UK—benefit from generational familiarity with medicine, medical families, confidence, and inherited understanding of how the system works. By contrast, many Black and Bangladeshi doctors may lack this lineage advantage. B1

sees subtle, inherited, non-technical behaviours and confidence as important assets in progression.

B1 is deeply sceptical about interview fairness. In their view, senior appointments are highly subjective and shaped by prior familiarity. B1 suggests, people usually know who they want beforehand, and marking during interview flexes accordingly unless the 'preferred candidate' performs disastrously. This disadvantages outside candidates, particularly those who have not trained locally and therefore have not had the opportunity to become known quantities within departments they later hope to join. However, B1 also recognised the value of appointing a known candidate who had 'earned their stripes', rather than basing selection solely on interview performance, irrespective of ethnicity. This highlights a tension within B1's account. On the one hand, B1 suggests that interview processes may be skewed towards a 'preferred candidate', thereby contributing to differential attainment. On the other hand, B1 acknowledges the perceived benefits of appointing a candidate who has gained the trust and confidence of the panel through sustained commitment and contribution to the organisation.

B1 also reflects on wider cultural stereotypes. In their view, different racialised groups are associated with different stereotypes in society, and these shape expectations in medicine as well. East Asian doctors may be seen as studious; South Asian doctors as entrepreneurial or well-connected, while Black doctors may be perceived through far more threatening or negative stereotypes. These broader perceptions, B1 argues, have not moved on enough and continue to shape professional life within medicine. B1 also distinguishes between Black British Caribbean and Black British African experiences. Through community outreach, B1 has noticed that Black British Caribbean boys are less easily drawn to medicine than girls or than many African-background pupils. B1 suggests that medicine is less culturally reinforced in some Caribbean communities, were entrepreneurship, sport, or the

performing arts may be seen as more desirable or affirming. B1 also notes that success as a Black doctor may not always be celebrated within the community and may even be framed as disloyalty or leaving one's roots behind.

Regarding role modelling, B1 believes representation matters, but in a complex way. B1 notes that many senior Black doctors do not foreground their blackness in the way people in media, arts, or business might. For B1, their primary identity at work is as a good doctor rather than as a Black doctor. However, B1 acknowledges that when one is the only Black person in the room, the pressure to fit in is real, and that more diverse groups create broader and better conversations. When considering solutions, B1 argues that responsibility should not rest solely on minority individuals to push themselves forward. The system must actively identify talent, seek people out, and nurture them. In their experience, programmes succeed when they stop making progression the sole burden of the individual and instead create structures that look for and elevate talent.

Finally, B1 links leadership representation to health outcomes. B1 argues that COVID revealed the importance of culturally credible leadership and engagement, citing their own experience: some Black patients accepted vaccination from them because they were a Black vaccinator whom they trusted. For B1, representation at the top helps create culturally appropriate systems, but it comes with an additional burden. The senior Black leader is expected not only to do the job well, but also to represent, educate, mentor, advocate, and withstand public abuse. B1 accepts this work as necessary but notes that it is far more than is asked of many of their White peers.

4.6.1c Narrative Emplotment – B1

B1's narrative is best understood as a story of slow ascent through attritional structures, shaped by the need for exceptionalism and sustained by the ongoing burden of representation. The plot is not simply one of exclusion; rather, it is one of progress achieved at disproportionate personal and structural cost, with B1 positioned simultaneously as evidence of change and as evidence that change remains incomplete.

Orientation: *Mixed progress, persistent exceptionality* **-** The narrative opens with a mixed picture. There are many Asian senior leaders, yet very few Black ones—particularly British-trained Black leaders. This establishes the central tension: progress is visible, but insufficient. B1 is present in senior spaces, but still as an exception rather than a norm.

Development: *Leadership as an attritional pathway* **-** The plot develops through B1's description of leadership pathways as attritional. Progression requires early planning, continual credentialling, and navigation of informal, gatekept opportunities. This is not portrayed as a neutral, meritocratic process; rather, for those unfamiliar with the "rules of the game," or who carry heightened risk awareness, movement is slower and more costly.

Turning point: *The making of the "bulletproof" Black doctor* **-** A critical turning point appears when B1 recalls being told that he was being watched as a "test case" for all Black doctors. This moment crystallises the need to avoid error and to overperform. The plot from this point centres on becoming "bulletproof": undertaking additional qualifications, working harder than peers, and maintaining constant vigilance against mistakes. This generates a narrative of delayed but highly defended progression.

Intensification: *From individual overperformance to structural critique* **-** The story intensifies as B1 moves from personal experience to a broader structural critique. Black

candidates, he argues, become appointable only when they are *clearly* superior, not marginally better. Subjective interview panels, familiarity bias, homophily, and generational or lineage advantages reproduce existing hierarchies. The narrative shifts from the individual level to a diagnosis of systemic inequality.

Differentiation: *Heterogeneity within minority ethnic groups* **-** Another key movement is B1's insistence that broad categories like "Black" or "Asian" obscure significant internal diversity. Asian groups differ from one another; Black groups differ from one another. This disrupts simplistic minority–majority binaries and introduces a more nuanced, stratified understanding of differential attainment.

Resolution: *Progress, but not parity* **-** The narrative resolves with guarded realism. B1 recognises meaningful progress relative to three decades ago and acknowledges their own presence in senior leadership as a sign of change. However, they remains sceptical that true parity will be achieved within their career lifetime. The story concludes not in defeat, but in an account of transformation that remains partial and unfinished.

Extension: *Leadership representation as system design and community trust* **-** The narrative extends beyond career progression into implications for healthcare design and community trust. Representation matters because it shapes who is trusted, whose perspectives inform system decisions, and how effectively minority communities are engaged. Yet the representative figure bears additional emotional, symbolic, and practical burdens that are not equally shared by White colleagues.

Core Narrative Meaning

The central meaning of B1's account is that Black doctors can reach senior leadership, but often only through exceptional overperformance within an attritional system that continues to

treat them as representatives rather than ordinary professionals. Progress is real, yet parity remains distant because institutions reproduce inequality through subjectivity, stereotype, and lineage-based advantage. B1's narrative reflects a form of exceptionalism under attrition: visible success for Black minority doctors exists alongside persistent underrepresentation, with many feeling compelled to overperform as a necessary survival and progression strategy in leadership pathways shaped by subjective and gatekept processes.

4.6.2 Black Participant 2 (B2)

Length of Service in the NHS - >25 years, Current Position – Senior Leadership Role/Executive

4.6.2a Narrative Summary – B2

Participant B2 is a Black [gender and ethnic origin removed for anonymity], UK-trained doctor with decades of service in the NHS. B2 presents a highly reflexive account of differential attainment, beginning by challenging the term "attainment" itself. To introduce nuance, they proposed the phrase *"differential presence"* when discussing Black and minority ethnic doctors in senior NHS leadership. B2 used this concept to situate the issue within a context where senior leadership roles are inherently limited, and where doctors—regardless of race—occupy only a small proportion of such posts, given that many require non-medical expertise (e.g., Chief financial officer). As B2 noted, *"….to start with, doctors in senior management…is not common…doctors of any race are generally not common in senior management apart from medical directors…maybe a few medical directors go on to become chief executives…."* This highlights the structural scarcity of doctors within this elite leadership category. However, B2 concluded their opening reflections by recognising DA among minority ethnic groups at senior levels, suggesting that Black and minority ethnic doctors remain especially uncommon. Drawing on their experience, they described some improvement in representation over recent years but emphasised that it remains limited: *"…. when I look in the room…how many Black and minority ethnic doctors do I see…years ago, very few…now one or two more…but still a minority phenomenon."*

B2 also emphasises that representation at this level is not uniform across gender**.** They note that, in their experience, among Black and minority ethnic senior leaders there appear to be more women than men**:** *"…I'm seeing a few more women and not so many men."* However, B2 is careful to stress that this is their personal impression rather than a statistical

claim: *"...I don't think I can talk about statistical significance… my eyeballing and experience is what I lean on."* B2 further highlights how rare progression to the highest levels remains, noting that when chief executives with a medical background were mapped nationally, there were approximately 20 in the country, of whom three were Black—two Black women and one Black man**.** They express concern about the difference between Black men and Black women at this level, suggesting that—based on typical career trajectories influenced by factors such as childbirth and caring responsibilities—it might seem logical that there would be more Black men than women. B2 wonders whether the observed pattern might relate to broader societal perceptions of Black men (threat; something to fear): *"...I wonder what the difference in the perception of a Black woman versus a Black man is… but that does not assume that there's a stochastic relationship that purely timing is equivalent to attainment, and in fact probably it is not."* Here, B2 suggests that this gender difference, particularly the apparent advantage of Black women relative to Black men, may be attributable to a perception among the White majority at senior leadership levels that Black women are less likely to be problematic or challenging to the status quo. B2 offers another hypothesis for this differential and reflects on an apparent preference for women in senior roles. They suggest that this may relate to the breadth of life experiences women bring: *"...I always say that… if you hire a woman of reproductive age, you get something really special, because to juggle life and childcare and everything else is a real task in leadership and management…"*

B2 suggested a reason for the differential attainment experienced by Black doctors, situating it in the belief that achieving parity at senior levels requires Black doctors to demonstrate exceptionality, a standard they feel is not equally applied to non-Black doctors: *"...I think of Black minority ethnic colleagues… they are excellent colleagues… but many*

would say that in order to progress, despite the challenge of progression, you have to be exceptional." B2 added: *"…I think there are still much more subtle, but no less debilitating challenges for Black minority ethnic doctors…"* at senior management levels, arising from these differential standards.

When discussing Black and Asian doctors comparatively, B2 stressed that their account is based on their own experience across the NHS and the few hospitals in which they have worked. They began by highlighting issues of pipeline and numbers: *"…it stems from pipeline early on… my observation is that there are few Black consultants coming through compared to Asian doctors, even relative to the overall number for both in the NHS, generally."* B2 supports this observation with further examples, including one drawn from their role as a senior leader—regularly sitting on consultant appointment panels: *"…I do sit on a lot of interview panels for consultants and there are very few Black candidates… more likely to see an Asian or White candidate."* In relation to the pipeline, B2 suggested that Black doctors face significant challenges throughout their NHS careers compared to other minority ethnic groups, noting that problems with progression occur at every milestone and cannot be explained by competence alone, but may be influenced by gatekeeping**.** They gave examples of bias in postgraduate examinations, particularly face-to-face observational assessments where candidates are judged not only on content but also on *"…how you present as much as what you present…",* suggesting this may contribute to subjective decision-making. B2 also offered broader reflections, noting that Black and minority ethnic doctors are more likely to experience investigations and disciplinary action. They summarised their *"living hypothesis"* as follows: *"… [in the NHS] if there is a penalty to be given, you are more likely to have it as a Black and minority ethnic individual… and if there is leniency to be given, you are more likely to have that as a White or non-Black individual."*

B2 then discussed the group dynamics, power, and influence of Asian doctors—factors they describe as interrelated—and suggested that this collective presence has implications for support, visibility, and advancement. In contrast, they observed that Black doctors are often solitary individuals, which may make their career progression more challenging: *"…it seems to me in the Asian community…there is already a multi-generational culture of people pulling each other up in every facet of life and in their communities… always pulling the generation up…that is not necessarily as well embedded in the Black culture, I think…"* B2 provided examples relating to advocacy and cultural awareness, noting that these dynamics can disadvantage Black candidates at higher levels where scrutiny during selection is more intense. They explained that they have often had to interpret cultural nuances and mannerisms—such as fluctuations in accent or tone when a candidate becomes passionate—to prevent them from being perceived negatively by interview panels. Recalling a particular consultant interview panel, B2 said: *"…I'm struck remembering a consultant interview panel I sat on, where a candidate was a Nigerian woman…in the midst of the interview, as we all do when we get excited…she became louder and her accent became stronger, and you could see the visible impact on the panel…"* B2 went on to describe how they help contextualised this for the non-Black panel members: *"…but because I was there, as a Black [mentions gender] and in my role as a [mentions high executive role], and because I was conscious of this…I asked the panel to divorce how she said it from what she said…and her answers were stronger than the other candidates…"* However, B2 also described the burden of having to intervene in this way, highlighting the potential risks for their own position as a senior leader, including concerns about being perceived as exerting undue influence or showing bias: *"…you need to be careful when you do this, so as not to be seen as exerting undue influence or bias for certain groups… but I think there is definitely something about representation and advocacy."* B2 concluded by stressing the importance of

having people with lived experience, understanding, and courage in decision-making spaces who are willing to *"speak up."* They extended this challenge to all senior leaders— *"…this includes White people, too"*—and offered a particularly strong call to Black leaders: *"…if you happen to be in that room [executive space] …I see this as a responsibility…I cannot be complicit by my silence in any of those rooms that I'm in…I have the responsibility to make sure I'm in as many of those rooms as possible…to give reason, hope, encouragement and neutrality to some of the decisions that are made…I think there's that."* B2 also raises the issue of *"unspoken… racism between the two groups,"* i.e. Black and Asian minority ethnic groups, and also arguing that previously used acronyms such as BAME (Black, Asian and Minority Ethnic), which homogenised all minority ethnic people, masked important differences and tensions between distinct ethnic groups.

A recurring theme in B2's interview is that progression is shaped not only by formal criteria but also by socialisation, exposure, and informal belonging**.** They offered a simple, everyday example— *"I don't ski… I don't drink"*—to illustrate how seemingly mundane social activities can become inadvertent sites of exclusion when they revolve around majority White cultural norms.

B2 also speaks at length about mentorship and sponsorship, distinguishing clearly between the two and emphasising the importance of *experience and exposure***,** in addition to qualifications. They described sponsorship as sometimes covert— *"mentoring by stealth"*: *"…I think I was passively mentored for a long time without recognising it… people have paved the way for me without me realising… there are people who I can call out in my career at various points where I would have jettisoned and left for the nonsense that was happening, [who] kept me on the track."* B2 stresses that access to the *"corridors of power"* often depends on invitation and networks: *"…there are gatekeepers."* They summarise the *"three*

Es" required for senior success as ***education, experience, and exposure*****,** noting that as one becomes more senior, the balance shifts decisively toward the latter two. While B2 recognises the value and necessity of mentorship—whether explicit or implicit—they were less certain about the importance of ethnic congruence between mentor and mentee: *"…my first thought is that the ethnicity of the mentor doesn't matter, but actually probably it does… and I think this comes to—as much as I hate the expression—White allies."* They explain that mentors from different backgrounds—particularly White mentors—may have access to rooms and spaces that others do not, meaning that "*the hue may be important from that point of view."* Furthermore, B2 asserts the responsibility of mentors: *"…using the path that you have trodden; the challenges you have faced, to make sure that it is easier for those who come behind—so 'lift as you climb' would be the responsibility… but don't set people up to fail."* Here, B2 is suggesting that a mentor's role is comprehensive: ensuring the mentee is fully equipped for what lies ahead, moving the relationship beyond passive guidance.

Another major theme in B2's narrative relates to the tension around authenticity. B2 openly acknowledges that even at [mentions their high-level position], they continue to grapple with whether there is space to be fully themselves. They describe authenticity as tolerated only "*so far as you're authentic enough to fit in***,"** and speak of the **"***constant consciousness of thinking***"** required to manage oneself in these spaces. This makes minority leadership, in B2's words, *"mentally exhausting."*

Finally, B2 links leadership representation to health outcomes and discrimination more broadly. They argue that the same cultural interpretations that shape interviews can also shape clinical care. Drawing on examples such as sickle cell disease, maternity care, and the ways patients are perceived based on appearance and demeanour, they contend that leadership diversity matters because it enables organisations to recognise and dismantle

discrimination: *"...I think people with lived experience may be more attuned…but they are not unique in that ...I would say that being a [mention role and gender] gives courage, inspiration, support and voice to both Black and other minority ethnic groups—staff and patients…though that comes with a double-edged sword…the same people can turn on you just as quickly."* However, B2 is equally clear that what matters most is not identity alone, but leadership that is willing to *"recognise, target and dismantle discrimination,"* sees diversity as *"an asset, not a deficit,"* and holds others to account.

4.6.2b Narrative Restorying – B2

Participant B2 is a Black [gender and ethnic origin anonymised] doctor who trained in the UK and has spent decades working in the NHS. They currently hold a high-level senior leadership role. In reflecting on differential attainment, they began by questioning whether the term *"attainment"* fully captures the experiences of Black and minority ethnic doctors in senior leadership. Instead, they preferred the concept of 'differential presence', emphasising that doctors in general are uncommon in senior NHS management outside medical director roles, and that Black and minority ethnic doctors are rarer still.

Looking back over recent years, B2 notes that the presence of Black and minority ethnic doctors at senior levels, such as medical director, has increased slightly but remains uncommon. They had observed a somewhat greater presence of minority ethnic women than men in these roles, though they emphasised that this is an impression rather than a firm pattern. At the very highest levels—such as Chief executive roles among medically qualified leaders—representation remains extremely low, with only a handful of Black doctors nationally occupying such posts. B2 explains this disparity partly through informal socialisation. They argue that professional life in senior leadership is shaped not only by formal skills and qualifications, but also by everyday interactions and cultural familiarity. Their example of not skiing or drinking illustrates how routine activities, conversations, and bonding practices may be more familiar to some groups—primarily the White majority—than to others, leaving minority ethnic doctors feeling separate or less naturally included.

When considering differences between Black and Asian doctors, B2 points first to demography: there are fewer Black doctors overall, and they are particularly underrepresented within medicine relative to the wider population. However, they also highlight group power dynamics**.** In their experience, Asian doctors often appear as groups

with influence, whereas Black doctors are frequently lone individuals. They also believe that racism between minority ethnic groups is insufficiently acknowledged, and that umbrella labels like "BAME" obscure important differences in power, support, and experience. B2 is especially struck by the relative absence of Black candidates on consultant interview panels. Having sat on many such panels themself, they observed that Black applicants appear far less frequently than their White or Asian counterparts. This led them to question what happens during the transition from junior [resident] doctor training to consultant position. They hypothesise that part of the issue may lie in postgraduate examinations and subjective assessments, where candidates are judged not only on content but also on presentation. They also connect this to disciplinary patterns, observing that Black and minority ethnic doctors appear more likely to receive formal penalties, while White doctors may be more likely to receive leniency. When considering solutions, B2 emphasises the importance of representation and advocacy in decision-making spaces. They recall an interview panel where a Nigerian woman's accent became stronger under pressure, and note that because of their own presence and awareness, they were able to ask the panel to focus on what the candidate said rather than how she said it. For B2, this example crystallises the need for people who understand bias—and who are willing to challenge it—to be present in the room.

B2 also gives considerable attention to mentoring, sponsorship, and career development**.** They believe mentorship is valuable, but place even greater emphasis on sponsorship and exposure. Reflecting on their own career, they recognise that they were often mentored passively before realising it, and that others had paved the way by providing opportunities at critical moments. They describe success in senior leadership as resting on three components—***education, experience, and exposure***—and argue that at more senior levels, the latter two become decisive. Crucially, access to these opportunities is often by

invitation, through networks and informal power structures, rather than through merit alone. B2 further reflects on the tension between authenticity and adaptation**.** Even at their very senior level, they remain uncertain about how fully they can be themselves in leadership spaces. They describe a constant need for self-monitoring—thinking carefully about how they speak, behave, and are perceived. This is mentally exhausting and, in their view, particularly acute for minority ethnic leaders. Despite these barriers, B2 remains committed to mentoring and supporting those who come after them. They believe senior leaders have a responsibility to *"lift as you climb,"* but also to avoid setting people up to fail. This means ensuring readiness—through development, leadership training, and adequate preparation—before opening doors, so that individuals are not prematurely exposed to hostile or unsupportive environments.

Finally, B2 connects leadership diversity to broader health outcomes**.** They observe clear parallels between how people are interpreted in interviews and how they are interpreted in clinical care. Biases related to appearance, demeanour, and cultural difference shape healthcare interactions just as they shape promotion and selection decisions. For this reason, B2 argues that senior leaders who recognise discrimination, value diversity, and hold others to account are essential—not simply because of who they represent, but because they help create safer and fairer systems for both staff and patients.

4.6.2c Narrative Emplotment – B2

Emplotted Narrative: *"Differential Presence in Hidden Power Structures"*

B2's narrative is best understood as a story of rare presence within hidden systems of power, where progression depends not only on formal achievement but on visibility, invitation, sponsorship, and the ability to navigate subtle social and organisational codes. The central plot is not that Black doctors fail to attain, but that they remain insufficiently present in the rooms where power is built, exercised, and reproduced.

Orientation: *From "attainment" to "presence"* - The narrative opens by reframing the problem. B2 resists a narrow focus on attainment and instead redefines the issue as one of differential presence. This is a key narrative move, shifting the question away from capability and towards the structural reasons why Black doctors remain scarce in senior spaces.

Development: *Rarity in the room* - The plot develops through repeated observations of rarity. Black and minority ethnic medical directors remain uncommon—even if slightly more visible than in the past. At the highest leadership levels, Black doctors are extraordinarily rare, and this scarcity becomes the central condition from which the rest of the narrative emerges.

Turning point: *The hidden mechanics of exclusion* - A pivotal shift occurs when B2 describes how exclusion often operates subtly rather than overtly. It is embedded in everyday socialisation, subjective gatekeeping, disciplinary patterns, and decisions made in "corridors of power." The narrative moves from visible underrepresentation to the hidden processes that reproduce it.

Intensification: *Sponsorship, Exposure, and Invitation* - The narrative intensifies around the idea that senior success depends less on qualifications and more on experience, exposure, and

sponsorship. Power appears relational and informal: it is not enough to be excellent; one must be invited, recognised, supported, and championed.

Crisis: *Authenticity under exhaustion* - An emotional high point emerges when B2 reflects on authenticity. Even at the highest level, they remain unsure how fully they can be themselves. Leadership for minority ethnic individuals becomes a story of constant self-regulation, vigilance, and mental fatigue, rather than security or ease.

Resolution: *Conscious advocacy and accountable leadership* - The narrative resolves with a call for conscious advocacy, sponsorship, measurement, and accountability. B2 expresses little faith in passive progress. Instead, they emphasise the need for leaders who are present in the room, willing to speak, able to recognise bias, and committed to dismantling discriminatory patterns.

Core Narrative Meaning

The central meaning of B2's account is that Black doctors' underrepresentation in senior NHS leadership is not primarily a question of insufficient attainment, but of *differential presence* within networks, invitations, and hidden decision-making spaces. Without sponsorship, exposure, and conscious advocacy, qualifications alone are insufficient to translate excellence into power. B2's narrative therefore foregrounds hidden gateways and differential presence for Black doctors, reframing the problem from *attainment* to *presence*. Their account positions differential attainment as an issue rooted in relational and often obscured structures of power, where formal qualifications are necessary but not enough, and where progression depends on sponsorship, exposure, and the courage of those already *"in the room"* to challenge subjective and discriminatory selection processes.

4.6.3 Black Participant 3 (B3)

Length of Service in the NHS - >20 years, Current Position – Senior Leadership Role/Director

4.6.3a Narrative Summary – B3

Participant B3 is a Black [origin and gender anonymised], UK-trained doctor and [exact current senior leadership title anonymised], with over two decades of service in the NHS. B3 offers a complex account of differential attainment based on their lived experience, career journey, and observations, beginning from a position of nuance rather than simple deficit. They initially state that *"minority ethnic doctors do excel in the NHS in general"*, suggesting that compared with other industries, people from minority ethnic backgrounds appear to occupy leadership positions in the NHS at various levels. They also recognise that such representation is more common at junior management levels, which is not the primary focus of this research, thereby implying that medicine may offer better progression opportunities than some other sectors. However, B3 quickly qualifies this observation by pointing to the differences in career progression between minority ethnic groups, particularly at senior leadership levels, noting that *"…particular groups do less well even within medicine… there's definitely evidence statistically that it's harder for people from minority ethnic backgrounds and, in particular, it is harder for Black people."*

Building on this, B3 attempts to pinpoint the stages at which differential attainment becomes most pronounced, describing a pattern of *"dropping off at levels… from junior [resident] doctors to consultant, and then again from consultant to clinical director [senior management] and beyond."* In their account, this pattern is not simply a matter of individual merit but reflects how organisational life—especially at higher levels—is socially structured around majority (White) cultural norms. B3 uses the example of skiing to illustrate how everyday forms of socialisation can inadvertently create exclusion: *"…there is absolutely*

something about socialisation… it's not easy being different… for example, I don't ski, and skiing has been very important for many doctors that I have worked with… it's a key part of how they interact… a key part of their conversations… probably because when I was younger, it wasn't a common thing for Black people to do… this may be a very banal example, but I'm using it to exemplify that there are lots of things which are everyday 'bread and butter' conversations or focuses of socialisation of different groups, which, if you're a minority ethnic person, you may not automatically share… therefore you're by yourself in that space." Furthermore, B3 suggests that important bonds and relationships are often formed within these informal settings, and these relationships then translate into workplace dynamics that influence opportunities, choices, and selection—whether consciously or not—particularly at higher levels.

When discussing Black–Asian differences in attainment within medicine, B3 rejects simplistic explanations. They acknowledge that some of the disparity relates to *"numbers"*—noting that *"there are fewer Black doctors in general in the country as a proportion of minorities"*—but argue that Black doctors are nonetheless *"disproportionately minoritised within medicine."* B3 extends this argument by suggesting that inter-minority tensions also contribute to differential attainment, specifically highlighting the presence of *"racism"* between minority ethnic groups. As they describe, "*there is an unspoken amount of racism between the two groups—Black minority and Asian minority group… so you cannot be sure as a Black person what factors are at play."* They add that *"there is a lot of quiet about the racism that exists between the two groups, and in the context of the power imbalance, it is more likely to be a group of Asian doctors that have power… than an individual Black doctor… there isn't the assuredness of support and allyship between racial groups as one might assume."* This dynamic, B3 suggests, creates an additional layer of complexity for

Black people navigating their careers in environments where leadership is both White and Asian. They note that *"it is more likely that there are a group of Asian doctors than an individual Black doctor, rather than the other way round… this has a bearing on Black doctors' overall representation at higher levels of the NHS."* B3 concludes that they have *"not seen or experienced very often where there are a group of Black doctors in an area and they have the kind of monopoly on that area like Asian doctors do,"* a pattern which they argue has consequences for representation and progression.

A particularly strong theme in B3's narrative is their rejection of the idea that Black people do not help each other. They challenge the narrative that Black people are dependent on majority White 'allies', or that—unlike Asian groups, who are often perceived to demonstrate solidarity and mutual support—Black people are individualistic, unsupportive, or gatekeep access to other Black doctors once they reach senior leadership. B3 describes this as a *"stereotype… I've lived with this stereotype my whole life… we have no evidence that it is true."* They further note that it mirrors the stereotype associated with so-called Black-on-Black violence, implying that Black people are not collegiate and are more likely to harm one another—an ingrained racial stereotype whose origins are rarely articulated. B3 explicitly links this narrative to *slavery* and characterises it as a form of "*internalised racism*." For B3, this narrative is historically loaded, reductive, deeply harmful, and inconsistent with their lived experience of Black people in senior leadership and more broadly. They emphasise that *"this narrative that we don't help ourselves is not any more or less true than it is of any other racial group… I will challenge anyone to actually bring out that data."* B3 also reflects on their upbringing, noting how this trope was repeatedly presented to them as a negative assumption about Black people—one that is often perpetuated within Black communities themselves—despite lacking any basis in reality: *"…people will suggest it, that Blacks don't*

help each other compared to other minority groups like Asian. I've grown up with it, and I've decided it's racism. It's our own internalised racism and we keep speaking to it."

B3 discussed the concept of a *"lag in the system"* to explain the differential attainment of Black doctors in senior leadership. This idea suggests that the increased representation of Black people—driven by decades of initiatives and cultural shifts—at the bottom of the pipeline will, in time, translate into better representation at senior leadership levels. B3 does not reject this hypothesis but does not view it as inevitable. Instead, they argue that statistical modelling should be used to predict future expectations, which should then be scrutinised: *"...we cannot assume that the rising numbers of Black doctors at the junior levels will lead to increased representation at senior management level over time… we should do the maths… calculate what we think it should be… then we'll know if there is really a problem, or it's just a matter of the lag of time."* B3 also reflected more broadly on the reality that some aspects of the differential attainment between Black and Asian minority ethnic groups may be related to "numbers"—specifically, the differing proportions of each group within Britain and within the NHS, where both are overrepresented relative to their population size. They further suggested that this numerical difference can be advantageous in terms of advocacy, organisation, and influence, ultimately affording more opportunities and privilege: *"...the Asian organisations got more numbers. It's a numbers game…"*

B3 moved the conversation toward a more personal reflection on the cost of representation and the challenges faced by Black individuals in senior leadership, where they remain a minority within a minority. They speak powerfully about the lack of psychological safety that comes with being the only Black person in a senior space: *"...for the solitary Black person in these senior positions, they may be endangered in these positions…"* B3 also

highlight the absence of security in such roles, regardless of rank: *"…what does seniority have to do with safety when you're the only Black person in the room? Nothing."*

B3 suggests that this lack of psychological safety fosters a self-preservation mentality among the very few Black individuals who occupy senior roles. As a result, they may not always be able to advocate robustly for other Black colleagues, returning to the idea that safety in numbers—a critical mass—is necessary for meaningful support: *"…as long as I'm in an organisation that functions with very few Black people at the senior level where I happen to be one, I may not be able to support you as a Black doctor, or help you in any particular way that you happen to think that you should be or could be supported or helped…"* However, B3 also emphasises that despite institutional challenges, Black doctors who aspire to senior management roles have agency and should not rely solely on the presence of other Black leaders to ease their progression. They warn against a mindset shaped by internalised racism or diminished agency: *"…you can make it as a Black doctor… don't internalise that you are a victim and therefore that other Black person up there in senior leadership should help you…"* They added, *"Black doctors shouldn't be sitting there thinking I should be helped, or I'm not being helped, or thinking it's because Black people don't help each other—and therefore we continue that narrative of internalised racism; it deeply frustrates me."* B3 argues that junior colleagues often fail to appreciate the burden carried by solitary Black leaders, including the need to protect oneself, manage visibility, and navigate whether to advocate, conform, or simply survive. They suggest that increased Black representation in senior spaces would benefit everyone, including the White majority, by broadening perspectives and ways of thinking. Paradoxically, B3 also notes that the presence of another Black senior leader—where there is still no critical mass—can heighten vulnerability: *"…I got used to being the only Black person in the space… which provides you*

some protection… and suddenly there is this other Black person now in your space where you've cultivated whatever persona… as being the only Black person in that space. So, there's complex dynamics." They added, *"…it's not just a matter of another Black person has turned up, and I must automatically support them… I've got my own stuff to deal with. I am unsafe in my own space."*

In terms of solutions, B3 emphasised the value of early mentorship, noting that its effectiveness is not dependent on race but on the quality and consistency of the mentorship over time. They highlighted that they have actively and boldly sought mentorship throughout their career: *"…I literally go up to any senior and ask them to mentor me…"*—describing this as *"climbing on someone's coat-tails"* and being proactive about their goals. While B3 are clear that mentorship matters greatly, they also emphasise that it does not always need to be race-concordant: *"…I have mentorship… some… related to being a Black person, but actually most of it wasn't… I just had someone who probably didn't care or notice that I was Black… but they were like, we'll support and mentor you."* They note that many of their mentors have been White, underscoring that what matters is not the race of the mentor but the person, their investment in the mentee, and the quality of the mentor–mentee relationship over time in pursuit of clear and achievable goals: *"…so the race doesn't really matter… just needs to be the right person who's interested in you and your goals."*

Finally, B3 frames resilience not simply as resisting or responding to racism, but as learning to heal while continuing to move forward. They argue that younger Black doctors need support not only in naming injustice but also in developing *"strategies for healing from racism",* which include self-forgiveness, forgiveness of others, and maintaining the ability to progress without becoming consumed by bitterness or fear. As they put it: *"…you've got to keep moving forward… you can't sit around talking about how terrible it is… acknowledge*

that it is terrible; find support for what's terrible… but keep moving forward." They continued: *"…you are going to meet racism; you're going to meet injustice. There are going to be times when you can get justice for some of that racism, but many more times when you can't… you can't get bogged down… you have to have strategies for healing; acknowledge that racism exists and be disappointed that it does… but you've got to forgive otherwise it's paralysing."*

4.6.3b Narrative Restorying – B3

Participant B3 is a Black [gender and ethnic origin anonymised] doctor who trained in the UK, has worked in the NHS for several decades, and currently holds a senior leadership role. Their account of differential attainment begins with the observation that minority ethnic doctors, broadly speaking, often do well in medicine compared with other sectors. However, they quickly differentiate within this broad category, noting that progression is uneven across groups, with Black doctors in particular experiencing greater difficulty progressing from junior [resident] doctor to consultant, and from consultant into senior leadership roles.

B3 describes this progression gap as a process of attrition occurring at multiple stages. In their view, there is evidence of "dropping off" as Black doctors move through the pathway, with the disparity becoming even more pronounced at the transition to clinical director and higher leadership roles. They also note that this pattern is specialty-specific, with some fields showing more acute underrepresentation than others. To explain these patterns, B3 points not only to structural barriers but also to socialisation and the experience of difference. They argue that everyday professional life contains countless informal spaces of bonding—such as shared leisure activities, cultural assumptions, and routine conversational norms—that minority ethnic doctors may not automatically share. Their example, *"I don't ski,"* is used to symbolise the broader reality that many everyday forms of belonging are shaped by majority cultural experiences, potentially leaving minority ethnic individuals isolated in these spaces.

When comparing Black and Asian minority ethnic doctors, B3 argues that part of the disparity reflects numerical differences: there are fewer Black doctors overall and therefore fewer at senior levels. However, they move beyond a simple numbers-based explanation, describing Black doctors as disproportionately minoritised even within medicine. They also

highlight racism between minority ethnic groups as a neglected issue, suggesting that the umbrella term "BAME"—now increasingly replaced by "minority ethnic"—obscures power differences, tensions, and unequal patterns of support. In their experience, Asian doctors are more likely to be present as groups in positions of influence, whereas Black doctors are more often solitary individuals. B3 strongly rejects the common claim that Black people do not help each other. They view this as a racist stereotype rooted in slavery and historical narratives that positioned Africans as betraying one another. For B3, this trope is not evidence-based but reflects internalised racism that Black people may themselves repeat. They insist that differences between Black and Asian groups cannot be reduced to simplistic claims about mutual support, as such claims disregard vastly different histories, power structures, migration patterns, and structural conditions.

A major strand of B3's account concerns psychological safety. They argue that being the only Black person in a senior room does not become safer simply because one is senior. As long as someone still answers to a boss or works in a system with very few others like them, their security remains fragile. They explain that younger Black doctors may expect senior Black leaders to help them automatically but may not appreciate the psychological burden and risk those leaders are navigating. B3 recalls situations in which being the only Black person in a space paradoxically felt safer than when another Black person arrived, because uniqueness provided a certain kind of protection, and the arrival of others altered the dynamics of scrutiny and association. They also reflect on the choices they make in predominantly White spaces. They note that when there are fewer Black people around, they speak less about aspects of their faith and culture, whereas in spaces with more Black colleagues, they feel freer to express culturally specific topics. This reflects an ongoing process of self-regulation and adaptation shaped by the surrounding environment.

In discussing leadership and organisational change, B3 emphasises that representation matters but that one person alone is insufficient. For minority issues to be addressed meaningfully, it is not enough for minority individuals to be in the room; they also need to feel safe enough to raise difficult issues. Doing so requires vulnerability and emotional labour, especially in spaces that remain unsafe. Thus, while representation may improve discourse, it only does so when there are sufficient collective presence and support to sustain those conversations.

B3's approach to solutions is practical and agentic. They encourage younger Black doctors to seek mentors proactively, pursue their ambitions boldly, and align their careers with what motivates them. They note that throughout their own career they have had mentors—some of whom supported them profoundly even though race was never explicitly part of the relationship. For B3, the key is not the race of the mentor but whether the mentor is genuinely invested in the individual and committed to supporting them. At the same time, B3 believes that mentoring spaces specifically for Black doctors are important—not because they resolve every issue, but because they create a space for shared experiences that were unavailable when they were junior. They stress, however, that resilience must not be equated with endless struggle. Black doctors need spaces where they can acknowledge racism, seek justice where appropriate, forgive themselves for times they could not respond, and develop ways to heal in order to keep moving forward. Their narrative therefore concludes with a conception of resilience that is not only about resistance but also about restoration: staying in motion, remaining purposeful, and refusing to let racism define the limits of one's future.

4.6.3c Narrative Emplotment – B3

B3's narrative is best understood as a story of solitary advancement within structurally unequal spaces, coupled with a refusal to accept reductive explanations for Black disadvantage. The plot centres on the tension between representation and isolation, and between structural realism and personal agency.

Orientation: *Success with qualification* **-** The narrative begins with a nuanced observation: minority ethnic doctors often succeed in medicine overall, but success is unevenly distributed across groups. This opening creates a differentiated—and not binary—frame from the outset.

Development: *The repeated "drop-off"* **-** The plot develops through B3's description of repeated attrition points: from junior doctor to consultant, and again from consultant to senior leadership. Black doctors, in particular, are depicted as falling away at multiple transitional stages.

Turning point: *Socialisation and minority difference* **-** A key interpretive turn emerges when B3 introduces the role of socialisation, illustrated through the skiing example. This reframes differential attainment as not merely structural or procedural, but deeply embedded in everyday cultures of belonging, familiarity, and social ease—spaces in which minority individuals may not automatically participate.

Intensification: *Rejection of the "we don't help ourselves" narrative* **-** The narrative intensifies when B3 challenges the stereotype that Black people do not support one another. They explicitly trace this trope to slavery and identify it as a form of internalised racism. This represents a central moral and political move in the narrative—an explicit refusal of deficit framing about Black communities.

Crisis: *Psychological unsafety in solitary Black leadership* **-** The emotional peak of the narrative appears in B3's reflections on psychological safety. Seniority, they argue, does not insulate Black leaders from vulnerability; being the only Black individual in the room remains unsafe. Leadership therefore becomes reframed not as an endpoint, but as continued exposure, scrutiny, and risk.

Resolution: *Mentorship, healing, and continued movement* - Their story resolves in a pragmatic but compassionate register. B3 promotes mentorship, agency, support networks, and resilience. However, resilience is framed not as perpetual struggle but as healing—encompassing forgiveness, perspective, and the ability to move forward without becoming trapped in bitterness or victimhood.

Core Narrative Meaning

The central message of B3's account is that Black doctors' differential attainment cannot be explained through simplistic or community-deficit narratives. Instead, it emerges from structural attrition at multiple career stages, solitary minority positioning, and the psychological burdens of navigating unsafe or exclusionary professional environments. In this context, progression depends on strategic support, high-quality mentorship, and the capacity to heal while continuing to move forward. B3's narrative is one of solitary resilience and an explicit rejection of racist and internalised deficit explanations for the experiences of Black doctors. They highlight the persistence of psychological unsafety even at senior levels and emphasise a model of resilience that encompasses healing and purposeful action, rather than resistance alone.

4.6.4 Black Participant 4 (B4)

Length of Service in the NHS - >20 years, Current Position – Senior Leadership Role/Director

4.6.4a Narrative Summary – B4

Participant B4 is a Black [gender anonymised] doctor who is UK-trained and working at a senior leadership level in the NHS, with over three decades of experience. They frame differential attainment through a strongly evidence-based and analytical lens. B4 begins by aligning their account with established literature, noting that there are objectively fewer minority ethnic doctors at higher organisational levels, thereby situating their narrative within a recognised structural pattern: *"…obviously…the evidence from literature…the more senior you go, the fewer minority ethnic doctors you see…".* They go on to contrast the significant presence of minority ethnic doctors at the lower levels of the organisation—and even the high number of minority ethnic doctors, particularly Asian doctors, at consultant level—which, in B4's observation, does not translate proportionally into increased representation at senior leadership: *"…what is striking is that doesn't translate into them being in senior leadership…that's more noticeable with the Black…."* B4 justifies this assertion by grounding it in evidence as well as their own organisational experience, expressing pride in being an evidence-led physician—a principle they apply to their day-to-day clinical work: *"I'm a doctor and a scientist… I look at what the evidence is… before I give an opinion… we know there aren't lots of Black clinical directors and Black people in senior leadership positions."*

B4 then quickly moves to the relational aspect of representation and the potential advantages it may offer to minority ethnic doctors considering leadership positions, recognising that for many, visibility at the top can provide inspiration and support attainment. They describe their early-career experiences, during which they had not initially considered

leadership, but had encountered a small number of Black minority ethnic leaders in senior roles who they felt had not inspired them, partly because these individuals had not met the expected standard: *"...she wasn't brilliant, unfortunately,"* and were therefore unable to effect meaningful change. Here, B4 introduces a critical nuance, suggesting that *"visibility does not necessarily equate to effectiveness or structural change…",* highlighting how 'poor' leadership from a minority ethnic individual may negatively influence the progression of others further down the pipeline. Furthermore, it appears that the standard not met by those senior leaders described as not being *'brilliant'* may indicate a different level of expectation that Black leaders are required to meet to achieve parity with non-Black colleagues. What remains unclear is whether B4 applies the same standard and associated consequences to White senior leaders who may also be ineffective, and whether this has any bearing on the career progression or leadership aspirations of White doctors.

Additionally, B4 discusses the idea of individual agency and drive. Although such drive may be buoyed by visibility of minority ethnic leaders in senior positions, they suggest that representation does not have a direct causal relationship with attainment. Rather, an individual's intrinsic drive is more determinative of leadership progression: *"...does somebody who looks like you make you think you may want to achieve similar? Yeah… we know that's the case… but you don't have to have someone who looks like you in that position for you to decide you want to be in that position… otherwise people of minoritised background would never have got into leadership… it's not a simple linear thing."*

B4 focuses the discussion on their observations throughout their career journey, reflecting on differences between Asian and Black doctors in terms of attainment generally and in leadership specifically. They begin by taking a broader view—situating these differences within the historical experiences of both minority ethnic groups in Britain,

drawing on childhood observations and personal experiences. Starting with the representation of Black versus Asian people in the UK and comparing this with the numbers entering medical school and the NHS at trainee level, B4 notes that both minority ethnic groups appear to be relatively overrepresented: *"…there are many more South Asian doctors… compared with the proportion in the population…. when it comes to Black doctors, I don't know the numbers…. but both are overrepresented now in medicine…"* B4 then introduces further granularity, suggesting the presence of important intra-ethnic differences—particularly further along the career pathway—which often go unrecognised, with the potential to marginalise groups that are otherwise homogenised under broad ethnic labels. They highlight that *"…it's about looking at the granular detail…. the proportion of Black senior leaders from West African, specifically Nigerian backgrounds, it's like about 95%."* B4 describes this as *"problematic",* arguing that although representation has increased at the lower and middle tiers—including at medical school entry—the benefits are disproportionately experienced by those of Black West African origin. As a result, others within the broader Black category, including those with longer histories in the UK such as people of Caribbean origin, risk being further disenfranchised: *"…it doesn't reflect the majority of the Black population in the UK, which are still people from Caribbean backgrounds…."*

B4 draws a clear distinction between numerical representation and leadership attainment. They emphasise this point by referring to their own medical specialty (details removed for anonymity) and then extrapolating to the wider NHS career structure: "*Asian doctors are numerically prominent",* yet this *"doesn't translate into them being in senior leadership positions."* This observation reinforces their broader argument that pipeline presence alone does not account for leadership disparities, even among groups with strong

representation at higher organisational levels. Throughout the discussion, B4 repeatedly returns to an evidence-based epistemology, rooting their reflections in data and collective experience rather than purely anecdotal interpretation. They explicitly challenge the assumption that simply increasing minority ethnic representation in the medical pipeline will naturally lead to proportional increases in senior leadership: *"It's not about what I think…. we know that that's not the case."*

When contrasting Asian and Black representation at senior leadership level, B4 drew on their lived experience in British society, expanding the argument through a comparative historical and socioeconomic analysis of South Asian groups. They suggested that migration history—specifically the arrival of middle-class doctors from India in the 1950s who accumulated wealth over time, including professional inheritance—has contributed to more favourable outcomes for this group in the NHS compared with other minority ethnic groups. B4 supports this with research evidence: *"…the wealthiest in the society, unsurprisingly, are British White people and British Indian people, with Black Africans being the poorest."* Furthermore, B4 contrasted the histories within Asian minority ethnic groups, noting that many Indian doctors arrived as middle-class professionals seeking opportunities within the newly established NHS in the 1950s: *"…in the 50s there was a big push by the NHS to bring in doctors. It turned out India trains doctors already in the British commonwealth… they were already made to suit the British system."* By contrast, other Asian groups, such as Bangladeshis, arrived in the UK under very different circumstances, with migration often driven by *"war, famine and flood."*

Discussing legacy advantage as a contributor to the differential attainment now observed between Black and Asian minority ethnic doctors, B4 recalled growing up as a *"very bright child"* who was ambitious and encouraged by their working-class parents.

However, B4 reflected on how isolated they felt navigating the system alone as a young person, partly due to their parents' lack of cultural capital—emotional support was available, but practical guidance was limited: *"…often times, if you're the individual in the family who is a clever kid who does all the stuff… you get a lot of praise, but no one is there to help you really, as they don't know what is needed… it comes from you."* B4 described how this wider cultural deficit left them less prepared for challenges and for understanding the mainstream cultural norms that shape professional success: *"…you need to already be fully formed and well-rounded… to improve your chances of success… this comes back to the support and preparation you get in your seminal years—parents etc."* B4 also spoke about the burden of being Black and the expectation of excellence required simply to be perceived as comparable to others: *"…you're Black, so you have to prove yourself more. There's no doubt at all. You have to be better if you're Black and that hasn't really changed…"*

B4 also anchors their understanding of differential attainment between Asian and Black minority ethnic doctors—including within the NHS and senior leadership—on socioeconomic factors, particularly the greater prevalence of poverty within certain minority ethnic communities. They link this again to their own early experiences. B4 further connects these socioeconomic differences to disparities in health outcomes observed between minority ethnic groups, adding nuance by arguing that the prevalence of certain diseases in some communities (e.g., diabetes) may reflect wealth rather than poverty. They explain: *"So, this also links to health outcomes for the different nationalities within each ethnic grouping… for example, maternity care outcomes—obviously we know that Black women have one of the worst rates of maternal mortality and neonatal morbidity. But also, the other group who have really poor maternal outcomes are Bangladeshi women, and then Pakistani women, with twice the rates of maternal mortality—higher than Black women. If you look at Indian*

women, that's not the case actually. And when you look at the wealth disparity, the people who match the wealth of White British people are actually the Indian people. And when you look at health outcomes for these groups—other than diabetes, which can be seen as a rich person's disease, particularly in places like India…"

Somewhat unique, B4 introduces an interesting social concept around the idea that physical beauty operates as a subtle but influential advantage in career progression, including for doctors in the NHS, regardless of their skill and expertise—which, in principle, ought to be paramount in selection. Physical attractiveness, B4 suggests, may even become decisive at the final stages of selection, particularly for Black candidates: *"It will help if you're good looking… being good looking gets to be more and more important as you get to some interviews. It just does. If you're too good looking, that can work against you, but you've got to be good looking enough to people… this is more important if you're Black probably than if you're not… more important if you're a woman than if you're a man… of course you have to be able to do the smart stuff—clever, but at this level, everyone can do the smart stuff…"*

Furthermore, B4 introduces a striking critique of meritocracy. They reflected that they once believed success required "exceptional" ability but later realised that many individuals in senior leadership positions are *"just ordinary"*. However, they noted that this standard does not apply equally across groups. For the majority White group, B4 observed: *"…if you're a White male, or female… you don't have to be stellar; you can be mediocre. Just ordinary… I work at very senior levels in the country… what I'm struck by is how often I go in the room, and actually, I know a whole heap more than everybody else…"* By contrast, for minority ethnic groups—particularly Black doctors—the threshold is markedly higher: *"…the point is that lots of people are ordinary… if however, you are brown, it's harder; if you're Black, it's even harder still. That's the difference. It's not to say that there's*

something special about the Black people, it is to say, actually in life normally you don't have to be exceptional to get a leadership position, but you do if you're Black… there is the difference." Essentially, B4 reframes differential attainment as a matter of "*differential thresholds" for success*, rather than differences in ability. They further highlight informal mechanisms of advancement, particularly *"tap on the shoulder"* opportunities, noting that such opportunities are unevenly distributed because *"people promote and support those who are like them. They can't help it."*

B4 also challenges traditional mentoring models, arguing that Black junior (resident) doctors are less likely to seek mentors due to cultural norms. For this reason, they argue that senior Black leaders must take a more proactive role: *"...the classic idea is that… mentees have to come and seek out mentors… that goes against the way I was brought up, actually it is the last thing you do—go up to some elder person who's in an exalted status to you and say… it's just not our culture… so, Black people in these senior positions have to seek out Black mentees because they are unlikely to come up to you… they are not the same as a middle-class White doctor who were brought up this way. It's just not the same."*

In examining their relationships with other Black doctors in senior leadership, B4 reflects on the tensions they have experienced over the years, describing dynamics shaped by insecurity, internalised racism, and what they term a form of *"Black-on-Black expectation,"* resembling an intra-ethnic civil war. They argue that this arises partly because Black people, like all ethnic groups, are not a monolith. In terms of motivation and support, B4 notes that some individuals successfully navigate NHS career pathways independently, while others require mentorship and guidance. However, they suggest that this individualism can generate animosity at senior levels, where expectations—both internal and external—are heightened: *"...I observe the disappointment in other Black people's faces who are equally in*

that senior position because they actually liked being the only Black person there and do not welcome the addition of other Black people or camaraderie… it is as if it somehow diminishes their achievement…. other minority groups don't necessarily feel that way." B4 contrasts this experience with what they describe as a general tendency among Asian colleagues to welcome others from their own ethnic background, which they suggest may partly explain their greater representation at senior levels. However, they acknowledge that inter-ethnic tensions also exist within Asian groups: *"…Asian people tend to welcome others – though there might be some differences within the nationalities e.g. Indian and Pakistani…. but us Black people big ourselves up…. but there's very much more of a kind of what I need to do is care about me and my family, not you… and you as another senior Black leader being in this space diminishes me. I've definitely had that."*

Although B4 laments this phenomenon, they recognise its roots in a more primal survival instinct, reinforced by the ways society homogenises Black people—particularly through negative portrayals and stereotypes in the media. This homogenisation creates additional pressure on Black senior leaders, who often feel compelled to be exceptional simply to counteract these stereotypes. B4 highlights the emotional and cognitive burden of this expectation, explaining that it leads to Black leaders having to *"police"* another Black leader who may not meet expected standards, yet whose perceived shortcomings could reflect on them: *"…I'll be worried… what if this person isn't good? How would they reflect on us? In my experience as a Black leader and having been often one of the only people in the space, you were the ambassador and you represented all the Black people… because oftentimes you're the only Black person that someone had ever met."*

Finally, B4 connects leadership disparities to wider societal and health inequalities. While they acknowledge that representation provides hope and symbolic value, they firmly

rejects simplistic explanations that attribute health disparities solely to under-representation: *"…if only it were as simple as that. It's such a lazy trope."* Instead, B4 emphasises the structural determinants of health: *"structural discrimination continues to exist, and that does affect people's access to good services"* and highlights poverty as a central factor: *"…Black people in Britain are poorer and if you are poor, if you are socially disadvantaged, it means that being poor is a proxy for having poorer housing, living in a more deprived area, less access to a good school, less access to green space, and actually that has a big effect on your health, including your mental health. That's what poverty means."* They conclude by noting that these communities also have a higher prevalence of childhood trauma and substance misuse, describing these intersecting factors as a *"perfect storm"* shaping health outcomes among minority ethnic groups.

4.6.4b Narrative Restorying – B4

B4 is a Black [ethnicity and gender anonymised] doctor, trained in the UK, who has worked in the NHS for over three decades and now holds a senior leadership role. Their account of differential attainment begins with recognition of a widely established pattern: as one moves up the hierarchy, minority ethnic representation decreases. However, they immediately complicate this general pattern by reflecting on their own experience, which includes early exposure to Black leadership within their organisation that was perceived negatively. Despite this exposure, B4 emphasises that representation alone is not sufficient. They recalled that a Black senior leader they encountered early in their career was ultimately not successful in the role, illustrating that presence does not necessarily equate to influence, effectiveness, or systemic change. This introduces a more complex understanding of leadership, where symbolic representation must be distinguished from substantive power and competence.

B4 frames their analysis through an explicitly evidence-based approach. They reject relying solely on personal observation and instead emphasise the importance of data and structural comparison. From this perspective, they assert clearly that minority ethnic representation at senior leadership levels is not proportionate to their presence in the workforce. They then shift the analysis from representation to structural explanation, arguing that differences in attainment between ethnic groups cannot be understood without considering historical, socio-economic, and migration-related factors. They highlight that many Black doctors in the NHS are first-generation immigrants who arrive with strong educational foundations and confidence. In contrast, Black British individuals grow up within a racialised society where they are socialised into a sense of marginalisation from an early age. This creates psychological and structural disadvantages that persist throughout their careers.

B4's narrative also contrasts different ethnic groups within the NHS, particularly South Asian communities. They explain that Indian migration to the UK included large numbers of already-trained doctors, leading to strong professional networks, intergenerational support, and accumulated social capital. In contrast, other groups arrived under very different conditions—such as poverty or displacement—which offered less institutional and familial support for navigating professional pathways. B4 further develops their account by challenging the assumption that success in leadership is purely meritocratic. Reflecting on their own career, they noted that they once believed only exceptional individuals could succeed. However, their experience in senior leadership revealed that many individuals in these roles are not exceptional but instead benefit from structural advantages. They concluded that while average performance may be sufficient for progression among White colleagues, Black doctors often need to demonstrate exceptional ability to achieve similar outcomes.

Another key element of B4's narrative concerns access to opportunity. They described how advancement often depends on informal mechanisms such as being *"tapped on the shoulder"* for opportunities. These mechanisms favour those who are already part of dominant networks, as people tend to support individuals who resemble themselves. They argue that this creates a structural disadvantage for Black doctors, who are less likely to be included in these networks. In response, B4 advocates for a more proactive approach to mentorship and sponsorship. They suggest that senior Black leaders must actively identify and support junior Black doctors, as these individuals may be less likely to seek out mentorship due to cultural norms or lack of confidence. B4 described their own efforts to engage with junior colleagues, encourage them, and create opportunities where possible.

Finally, B4 reflects on the broader implications of leadership representation. While they acknowledge that seeing someone in a senior role who shares one's background can

provide hope and inspiration, they caution against oversimplifying the relationship between representation and outcomes. In their view, structural inequalities—such as poverty, social disadvantage, and exposure to trauma—play a far greater role in shaping health outcomes than representation alone.

4.6.4c Narrative Emplotment – B4

Emplotted Narrative: Differential Thresholds in a Structurally Unequal System

Orientation: *Recognising unequal representation* **-** The narrative opens with an acknowledgement of a structural reality: minority ethnic doctors become increasingly under-represented at senior organisational levels. This situates the story within a wider context of systemic inequality.

Complication: *Representation is present but not sufficient* **-** B4 introduces nuance by arguing that while minority ethnic representation does exist at certain levels, its presence alone does not guarantee influence, effectiveness, or structural change. The narrative therefore shifts from a discussion of absence to one of insufficiency.

Turning point: *Structural and historical explanation* - The story deepens as B4 incorporates historical, socioeconomic, and migratory contexts, marking a key turning point. They highlight that different minoritised ethnic groups enter the system with unequal levels of social capital, guidance, and opportunity, shaping their experiences of attainment and progression.

Intensification: *Unequal thresholds for success* - The central tension becomes explicit: White doctors can succeed while being "ordinary", whereas Black doctors must be "exceptional" to achieve comparable recognition. This crystallises the core conflict—the required threshold for success is not uniform but stratified by identity. The narrative reaches its peak as B4 exposes the informal, relational mechanisms that govern progression into senior leadership. These include "tap-on-the-shoulder" invitations, sponsorship, and access to influential networks. Such mechanisms are not meritocratic but shaped by proximity, familiarity, and social alignment, thereby reproducing inequality.

Resolution: *Active intervention and realism* - The narrative resolves through a blend of pragmatic action and structural awareness. B4 advocates for proactive mentorship and sponsorship, particularly for Black junior doctors, explicit recognition of entrenched structural inequalities, and rejection of simplistic assumptions—such as the notion that representation alone will correct systemic disparities.

Core Narrative Meaning

Differential attainment is not rooted in individual deficits but in differential starting points, unequal access to networks and support, and unequal thresholds for success within a system stratified along racialised, socio-historical and socio-economic lines.

4.7 White Participants

4.7.1 White Participant 1 (W1)

Length of Service in the NHS - >15 years, Current Position – Senior Leadership/Director

4.7.1a Narrative Summary – W1

W1 began by reflecting on their experiences of differential attainment from medical school training outside London through to their current senior leadership role. They focused on wider societal observations and the variation they noticed within the National Health Service (NHS) throughout postgraduate training—from junior [resident] doctor to consultant, and eventually into leadership.

W1 began their account by describing early encounters with minority ethnic doctors, predominantly those from Asian backgrounds. They linked this observation to what they perceived as stronger academic achievement among doctors from Asian backgrounds compared to other minority ethnic groups. W1 recalled that Asian doctors were *"often… very high achieving"* and therefore *"well represented in consultant posts"* within the NHS. This suggested that, at that stage, W1 did not recognise differential attainment either between minority ethnic groups or more broadly as a significant issue. W1 also reflected on the generational history of Asian doctors in the UK, focusing in particular on Indian doctors, acknowledging the diversity within the broader Asian ethnic category. They suggested that historically, although the number of Indian doctors who migrated to the UK was relatively small, they "*tended to be top of the class… so well represented in consultant posts in the NHS."* W1 linked the achievements of these Indian doctors to socioeconomic status, noting, *"I got the distinct sense… they came from affluent backgrounds… so there wasn't a divide in terms of socio-economic status compared to White."* Here, W1 emphasised that this

additional privilege—rooted in class, social capital, and cultural capital—may have conferred generational advantages for some Asian doctors. In contrast, W1 described a striking absence of Black doctors during their early training, a pattern that persisted throughout their postgraduate years. They recalled that *"only one medical student in my year… was Black,"* and added, *"in fact, I cannot remember working with any Black junior [resident] doctor in [area of England—removed for anonymity]."* W1 went on to state that even later in their career, as they moved regions and progressed into management and leadership roles, the same pattern remained: they *"cannot recall Black doctors in positions of senior management… even in areas where there was a large Black community."* However, W1 also acknowledged that the presence of a *"large Black community"* in an area does not necessarily correlate with the presence of Black doctors in local hospitals.

W1 also situated their observations within the wider changes in the NHS over the course of their training, particularly broader structural shifts affecting the workforce—for example, the impact of European Union (EU) policies that opened NHS recruitment to doctors from across the EU. W1 noted that these demographic changes did not include Black doctors, which may have compounded the situation: *"…Eastern European or Greek doctors came in… career dynamics changed for everyone… In terms of who was coming in… I would say there was underrepresentation of people of Black ethnicity."* This, W1 emphasised, did not translate into better representation of Black doctors in NHS leadership roles. W1 noted that, over their career in the NHS, there have been significant changes aimed at increasing minority ethnic representation within medicine and medical education, supported by a range of government and institutional initiatives such as widening participation and outreach programmes. Nevertheless, W1 suggested that these changes have not made a substantial difference at senior levels for Black doctors: *"…I think representation is changing… the*

speed of change is slow, and I definitely would say I still think there is underrepresentation of Black ethnicity in senior positions…." W1 continued, *"…I rarely see people of Black ethnicity [in leadership positions] compared to their proportion in the junior ranks."* Furthermore, W1 suggested that this disparity is not limited to leadership opportunities within NHS management structures but extends into academia—both undergraduate and postgraduate medical education leadership. W1 reflected that the differential may be even worse for Black doctors in academic contexts: *"…the underrepresentation even in academic positions is worse still… within senior management in medical schools."* W1 contrasted this with other university disciplines, suggesting that the disparity in medicine and medical education leadership is more pronounced: *"…I think it is worse more so in medicine than when I look at some of my colleagues who work in other areas of the university, e.g. [mentions other courses], where I think there is more representation of Black people."*

When reflecting on the causes of differential attainment between minority ethnic groups—particularly Black and Asian doctors—W1 acknowledged disparities within the broader categories themselves: *"…I think Black doctors are still underrepresented… compared to the Asian group."* W1 emphasised the need to further disaggregate minority ethnic categories to understand nuance, noting differences within the Asian group: *"…I'd say within the Asian group… nationalities such as Bangladeshi are underrepresented… In [mentions a region of the country], there is a significant number of Bangladeshi people, but the senior leadership roles are often held by those from Indian backgrounds."*

When reflecting on the causes of this differential in general, W1 characterises the issues as *"very multifactorial… but the first thing, obviously, I think there is a component of racism."* W1 revisited their journey through medical school and postgraduate training, noting how few Black doctors they encountered even in areas with significant Black populations.

W1 contrasted this with the prevalence of Asian doctors throughout his medical school experience, postgraduate training, and senior leadership roles—a pattern W1 suggested might appear inevitable given the strong representation of Asian groups throughout the medical pipeline. As W1 stated, *"there is a component of prejudicial bias throughout the medical journey: from the point of gaining entry into medical school… to more prestigious training programmes… this carries on to appointment as senior management positions… so, this is just part of it."*

W1 then broadened their explanation of the differential between Asian and Black doctors by situating it within the wider social context of the UK. W1 described the role of socio-economic status, cultural and social capital, and access to high-quality education—often private—as well as family ambition and the challenges faced by those who are first in their family to pursue medicine, a scenario W1 suggested was more common among Black families than Asian families. W1 observed a *"very strong correlation between deprivation and ethnicity…"* adding *"so I think that's an important driver is family wealth and prior attainment... predicts future attainment… your chance of getting into medical school is dependent on… early life education opportunities, deprivation… and belonging."* Regarding senior leadership positions, W1 discussed issues of *"welcomeness"* and belonging for the few Black doctors who do reach senior roles in the NHS. W1 expressed concern about feelings of comfort and security within these positions, stating that *"even if a Black person was welcomed into a group which comprised all White people—a homogenous group—it is difficult for the Black person to feel a sense of belongingness."* W1 added, *"even if you were welcomed… but everyone else behaves differently or looks different in terms of skin colour… I think that's a barrier to progression."*

W1 also highlighted challenges they observed in senior leadership recruitment processes, particularly for minority ethnic doctors seeking advancement, where gatekeepers are often White or non-Black. They noted that *"confirmation bias is a big part… the desire to appoint someone who looks and behaves like yourself is significant… it spans even the gender biases… people like to like their own… if you talk to someone who shares your hobbies or has a shared interest… that creates a bond, and I think skin colour can create that same bond."* W1 reflected on the difficulties of senior appointment processes in which shortlisted candidates are often equally strong, making the subtle influences on decision-making more consequential. They recognised that sometimes decisions appear predetermined unless an exceptional candidate clearly outperforms others: "*one of the challenges in interview panels for senior positions is the subtleties of what influences a decision… it is often very easy to put forward an argument that fits your answer for your desired candidate… and if you look at the minutes of the discussion, you wouldn't be able to trace the unconscious or conscious bias."*

Finally, W1 highlighted the broader implications of these disparities, which extend beyond leadership and into healthcare delivery. W1 reflected that *"the big epidemiology of health outcomes of people of Black ethnicity versus White—the disparities are enormous."* W1 described how bias can influence clinical decisions, including pain management and maternal outcomes, citing UK data: *"there are many things of association driven by colour of skin, however, the maternity aspect of disparity of outcomes is very troubling… research around maternal outcomes and infant outcomes showed that if you're treated by a healthcare provider who is ethnically congruent… you have better outcomes than if your doctor was White."* W1 argued that this is *"a very stark sort of clear evidence that there is probably unconscious bias or conscious bias feeding into clinical decision-making."* However, W1

stressed that many observed health inequalities are driven not by biological differences but by social determinants such as deprivation, access to care, and cultural factors. W1 acknowledged that increased minority representation in senior leadership may help address some of these inequalities but is not a panacea for the wider systemic issues.

4.7.1b Narrative Restorying – W1

Participant W1 reflects on their experience of differential attainment within medical training and leadership in the National Health Service over approximately 15–20 years. In their early career, W1 recalls that the minority ethnic doctors they encountered were predominantly of Asian background, particularly Indian, and were widely perceived as high achieving. These individuals were described as well represented in consultant positions, often associated with strong academic performance and, in W1's perception, relatively affluent socio-economic backgrounds. W1 also referenced the historical migration of Asian—particularly Indian—doctors to the UK and the legacy benefits related to culture and capital. As a result, W1 did not initially perceive a strong socio-economic divide between Asian minority doctors and White doctors based on W1's lived experience during medical school and postgraduate training in the NHS, which also related to the geographical areas in the UK where they initially trained, and where Black communities were fewer. In contrast, W1 reports minimal exposure to Black doctors during medical school and early training, particularly in the region of England where they completed their undergraduate medical training. W1 recalls encountering only one Black medical student and no Black junior (resident) doctors. Although ethnic diversity increased as W1 moved around the country for postgraduate training and progressed into leadership roles, they still perceived a persistent absence of Black doctors in senior leadership or management positions.

W1 identifies a shift in workforce demographics following the introduction of European Union employment policies, which facilitated the recruitment of doctors from across Europe. However, this diversification did not substantially increase the representation of Black doctors in senior roles. W1 notes that this wave of recruitment did not include Black doctors from other global regions who might otherwise have contributed to increasing

representation in the NHS. Over time, W1 developed an awareness of persistent underrepresentation of Black doctors, particularly in senior leadership and academic positions. While acknowledging some improvement in *[region removed]*, W1 describes the pace of change as slow and uneven, with underrepresentation continuing across senior clinical and academic leadership structures.

When reflecting on the causes of differential attainment, W1 identifies multiple contributing factors. These include structural and systemic issues such as racism and bias throughout the medical career pipeline, beginning with access to medical school and continuing through specialty training and leadership appointments. W1 also highlights the role of socio-economic disadvantage and prior educational attainment in shaping career trajectories. In addition, W1 emphasises the importance of belonging and group identity, suggesting that individuals from minority backgrounds may experience difficulty integrating into predominantly homogeneous professional environments— *"White spaces"*—even where overt inclusion is attempted.

W1 further reflects on the role of unconscious bias, drawing attention to how subtle associations between ethnicity and negative stereotypes may influence both perceptions and decision-making. These biases are described as cumulative and often unrecognised, shaping interpersonal interactions and formal evaluation processes. Within leadership and senior leadership selection processes in the NHS, W1 highlights the opacity of decision-making, noting that interview panels may retrospectively justify appointment decisions while underlying preferences—such as affinity for candidates who resemble existing leadership—remain unspoken. W1 rejects the notion that disparities will resolve automatically over time, instead describing a self-reinforcing cycle in which underrepresentation perpetuates bias, which in turn limits future representation.

Finally, W1 identifies potential solutions, including mentoring, visible role models, and increasing awareness of differential attainment among decision-makers. W1 emphasises the importance of representation—particularly ethnically congruent role models—in shaping aspiration and progression, referencing literature and evidence on poorer maternity outcomes for Black women. W1 also reflects on the broader implications of inequality, including its impact on healthcare delivery. They highlight how unconscious bias may influence clinical decision-making, citing disparities in pain management and maternal outcomes. W1 emphasises that many health inequalities are driven not by biological differences alone but by social determinants such as deprivation, access to care, and cultural factors. While acknowledging that increased minority ethnic representation in NHS senior leadership may help address some of these inequalities, W1 stresses that these are part of a wider structural societal problem.

4.7.1c Narrative Emplotment – W1

The narrative plot for W1 moves from an initial relative unawareness of the scale of differential attainment—particularly between minority ethnic doctors—to a gradual awakening prompted by reflection on personal experiences and professional environments throughout training. This process leads W1 toward recognition, critical reflection, and ultimately a stance of advocacy.

Orientation - W1 began with a normalisation of inequality around differential attainment, shaped by the perception that Asian doctors were high achieving and therefore well represented from medical school through to NHS leadership. In contrast, Black doctors were largely absent, though W1 did not critically interrogate this disparity at the time.

Turning point - As W1 progressed through their career, they began to recognise inequalities both between White and minority ethnic doctors and between different minority ethnic groups. This recognition became particularly salient during progression into management and leadership roles, where W1 noted a striking absence of Black doctors in postgraduate medical training and specialty training posts leading to consultant and leadership positions. W1 also observed that this lack of representation persisted even in areas with large Black communities. This shift from passive observation to active recognition marked an important turning point.

Interpretation - W1's narrative then developed into an exploration of the underlying causes of differential attainment—both in general and between minority ethnic groups—in senior NHS leadership. W1 adopted a broad explanatory frame, identifying structural racism within both the NHS and wider society; socio-economic inequality, which they suggested may account for differences between Indian doctors and others, including Black doctors and

underrepresented groups within the Asian category such as Bangladeshi doctors; and the influence of various forms of bias—conscious, unconscious, and confirmation bias—operating within senior leadership selection processes. W1 also suggested that for the few Black doctors who do reach senior leadership positions, the predominantly White culture of these environments may negatively affect their experiences of "welcomeness" and belonging. At a micro level, this insight was important for W1, as it framed inequality not as overt discrimination but as an embedded, subtle, and difficult-to-detect set of dynamics, exemplified by interview panel processes and other decision-making structures. At this stage, W1's thinking shifted from individual-level explanations toward a recognition of systemic and institutional mechanisms.

Resolution - W1 is cautiously optimistic, acknowledging that "progress is slow" but recognising that there has been gradual improvement. They emphasise the need for proactive intervention, including structured mentoring for minority ethnic doctors aspiring to leadership roles. These mentors do not necessarily need to share the same ethnic background—though W1 recognises the advantages of such congruence—but should instead have experience, influence, and access that can support meaningful progression.

Core Narrative Meaning

Participant W1's narrative reflects a clear progression from early normalisation of differential attainment to a more developed critical awareness of structural and institutional factors shaping senior leadership inequality in the NHS for minority ethnic doctors—particularly Black doctors. Through retrospective reflection, W1 constructs a narrative of *"awakening,"* in which the absence of Black doctors in senior roles (NHS and medical academia) becomes increasingly visible and is interpreted through the lenses of structural inequality, unconscious bias, and institutional practice. This narrative highlights the role of subtle, cumulative, and

often opaque processes in reproducing leadership disparities, while reinforcing the need for active intervention rather than passive reliance on gradual change over time.

4.7.2 White Participant 2 (W2)

Length of Service in the NHS - >25 years, Current Position – Senior Leadership/Executive

4.7.2a Narrative Summary – W2

W2 reflected on differential attainment in the NHS at senior leadership level by drawing on their experiences from medical school through their long service in the NHS. W2 stated, *"When I trace back my experience… what I see is obviously we don't have as many Black junior (resident) doctors compared to other minority ethnic doctors."* Situating this within the broader social climate of Britain before the Equality Act 2010. W2 noted, *"I think probably in the 70s and 80s, the country was different back then… particularly for Black people,"* and added, *"The only Black doctors I came across were international medical graduates who came to the UK for work… but couldn't get jobs in their chosen specialty and settled for what they could."*

W2 believes there has been positive change over time for minority ethnic doctors, including Black doctors: *"I would say… though I couldn't put a figure on this… but anecdotally, there are more Black doctors now… it has increased a little bit… certainly at junior levels."* However, W2 emphasised that this improvement is largely confined to the entry level. W2 noted that increased representation among junior ranks does not translate into specialty training programmes—the pathway to consultancy—and subsequently into leadership or senior leadership roles in the NHS: *"I see a lot of Black doctors in the very junior ranks… but I don't see that translated into higher training, and therefore they don't become consultants… as a result won't achieve senior leadership positions in the NHS."*

W2 contrasted the experiences of Black and Asian minority ethnic doctors, suggesting that doctors from Asian backgrounds—particularly Indian and Pakistani heritage—appear to

fare better with career progression. This includes securing specialty training posts, progressing to consultancy, and, for some, entering leadership roles: *"…a lot of Asian junior [resident] doctors are coming into higher training."* In contrast, W2 found the barriers facing Black doctors more difficult to explain: *"I'm just not sure why this is the case… maybe it is to do with having more Asian doctors already at the top, mentoring other Asian doctors."* W2 described the issue as likely multifactorial and pervasive across all key milestones in the medical career pathway for doctors. Black medical graduates who are competent still appear to struggle to progress once they enter the NHS system—whether in obtaining specialty training posts, advancing through the Annual Review of Competence Progression (ARCP), avoiding disproportionate disciplinary processes, or securing leadership roles. W2 viewed this as troubling and persistent: *"I honestly don't know the answer… amongst the Black doctors I've mentored, I wouldn't say there is any difference in academic attainment or career drive."* W2 further reflected that wider workplace, societal, or cultural factors may discourage Black doctors from aspiring to more senior roles: *"…perhaps it is something within the workplace… wider societal or cultural issue that either discourages younger Black doctors coming through… or makes them think I don't want to do it because of historical barriers to it."* Finally, W2 suggested that bias in NHS recruitment and career progression persists: *"…there is bias towards White people in getting jobs in the NHS… conscious or otherwise, and this also exists for Asian doctors coming through because they seem to be doing better than Black doctors."*

A central explanatory thread throughout W2's account is the importance of role modelling and representation: *"…it's about role modelling, isn't it?"* W2 contrasts the experiences of Black and Asian doctors, suggesting that the strong presence of Asian doctors at all levels of the NHS provides a significant advantage for other Asian doctors. As W2 puts

it, *"…more Asian doctors mentoring other Asian doctors is perhaps leading to higher achievement and gaining senior roles in the NHS…which can be an unforeseen consequence perpetuating the problem for Black doctors who lack representation at the same levels."* W2 describes this as a "vicious cycle," whereby a lack of representation reinforces further underrepresentation: *"…if Black doctors aren't getting to more senior roles, then the next generation of younger Black doctors think again, either consciously or subconsciously—well, I won't attain that level because I'm Black."* W2 emphasises here the importance of visibility at senior levels for minority ethnic doctors—particularly those currently underrepresented—as well as the need for role models, mentors, and early proactive support.

W2 also situates differential attainment within broader organisational culture, describing senior NHS leadership as *"…a bit of an old boys' club"* where informal affinities and historical patterns continue to favour White doctors: *"…the White lad who trained at the right school and right hospital and played rugby."* Although W2 believes merit matters, W2 argues that key barriers arise earlier in the training pathway—particularly the transition to higher specialist training and progression into consultant roles. W2 acknowledges significant bias in selection processes, especially at consultant and senior leadership levels, which disproportionately affects minority ethnic candidates, and Black doctors in particular. This W2 felt is exacerbated by limited Black representation at senior levels: *"…let's say an interview panel…because we don't have Black consultants, the panel consists of seven White and three Asian…with Asian doctors often the only minority representation"* which meets hospitals guideline for a diverse interview panel. W2 adds that Black candidates may face both conscious and subconscious resignation when confronted with such panels: *"…you've got to feel for the candidate who is Black being interviewed by this panel…must be quite intimidating…I think it's automatically already a disadvantage for them."*

Reflecting specifically on differences in progression between Black and Asian doctors at senior leadership levels in the NHS, W2 describes the gap as "stark and significant": *"…no doubt there is a difference…not only do you not really see Black males, you don't even see Black females at the highest level…mostly, I can name a lot of Asian doctors…but I could only name one Black doctor at this level."* W2 attributes this disparity partly to population-level differences between Asian and Black communities in the UK, which they believe is reflected in the NHS workforce: *"…there are more Asian people already in the consultant role…so therefore a bigger pool to go from…and I do think at this level [senior leadership] it does come down to how good you are…"* W2 suggests that because Asian doctors are more numerous at the consultant level, they form a larger proportion of the eligible pool for senior leadership roles. Furthermore, W2 believes that wider societal discourse and the portrayal of minority ethnic people—for example, in the media—shape how individuals think about and perceive members of these communities. W2 further distinguishes that although portrayals of minority groups often carry negative connotations, there are nuances and differences between groups. In some instances, Asian minority ethnic people appear to fare better: *"…in the media, for Asians becoming a doctor is very much a normal thing in our society…. Black people are not perceived the same way…."* W2 added *"amongst my demographic, i.e. White people, we see that the Asian community want to see their children become doctors…. Within the Black community it's different, there's not this stereotypical vision of Black people becoming doctors… it's often worse things… that's the perception I get from the media."*

Finally, W2 extends the issue beyond careers to the health outcomes of minority ethnic communities and the way healthcare is delivered. W2 argues that poor minority ethnic representation at senior levels has consequences because medicine remains culturally narrow: *"…there is a lot of bias in medicine and medical practice… and it starts from the*

way we were taught… the textbooks are based on the average White male." W2 expands this argument into everyday medical practice, explaining how lack of representation affects the quality of care received by minority ethnic people in the NHS: *"…understanding cultural differences between patients and how they react to disease and their expectations is really important in what we do… COVID was an example of this… you need people and doctors to advocate for their communities and bring nuance and lived experience."*

4.7.2b Narrative Restorying – W2

Participant W2 explains their understanding of differential attainment by tracing it back through the medical training pathway rather than beginning at senior leadership itself. They begin by observing that, even at the junior (resident) doctor level, there appear to be fewer Black doctors than other minority ethnic groups. While W2 believes there may have been some increase in Black representation among junior ranks over time, they note a marked reduction in visibility as careers progress into higher specialist training, consultant-level posts, and ultimately senior leadership positions. W2 links this pattern partly to specialty-specific pathways. They describe some specialties, such as their own, as historically more welcoming for minority ethnic doctors and as having provided opportunities for international medical graduates—including Black male doctors—who may initially have trained in other specialties, such as surgery, but were unable to secure posts there. W2 gives the example of a Black mentor *[nationality removed for anonymity]* who came to the UK intending to work in surgery but instead moved into *[specialty removed]* as a staff-grade doctor (non-training grade), later progressing when consultant opportunities expanded. For W2, this illustrates an earlier, more flexible and bespoke route into consultant practice that differs significantly from current formalised training structures.

In contrast, W2 now sees many Black doctors in junior roles but does not see these numbers translating into higher specialist training, consultancy, or senior leadership positions. This perceived lack of progression prompted W2 to consider why Black doctors appear to fall behind both White doctors and other minority ethnic groups, particularly Asian doctors. W2 reflects that Black doctors' experience greater differential attainment than Asian doctors, noting that they have not observed differences in academic ability or ambition among the Black doctors they have supervised. Instead, they suggest that barriers may lie

within organisational culture, wider societal influences, or historical exclusion. W2 raises the possibility that a persistent lack of representation may dampen aspiration among Black doctors, while Asian doctors may benefit from more established role modelling and mentoring within their communities. W2 repeatedly emphasises the importance of representation. They suggest that because Asian doctors already occupy more senior positions, they can more readily mentor junior Asian colleagues, creating a reinforcing cycle of progression. Conversely, the underrepresentation of Black doctors at senior levels means that junior Black doctors may not see leadership as attainable. W2 describes this dynamic as operating both consciously and subconsciously.

W2 also reflects on mentorship, distinguishing it from appraisal and arguing that meaningful mentorship should be formalised and long-term. They acknowledge that the ethnicity of a mentor may matter, particularly for Black trainees or consultants seeking someone who has *"gone through the same struggles."* Although W2 believes mentors should fundamentally be chosen on ability and commitment, they recognise that a young Black doctor may find a White senior male mentor intimidating or less relatable.

At the organisational level, W2 characterises the upper tiers of the NHS as historically dominated by White men, often with surgical backgrounds, and shaped by *"old boys' club"* dynamics. In their view, appointment processes are influenced not only by merit but also by affinity, established networks, protégés, and entrenched expectations of what leadership looks like. W2 does not believe that disparities will resolve simply through demographic change over time. While acknowledging that earlier generations of senior leaders were drawn from a more exclusively White male workforce, W2 argues that the persistent underrepresentation of Black consultants indicates that time alone is insufficient given the increase in the number of Black doctors over the last decade or so. Instead, they identify a lack of role modelling,

mentorship, and active talent development as a possible driver. In W2's view, consultants and senior leaders must identify promising minority ethnic doctors early, encourage them, assign mentors, and create opportunities for leadership exposure, rather than waiting for trainees to seek this support themselves.

Finally, W2 argues that underrepresentation at senior level affects not only professional progression but also health outcomes for minority ethnic patients. They suggest that limited cultural representation in medicine contributes to poorer care because the discipline continues to be taught and practised from a culturally narrow perspective. They highlight examples across practice: vaccination messaging (e.g., inadequate consideration of religious requirements), pain assessment (e.g., differential treatment of Black women and children), dermatology (e.g., textbooks centred on White skin), and psychiatry (e.g., over-medicalisation of Black people). W2 argues that greater representation and cultural understanding would enable the NHS to respond more effectively to the needs of minority communities.

4.7.2c Narrative Emplotment – W2

Orientation – W2's story begins with their early observations at the junior (resident) doctor level, where they noticed uneven representation among minority ethnic doctors. W2 observed that there were "not as many Black junior doctors," although they acknowledge that this has improved over time. For W2, this establishes the baseline tension: underrepresentation is present from the outset of the medical career pathway and persists throughout the NHS.

Development – W2 then describes how the pipeline of doctors—from medical school to senior NHS leadership—narrows for minority ethnic doctors, particularly Black doctors, as careers progress. W2 repeatedly notes that while Black doctors may be visible in junior roles, this visibility does not extend into higher specialist training, consultant posts, or senior leadership. This is the key narrative movement: initial representation does not translate into progression, especially for Black doctors.

Historical perspective – W2 reflects on earlier generations of international medical graduates, including a Black mentor, who were able to access consultant posts through more flexible or non-standard pathways. W2 contrasts these earlier opportunities with the current situation, where Black doctors appear to struggle to reach the same levels despite having comparable academic competence. W2 expresses frustration and a sense of being unable to identify a clear explanation.

Turning point – The narrative intensifies when W2 compares the experiences and career progression of Black and Asian doctors in the NHS, including at senior leadership levels. They observed that Asian doctors move into higher specialist training and senior leadership roles in disproportionately greater numbers—even relative to their population in the UK—while Black doctors do not. W2 clearly states that they do not believe this gap is attributable

to differences in academic performance or motivation. This shifts the narrative towards structural, historical, and relational explanations.

Causal interpretations – For W2, the underlying mechanisms centre around role modelling—early, active, and intentional—and tackling bias and institutional cultures that perpetuate differential attainment. W2's account links several causal factors: the lack of visible Black role models in leadership; persistent workplace biases, such as non-representative interview panels; the intimidating and homogeneous nature of these panels; possible confirmation bias among White gatekeepers; and shortcomings in mentorship and active talent development. W2's narrative implies that attainment is socially reproduced through networks, representation, and affinity—not merely awarded through merit—which they find deeply problematic.

Resolution – W2 rejects the assumption that differential attainment will resolve over time as more Black medical students progress through the system. They argue that passive demographic change is insufficient and that active intervention is required. W2's narrative resolves with a call for deliberate and targeted efforts: identifying minority ethnic talent early; providing sustained mentorship (not necessarily ethnically matched); increasing visible representation of minority ethnic leaders to motivate aspiring clinicians; and nurturing minority ethnic doctors throughout their career pathway. W2 further extends their narrative beyond workforce progression to clinical practice, arguing that underrepresentation at senior levels contributes to limited cultural awareness in medicine. This, W2 suggests, results in poorer healthcare outcomes for minority ethnic communities. In doing so, W2 broadens the narrative from an occupational issue to a wider systemic problem within healthcare.

Core narrative meaning

The central meaning of W2's account is that Black doctors are not underrepresented at senior levels due to lack of ability, but because the system fails to support their progression through the professional pipeline. This systemic failure then perpetuates itself by diminishing aspiration, narrowing access to mentorship, and reducing institutional familiarity for the next generation.

4.8 Summary & Conclusion

This chapter presented a narrative analysis of the nine selected participants, employing summary, restorying, and emplotment to interpret their accounts in relation to the research questions. The voices of the participants remained central throughout, and their experiences were represented as faithfully as possible. This was achieved despite the limitation of not being able to return the restoryed narratives to participants for co-construction, due to time constraints and limited availability. Through their life stories, participants consistently recognised the presence of DA, not only between White majority and minority ethnic doctors but also within minority ethnic groups. These accounts added important nuance and complexity to the discourse, highlighting the relational nature of structural and systemic factors. In particular, participants emphasised the influence of differing migration histories, intergenerational advantages, and socio-cultural capital as key factors that contribute to, and in some cases exacerbate, DA among minority ethnic doctors at senior leadership levels within the NHS.

In the second part of the findings chapter (Part B), I present a cross-case analysis using reflective thematic analysis (RTA), which is integral to addressing the three research questions in this DPhil study.

CHAPTER 5: PART B - Reflexive Thematic Analysis (RTA)

Overview

In this section of the findings chapter (Part B), I present the cross-case analysis of shared patterns of meaning across all 25 participants using reflexive thematic analysis (RTA). This analysis explores the significance of these patterns within their context and how they address the three research questions. I first outline the themes generated through the RTA before briefly describing each main theme and its relevance to the study. Subthemes are illustrated through carefully selected participant excerpts that exemplify and, where relevant, challenge the central theme. Consistent with the principle of authenticity (Cristancho et al., 2021), excerpts were selected to provide readers with direct access to dominant and representative patterns within the dataset rather than privileging individual voices or particularly emotive accounts. I then consider the implications of each theme and their contribution to the existing literature. Finally, I reflect on how my experiences and interpretations may have shaped the analysis and provide contextualisation through reflexive commentary (Morrow, 2005).

5.1: Introduction

In this study, I identified 9 themes and 19 subthemes constructed through a reflexive thematic analysis (RTA) of all 25 participants, constructed through the lens of the three research questions outlined in Part A. Collectively, these themes address DA in senior leadership positions within the NHS, focusing on: (1) White doctors compared with minority ethnic doctors, (2) Black doctors compared with Asian minority ethnic doctors, and (3) The impact of DA on minority ethnic communities.

The 9 themes are as follows:

1. From Meritocracy to Marginalisation: Minority Ethnic Doctors' Career Progression in the NHS Leadership
2. Power, Social Capital, and Informal Gatekeeping in NHS Leadership
3. Conditional Inclusion and the Burden of Representation
4. Inter-Minority Ethnic Hierarchies and Differential Leadership Trajectories
5. Organisational Mechanisms of Sponsorship, Visibility, and Opportunity Access
6. Cultural Capital, Identity and Belonging in NHS Leadership
7. Minority Ethnic Leadership Representation as Structural Advocacy
8. Cultural Competence, Credibility and Patient Experience
9. Structural Inequality as a Driver of Health Inequality

Table 1 below details and shows the relationship of the research questions to the themes and subthemes. Each theme is discussed in full in the remainder of this chapter, beginning with a reminder of the research question to which it pertains. The chapter concludes with a summary and synthesis of the nine themes, including an exploration of the relational aspects between them.

Table 1: Themes and Subthemes by Research Question

Research Questions	Themes	Subthemes
RQ1: What are participants' perspectives on the DA between White majority and minority ethnic doctors in senior leadership positions within the NHS?	**THEME 1: From Meritocracy to Marginalisation: Minority Ethnic Doctors' Career Progression in NHS Leadership**	1.1. Relative Meritocracy in Early Career Advancement 1.2. Structural Filtering at Senior Leadership Transitions 1.3. Institutional Normalisation of Unequal Leadership Outcomes
	THEME 2: Power, Social Capital, and Informal Gatekeeping in NHS Leadership	2.1. Informal Decision-Making Beyond Formal Structures 2.2 Affinity Bias and the Reproduction of Dominant Leadership Identities
	THEME 3: Conditional Inclusion and the Burden of Representation	3.1. Overperformance, Unequal Thresholds, and Hypervisibility 3.2. Conditional Belonging and Identity Negotiation
RQ2: What are participants' perspectives on the DA between Black and Asian minority ethnic doctors in senior leadership positions within the NHS?	**THEME 4: Inter-Minority Ethnic Hierarchies and Differential Leadership Trajectories**	4.1. Differential Progression and the Masking Effects of Ethnic Aggregation 4.2. Black Underrepresentation through Structural Exclusion and Racialised Stereotyping

	THEME 5: Organisational Mechanisms of Sponsorship, Visibility, and Opportunity Access	5.1. Sponsorship as a Relational Mechanism of Leadership Progression 5.2. Representational Visibility and the Shaping of Leadership Aspiration
	THEME 6: Cultural Capital, Identity, and Belonging in NHS Leadership	6.1. Unequal Access to Cultural Capital and Intergenerational Advantage 6.2. Internalised Leadership Ceilings and Self-Exclusion
RQ3: What are participants' perspectives on the health implications of DA at senior leadership level in the NHS for minority ethnic communities?	**THEME 7: Minority Ethnic Leadership Representation as Structural Advocacy**	7.1. Relational Harm from the Absence of Minority Ethnic Leadership 7.2. Representation as a Mechanism for Community Health Improvement
	THEME 8: Cultural Competence, Credibility, and Patient Experience	8.1. Relational Trust, Representational Credibility, and Healthcare Access 8.2. Cultural Understanding as a Mechanism for Reducing Bias and Inequality
	THEME 9: Structural Inequality as a Driver of Health Inequality	9.1. Leadership Inequality as a Determinant of Minority Ethnic Health Outcomes 9.2. The Limits of Representation Without Structural Change

Summary and Focus of Themes

- **Theme 1** findings examine how the career progression of doctors in the NHS appears relatively meritocratic in the early stages but becomes increasingly constrained by structural barriers as they progress through their careers, worse at senior leadership levels, resulting in unequal leadership outcomes for minority ethnic doctors.

- **Theme 2** findings explore how informal networks, cultural gatekeeping, affinity bias, and social capital shape access to leadership opportunities for minority ethnic doctors beyond formal recruitment and promotion processes.

- **Theme 3** findings focus on how minority ethnic doctors, particularly those from underrepresented groups, including Black minority group, often face higher performance expectations, greater visibility, and pressures to adapt their identities to dominant leadership norms in order to advance.

- **Theme 4** presents the variations in leadership progression specifically within minority ethnic groups, highlighting how aggregated ethnic categories can mask disparities and how Black doctors experience unique and compounded disadvantages.

- **Theme 5** findings analyse the role of sponsorship, mentorship, visibility, advocacy, and access to developmental opportunities as key mechanisms that influence leadership attainment of minority ethnic doctors in the NHS and as contributory factor for differential progression.

- **Theme 6** findings explore how unequal access to cultural capital, professional legacy, and intergenerational advantage influences leadership aspirations, confidence,

belonging, and perceptions of accessibility to senior roles between minority ethnic doctors in the NHS.

- **Theme 7** findings are related to the value of minority ethnic representation in senior leadership as a mechanism for advocacy, inclusive decision-making, role modelling, and improving outcomes for minority ethnic communities.

- **Theme 8** findings relate to how leadership diversity at senior leadership in the NHS contributes to trust, cultural understanding, representational credibility, and more equitable healthcare experiences for minority ethnic patients beyond symbolic representation.

- Finally, **Theme 9** findings focus on the relationship between organisational inequalities in NHS leadership and wider health inequalities, demonstrating how workforce inequities can influence healthcare access, engagement, organisational priorities, and minority ethnic community health outcomes.

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5.2 RQ1: Participants' perspectives on DA between White majority and minority ethnic doctors in senior leadership positions in the NHS

5.2.1 THEME 1: From Meritocracy to Marginalisation: Minority Ethnic Doctors' Career Progression in NHS Leadership

In this theme, many participants discussed a dichotomy that they believed exists within the NHS. On the one hand, the organisation is seen as a place where minority ethnic people flourish, given their significant representation relative to the overall population. On the other hand, participants identified marked DA along both racial lines and inter–minority ethnic lines with regard to career progression and the challenges experienced by different groups within the workforce. Participants suggested that, on closer examination, there is a surface-level meritocracy within the organisation that is conditional and applies only up to a certain level, including for doctors. Participants suggest that this apparent meritocracy reflects the comparable qualifications at entry level for all doctors, regardless of ethnicity—namely, successful graduation from medical school. However, Black participants in particular, described a different experience in which meritocracy appeared to end at this entry point, with difficulties emerging as early as the first stage of career progression—getting a specialty training post which puts doctors on tract to become a specialist/consultant. They highlighted additional difficulties including progressing through postgraduate examinations, obtaining consultant posts and leadership roles, and sustaining progression throughout their careers. Participants framed these experiences as manifestations of systemic marginalisation within the NHS and associated governing bodies, such as the Royal Colleges (in relation to postgraduate examinations) and the General Medical Council (GMC) (in relation to disciplinary practices). Participants perceived these systems as disproportionately affecting

Black minority ethnic doctors and international medical graduates (IMGs), and, to a lesser extent, British Asian minority ethnic doctors.

5.2.1a 1.1 Relative Meritocracy in Early Career Advancement

Illustrative quotes

Many participants recognised that the NHS employs a significant number of minority ethnic staff in general and qualified staff including doctors enter the organisation on merit. Beyond this entry level many participants felt that this idea of meritocracy was *"conditional and stage-dependent….and not universal"* [A4], implying there was differential by race and other informal criteria at all levels of the organisation: "*on average, diversity across the organisation is concentrated at the lower levels, where minority ethnic individuals are more represented, while the majority population is concentrated at the top"* [B1], and as doctors progress through their training, *"…meritocracy is relative in the NHS……. colleagues ascend according to their performance, exam success…. but we know there are prejudice and bias against minority ethnic doctors in how the assessments are done"* [A2]. Another participant acknowledged the overall success of minority ethnic doctors within the NHS but highlighted evidence of DA across medical career progression, particularly for Black doctors:

> *Minority ethnic doctors do excel in the NHS in general... However, statistically, we know that certain groups do less well, even within medicine. So, if you're talking about the journey from junior doctor to consultant, there is evidence that it is harder for people from minority ethnic backgrounds and, in particular, for those from Black ethnic backgrounds. [B2]*

Many participants described a *"drop off"* [B1] along the training pathway along racial lines, which is worse at the higher leadership levels*: "…there is a significant increase in visibility of non-White clinicians at a lower level…. however, this is not the case at the top…and I've been in the game for 30 plus years, and it still feels like I'm the only person [Black] in the room"* [B4]. This was echoed by other participants suggesting that even when minority ethnic participants make it to consultant grade—the minimum requirement for consideration for senior leadership roles, they suggested those doctors struggle to attain higher leadership

position: *"....it is striking that this (attaining consultant post) doesn't translate into them being in senior leadership positions"* [B2].

Furthermore, there was also a perception that organisations may have little incentive to promote minority ethnic doctors who are excelling in their current roles and delivering crucial services. One participant suggested:

> *...For Black doctors, becoming a consultant is a challenge for many reasons. One is that they are often not encouraged or invited into training pathways. I know I'm generalising, but many doctors from African backgrounds are highly competent, yet find it difficult to secure training posts leading to consultant roles. They are often employed in non-training positions, such as trust-grade roles. The fact that they frequently work above the level at which they are employed can mean that organisations, overtly or covertly, keep them in those positions rather than support their progression* [B6].

This perception also applies to non-British minority ethnic doctors who trained overseas—international medical graduates (IMGs), who find career progression in the NHS challenging for similar reasons alongside other specific challenges such as immigration and geographical restrictions. However, there is evidence that Black British doctors are similarly marginalised, as suggested in this research, *"I'm not sure why Black doctors are marginalised in senior leadership. It's not a lack of experience, intellect, or understanding of the role. I think it stems from a perception, on both sides, that this is not quite their world"* [A5]. However, in this study, several participants—mainly White participants—acknowledged that, while differential attainment affects minority ethnic doctors at all stages of career progression within the NHS, they did not believe this extended to senior leadership. They felt that senior positions were attained on *"merit"* [W2], regardless of race, and suggested that the relatively strong representation of Asian doctors at this level supported this view: *"...there are lots of Asian doctors in my world of senior NHS management. They are very successful and very ambitious, much like White doctors."* [W3]

Implications and Reflexivity

This theme supports existing literature indicating ongoing differential attainment at multiple stages of career progression for minority ethnic doctors (Sait et al., 2020), reflecting a failure to realise the ideals of meritocracy (Howarth et al., 2024), particularly for Black doctors (Woolf, 2020). As a researcher and senior doctor working within the NHS for nearly two decades, I was attuned to participants' accounts as they described challenges they observed and experienced in relation to differential meritocracy for doctors within the NHS. These challenges appeared to emerge at a critical transition point in a resident doctor's or junior doctor's career—namely, when seeking entry into training or specialty posts that place them on the pathway to becoming a specialist or consultant.

Through both my professional experience and the participants' narratives, I have observed that minority ethnic doctors, particularly Black minority ethnic doctors, appear to struggle at multiple milestones of career progression, often without an obvious or sufficient explanation that accounts for the consistency of this pattern across a wide group of Black doctors (Woolf, 2020). I believe this suggests a group-level phenomenon rather than isolated individual experiences. This perception was echoed by many participants and supported by my field notes, in which participants frequently expressed perplexity regarding causality. I believe this issue can be described using the industry term a 'wicked problem', characterised by complex, interrelated factors and no single clear cause or solution (Rittel & Webber, 1973). While direct causal evidence linking ethnicity to poorer attainment in career progression and leadership remains inconclusive, there is substantial evidence (Kline, 2014; Chakravorty, 2021), documenting the range of significant challenges faced by minority ethnic doctors—particularly Black doctors—throughout training in the NHS (Woolf, 2020). In my experience, these cumulative challenges within the training pipeline contribute to differential

attainment at senior leadership levels. If Black doctors experience inequitable progression unrelated to competence or skill at junior stages, it logically follows that they will be underrepresented in senior leadership roles within the organisation. These findings may therefore help inform policymakers within the NHS by highlighting where interventions are needed to address attainment gaps, particularly through more granular analysis of ethnicity related differentials.

5.2.1b 1.2 Structural Filtering at Senior Leadership Transitions

Illustrative quotes

Participants suggested that there were higher level of scrutiny for minority ethnic doctors through their early careers which impacted progression: *"I remember being told as a junior doctor that I was being watched as a sort of test subject for all Black doctors…So, [I didn't] really want to mess up both for myself and Black doctors to come, because it would be bad for everybody else"* [B1]. Similarly in pursuit of leadership or higher leadership roles, this closer scrutiny and introspection continued: *"I was probably more focused on keeping my job than I was actually [on focusing on] anything else like career progression…I spent a lot of time on this preoccupation"* [B2]. Some participants suggested lack of diversity at the top of the NHS organisation was systemic:

> *I look at the corridors that we walk around and there are predominantly White men…. I feel like I've grown up in the NHS where I knew there was systemic racism and I think there still is. I was brought up with expecting racism in the NHS. Though I think people are more wary of what they say now… there are some endemic systemic issues [that are] still there…. there's a sense of glass ceilings (for minority ethnic doctors)"* [A2].

This was experienced by minority ethnic doctors at this higher level in many ways, ranging from a lack of parity despite comparable levels of achievement and similar formative experiences in British culture and society:

> *I went to a well-known school and a very well-known university, then attended medical school. I speak the language and have the requisite skills. Yet there are certain rooms and spaces where my voice is not heard as loudly as others'. I cannot explain this by anything other than racism. I just can't [*A5].

Participants also described informal rules of engagement that were perceived to influence access to senior leadership positions: *"What you need to realise is that, for these senior leadership jobs, the 'real' interview takes place outside and before the actual interview."* [W3]. This perception suggested that selection processes at senior levels may be shaped, at least in part, by informal networks and interactions that occur beyond formal

recruitment procedures, potentially disadvantaging individuals who lack access to these influential spaces and relationships. Furthermore, many participants highlighted the intersectional nature of structural and systemic marginalisation, particularly at the nexus of race and gender. One participant observed that *"those roles (senior leadership) were occupied by men rather than women… you see both colour (racial) as well as gender differences"* [A3]. While such observations pointed to broader structural inequalities, some participants also offered explanations for gender disparities that emphasised individual-level factors, albeit within a context shaped by racial dynamics. As one participant noted:

> *I also think there is a gender divide. Women often self-exclude until they feel they meet all the requirements, unlike men, who are more likely to apply regardless. But there is also something about visibility. If all the senior leaders you see are White men, it sends a message that there is a leadership mould—and it doesn't look like you* [A7].

Other participants situated these issues within a broader societal and historical context, highlighting differences between minority ethnic groups in representation at senior leadership levels within the NHS. One participant suggested:

> *I would say that Asian doctors have a reputation of being very high achieving. Indian doctors historically who came over to Britian tended to be top of the class. I got the distinct sense they came from affluent backgrounds, so there wasn't any divide in terms of the socio-economic status compared to White…. I don't think it's the same for Black doctors historically. It is usual to see Indian people as doctors* [W1].

Other participants discussed additional challenges—both systemic and otherwise—that contribute to DA in career progression within the NHS between minority and majority doctors, as well as influencing decisions to pursue leadership roles. One participant suggested:

> *It's an attritional pathway and it's not for everybody. I think first thing is that everyone [who] wishes to do that kind of work – leadership - must understands the challenges. If you choose to do it, the pathway is attritional and requires a lot of hoops to go through. I think that if you're going to go up that path, you either must start early or you have to do an awful lot of work to build currency in those spaces* [B1].

Many participants emphasised the importance of diversity—beyond race and ethnicity, within interview panels during leadership selection processes for minority ethnic doctors. One participant reflected on the role of panel composition in promoting fairness and influencing candidate performance:

> *...As the Black interview panel member... I don't appoint people based on their ethnicity. However, I'm very clear that people perform differently when the panel is diverse. I think they do better. Having never been on an all-White panel or an all-Asian panel, I wouldn't know what that looks like, but what I would say is that a diverse panel gives you a diverse answer, and that diversity could be any characteristic that you want to talk about* [B1].

This perspective suggests that panel diversity encompasses forms of intersectionality beyond race and that such diversity may not only enhance perceptions of fairness but also enable candidates to perform more effectively by fostering a more inclusive and representative selection environment.

Furthermore, participants argued that the importance of a diverse interview panel extended beyond the selection process itself and contributed to shaping organisational culture. In particular, diversity within leadership and recruitment panels was seen as enhancing transparency, fostering a sense of belonging among minority ethnic staff, and increasing the visibility and representation of minority ethnic leaders. As one participant explained:

> *As a minority ethnic applicant for a senior role, if you look at the hiring team and don't see anyone like yourself, you may feel that you don't belong or will be accepted. However, after joining, I realised there was no gatekeeping—it was largely our perception* [A4].

This suggests that visible representation within recruitment and leadership structures may play an important role in shaping perceptions of inclusion and accessibility among prospective and existing minority ethnic staff.

Implications and Reflexivity

My reflections as the researcher are that I was particularly struck by participants' nuanced accounts and their deliberate attempts to disaggregate minority ethnic groups. I observed frustration among many participants with the NHS system and associated regulatory bodies, which continue to frame minority ethnic doctors as a single homogeneous group for example using the BAME or BME acronym (Kline, 2014; NHS England, 2026). There is evidence to suggest that this homogenisation overlooks the distinct histories of different groups, both within Britain and across the diaspora, which significantly shape doctors' sense of self, lived experiences, and the specific challenges faced by those aspiring to leadership roles within the NHS (Kalra et al., 2009). In addition, I believe these experiences must also be understood as products of wider structural inequalities within the British society more broadly (Macpherson, 1999). I believe this strengthens the argument for greater granularity in research on DA among minority ethnic groups. While progress has been made at an aggregate level, this progress may be unevenly distributed within minority ethnic populations, such that some groups (for example, those of Black African or Indian heritage) may fare better than others (Woolf, 2020). Recognising these intra-group differences is essential if inequities are to be accurately understood and addressed. The implications of these findings are considerable, both for the retention of minority ethnic staff within the NHS (Chastney et al., 2024) and for organisational legitimacy. Furthermore, improving equity in leadership representation has the potential to enhance trust, healthcare access, and service uptake among minority ethnic communities (Kline, 2014; Ross et al., 2020).

5.2.1c 1.3 Institutional Normalisation of Unequal Leadership Outcomes Illustrative quotes

Some minority participants suggest there appear to be a *"glass ceiling"* [B2] for minority ethnic doctors wishing to progress to senior leadership levels in the NHS, while other suggested a *"disappearance of minority representation"* [A3] at this level which they feel is *"problematic"* [B4] for career aspiration of other minority ethnic doctors at the start of their careers. With one participant asserting: *"There is a sense of celling…I don't see anyone two steps above me from my background. So, maybe I'm not meant to be there. It's self-perpetuating…so people aren't pushing themselves forward"* [A2]. Furthermore, many participants suggested that minority ethnic doctors experience racial marginalisation within senior leadership contexts. One participant stated: *"There is a sense of the type of person they are looking for…and it is often not a minority ethnic doctor"* [A3]. While participants acknowledged the complexity of senior leadership recruitment and advancement, many drew upon their own observations to explain persistent disparities. They suggested that whatever the underlying mechanisms, the conditions within these spaces appear to disproportionately favour members of the majority group, who already occupy many senior positions and may, consciously or unconsciously, contribute to maintaining the status quo. As one participant reflected: *"It's complex. Just because a White person is in a senior position doesn't mean they aren't qualified—they are. But, for whatever reason, they receive preferential treatment when it comes to getting the job."* [A4].

Many participants suggested that the normalisation of unequal leadership outcomes has complex roots that cut across race, ethnicity, and cultural identity, including notions of Britishness. One participant reflected:

> *My experience is that there is, of course, differential attainment, but it is complex. It ties into a broader national position, on immigration…and how we adopt the dominant (White) culture. There is intersectionality here whereby everyone might be equally British, but there are for example certain accents that are considered desirable at this level (senior leadership), as well as particular qualities associated with them* [A1].

This perspective highlighted how leadership progression may be shaped not only by race and ethnicity, but also by culturally valued markers of identity and belonging. Nevertheless, other participants framed these disparities in terms of organisational legitimacy and public credibility, arguing that, as a public institution serving a diverse population, the NHS should reflect the communities it serves at all levels of leadership. They suggested that visible ethnic diversity within leadership structures is important for demonstrating fairness and ensuring confidence in equal opportunities. As one participant stated: *I think NHS leadership boards should include people from different ethnic backgrounds, so there is no perception that ethnicity affects opportunities. It sends an important message that everyone has an equal chance to succeed* [A4].

Implications and Reflexivity

I was particularly struck by the extent to which participants recognised unequal expectations across racial groups, and by the degree to which this inequality appeared to be normalised and accepted. I was also struck by the fact that many participants, across all racial groups, acknowledged their own participation in the continuation of these unequal standards, albeit for different reasons. I observed, and reflected in my field notes, that some White and Asian participants acknowledged that Black individuals in senior leadership positions were often perceived as 'exceptional', whereas different—often lower—thresholds appeared to apply to White candidates. Black participants likewise described how this inequality can be perpetuated through heightened expectations of 'excellence' for Black candidates, while 'average' performance may be deemed acceptable for non-Black candidates. However, it was

unclear whether these higher thresholds applied to Asian candidates in this context, although there were indications that any such effect was less pronounced.

Several Black participants expressed disappointment when Black candidates aspiring to senior leadership were 'average' rather than exceptional, thereby holding Black candidates to a higher standard than their non-Black counterparts. Some Black participants explicitly acknowledged the tension between two competing imperatives: on the one hand, the desire to put forward candidates who are exceptional, perceived as beacons for minority ethnic doctors and seen as infallible by predominantly White gatekeepers; and on the other, the need to challenge misconceptions surrounding the 'EDI (Equality, Diversity and Inclusion) candidate' and resist the reinforcement of unequal standards for Black candidates. This phenomenon is supported by existing literature describing the institutional acceptance of disparity, whereby different rules are applied within leadership appointments (Ross et al., 2020), negatively affecting minority ethnic NHS staff, including doctors. Such practices have significant implications for staff morale (Sait et al., 2020), attrition rates, and the retention of minority ethnic staff (Chastney et al., 2024), as well as for the representational value system that the NHS purports to uphold.

5.2.2 THEME 2: Power, Social Capital, and Informal Gatekeeping in NHS Leadership

This theme captures participants' experiences as they navigate their career journeys into leadership within the NHS, where they describe a range of systemic barriers. Many participants also discussed expected cultural norms grounded in dominant White traditions, which were perceived to advantage minority ethnic doctors who are able or willing to adopt these norms. Other participants, however, described barriers that persist despite such cultural adaptation, including affinity bias and both conscious and unconscious bias, which continue to impede career progression even for minority ethnic doctors who appear to have assimilated into the dominant White culture. Some participants further identified additional socio-cultural barriers that were not always transparent but nonetheless seemed to influence decision-making, particularly at more senior levels of career progression. At these levels, participants perceived that entry criteria could shift depending on the 'preferred candidate'.

Participants also described the relative advantages experienced by minority ethnic groups who, over the past decade, have gained ground or achieved greater representation in senior leadership roles. This increased representation was perceived to create opportunities—such as mentorship, networks, and professional connections—for other minority ethnic doctors from similar backgrounds who aspire to leadership positions.

5.2.2a 2.1 *Informal Decision-Making Beyond Formal Structures*

Illustrative quotes

Many minority ethnic participants highlighted the importance of understanding and adopting White cultural norms, which can act as barriers to access at higher levels of the NHS organisation. One participant suggested:

> *There's an absolute thing about socialisation. By that I mean that it's not easy being different. Let me give you an example. I don't Ski, for example, and skiing has been very important to many doctors that I have worked with. It's a key part of how they interact. It's a key part of their conversation. If you're in a minority ethnic person, you may not automatically share those same socialisations. Therefore, you're by yourself in that in that space* [B3].

Others added that there are important decisions that are made:

> *…Outside the room, in these social spaces that you might not be invited to, or that you might not wish to attend on cultural or religious grounds. You might be excluded because you don't fit… even if you cared to attend* [A3].

Others highlighted additional forms of informal gatekeeping by individuals already occupying positions of privilege—often White men—which could exclude others, either intentionally or inadvertently *"...some of the rooms where these decisions are made are rooms where you do not find Black and minority ethnic people."* [B4] Furthermore that:

> *At the top of the NHS, there is still a bit of an old boys' club, probably my demographic [White], who went to private schools, which Black people certainly wouldn't have done in the past… you wear the right tie, you played the right sport, etc* [W2].

These accounts suggest that access to influential networks and decision-making spaces may remain unevenly distributed. Furthermore, many minority ethnic participants, particularly women, expressed frustration that even when they gained access to such spaces, existing power dynamics often marginalised or diminished their contributions. This was described as both discouraging and demoralising. As one participant explained:

> *As a minority ethnic leader at senior management level, I've found that some voices are not always heard. Minority ethnic doctors may raise an issue without it gaining attention, yet the same point can be acknowledged and discussed when voiced by a non-minority colleague* [A5].

This suggests that representation alone may be insufficient if minority ethnic leaders continue to experience barriers to influence and recognition within senior leadership environments.

When discussing opportunities for minority ethnic doctors aspiring to leadership and senior leadership roles within the NHS, many participants highlighted challenges related to access to influential networks and decision-making spaces—often referred to as the "corridors of power." One participant stated:

> *There are gatekeepers. You only get access by invitation. You have to get invited into these spaces. In my experiences I think you need a lot more than competency to get senior leadership roles. You need education, experience and exposure – the 3 'Es' to be successful or reach a senior level in many organisations, including the NHS. And as you become more senior, the balance swings to experience and exposure. They're selective invitation to some incredible corridors of power that, unless you are in the know, networked to the right people, you will never even know about them. Decisions are made in interesting spaces. Don't think they're happening in the meeting that you're sitting in... they are not* [B4].

Many participants emphasised that the importance of these informal spaces—both within and outside the workplace—cannot be underestimated. However, by their nature, such spaces may inadvertently exclude others, including those who, even if invited, may not feel able or willing to engage due to cultural and/or religious considerations. The participant further elaborated:

> *Decisions are made in spaces outside of designated work environment like meetings and corridors of power, in informal places to do with socialisation e.g. golf courses and even pubs. Is there a disadvantage to marginalised people who may not frequent these spaces, e.g. a Muslim who may not go to pubs? Yes, I am afraid they will be excluded indirectly or may not be in consideration* [B4].

Another participant added:

> *There's an element of networking… some of those things involve alcohol and going out, having drinks after meetings. Now, that's not something that I enjoy. It's not something that I pursue. So that naturally then puts you at a disadvantage. People say this type of socialisation shouldn't make a different to your career progression, but they do make a difference because you don't get to know people in that regard. And if you're not seen in the right place, with the right people, you're not going to be talked about. People don't know you in the same way as they do others. So, I think that's problematic* [A3].

Other participants suggested that gender and racial preferences may influence access to senior leadership positions for minority ethnic doctors. For candidates who do successfully gain entry, this can give rise to heightened self-scrutiny and a sense of pessimism. One participant observed:

> *I noticed people of my generation (middle age), find being led by women a little bit irksome. But I'm good with that. Some people find it difficult being led by a Black person, particularly, if I'm in a shouty mode. I'm allowed to shout because I've got a voice, but then again that can be kind of overbearing and misinterpreted. Again, it's about taking gauge of yourself. Am I being too Black in this room for my own good and anybody else is good. I think we are in the midst of a transition. So, it's just it's going to take a long time. it's going to take decades if not more than that for this to move forward. At some point down the road, this will not be an issue. But I can't see it happening in my lifetime* [B1].

Here, among other issues, including leadership preferences along gender and racial lines, the participant highlights the relationship between belonging, authenticity, and leadership participation. The findings suggest that the presence of minority ethnic doctors within senior spaces does not necessarily equate to inclusion if individuals feel unable to express their identities authentically or feel pressure to conform to prevailing organisational norms.

Implications and Reflexivity

I observed how participants acknowledged the various privileges they had experienced across their educational trajectories—from schooling through to becoming doctors—based on their backgrounds, family circumstances, and upbringing. Many participants believed that these advantages continued to benefit them within the NHS, particularly in relation to career progression. I noted how this form of 'currency' included socialisation processes, such as adapting to and adopting dominant White cultural norms, which participants had learned through multigenerational exposure to medicine. This was particularly evident among participants who came from families with multiple generations of doctors who had already navigated the challenges of NHS career progression, thereby smoothing the pathway for subsequent generations. These advantages extended beyond formal structures to include

informal networks, access to unspoken knowledge, and opportunities to gain experiences that are not equally available to all doctors. This pattern was especially striking among British Indian doctors, where several participants described having multiple generations of doctors within their families. The insights gained from this sub-theme support existing literature on the advantages conferred by privilege and cultural capital (Abel, 2008), including access to networks and mentorship (Ross et al., 2020). These resources are not universally available and can vary significantly along racial and ethnic lines (Woolf et al., 2023; Sait et al., 2020). I believe the implications of these findings are significant, particularly in raising awareness among organisational leaders and gatekeepers of the need for targeted and proactive interventions. Such approaches may be required for different staff groups within the NHS in order to address structural inequities and the cumulative advantages that contribute to DA.

5.2.2b 2.2 Affinity Bias and the Reproduction of Dominant Leadership Identities

Illustrative quotes

Many participants acknowledged the pervasive presence of bias throughout medicine, affecting doctors at multiple stages of their NHS careers, including key milestones such as progression into leadership and senior leadership roles. One participant reflected on this, stating:

> *Subconsciously I think it's very hard to deny that if you have strong views about something, then that association wouldn't influence your decision making... If the person who is applying for the job have similar behaviours that you conceptually associate with; It influences us...skin colour has the same effect... and confirmation bias plays a very big part of it* [W2].

Others approached this issue from a different perspective, focusing on other protected characteristics as defined under the Equality Act, 2010. One participant suggested: *It's not always, but sometimes it's quite easy to tell when someone was born abroad and I do believe that either consciously or subconsciously, that sometimes works against them* [A1].

Furthermore, some thought that there were:

> *Overt cultural signs above and beyond the colour of skin and we should embrace and celebrate them. But we've got to be honest to know that sometimes that will unconsciously highlight the differences between me and you. On a very personal level…I believe that the way to break down barriers between me and others is sometimes for me to adapt (to the dominant White culture norms) [*A1].

Others pointed specifically to issues arising during interviews and the appointment process, including for leadership roles. One participant suggested:

> *"The desire to appoint someone who looks and behaves like yourself is significant… it spans even the gender biases that we have because internally we are naturally drawn to a reflection in the mirror—that people like to like their own. Skin colour can create that same bond".* [W1]

This is in addition to the gatekeepers who are mainly White men operating an *"old boys clubs"* [W2] with confirmation biases related to for example where doctors *"went to school"*

[W2] and other affiliations around White norms, while other emphasised the idea of 'fit' at this level which moves beyond race:

> *…And additional consideration is that when you're appointing senior people, you're appointing someone to work within teams, not to be the outstanding individuals necessarily. You're trying to get somebody who's going to fit and that's that the crux of it and it quite tricky. For example, I work in a very diverse group of consultants in my department and lead a very diverse team, but there are guys who just don't fit in and that isn't necessarily about their ethnicity. It's about shared values and behaviours which are compatible…. this encompasses ethnicity and beyond* [B1].

Furthermore, many participants suggested that at the highest levels—where senior leaders are appointed—the most important considerations are not necessarily meritocracy or selecting the best candidate on the day. One participant noted:

> *With regards to selection of the successful candidate by a panel, it's never just about the performance on the day. it's about the person that they want, and they'll skew the marking to accommodate that person. The interview questions won't change, but how their mark it will change depending on who they want. So, unless this preferred candidate makes comments are factually incorrect... or they're terrible, the panel will always flex towards this candidate or a candidate who is best known to them. So, it's normal and it's not unsurprising that the panel will appoint the person they know best. And I have no problem with somebody who has worked in the department etc., getting the job* [B2].

Participants described tensions and perceived limitations between the NHS organisational agenda to increase minority ethnic representation at all levels and the lived realities of minority ethnic doctors already occupying these spaces. While the organisation encourages cultural contribution and inclusion, participants highlighted constraints in how this is experienced in practice. One participant explained:

> *Authenticity is everything we advocate, but only so far as you're authentic enough to fit in. And there is a tension that comes from that. There is an exhaustion that comes from that constant consciousness of thinking – you can't just relax and be your normal self. We all have biases... trying to manage it can be mentally exhausting. This may impact minority ethnic doctors in these spaces* [B4].

Implications and Reflexivity

Here, aware of my positionality, I remained reflexive to the ways in which participants discussed issues pertaining to this subtheme in relation to their practice, particularly the sense

of futility surrounding the notion of meritocracy at senior leadership levels within the NHS (Kline, 2014; Srinivas et al., 2021). I noted participants openly discussing issues of bias—both subconscious and confirmation bias—where they felt that, at senior levels, there is often very little to differentiate candidates in terms of competence. As a result, selections were perceived to be influenced by the existing composition, norms, and preferences of the current leadership structure, including its racial makeup. These accounts strengthen the analytic credibility of participants' assertions that, for Black doctors in particular—unlike some Asian doctors who may already be represented in greater numbers at these levels—progression into senior leadership is less likely to improve significantly if affinity bias continues to operate. There is supporting literature highlighting the significant role of bias, including unconscious bias, in leadership appointments within the NHS (Kline, 2019). Some scholars have therefore suggested the need for unconscious bias training for managers and key decision-makers (Adegoke et al., 2025) as a means of increasing awareness and beginning to address this contributory factor to DA at leadership levels. Others have proposed the incorporation of artificial intelligence into NHS leadership selection processes as a potential mechanism to mitigate bias (Aryasinghe et al., 2025).

5.2.3 THEME 3: Conditional Inclusion and the Burden of Representation

This theme captures the idea that Black doctors in leadership positions are not only required to be exceptional but must also demonstrate exceptional resilience to attain, maintain, and secure leadership roles within the NHS. Within this theme, many participants—particularly Black participants—described experiences of differential expectations around performance at senior leadership levels, structured along racial lines. Participants highlighted how the playing field is not level, with minority ethnic doctors expected to perform to a higher standard in order to achieve parity with their White colleagues.

Many participants asserted that these unequal expectations are present throughout the careers of minority ethnic doctors but become increasingly magnified as they approach senior leadership roles, where expectations were perceived as particularly disproportionate. Black participants, alongside some White participants, suggested that this unequal burden is especially pronounced for Black doctors. Asian participants also recognised this phenomenon, noting that it can extend to Asian doctors who are visibly 'other', for example through visible religious or cultural identity e.g. Muslim or Sikh, etc.

For Black doctors, this perception—believed by participants to be grounded in lived experience—was described as placing a significant burden on them, leading to sustained overperformance in order both to secure leadership positions and to maintain them. Many participants characterised this unequal threshold as mentally taxing and ultimately unsustainable. Notably, while most participants acknowledged the presence of this differential expectation, they also reflected that it did not originate solely from White leadership structures. Rather, some participants observed that these expectations were also

reinforced by other minority ethnic leaders, including Black leaders themselves who expect more from Black candidates.

5.2.3a 3.1 *Overperformance, Unequal Thresholds, and Hypervisibility*

Illustrative quotes

Many Black participants reflected on their experiences and the perceived need to over-credential as a prerequisite for attaining leadership and senior leadership positions within the NHS. Some described deliberately delaying applications for such roles until they had reached what they perceived to be necessary—though often arbitrary—credentialing thresholds. However, they observed that non-Black colleagues often appeared to place less emphasis on this level of credential accumulation. One Black participant described their experience as follows:

> *I was brought up to think qualifications where everything. I spent my life amassing qualifications. To some extent it's a love of learning... I realised I had so many letters after my name and that doesn't get your jobs…not at the higher levels. You need to have the experience and the exposure and that's why a sponsor is important because it's not enough to just have qualifications… I later found others in those high positions who had [fewer] qualifications than me* [B3].

Another added: *"I think anybody who comes from a diverse group... not familiar with how to progress in these systems has an over dependency on credentialing. And an unwillingness to take a job on a punt"* [B1]. Furthermore, participants highlighted that credentialing through formal qualifications does not necessarily equip individuals with the skills required at senior leadership levels, suggesting:

> *I've come across members of staff… who have incredible qualifications. But [do not] have the insight into what is required at these levels. They have not had the exposure. And so, they're disadvantaged. They lack the cultural expectations for this environment which is based around the dominant British culture versus your own culture. For example, I talk straight, which doesn't land well. You need to learn to "talk in corner" ... to learn how to make your point without upsetting the applecart. How to choose your battle - where and when. Everything else we've learned in life is to be honest, be candid. However, it's somewhat different when you are in this environment, especially as a Black person. It's difficult to present your best self [*B4].

While some participants suggested that assumptions were made along ethnic lines regarding who was perceived to be better suited for senior leadership roles—based on factors beyond

formal qualifications—one participant observed: *"Minority doctors I've come across in this space (senior leadership) were predominantly of Asian ethnicity. I would say that they had a reputation for being very high achieving compared to others"* [W1].

Some participants described nuances that they felt were not always fully understood by the White majority, particularly in distinguishing between race and ethnicity. These misunderstandings were perceived to contribute to the complex nature of differential attainment at this level, often leading to heightened introspection and a tendency towards overperformance among minority ethnic individuals. One participant suggested:

> *...Sometimes what they (White leaders) see is as a race issue i.e. I'm Black rather than an ethnicity issue i.e. Black British, for example. This is not a conversation that White people have i.e. is it because I am White that they don't like me? I mean for White people; it can because I'm poor or because I am a woman or because I'm differently abled. I think this perception does drive some kind of excess of introspection for Black doctors - a lot of navel gazing happens in that space, and that tend cause a lot over performance from them in that regard which is unhelpful with (career) progression [*B1].

Furthermore, participants suggested that Black and minority ethnic individuals carry additional burdens when operating within predominantly White spaces. In such contexts, it is often difficult to separate race from the individual, with adverse outcomes more readily attributed to the group rather than the person. One participant reflected:

> *I think there's an ongoing narrative that sits within a lot of Black British doctors that they feel they have to be better to get on. That they have to be absolutely bulletproof to get on. And that people are watching them. So, there is a definitely a vulnerability where they feel that anything that happens to them, that is adverse, relates to their ethnicity or race rather than them personally* [B1].

Some participants reflected on their childhood experiences of growing up in a racialised society, highlighting lessons imparted by their families that continue to shape their perceptions, despite their significant professional achievements. One participant noted:

> *The first thing is that you get taught at home as a Black child is that you have to be better and work harder. As a senior leader, what I tend to find is that if a Black candidate is appointed, that means they are clearly the best candidate by a million miles. They are never a punt; they're always by far the best candidate. They are never a marginal choice. There's not even a*

> *question to be asked. And I wonder, and I think that there's an expectation in some regards…that I as a Black doctor in leadership role…you have to be really super good [*B2].

Other participants explicitly distinguished between differential attainment within racial groups and differential attainment along ethnic lines, highlighting the importance of recognising internal heterogeneity within broadly categorised groups.

> *I wonder if there's also difference from Pakistani and Indian backgrounds because for me, I see people from an Indian heritage more often in those roles (senior leadership). Also, if you look at those of Caribbean and African heritage…I think there is a difference (skewed) towards those from West African background. And then if you extend the Asian group further looking at for example those from Chinese, Japanese and Korean background, I think there is a wider difference in attainment. This creates a minority within minority groups, and the difficulty is that they don't get mentors from people like them* [A3].

Other participants adopted a historical perspective, highlighting the differing migration histories of nationalities within racial groups as a potential explanation for some of the observed disparities in attainment.

> *A lot of the Pakistanis who came to the UK decades ago came to work in the shops and do manual labour, which was different from those from Indian background who were by and large professionally qualified. So, there is a whole social class divide. So, any work we do societally and in the NHS is going to take another generation or two to come to fruition. But we are starting to see it now certainly within the Asian communities, it's becoming more equivocal* [A1].

Implications and Reflexivity

My background as a Black doctor and as the primary researcher informed my analytical sensitivity to this sub-theme, particularly the perception that different standards are required of, and applied to, Black doctors in leadership roles. I also perceived heightened scrutiny of Black leaders, contributing to a sense of insecurity in their positions which, as evidenced by the accounts of Black participants in this study, can result in sustained overperformance in order to maintain those roles. A particular moment of tension articulated by minority ethnic participants related to the balance between maintaining their leadership positions and advocating for junior doctors or minority ethnic communities more broadly. The insights

generated from this sub-theme highlight two key issues, particularly relevant to Black doctors, which are supported by existing literature. First is the phenomenon of perceived overperformance by Black doctors to achieve parity with non-Black colleagues (Ford, 2025). Second is the significant burden this place on Black doctors, including increased risk of attrition and erosion of trust in the system (Ross et al., 2020; Woolf et al., 2023). The implications for an organisation such as the NHS are considerable, given its highly ethnically diverse workforce—albeit predominantly represented at more junior levels. If minority ethnic staff do not feel valued, supported, or secure, this has consequences for retention, leadership sustainability, and organisational credibility (Kline, 2019).

5.2.3b 3.2 Conditional Belonging and Identity Negotiation

Illustrative quotes

Many participants described the differing expectations placed on minority ethnic doctors as they progress through their careers and move into more senior positions within the organisation. They highlighted multidimensional dynamics centred on White dominant norms and the need to understand how to navigate such environments. This navigation was seen as influencing both how individuals are perceived and their relational positioning in relation to success. One participant suggested:

> *…There are very overt cultural signs above and beyond the colour of our skin and we should embrace and celebrate them. But we've got to be honest to know that sometimes that will unconsciously highlight the difference between me and you. On a very personal level, and it may just be where my priorities lie, I also believe that the way to break down barriers between me and others is sometimes for me to adapt (to White dominant culture norms)* [A1].

Others highlighted more specific factors that may influence how minority ethnic individuals are perceived within these spaces:

> *...Do you talk like me (suggesting a British accent) …these aren't conscious choices people make, but we subconsciously pick them up. Do you dress like me (suggesting a westernised approach to attire). This has impact on decision making at these high levels…that you understand some of the softer nuances about communication expected at this level* [A1].

Furthermore, that:

> *…There is a whole bunch of soft social cues that you are expected to appreciate at this level, and this relates to being familiar with the British way. Britain has one of the most class-based societies. There is an intersectionality here where actually whilst everyone might be as British as the other person, but actually, you know the sort of accents etc…that differentiates people…* [A1].

Another mentioned that:

> *…Sometimes the first thing you think about when you see someone who is from minority ethnic background is you associate with their skin colour with a particular behaviour… for example a behaviour of corruption, a behaviour of crime…because that's how we have been conditioned in society. It will influence people's decisions even at these higher levels* [W1].

Some participants reflected on their experiences as senior leaders within these spaces, offering insights based on their observations and perceptions over time. One participant described their experience, stating:

> *It is predominantly a White space, which in and of itself is not an issue. But yes, I encounter issues which I would put down to discrimination rather than differential attainment as such. Throughout the initial part of my senior leadership roles, I educated myself and I was more aware. I was willing to embrace opportunities wherever they present and see where it took me. However, I was left silenced in some roles. I was squashed and I ended up extremely stressed, tearful, anxiety ridden and what have you. I mean, I've sat in meetings where I've not said a word for two hours. I've been in meetings where I would say nothing, and by this time I've been a consultant for 20 years, which is saying a lot. I felt like I've entered a world (senior leadership) where I was no longer a doctor (loss of identity), and I was in this room where nobody knew who I was or cared to know. I felt excluded. In fact, in one meeting, I was asked if I had come to take notes for meeting because they just didn't know who I was even though I was very senior in my organisation. I guess they just don't see the likes of me often in those spaces* [B3].

Implications and Reflexivity

As both the researcher and a doctor working within the system, I was particularly attuned to how minority ethnic participants described the relationship between organisational success and the adoption of White majority norms, including processes of socialisation. I observed a degree of tension among Asian participants, some of whom felt they had successfully navigated and adopted these norms, while others perceived that being visibly 'other'—through cultural and/or religious affiliation—continued to act as a barrier to progression. This was the case even when participants identified as culturally British and aligned with many dominant White norms. Moreover, I remained reflexively aware that many minority ethnic leaders accepted that progression into senior leadership positions was smoother when these norms were adopted, including participation in social activities external to the formal organisation. There is existing evidence that minority ethnic staff experience pressure to conform to dominant cultural norms in order to progress within the NHS (Kline, 2014; Kline, 2025; Walker et al., 2026). The implications of these pressures are significant. When staff feel unable to be their authentic selves within their organisation, this can negatively affect

both individual wellbeing and professional fulfilment (Salway et al., 2016). Furthermore, such pressures may also impact the quality of care delivered to patients, with broader consequences for organisational culture and effectiveness (Kline, 2019; Ross et al., 2020).

5.3 RQ2: Participants' perspectives on the DA between Black and Asian minority ethnic doctors in senior leadership positions within the NHS

5.3.1. THEME 4: Inter-Minority Ethnic Hierarchies and Differential Leadership Trajectories

In this theme, participants explored the differing career journeys of Black and Asian doctors within the NHS, from junior doctor roles through to senior and leadership positions. Participants discussed the significant challenges faced by minority ethnic doctors, particularly Black doctors, as they navigate the system. These challenges were described as not being related to skill or competency, but rather to structural biases, racial stereotypes, and systemic marginalisation. Participants argued that these factors contribute to poorer attainment outcomes for minority ethnic doctors—especially Black doctors and international medical graduates (IMGs)—which in turn affects minority ethnic representation at the highest levels of the organisation. Participants primarily drew on their decades of experience within the NHS, reflecting on long-standing patterns they had observed over time. While acknowledging that formal evidence has begun to emerge in support of these observations, participants also expressed frustration at the continued lack of granularity in much of the existing evidence base. Specifically, they criticised the ongoing use of homogenising classifications, such as BAME or BME, which obscure important disparities both between and within minority ethnic groups.

5.3.1a 4.1 *Differential Progression and the Masking Effect of Ethnic Aggregation*

Illustrative quotes

Participants discussed the complex nature of differential attainment both within and between minority ethnic groups:

> *For minorities, especially Black minority people to feature at the top level its tough. Its increasingly hard for anyone, even White majority person. So, if it is hard for a White person, then it would be near impossible for a Black person. This is how it is. But an Asian person seems to be somewhere in the middle. I'm not exactly sure why this is* [W2].

With many participants acknowledging that Black doctors appear to encounter greater challenges in career progression throughout their careers, one participant observed:

> *I do think Black doctors face greater challenges than Asian doctors. One reason may be that there are not enough Black leaders to show that these roles are achievable. Someone has to be the first. So, I do think it is harder for Black doctors to be considered for senior roles than it is for Asian doctors* [A7].

However, opinions varied regarding the reasons for the apparent differences in representation between Black and Asian minority ethnic doctors at senior leadership level. Some participants attributed this disparity to the more established presence of Asian doctors within senior positions and the resulting availability of support networks and role models. As one participant *explained:*

> *One reason Asian doctors may be better represented in senior leadership is simply their greater numbers. I also think there is a stronger sense of collective identity and mutual support. They may feel more comfortable among people from similar backgrounds and actively help others from their community progress. In contrast, many Black people are often more accustomed to assimilating and adapting to environments where they are in the minority. As a result, they may be more likely to navigate those spaces individually, whereas Asian colleagues may be more likely to build support networks that make those environments more inclusive for others from their community* [B6].

Participants also highlighted the role of established professional organisations in facilitating networking, mentorship, and career progression among Asian doctors. Such organisations were described as having a direct and positive influence on access to senior leadership opportunities:

> *There's something to be said for building networks and having strong professional organisations. For Indian doctors, at least, we have [organisation name], which has been around for about 25 years and has worked hard to support us. Through that network, I've found both female and male mentors from across the UK whom I would never otherwise have met, and that has helped my career progression* [A7].

Furthermore, participants suggested that these networks extended beyond national organisations into local professional and community structures, creating a culture of mutual support that facilitated both individual and collective advancement. As one participant reflected:

> *I think Asian doctors are very good at supporting each other. They recognise the strength in numbers and take great pride in seeing people from their community do well. The Black doctors I've worked with, and certainly Irish people, don't tend to do that. We're very individualistic. When we become successful, we don't tend to come together in the same way* [W5].

However, there was pushback against the perception that Black doctors in senior leadership positions do not support other Black doctors in the same way that Asian doctors support their peers. Instead, participants suggested that the combination of the limited number of Black doctors in senior leadership and the heightened scrutiny they experience may contribute to a sense of insecurity and isolation within these roles. As a result, some Black leaders may feel less able to challenge existing systems or advocate openly on issues affecting minority ethnic colleagues. One participant explained:

> *I genuinely think that Asian doctors have historically been better at supporting one another after achieving seniority. But Black doctors also support one another. It may be that, for Black doctors who have reached those positions, the struggle to get there means they are less willing to rock the boat or be seen as causing problems, especially when they are often on their own in those spaces* [B6].

This perspective suggests that differences in visible advocacy or sponsorship may reflect structural conditions and the experience of isolation within senior leadership environments, rather than an absence of solidarity among Black doctors.

There was also a clear recognition about the gender intersection in DA within minority ethnic doctors—Black male and female doctors: "*There is no doubt you see a lot more Asian doctors at senior leadership levels. But you do not see Black males, maybe some Black females. Mostly, I come across a lot of Asian doctors…. I have only come across one Black male at this level (senior leadership)"* [W2]. This was echoed by several Black participants, with one hypothesising:

> *I wonder what the difference in perception is of a Black woman versus a Black man and why Black women are preferred at this level in these spaces…perhaps they think [they] would be more receptive…less challenging or perhaps women chose careers specialities that gives them better opportunities at senior management. I don't know but that doesn't assume there is a stochastic relationship…in fact probably it is not* [B3].

Participants reflected on their extensive experience within the NHS and their journeys towards attaining senior leadership roles, drawing on these experiences to inform their present perspectives. Several participants suggested:

> *My experience while I was training, about 25 years ago, it was uncommon to see Black person in these positions. It was more common to see Asian. But even they were a minority compared to White colleagues. When I then became a consultant, which was in the year 2000, looking at across the patch of all the places I did my training, it was still pretty light on Black senior doctors and it's the same problem still. You're more likely to be a Brown person in this senior position. And it is even worse for other ethnicities such as Filipinos* [A3].

> *Some of its numbers; you know, there are fewer Black doctors in general in the country as a proportion of the of minorities in the country – population wise. But we, Black people, are disproportionately minoritised within medicine. Though I think representation of minority ethnic doctors is disproportionately higher in medicine than our overall number in the country. However, I think there is unspoken amount of racism between the two groups – Black minority and Asian minority group, which feeds into this problem. So, you cannot be sure as a Black person what factors are at play. I've not seen or experienced very often where there are a group of Black doctors in an area and they have the kind of monopoly on that area, unlike Asian doctors who do* [B2].

> *…I think there is a lot of quiet about the racism that exists between the two groups (Black and Asian). And from the perspective of the power imbalance, it's more likely to be a group of Asian doctors that have power over an individual Black doctor. So, there isn't the assuredness of support and allyship between racial groups and so that BAME acronym for example hides a lot of that* [B3].

Some participants acknowledged that these issues also exist within different nationalities encompassed by the broader Asian category, suggesting:

> *...Some Asian doctors are doing much better than others at higher levels… and this needs to be recognised. There is racism within the different nationalities of the Asian group. For example, I think Bangladeshi doctors get treated far worse. The Asian category is a large group of people and there's obviously some racism between Asian groups, terrifyingly so. So, there's a bit around recognising this phenomenon existing within this group* [B1].

There was also an acknowledgment that, over the past decade, there has been a concerted effort to widen access to medicine, creating greater opportunities for individuals from minority ethnic backgrounds to enter medical school. Some participants viewed this development positively, noting that it has the potential to increase the number of minority ethnic doctors progressing through the system and, ultimately, into senior leadership roles. At the same time, they recognised the persistent challenges faced by minority ethnic doctors as they navigate career progression within the NHS. One participant suggested:

> *Some of the other reason why there is differential attainment between Black and Asian minority is that there is a lag in the system. There are now more Black doctors coming through the system and represented at junior levels. It takes 10 years or more for us to see the effect at senior management level. So, there's a lag. However, we cannot assume that the rising numbers of Black doctors at the junior levels will lead to increased representation at senior management level over time… we have to do the maths and make sure this holds at the top of organisation in years to come [*B2].

Another participant challenged the simplicity of this assumption, arguing:

> *The lack of representation of Black people in NHS senior leadership over the years is not just a lag in the system. It's not that simple. The complexity still exists around volumes i.e. total numbers of Asian doctors versus Black doctors going through the NHS system. It may be that with more awareness now, that talent management's career progression will enable us as organisations to start to look at people differently and not based on their ethnicity… and start to encourage more Black doctors to pursue leadership positions and create the right environment to succeed* [B3].

Participants expressed scepticism that the issue is merely attributable to a lag within the system, instead suggesting that it reflects deeper, systemic issues within the NHS that underlie differential attainment between minority ethnic groups:

> *Differential attainment at senior leadership levels between Asian and Black doctors [can be] explained by the already significant presence of Asian doctors at the top, pulling each other up. It's a vicious cycle, which means that if you're a Black doctor at the top, you better pull too... In the Asian community there is already a multi-generational culture of people pulling each other up in every facet of their life and in their communities. That is not necessarily as well embedded in the Black culture, I think* [B1].

There were suggestions that, while Black doctors appear to be underrepresented within the broader minority ethnic category, minority ethnic doctors as a whole face significant challenges in progressing to senior leadership levels. Participants attributed this, in part, to wider societal perceptions, which shape organisational cultures within the NHS and influence how minority ethnic individuals are viewed and evaluated:

> *In British society, we are constantly exposed to negative stereotypes of Black people. Unless you really understand the complexities behind that, you can start to believe them yourself. That is why some Black people may be more likely to trust or favour a White person over a Black person. In contrast, Asian people are often presented through more positive stereotypes, with examples of success in leadership and public life. As a result, Asian communities are not negatively stereotyped to the same extent as Black communities, and I think these wider societal attitudes also affect the NHS* [B6].

Implications and Reflexivity

The implications of this subtheme relate, in part, to structural issues in how ethnicity data has been collected and categorised over recent decades. Minority ethnic staff in the NHS have often been homogenised through the use of acronyms such as BME or BAME, which fail to disaggregate diverse groups and instead create a "one-size-fits-all" classification (Aspinall, 2021; Malik et al., 2020).

A second implication concerns legacy and intergenerational advantage, including forms of cultural and social capital that confer privilege on some members within minority ethnic groups. This creates a relational dimension to career progression within the organisation; whereby certain groups are better positioned to navigate and succeed within existing structures. For policymakers and statutory bodies such as the Workforce Race Equality

Standard (WRES), these findings suggest that a failure to recognise these nuances and implement proportionate, targeted interventions is likely to perpetuate—at a minimum—existing inter-racial and intra-ethnic disparities. At worst, such approaches may exacerbate inequalities by disproportionately benefiting those minority ethnic groups who already possess greater cultural capital, thereby reinforcing existing advantages.

In this study, I was therefore careful to reflect the voices of participants from a range of backgrounds. For example, senior leaders of Asian heritage were represented across different cultural groups, including Indian, Pakistani, Sri Lankan, and Korean participants. Reflections from participants—including both minority ethnic and White individuals—suggested that there was merit in this argument, based on their observations of organisational dynamics within the NHS.

5.3.1b 4.2 Black Underrepresentation through Structural Exclusion and Racialised Stereotyping

Illustrative quotes

Many participants discussed the marginalisation experienced by Black doctors in relation to career progression, highlighting a perceived correlation between systemic issues within the NHS and broader societal perceptions of Black people in British society. One participant suggested:

> *…There's this attitude, is sort of perpetuated in the media that for Asians, becoming a doctor is very much a normal thing in our society. Black people are not perceived the same way… amongst my demographic (White)…we see that the Asian community very much want to see their children become doctors. They rise to the top. However, the perception I get from the media is that within the Black community...there isn't the same positive stereotypical vision of Black people, never mind becoming doctors* [W2].

Furthermore, participants suggested that these perceptions may permeate the interview and selection processes in the NHS, thereby reinforcing existing biases:

> *…Let's say you're got an interview panel of 10 people. And because we don't have many Black consultants, you've got 7 white, three Asian senior leaders making up the 10 people interview panel. I think that does make a difference for that Black candidate… you've got to feel for that Black doctor being interviewed by this panel, that must potentially feel quite intimidating. I think its automatically already at a disadvantage* [W2].

Building on the idea that the established and significant presence of Asian doctors at senior levels may contribute to these disparities, participants suggested:

> *…The suggestion that Asians are better represented at these levels compared to Black doctors because of things like better organisation, advocacy groups, more mentoring, leadership and better organisation as a group….is a stereotype. I've lived with this type of stereotype my whole life. This stereotype comes from slavery. It's the same stereotype associated with of Black-on-Black violence…. the suggestion 'we sold our own selves into slavery'… that we are not a collegiate set of people…that we're more likely to injure our own selves. That's an ingrained racial stereotype that we all have, but we haven't articulated where it's from. We have no evidence that it is true. We have evidence that we are socialised in certain ways, racialised in certain ways, but this narrative that we don't help ourselves is not more or less true than it is of any other racial group. People will suggest it... that Blacks don't help each other compared to other minority ethnic groups e.g. Asians. I've grown up with it, and I've decided it's racism. It's our own internalised racism and we keep speaking to it [*B2].

Others suggested that a contributory factor relates to familiarity and homophily, whereby individuals in senior positions may be more likely to select candidates who share similar backgrounds. This dynamic can also advantage those from Asian backgrounds, given their more established presence at senior levels compared to other minority ethnic groups:

> *...If you on interview panels for higher positions in the NHS, you're more likely to get an Asian person on that panel as the EDI person, rather than a Black person. There is possibility that if there is a tight decision which comes down to a Black and Asian candidate, that they're probably more likely to select the Asian candidate...so, the Asian person is more likely to employ another Asian person. So, there's this pull up because they are already a number of Asian people at these levels, they're more likely to pull up other Asian people. However, because there is lack of Black people at this level, then there aren't enough Black people either mentoring or pulling up. That is my experience* [A2].

Other participants described similar experiences but added further nuance, highlighting the presence of informal rules operating at this level of selection. One participant suggested:

> *One of the challenges often when you're in interview panels for senior positions are the subtleties of what influences a decision. It's often very easy to put forward an argument that fits your answer. It's interesting to observe the panel discussion after an interview… and then look at the minutes of the discussion. You wouldn't be able to trace the unconscious or conscious bias; It almost inevitably. In an interview, often there is someone who's clearly better or worse based on entry, but often times outcomes can be swung towards the preferred candidate… the panel can put weight on those questions the candidate did better on. So, it is a very opaque system… how people get appointed for the top job. I don't want to say meritocracy is dead because I think good people can succeed irrespective of their origin… what I'm trying to say is that some of the barriers are stacked against some minority people* [W1].

Other participants referred to challenges encountered earlier in the career trajectories of Black and minority ethnic doctors, particularly in relation to regulatory bodies and postgraduate colleges responsible for setting professional standards, including the examinations required for career progression:

> *If we look at the GMC (General Medical Council) survey that suggest Black and minority ethnic doctors experience disciplinary process compared to their White counterpart. Further work suggested that it wasn't that the disciplinaries were excessive for the Black doctors, but that they were not sufficient in their White counterpart. My living hypothesis is that if there is a penalty to be given, you are more likely to have it as a Black and minority ethnic doctor…. and if there is leniency to be given, you are more likely to have that as a White, non-Black individual. That is what I have observed in my career. This is my hypothesis* [B4].

There were also discussions regarding the attributes often associated with minority ethnic individuals who attain senior leadership roles, including the heightened expectations placed on minority ethnic candidates aspiring to similar positions. One participant suggested:

> *In the first instance, the minority person that penetrates have to be exceptional. What I tend to find is that the exceptional candidates, who've become senior leaders take a dim view of the ordinary candidate who shares their demographics. They question why they are just ordinary. I think when we Black senior leaders get to the point where we can appoint another Black doctor, perhaps an average one as a matter of course, we likely to go with average White candidate, because we're still saying to the Black candidate that you cannot be like everybody else is here, you just got to be better, and not just little bit better. We expect the Black candidate to gain demonstrably higher point on each interview question* [B1].

This heightened expectation placed on Black candidates by other Black leaders was further explored by several participants. Paradoxically, some suggested that it may serve as a form of safeguarding, preparing Black candidates to navigate a system in which they are more likely to be judged harshly and penalised for perceived mediocrity, particularly at the highest levels. One participant explained:

> *It follows that our errors are more visible. There's no doubt that. When a clinician messes up for example or has an issue in their training… as a Black doctor, you're much more likely to be taken down a formal disciplinary route. Now, the rationale for doing that is interesting. I think previously you would say it was done from a pejorative reason. Now I think people are scared of being seen as being biased. So, rather than just say 'I have a word with you', instead in order to be seen as transparent and prove everything is above board, for fear of being accused of racism, they go down the more formal route…. whereas the White doctor may be given an informal conversation. This tentativeness around diversity make people formalise even small issues related to minority ethnic doctors. I think people find it so hard to be fair; to be seen to be above board. Ultimately, I don't think you can win* [B6].

Implications and Reflexivity

The insights gained from this subtheme were significant, particularly those derived from the observational data and the lived experiences of many participants, including non-Black participants. These insights highlight the role of structural and systemic marginalisation rooted in wider societal contexts (England & Brown, 2001; Solomos, 1988), such as the negative stereotyping of Black men in particular (Atewologun & Singh, 2010; Osbourne et al., 2021). This may have a relational impact on the perceived marginalisation of Black men

at higher organisational levels. Evidence from industries outside the NHS suggests that Black men are more marginalised at senior levels, whereas Black women appear to have comparatively greater representation, although they also remain underrepresented overall (Goyal & Kakabadse, 2025). Within other minority ethnic groups, there is also evidence of intra-group marginalisation—for example, among UK Bangladeshi (Salway, 2008)—indicating that these disparities are complex and nuanced across different communities.

In reflecting on this study, I sought to ensure that the voices of both Black men and women in senior leadership were central to the analysis. This approach has deepened my understanding of the nuanced dynamics, including the perceived preference for Black women at the most senior levels relative to Black men. I also ensured the inclusion of perspectives from non-Black participants on this issue. While some shared observational insights supporting this perception, they suggested that the underlying causes are likely to be multifactorial, while acknowledging that broader societal stereotyping of Black men may be a contributing factor.

5.3.2 THEME 5: Organisational Mechanisms of Sponsorship, Visibility, and Opportunity Access

In this theme, participants discussed the complexities of minority ethnic DA, particularly at senior and leadership levels within the NHS. They suggested that this phenomenon coalesces around several interrelated factors, including the generational and legacy advantages held by some Asian minority ethnic doctors. These advantages were described as conferring increased access, visibility, and sponsorship for younger Asian doctors aspiring to leadership roles within the NHS. Participants also identified additional contributory factors, such as the relative size of different minority ethnic groups—for example, the greater number of Asian doctors compared with Black doctors—suggesting a mathematical component to DA. Furthermore, participants highlighted the role of mentorship and role modelling from minority ethnic leaders, particularly Asian leaders who are already represented in greater numbers at senior leadership levels, compared with Black minority ethnic leaders. Importantly, participants also emphasised the need for nuance by drawing attention to variability within minority ethnic groups. For example, those of Indian and Black African heritage were perceived to be over-represented within Asian and Black senior leadership, respectively, compared with other groups within these broader categories, such as Bangladeshi or Caribbean doctors.

5.3.2a 5.1 Sponsorship as a Relational Mechanism of Leadership Progression

Illustrative quotes

Many participants drew on their experiences, reflecting on instances where they had intervened on behalf of minority ethnic colleagues by virtue of their positions within senior leadership and decision-making spaces. One participant recalled:

> *I suppose I'm struck and remembering a consultant interview panel that I sat on, where the candidate was a Nigerian woman. During the interview, as we all do, when we get nervous excited, she became louder and her accent became stronger, and you could see the visible impact on the panel. But because I was there – as a Black person in my role as the most senior member of the panel, and because I was conscious of this, I asked the panel to divorce how she said it from what she said, and her answers were stronger than the other candidates. [However], you need to be careful when you do this, so as to not be seen as exerting undue influence or bias for certain groups. So, I think there is definitely something about representation and advocacy. So, if you have people who have lived experience, understanding and courage to be present in spaces where decisions are made and to speak up...that consciousness of the situation…can help to promote equality* [B4].

Some participants suggested that minority ethnic individuals aspiring to leadership within the NHS should actively seek out opportunities—such as mentorship from ethnically congruent senior leaders—throughout their career trajectories to enhance their chances of attaining leadership roles.

> *If I was a Black doctor, I would probably almost gravitate to another Black doctor who has achieved a senior role because they can see the vision and potential future for them. And I think there might be a benefit in that... I also think a Black doctor is more likely to listen to another Black consultant because they recognise that you might have gone through the same struggles as they're going through, whereas they look at me- a White consultant - demographically what everyone thinks a consultant is, they might just think it's actually been easy for me and I've not got much to tell them* [W2].

While others broadly agreed that minority ethnic senior leaders hold a responsibility towards supporting aspiring minority ethnic candidates, one participant stated:

> *…The mentorship responsibility is using the path that you have trodden; the challenges that you have faced, to make sure that it's easier for those who come behind, so you know, "lift as you climb" would be the responsibility…and the second bit for me is don't set people up to fail. We do that so often, so really great people, really talented, really intelligent Black doctors, who come to you for mentorship... but on reflection, you think actually, they haven't done the initial work such as leadership training. We need to prepare them for what is in store for them at this level... and sometimes that involves a frank conversation if they are not yet ready [B4].*

Implications and Reflexivity

Participants suggest that minority ethnic groups with established internal and external advocacy networks, may positively influence career progression through networking opportunities and advocacy on behalf of their members and wider minority ethnic groups. This includes support in areas such as disciplinary processes and employment-related matters (Chakravorty et al., 2021). The implications for career progression relate to the often intangible yet significant impact of networking, access, and mentorship on career opportunities and advancement. These factors operate beyond the clinical skills and competencies required of doctors, which are typically considered baseline or minimum standards rather than distinguishing criteria for leadership and senior leadership roles. In this study, it was important to explore this idea across all participants. I observed tensions along minority ethnic lines, where perspectives diverged. Some participants suggested that the influence of large minority-based organisations is limited and largely dependent on individual engagement, while others—particularly those not affiliated with such groups—perceived their influence as far-reaching.

5.3.2b 5.2 Representational Visibility and the Shaping of Leadership Aspiration Illustrative quotes

Many participants emphasised the importance of minority ethnic visibility at all levels of the organisation, both for enhancing legitimacy and for supporting the aspirations of the substantial minority ethnic workforce within the NHS. Participants highlighted the need for active interventions, including role modelling and increased visibility of minority ethnic leaders across all levels. However, achieving this requires a more proactive and critical review of selection processes and the challenges encountered along career pathways. Such efforts are necessary to build on the progress made in increasing the representation of minority ethnic doctors at entry points into the NHS. Without this, there is a risk that gains at entry level may not translate into equitable representation at senior leadership levels. Reflecting this concern, one participant noted:

> *...Despite the increase in Black doctors in junior ranks for years now, we are still not seeing them in the consultant ranks. So why is that? Again, I think it is potentially the lack of role modelling i.e. seeing other Black doctors in senior leadership roles, but also, it's a potential failure of mentorship as well... making these younger Black doctors think they can't attain that level because no one else (Black doctor) has. So, there's the perception that they have to work doubly hard or make extra effort, so to speak... It's beholden on us to help them achieve those objectives and bring them along to observe us as senior leaders. We need to seek them out rather than waiting for them to come and ask us to be mentors* [W2].

In discussing the characteristics of effective role models, most participants agreed that while having a racially or ethnically congruent role model can be beneficial, it is not essential. Instead, they emphasised that other qualities and forms of support may hold greater significance. One participant suggested:

> *It does matter if the role models share the same ethnic background of course… ideally the role models should represent the people we're trying to role model, but this is not an absolute. Having role models the reflects the workforce and aspirations of the workforce is a really good example of role modelling… and not just White men. Someone from a minority ethnic background who is in a senior position is really important for role modelling. I also think the other thing that's really important is having the other members of faculty in general, who are White or Asian, making sure that they are aware of the issues such as differential attainment between groups... because I think the more we talk about it, the more there is conversation*

> *about it… the more we are likely to reflect on it in at interviews for example, in a decision making process such that those unconscious biases play less of a role* [W7].

Others agreed that a pragmatic approach to mentoring is also important, particularly given the current underrepresentation of minority ethnic doctors at senior levels. One participant added:

> *If you see more of your own self, you're more likely to progress. However, there wasn't as much minority representation at the top in the past, though there is a little bit more now of role models for example for Black doctors in particular. However, a non-minority ethnic mentor who is already in this position might be just as beneficial for the aspiring minority ethnic doctor in terms of access and understanding of the culture at these levels* [B9].

Implications and Reflexivity

This subtheme highlights the crucial importance of representation, particularly at senior levels within organisations, and especially within the NHS, where societal health and wellbeing are profoundly influenced. Many participants framed representation as both an existential issue for community cohesion and a practical necessity. Almost all participants referenced the COVID-19 pandemic as a defining example, drawing on lessons from the lack of minority ethnic representation, which was perceived to contribute to excess morbidity and mortality among minority ethnic communities (Aldridge et al., 2020; Mahmood et al., 2021).

In this study, I considered it essential that the voices of all participants were central to the exploration of this theme. While most recognised the general advantages of representation, there were nuanced and, at times, opposing views regarding its practical implementation—particularly in relation to race and ethnicity. Some participants argued that cultural credibility is not solely determined by race, and that role modelling can transcend ethnic boundaries. Others, however, emphasised the importance of visibility itself, suggesting that seeing individuals from similar backgrounds in senior positions is critical in enabling aspiration and progression.

A central implication arising from this theme is the notion of legitimacy. Many participants expressed the view that the NHS risks being perceived as lacking legitimacy if its leadership does not reflect the communities it serves at all levels, including the most senior positions. This perceived lack of representation was thought to have tangible consequences, whereby minority ethnic communities may be less likely to access or engage with healthcare services if they do not feel that institutional voices reflect their cultural values and lived experiences.

5.3.3 THEME 6: Cultural Capital, Identity and Belonging in NHS Leadership

This theme captures the historical perspectives of minority ethnic people in the UK, focusing specifically on the relational role of generational and legacy factors in shaping career opportunities and progression for doctors within the NHS. Many participants drew on their family histories, often tracing back to first-generation immigrant journeys, to explain the advantages they currently experience within UK systems, advantages which also translate into the NHS and confer professional benefits.

Some participants—particularly Asian participants of Indian origin—described the advantages of being third- or fourth-generation doctors. They spoke of growing up with a deeper understanding of NHS structures and processes, as well as access to guidance on navigating the system through socialisation, adaptation, and professional connections. In contrast, other participants, particularly Black participants, described being first in their families to attend medical school. As a result, they lacked the social networks and institutional knowledge that confer ongoing advantages, which they perceived continued to affect their career progression despite possessing postgraduate qualifications and demonstrable competence. Participants suggested that while technical competence was viewed as a minimum requirement for leadership roles, non-technical assets—such as connections, access, and cultural capital—were more influential at senior levels. Participants, including White participants, also described inter-ethnic variation within minority ethnic groups. For example, they suggested that individuals of Indian and, to a lesser extent, Black African heritage may benefit from diasporic middle-class backgrounds, which provide forms of capital such as particular mindsets and a strong emphasis on academic achievement, thereby offering comparative advantage over other groups within broader ethnic categories.

5.3.3a **6.1** *Unequal Access to Cultural Capital and Intergenerational Advantage*

Illustrative quotes

Many participants discussed the relationship between the migration histories and legacies of minority ethnic groups, particularly those from Asian backgrounds.

> *...About the progression doctors of Asian backgrounds, number one is, it's quite a diverse group - Indian, Pakistani, Bangladeshi, etc. If you look at Bangladeshi group… they are not really pushing forward at all. It goes back generational of course where the Indian doctors are third, fourth generation doctors. So, they're going to have known the game and then the system for ages… they have been in the system for long periods of time. Whereas those who come from Bangladeshi or Black backgrounds maybe first or second generation or do not have the same lineage advantage or insight. You can see it in the way the third or fourth generation Indian and Pakistani doctors carrying themselves…and the confidence they have. I think about it. I mean, I've been in this game for such a long time that…I could see it a mile off…somebody who has come from a medical family and someone who has not* [B1].

In addition, they suggested that the culture and capital accumulated through generational experiences—both within the NHS and wider British society—act as forms of privilege that contribute to differential attainment, both within Asian ethnic groups and between broader racial groups. One participant reflected:

> *Those who don't come from medical families often lack that natural support network. We don't do enough to help them navigate the system or understand how to progress in their NHS careers. I think Asian doctors from medical backgrounds tend to do this better and are generally very supportive of one another* [A8].

Furthermore, participants highlighted the importance of intangible attributes—particularly non-technical skills—associated with this legacy. These qualities were seen as highly valuable, especially at senior leadership levels, where such non-technical attributes are often regarded as essential. One participant suggested: *"I think there's a set of behaviours which are so to so non-technical and so non-visible that they inherit… this can be the deciding factor at this level (senior leadership interviews) … where the criterion for selection is not transparent".* [A1]

Others suggested a further cumulative advantage, particularly for doctors of Asian origin, supported by access to well-established organisations and advocacy networks. These structures provide opportunities for aspiring leaders to engage with senior figures, as well as to build professional networks and connections within the NHS. Many participants emphasised that this form of social capital functions as an important currency, offering tangible benefits in career progression: *"The Asian organisations have more numbers. It's a numbers game… and they are organised. So, they are more influential as a group and this translates to better opportunities, particularly for those who are already doing well within the Asian group".* [B2]

Implications and Reflexivity

The implications of this subtheme suggest a relational advantage for some minority ethnic groups who benefit from intergenerational advantages that support career progression through access, networks, and social capital. These advantages are often attributed to a deeper understanding of organisational systems and structures, gained through the experiences of immediate and extended family members who are currently, or have previously been, doctors within the NHS (Esmail, 2007; Simpson, 2018; Robinson & Carey, 2000; Gaind, 2017). Participants in this study reflected on the benefits of non-technical skills derived from such cultural capital and legacy, often describing these advantages as a form of privilege that those who possess it may not readily recognise.

5.3.3b 6.2 Internalised Leadership Ceilings and Self-Exclusion

Illustrative quotes

Many participants expressed concern that, although the NHS has made progress over the past decade in increasing minority ethnic representation at junior leadership levels, representation at the most senior levels of the organisation continues to lag. This was seen as particularly pronounced for doctors from Black backgrounds. Participants attributed this disparity to a range of factors, including a perceived sense of exclusion and the persistence of a "glass ceiling" that limits progression for minority ethnic doctors at the highest levels of leadership:

> *I think there's probably an element of the welcomeness and belonging which is not specifically about race or ethnicity but appear to impact minority ethnic doctors more at this higher level of the organisation. So, even if a Black person was welcomed into a group (senior leadership) which comprises of all White people – a homogeneous group – it is difficult for the Black person to feel a sense of belongingness. And I think that is something that's always very hard to change...If you were welcomed in the group but everyone else behaves differently or looks different in the case of skin colour, I think that is a potential barrier to success in that space* [W2].

Furthermore that:

> *…At this level confirmation bias contributes to the differential attainment of Black and minority ethnic group in achieving these senior roles. I think that's a very big part of it. I think the desire to appoint someone who looks and behaves like yourself is significant. I think it spans even the gender biases that we have because internally we are naturally drawn to a reflection in the mirror - that people like to like their own… it creates a bond, and I think skin colour can create that same bond* [W1].

Others acknowledged that, while there is a perception of a "glass ceiling," minority ethnic doctors are represented at higher levels within the NHS. They suggested that those who aspire to such roles must demonstrate resilience and focus in pursuing their objectives:

> *You still have to keep moving forward. You can sit around talking about how terrible it is, and you can live in fear of how terrible it is... or you can acknowledge that it's terrible, find support for what's terrible...but you got to keep putting one foot in front of the other. You are going to meet racism. You are going to meet injustice. There [are] going to be times when you can get justice for some of that racism. There [are] going to be many more times when you can't... and if you get bogged down. You have to have some strategies for healing from racism. Acknowledge that it exists. Be disappointed that it exists. Sometimes seek justice for it, but you've also got to learn how to move on, enjoy peace, wisdom, forgiveness. You got to forgive people. People are racist. Honestly, you have got to learn how to forgive them and we don't talk about that enough* [B2].

In addition, participants recognised the pressures faced by minority ethnic individuals who attain these positions, noting that they may not always feel sufficiently secure to advocate effectively for others, including members of their own communities:

> *I don't always have to be in advocate mode. It is important to forgive yourselves for the time that you haven't been able to stand up for other people and forgive the people who have been racist towards you. There's no healing if you don't do that. That ingrained bitterness, that ingrained mistrust, that ingrained agitation and indignation, makes us less healthy. Resilience isn't just about getting justice... It isn't just about always fighting. Sometimes it's just about healing and then moving forward, because that's what we need to do to succeed at this level* [B2].

Implications and Reflexivity

The insights gained from this subtheme relate primarily to the experiences of Black participants and the perception that structural and institutional marginalisation in wider society contributes to heightened self-scrutiny and, at times, self-exclusion from leadership and senior leadership opportunities. This is both a perceived and observed phenomenon, whereby Black doctors who do not see themselves represented in senior positions may interpret these spaces as unwelcoming. In conducting this study—as a researcher who is also working towards this milestone—I was conscious of the need to minimise my influence on participants and made a deliberate effort to foreground their authentic voices in both the narrative and my interpretation. Many Black participants articulated this experience as disempowering. The implications of these findings suggest that minority ethnic talent may be lost to NHS organisations, as some participants described choosing not to pursue senior roles within the NHS or opting instead to seek opportunities in other sectors where they feel more valued (Irons, 2024; Iacobucci, 2022; Martin et al., 2023; Woolf, 2023; Esmail, 2007).

5.4 RQ3: Participants' perspectives on the health implications of DA at senior leadership level in the NHS for minority ethnic communities

5.4.1 THEME 7: Minority Ethnic Leadership Representation as Structural Advocacy

This theme captures participants' ideas about the value of minority ethnic representation in senior leadership, both as an intrinsic good and as having a beneficial impact on the health outcomes of minority ethnic communities. Almost all participants suggested that, at the very least, visible minority ethnic representation at senior decision-making levels has merit, as it is likely to encourage consideration of the health needs of minority ethnic communities. Many participants drew on lessons from the COVID-19 pandemic, suggesting that greater representation at senior levels may have led to better outcomes for minority ethnic populations, or at the very least provided reassurance that the needs of minority ethnic communities were being considered alongside those of the White majority population. However, some participants cautioned against tokenism, arguing that visibility should not be conflated with meaningful progress. Instead, they advocated for proportional minority ethnic representation that reflects local demographics, depending on geographical context. Participants also suggested that even in areas with predominantly White populations, diversity in senior leadership is valuable in itself, contributing to diversity of thought and experience. This was perceived as likely to benefit all populations, as evidenced by outcomes observed in other sectors.

5.4.1a 7.1 Relational Harm Arising from the Absence of Minority Ethnic Leadership

Illustrative quotes

Many participants reflected on the COVID-19 pandemic and the lessons learned, particularly in relation to the interplay between representation, agency, and organisational structures, and how these factors influenced healthcare outcomes for both minority ethnic NHS staff and the wider communities they serve. Several participants asserted:

> *In my opinion, if you don't have leaders who are part of those minority communities, the entire downstream system becomes conditioned to make assumptions about certain individuals and communities, which may not be beneficial for those communities* [A5].

> *...Having a huge voice to advocacy for your community at leadership level can make a difference. You need this influence and power as a cohesive group to make a difference. And the larger it is, the more agency you have and most likely you will have people in there who have networks of power that will help to influence change. There is something about bringing together groups (minority ethnic) that are aligned, but it's not always easy. There is also a thing about trust which has an impact healthcare delivery...this goes in hand with cultural understanding, but it is also about visibility. The bottom line is yes, the bigger you are as a cohesive minority ethnic group, the more agency you have to influence change at the highest level of the NHS* [B3].

Some participants recalled instances of harm arising from inadequate representation at the highest levels of the NHS. They suggested that this lack of representation meant that the needs of minority ethnic staff and patients were not appropriately considered in a timely manner, contributing to misinformation and an erosion of trust in the system:

> *...A lot of minority ethnic people were getting their information from social media, chat rooms, from non-credible sources. They didn't trust the credible sources. They were written in White. I think that is a problem. We need to build a more culturally diverse system where we have the minority ethnic academics, and not about tokenism. A Black face is not an admission of failure. It's a recognition of somebody having a skill set. And I think that a lot of time in British society...a Black face is seen as being a diversity push. I don't want to be part of that conversation because that's not what I'm about. I don't want to be portrayed as being someone's prized pig because I'm a Black doctor... never mind the 30-40 years I've been working hard to reach this senior position* [B1].

> *From a workforce point of view, people from minority ethnic background were put at risk during COVID from inadequate risk assessment of the staff...only for us to find out we were at increased risk. I believe if this had been identified at the highest tier more vocally and more powerfully, it could have made a difference to lives...people felt very vulnerable being from a particular background (Black and Asian minority ethnic) because they were more at risk, but*

> *there were no adjustments were made for them. If there were conversations being had at the highest level, by the right people who are members of the community...maybe the story would be different. Similarly, across the community, if you've not got people championing those things, in positions of authority, there'll be health inequality* [A3].

Other participants discussed the practical responsibilities associated with minority ethnic leadership at senior levels, highlighting the expectations and challenges inherent in these roles. One participant suggested:

> *Minority ethnic issues are likely to be addressed better if there are more minority people in senior leadership positions. However, you have to be conscious of it – the issues. You have to be willing to discuss it. You have to be vulnerable to bring it up. You have to strike the right balance because at this top level, you are there for everyone. So, if you are seen as always bringing up race issues, then the non-minority members who are the majority in this space will switch off* [B2].

Implications and Reflexivity

The insights gained from this subtheme reflect lessons from the COVID-19 pandemic, during which almost all participants discussed the correlation between the lack of minority ethnic representation at senior leadership levels—both within government and the NHS—and increased morbidity and mortality among minority ethnic communities (Aldridge et al., 2020; Mahmood et al., 2021). I was struck by the range of examples participants provided—both personal and observational—to illustrate the relationship between representation and healthcare outcomes. Other participants drew on existing literature, which suggests that ethnic concordance between doctor and patient is associated with improved health outcomes (Lister et al., 2019; Montalmant & Ettinger, 2024*)*.

5.4.1b 7.2 Representation as a Mechanism for Community Health Improvement Illustrative quotes

Participants recognised the importance of proportional representation at the highest levels of the NHS organisation as a means of advocacy and as a positive influence on health outcomes for their respective communities and beyond. One participant suggested:

> *It is important that we have representation of ourselves at the decision-making table. It promotes the agenda and needs of your community. Our visibility is important because it will expand what is talked about… the lived experience of the people is important in these settings. Being able to bring the witness of who you are and what your community is and needs is powerful. It helps us to have necessary conversations that helps us to shape pathways now and for the future. It helps us address our assumptions, prejudices and biases, because that's what we've grown up with. Diverse leadership help us challenge... so, we come up with a better solution. Also, if you're not visible then they don't know about you... your community. They're not thinking about you. There's something about being able to put that challenge in and challenge any false or incorrect assumption about your community... but that requires you to be in the room* [B3].

This suggests that greater minority ethnic representation in NHS senior leadership is seen as essential for ensuring inclusive decision-making, challenging bias, amplifying underrepresented voices, and developing better policies and services for both staff and patients. Another added more broadly about the universal benefit of diversity:

> *I've always thought it's good that we have representation leadership that reflects their areas. For example, those with large minority ethnic population should have proportional minority ethnic senior representation. Actually, perhaps what we should be saying is that diversity would be a good thing anywhere, because if I'm saying it's a good thing... in this heavy minority area, what am I saying about a little village in northern England that's all White? Am I saying that their board should be all White and represent their population? I suggest I'm probably not saying that because that doesn't feel right, as I say it out loud. So, I think the message has to be diversity in itself; It's a good thing that creates diversity in thought. There is evidence, actually, in other industries that the more diverse a company is, the more profitable, more productive. So, there is already evidence out there* [A1].

This reflects a perspective that extends beyond demographic representativeness towards an appreciation of diversity as an intrinsic organisational strength. While the participant initially advocated for leadership that reflected local population demographics, they subsequently challenged this position, arguing that diversity should be valued irrespective of local ethnic composition. The participant suggested that ethnically diverse leadership contributes to

greater diversity of thought, more effective challenge within decision-making processes, and ultimately improved organisational performance. This finding indicates that participants viewed minority ethnic representation not solely as a mechanism for community advocacy but also as a source of cognitive diversity that can enhance leadership effectiveness and organisational outcomes.

Other participants discussed the challenges associated with advocacy when occupying senior leadership positions, particularly highlighting the differences between being the sole minority ethnic representative versus being part of a more diverse group:

> *I think that when you're on your own in the room, as the only Black person...you just want to fit in. But if there's two or more diverse people in that group, you can have a different kind of conversation. For example, when we started employing female colleague's conversations completely changed...what we talked about in these spaces became more diverse in general. So, I think when you have a diverse group at the top, you have generally broader conversation and are prepared to consider more issues around it* [B2].

This participant highlighted the limitations of tokenistic representation within senior leadership structures. While acknowledging the presence of minority ethnic leaders, the participant suggested that being the sole representative of a minority group may create pressures to conform to dominant organisational norms rather than express alternative viewpoints. In contrast, the presence of multiple individuals from diverse backgrounds was perceived to facilitate more open discussion and greater consideration of a wider range of issues. Drawing parallels with increased gender diversity in leadership, the participant argued that diversity broadens organisational dialogue and enhances collective decision-making. This finding suggests that participants viewed meaningful inclusion as contingent not merely on representation, but on achieving a critical mass of diversity capable of influencing leadership culture and discourse.

Other participants discussed the tension experienced by minority ethnic senior leaders, particularly the balance between advocacy for others and self-preservation. They highlighted how the presence of a critical mass of minority ethnic representation at senior levels can help alleviate some of these pressures:

> *There is a price you pay as that minority individual in senior leadership position, particularly if you are Black. For example, my White colleagues, can come to work, go home, see his kids, and that is their job done. But you're asking me as the Black senior leader in the same position to get on a bandwagon and do all this additional stuff as well and be the target on a bullseye for any racist people to have a go at, because I just don't happen to be White. You're asking a lot of people for nothing. I've done it for a long time, OK! And if you look at my Twitter account, It's just full of abuse right now. I don't bother to read it anymore. And anything I do as public facing, I get this: you know you're only there because you're Black. It's quite onerous. So, numbers are important. If it's just one person doing all this work for the community – Black community – it's quite a lot of stuff. When you've got 50 people saying the same thing, it's a much easier load* [B1].

Here, the personal costs associated with being one of a small number of minority ethnic leaders within senior NHS structures is highlighted. Beyond their formal leadership responsibilities, the participant described undertaking additional diversity and advocacy work, alongside managing experiences of racism and challenges to their professional legitimacy. The participant illustrates how minority ethnic leaders may become symbolic representatives for their communities, creating a disproportionate burden of responsibility. Furthermore, they emphasised the importance of increasing representation, arguing that a larger cohort of minority ethnic leaders (a critical mass) could distribute this labour more evenly and provide collective support. These findings suggest that discussions of representation should extend beyond numerical presence to consider the emotional, professional, and organisational costs borne by minority ethnic doctors who occupy senior leadership positions within the NHS.

Implications and Reflexivity

In this subtheme, many participants discussed issues related to the disaggregation of minority ethnic leadership and the potential relational impact for their respective communities. Participants suggested that, while visible minority ethnic representation is important, this must move beyond mere optics and tokenism. Instead, leadership should either reflect the composition of the minority ethnic communities they serve or involve representatives from those communities, with minority ethnic leaders acting as conduits between these communities and the wider NHS organisation. Other participants extended this argument, suggesting that if outreach to minority ethnic communities is both targeted and sufficiently comprehensive—encompassing the diversity within minority groups—then the designated NHS leader does not necessarily have to be from a minority ethnic background. This perspective introduces an important nuance between cultural competence—the ability to work effectively across different cultural contexts (Liu et al., 2021)—and cultural credibility, which refers to recognition by minority ethnic communities as a trusted and authentic representative (Nguyen et al., 2021; Schim & Doorembos, 2010).

5.4.2. THEME 8: Cultural Competence, Credibility and Patient Experience

This theme encompasses both the optics of minority ethnic representation at leadership levels—as visible representation for minority ethnic communities—and its aspirational value for the minority ethnic workforce, who may benefit from seeing themselves reflected in senior leadership. It also engages with the deeper and broader meanings of representation, particularly in relation to the lived experiences—both past and present—of representatives as credible members of minority ethnic communities. This moves beyond proportional representation towards proportionate inclusion; that is, beyond the numerical presence of representatives to meaningful participation and influence through seniority and impactful leadership contributions.

Participants also discussed the concept of cultural competence, which recognises the need for healthcare systems and providers to be aware of, and responsive to, patients' cultural perspectives and backgrounds, including patient and family preferences, values, cultural traditions, language, and socioeconomic conditions (Stubbe, 2020). Many participants suggested that representation in this context extends beyond being perceived as legitimate by the White majority. Rather, it requires acceptance by the minority ethnic community itself, where leaders are viewed as authentic, credible, and trusted advocates.

This distinction in cultural credibility highlights the dual competence expected of minority ethnic leaders: being recognised as technical 'experts' in their professional fields (for example, as senior doctors), while also being acknowledged as authentic community members who, irrespective of social mobility or class positioning, continue to embody and understand the values, histories, and concerns of the communities they represent.

5.4.2a 8.1 Relational Trust, Representational Credibility, and Healthcare Access

Illustrative quotes

Participants discussed both the importance of representation and the characteristics of effective representatives, emphasising the need for credibility and competence in advocating for minority ethnic groups. They also highlighted the potential positive impact that such individuals can have on minority ethnic staff within the NHS, as well as on the wider communities they serve:

> *You need people and doctors to advocate for their communities and bring nuance and lived experience. Sometimes, it doesn't need to be a doctor. Though you could argue they should be a doctor because of the credibility of the science behind it. But actually, it could be someone who looks at the issues affecting a community or a proposal from the top (management) a little bit more broadly with respect to how it may affect a marginalised group or community. For example, if we think back to COVID-19 vaccine uptake, that trusted individual could have intervened earlier... something like that... hold on a second this plan might not work for this community for these reasons, etc...* [W2].

Another added:

> *There is something to be said for having someone who is either from minority ethnic community or culturally aware advocating for the needs of a community at the highest level of the NHS organisation. Absolutely* [B2].

Others supported, adding:

> *I think you need someone who is keen on recognising and targeting and dismantling discrimination. Someone who sees diversity as an asset, not a deficit, and someone who holds people to account for behaviours that should not be tolerated. I think often people who have lived experience may be more attuned to that, but they are not unique in that...* [B4].

These participants highlight a distinction between ethnic representation and effective advocacy within NHS leadership. Participants recognised the value of leaders with lived experience of minority ethnic communities, particularly in identifying how organisational decisions may disproportionately affect marginalised groups. However, participants also emphasised that advocacy is not solely contingent on shared ethnicity. Cultural awareness, commitment to anti-discriminatory practice, and the willingness to challenge inequity were viewed as equally important leadership attributes. Consequently, while minority ethnic

representation was seen as advantageous in bringing community knowledge and lived experience to decision-making processes, participants argued that responsibility for advancing inclusion should be shared across all senior leaders rather than resting exclusively with minority ethnic individuals. This perspective reflects a move from a narrowly representational model of diversity towards a broader conception of inclusive and accountable leadership. Furthermore, many participants shared more routine experiences from their time in the NHS, reflecting on their observations of how some minority ethnic patients are treated when accessing healthcare services:

> *I think pain is a good example of where you want that cultural representation & community representation. For example, there are cultural differences in how people present when they are in pain, and this could affect how well they are treated and the perceptions the healthcare worker have of them, unless they are culturally aware. We see this all the time where minority ethnic patients are judge by how they are presenting with illness, rather than us managing their condition sensitivity...this comes down to lack of cultural awareness...the right leadership...who is cultural attuned or from those community might help shape culture of the hospital or set the agenda. It really can make a difference* [W2].

However, many participants felt that an effective advocate does not necessarily have to be a minority ethnic doctor from a specific community, given the diversity within broad racial categories and the variation in needs across different nationalities and geographical contexts. At the same time, many acknowledged that ethnically congruent representation at senior levels of the NHS is more likely to foster trust among minority ethnic communities compared to advocacy provided by individuals from the White majority.

> *"There is absolutely a need and a benefit to having someone advocate for any community. However, it doesn't matter who as long as the person does it well. For example, take a senior leader is of Nigerian origin, they may understand a little bit more about Nigerians, the needs of the Nigerian community...but does that mean they understand about the needs of all Black people? No. All black communities? No. Perhaps a little bit more than a non-Black person, but not completely. So there still needs to be a humility from whoever the person is to recognise that I'm advocating for a disparate group of people...I may not know all that's needed. Therefore, I think the representative can be from any racial group really...as long as they're willing to do the journey about learning and being around, learning about that the needs of that particular community* [B2].

Here, this participant challenged essentialist notions of representation by arguing that shared ethnic identity does not automatically equip leaders to speak for entire communities. While recognising the advantages of lived experience, the participant emphasised the heterogeneity that exists both within and between minority ethnic groups. Consequently, the participant suggested that effective advocacy requires humility, ongoing engagement, and a willingness to learn from the communities being represented. Importantly, the participant argued that leaders from any ethnic background could perform this role effectively, provided they develop sufficient understanding of the needs and experiences of marginalised groups. This perspective shifts attention away from demographic representation alone towards the relational and experiential processes through which leaders acquire legitimacy as advocates.

Another added, affirming the direct value of the ethnicity congruent practitioner or advocate on uptake of health care from minority ethnic patients:

> *So, COVID exposed a lot of failings in the healthcare system, about language, about understanding, about back story of minority people, about not really appreciating how you work with community. It was really good learning experience. There's no doubt that when I was trying to get people to vaccinated, being a Black vaccinator was a big deal. Black people let me vaccinate them and not necessarily anybody else because we had the conversation...about their concerns...they didn't feel judged or ridiculed. That's not just about being the right person. That's been both culture credible and culturally competent... We go through the back story about things that have been done to us in the past by the dominant culture which makes people hesitant and afraid to trust the health system...we'll talk to all sides...in our second, third languages... and it makes patients happy* [B1].

In this participant's account, representation is not merely about having diverse leaders around the boardroom table, the participant moves beyond this to the practical implications for trust, legitimacy, communication, and the successful implementation of healthcare initiatives within minority ethnic communities.

Implications and Reflexivity

The insights gained from this subtheme reiterate the value of cultural credibility as an asset for organisations seeking to invest in both their workforce and the health outcomes of their local communities. By highlighting this asset and its relational impact on trust among minority ethnic populations, participants suggested that there is both greater congruence in healthcare outcomes for minority ethnic individuals (Goyal et al., 2015) and a likely increase in engagement with healthcare services, such as vaccine uptake (Scheppers et al., 2006). The implications of this finding suggest that organisations should take active steps to ensure that their leadership structures at all levels reflect the communities they serve. This representation may help shape organisational agendas and better inform the healthcare needs and priorities of these communities. In doing so, organisations can also work towards fulfilling their statutory obligations, as outlined in the Workforce Race Equality Standard (NHS, 2025 report), as well as their broader strategic aims of improving healthcare outcomes for minority ethnic populations (Ross et al., 2010).

5.4.2b 8.2 *Cultural Understanding as a Mechanisms for Reducing Bias and Inequality Illustrative quotes*

Participants discussed, in more specific terms, the importance of ethnically congruent doctors and healthcare providers, particularly at the point of care delivery when minority ethnic patients are accessing services. This was distinguished from the value of minority ethnic representation at a strategic level, where individuals in senior leadership positions influence organisational direction. However, these roles were not viewed as mutually exclusive. Participants emphasised that minority ethnic senior leaders can play a critical role in shaping organisational culture from the top, which may, in turn, have a direct and positive impact on the quality of care received by minority ethnic communities, irrespective of who delivers that care.

> *As a doctor, I like to understand how patients think and behave when seeking healthcare. It helps me tremendously to understand why patients from different groups react in certain ways to certain things... for example, what is the history behind it? It would be really valuable if you take the time to educated yourself culturally. We know that our medical education... at least when I was at medical school... was culturally lacking – except for the majority White culture. I think dermatology is a great example, where all the skin conditions we learnt were all on White skin and we are supposed to adapt that the melanated skin now in clinical practice with negative impact on those patients* [W2].

Another added:

> *...In terms of epidemiology of health outcomes of people of Black ethnicity versus White...the disparities are enormous. There are many things of association driven by colour of skin...however, the maternity aspect of disparity of outcome is a very troubling... research around maternal and infant outcomes, particularly the US research, showed if you're treated by a healthcare provider who was ethnically congruent i.e. so if you're a Black woman and your doctor is Black, you have better health outcomes than if your doctor was White. That I think is a very stark sort of a clear evidence that there is probably unconscious bias or conscious bias feeding into decision making. So, I think there are definitely issues around healthcare that are directly related to colour. We need more education around this and perhaps having doctors in leadership positions where their voices make a difference may help change the culture* [W1].

The participant links disparities in patient outcomes to bias in healthcare decision-making and proposes both enhanced cultural awareness and greater minority ethnic representation in leadership as ways to create a more equitable NHS culture. This suggests that cultural

understanding is viewed not merely as an individual competency but as an organisational resource that can be strengthened through diverse and influential leadership.

Implications and Reflexivity

In this subtheme, there is a subtle nuance in how participants attempted to differentiate between cultural credibility and cultural understanding as mechanisms for reducing bias and inequality affecting minority ethnic communities. In the former, participants described cultural credibility as encompassing knowledge and understanding of the needs of minority ethnic communities, grounded in lived experience as a member of that community or through first-hand knowledge of these pertinent issues. This framing suggests that being a minority ethnic individual is, to some extent, a prerequisite for such credibility. In contrast, cultural understanding was described by many participants as extending beyond the ethnicity of the individual. Here, participants characterised such individuals as those who, through study and personal commitment, are aware of the needs of minority ethnic communities and actively champion their cause—serving as advocates who move beyond ethnic and racial boundaries. The implications extend beyond the visible representation of minority ethnic doctors in leadership positions, suggesting that ethnicity and race alone are neither guarantees nor sole determinants of improved morale and welfare for minority ethnic NHS staff, nor of improved healthcare outcomes for minority ethnic communities (Kalra et al., 2009; Mahmood et al., 2021; Ashraf, 2013; Ross et al., 2020).

In reflecting on the interviews, I observed tensions among many minority ethnic leaders, who appeared to hold two coexisting perspectives: a strong conviction regarding the importance of visible minority ethnic representation in senior leadership, and its perceived correlation with improvements in staff morale and healthcare outcomes; alongside the

recognition that non-minority ethnic senior leaders can also serve as strong and effective advocates for minority ethnic staff and communities. However, trust remains a significant issue, shaped by the legacy of historical injustices and unequal treatment experienced by minority ethnic communities (Paul et al., 2022).

5.4.3 THEME 9: Structural Inequality as a Driver of Health Inequality

In this theme, many minority ethnic participants focused on their personal experiences, which they felt had a significant positive impact when delivering healthcare services and advice to other minority ethnic individuals, both in their professional roles and within their communities. Participants cited examples in which access to, uptake of, and engagement with healthcare services were perceived to be improved when care was delivered by minority ethnic practitioners, when minority ethnic leadership was visible, or when specific cultural or religious considerations had been explicitly recognised and addressed.

5.4.3a 9.1 *Leadership Inequality as a Determinant of Minority Community Health Outcomes*

Illustrative quotes

Participants discussed the current structure of the NHS, noting that leadership at the highest levels does not adequately reflect the communities it serves, particularly in areas with large minority ethnic populations. They suggested that this lack of representation may contribute to poorer health outcomes for these communities, alongside other socio-economic determinants such as poverty. Participants also highlighted the challenges faced by minority ethnic doctors in accessing these senior positions, attributing them to organisational structures and forms of gatekeeping at the top of the NHS. They further emphasised the downstream effects of this exclusion, both on the experiences of minority ethnic staff within the organisation and on the quality of care received by minority ethnic communities.

> *It is rare for a new entity to come in, take current senior leadership –often White men, by storm and be put into these positions. You have to prove yourself over many years and that still isn't a guarantee. However, the rules are not fairly applied as non-minority ethnic doctors seem to penetrate these spaces better. What we need to do as NHS organisation is to recognise all people and their talent...accept them on merit and offer them the opportunity to be in these positions...which have a huge impact both on them and their communities, potentially..."* [A3].

Others considered the potential positive impact that addressing inequalities in access to senior leadership positions could have on both NHS staff and the communities they serve. They also highlighted the importance of non-minority ethnic senior leaders who demonstrate cultural sensitivity and a strong awareness of the needs of diverse populations.

> *...I'd like to think that representation of Black people around leadership table invites people to consider their biases or think about the needs of minority ethnic group around health provisions. I think it's true. I think the people will mind their manners... But the principled people will have that conversation whether or not there's a diversity person there or not. So, I don't necessarily think that people will think about diversity needs because there is a minority person in the room. Whether or not we're teaching leaders to lead appropriately is different question, and if we need to have somebody of colour in a room to have that conversation, then we should* [B1].

Others suggested a direct correlation with lack of minority ethnic leadership on the health outcomes of minority ethnic communities:

> *During COVID, there were evidence suggesting that actually the lack of leadership at the decision-making table may have contributed to poorer outcomes in our [minority ethnic] communities. There was gross failure from our NHS leadership. So, there is a link between health outcome and representation. I think over our generation will always use COVID as the great example of that. It breaks my heart to think if only there were the people up there [senior leadership] advocating for us... If we had people of colour at those in those boardrooms... outcomes may have been better. You've got to be in the room where it happens... It's that old expression but it's true. I think we have enough examples now, so what we need is change. And minority ethnic leaders already in these positions must keep pushing on... you got to speak up! Even when people don't always want to hear our voices* [A2].

Here, the participant argues that the underrepresentation of minority ethnic individuals in senior NHS leadership contributed to failures in addressing the needs of minority ethnic communities during COVID-19. They position minority ethnic leaders as essential advocates whose presence in decision-making spaces can promote more inclusive policies, challenge systemic blind spots, and contribute to improved health outcomes.

Implications and Reflexivity

The key insight from this subtheme reinforces the idea that the care needs of minority ethnic communities are likely to improve with better and more proportionate representation at leadership and senior leadership levels within NHS structures. Many participants cited examples during the COVID-19 pandemic, suggesting that increased morbidity and mortality among minority ethnic communities may, in part, be attributed to disparities in representation at both local and national leadership levels (Mahmood et al., 2021; Aldridge et al., 2020). Furthermore, participants highlighted a relational aspect to healthcare access, noting that minority ethnic communities may face barriers to accessing healthcare services (Szczepura, 2005) or may be less likely to seek care appropriately (Germain & Yong, 2020). This was perceived to be partly due to a lack of ethnic congruence in the delivery and provision of healthcare services (Hussain et al., 2022; Razai et al., 2021; Scheppers et al., 2006). These implications are supported by the literature and emphasise the role of minority ethnic leaders in contributing positively to healthcare uptake (Chan et al., 2020; Wilson et al., 2012), as well as the value of racially and culturally concordant healthcare providers in improving health outcomes for minority ethnic populations (Goyal et al., 2015). As a senior NHS doctor, I have observed aspects of this phenomenon, including differential treatment of minority ethnic staff and patients and differences in healthcare uptake associated with patient–doctor ethnic concordance, particularly during a COVID-19 vaccine outreach programme for minority ethnic staff. To enhance the robustness of this finding, I included participants from both minority and non-minority ethnic backgrounds.

5.4.3b 9.2 The Limits of Representation Without Structural Change

Illustrative quotes

Many minority ethnic senior leaders reflected on the shared challenges and limitations of their positions in terms of advocacy and their ability to effect meaningful change. These challenges were particularly pronounced in the absence of a critical mass of minority ethnic representation at senior levels, which limits the capacity to exercise collective influence. Participants also discussed experiences of isolation, as well as concerns relating to safety and job security when operating as a minority within these spaces.

> *What does seniority have to do safety when you're the only Black person in the room? Nothing. There's someone above me. As long as I have a boss...I'm just as unsafe as you are. So as long as I'm in an organisation that functions with very few Black people at the senior level where I happen to be one, I may or may not be able to support you, as a Black doctor, or help you in any particular way that you happen to think that you should be or could be supported or helped. This does not mean I don't try...but I'm working under constraints and enormous pressure* [B2].

Others supported, suggesting:

> *...For the solitary Black person in these senior positions, we may be endangered in these positions. People don't have any idea what it is to be a senior Black person by yourself in an area…the psychological safety that those people do not have. Regarding psychological safety, what I mean is how to be safe when I'm the only Black senior person in this room. Other Black people not in the room or coming up the ranks don't always understand what it is like in this space...how could they? You can't, until you are here. I have to be willing to be vulnerable and expose myself in a place where I'm the only one. So why should I be expected to do this... every day?* [B3]

These accounts challenge the notion that the presence of minority ethnic individuals in senior leadership positions automatically translates into greater support for minority ethnic staff. Participants described experiences of isolation, limited psychological safety, and significant organisational constraints when occupying leadership roles as the sole minority ethnic representative. While representation was viewed as important, the data suggest that meaningful change requires more than numerical diversity. Furthermore, it also requires organisational cultures and power structures that enable minority ethnic senior leaders to exercise influence without bearing disproportionate emotional and professional burdens.

Thus, the findings highlight the distinction between being present at the decision-making table and being genuinely empowered to shape decisions and advocate for equity.

Implications and Reflexivity

The insights in this subtheme were drawn mainly from many of the Black minority ethnic participants and a few Asian participants. They acknowledged the significant challenge of addressing the differential attainment between minority ethnic and White doctors in senior leadership in the NHS. They recognised that systemic issues throughout the career pathway of minority ethnic doctors act as significant contributory factors (Morrison et al., 2024; Shah & Ahluwalia, 2019; Woolf et al., 2016). Many admitted that no single minority ethnic leader is likely to affect the level of change required to substantially reduce the attainment gap or significantly improve healthcare outcomes for their communities, which was both apt as well as pragmatic.

During the study, I observed a degree of frustration and, at times, resignation among participants, who felt that the persistent lack of minority ethnic representation at senior levels makes it challenging for the few individuals present to drive meaningful change. Participants suggested that achieving a critical mass of minority ethnic representation is essential to amplify their voices and enable substantive organisational influence. Moreover, some participants indicated that, in the context of this underrepresentation, the small number of minority ethnic senior leaders—particularly Black leaders—often feel compelled to adopt dominant White cultural norms in order to assimilate and maintain job security. Participants suggested that this expectation can constrain their ability to be authentic, which, in turn, may limit their capacity to advocate effectively for their communities. The implications of these findings suggest that a significant cultural shift at the highest levels of NHS leadership is required (Kline, 2014, 2019). This includes fostering an environment that unconditionally

welcomes minority ethnic doctors in senior leadership roles, allowing them to be authentic rather than expecting them to conform to established White cultural norms. In reflecting on this subtheme, it was also important to engage White participants and non-Black participants so that their perspectives could inform a deeper understanding and broader evaluation of this important finding.

5.5 Summary & Conclusion

The cross-case analysis of participants generated nine main themes and several subthemes, which helped to address the three research questions. This analysis both confirm established literature but also offers new and unique insights into the issue of differential attainment, particularly between Asian and Black minority ethnic doctors in particular at the highest levels of the NHS organisation. This study not only contributes to the existing discourse but also provides original insights, particularly given the influential positions held by the participants, whose lived experiences throughout their career trajectories inform their current roles as key agents of organisational change.

In the next chapter, I discuss the findings from this reflective thematic analysis (RTA) in greater detail, situating them within the broader context of the existing literature, theory and examining their implications in relation to the three research questions.

PART IV: DISCUSSION OF FINDINGS

Chapter 6 Discussion

Overview of Chapter

In this chapter, I interpret the research findings, contextualising them within the NHS as an organisation—its internal and structures, governance, power dynamics, and the implications for its workforce and their wider communities. This section moves beyond participants' narratives and their RTA analysis to consider the implications of the findings for aspiring senior NHS leaders, NHS organisations with its large minority ethnic workforces, and the communities they serve.

The discussion in this chapter is organised primarily around the three research questions, drawing on the main themes arising from the findings, including the theoretical frameworks of Bourdieu's concept of capital, habitus and field, and Merten's transformative framework.

In discussing the findings, I used the past tense when describing participants' perspectives and the present tense when providing my interpretation. In addition, I use the term *'participants'* when presenting findings related to the group as a whole, and *'minority ethnic participants'* when presenting findings specific to all minority ethnic participants in the study. Where greater specificity is required, I use the terms *'Asian participants'*, *'Black participants'*, and *'White participants'* to refer to findings from Asian minority ethnic, Black minority ethnic, and White participants, respectively.

6.1 Introduction & Reminder of Study Rationale

In this study, I explored the experiences of minority ethnic senior doctors in leadership positions within the NHS through narrative enquiry and RTA, examining their career trajectories from entry level to senior leadership. Attention was given to DA between minority ethnic groups—specifically Black and Asian doctors—at this level, while acknowledging the limitations and tensions inherent in broad ethnic categorisations.

Previous research has consistently demonstrated DA across multiple stages of medical education and career progression in the NHS (De Bere et al., 2015; Shah & Ahluwalia, 2019). However, these studies have often homogenised minority ethnic doctors, for example through the use of acronyms such as BAME or BME, which are now widely recognised as problematic due to their lack of granularity and their potential to obscure inequalities both within and between minority ethnic groups (Aspinall, 2021; Malik et al., 2020). An extensive review of the literature across major databases (2000–2025) suggests that no qualitative study has examined this topic through the combined lenses of: (1) British doctors in senior leadership roles (top-down); (2) comparative perspectives of Asian, Black, and White senior doctors; and (3) the integration of narrative enquiry with reflexive thematic analysis (RTA).

This study therefore sought to move beyond descriptive workforce data commonly used by NHS organisations and statutory bodies such as the WRES, to explore the underlying mechanisms shaping the leadership trajectories of minority ethnic doctors—including intra-minority ethnic differences—throughout their careers. It does so specifically through the lens of senior leaders—an under-researched group—who have successfully navigated organisational structures and societal barriers to reach the highest levels of leadership within the NHS.

6.2 Summary of Research Findings

The findings from this research suggest that DA among Black and Asian minority ethnic doctors in senior leadership positions in the NHS cannot be adequately explained through traditional meritocratic narratives that emphasise individual capability, effort, or ambition alone. Patterns of behaviour by NHS trusts over the past two decades of ethnicity monitoring (NHS England, 2026), alongside interventions and recommendations (Chakravorty et al., 2021), have often centred on individuals rather than on comprehensive structural transformation, suggesting that organisational priorities may lie elsewhere.

Participants across all represented racial groups described a complex and interconnected system of structural, organisational, and cultural barriers that continue to influence access to opportunities, visibility, sponsorship, and advancement, despite individual achievement. Participants reflected that many of these barriers originate in formative life experiences within a racialised Britain and reflect the enduring influence of broader societal systems and structures—realities from which the NHS is not exempt. Participants characterised these barriers as wide-ranging, from overt discrimination to more subtle, informal, and embedded processes within organisational practices (e.g. socialisation and homophily), making them difficult to identify and challenge openly. Consequently, minority ethnic participants, particularly Black doctors, perceived leadership progression as being shaped less by merit than by power, networks, access, social capital (Ahmed, 2012), and an NHS culture characterised as institutionally racially biased at senior levels (Kline, 2014, 2025). This chapter therefore argues that the findings of this study support a structural interpretation of DA, whereby leadership progression is shaped not only by individual merit and achievement but also by organisational cultures, informal networks, sponsorship practices, and institutional power structures that can differentially affect minority ethnic

doctors. Furthermore, rather than viewing inequalities as isolated instances of discrimination or individual disadvantage, the findings suggest that progression within the NHS—particularly into senior leadership—is shaped by broader systems of power operating both within the organisation and across wider British society, which reproduce existing patterns of inequality.

This study contributes new knowledge by demonstrating variation in attainment at senior leadership level both within and between minority ethnic groups, particularly among Black and Asian doctors. The findings suggest that the under-representation of Black doctors in senior leadership cannot be explained by workforce demographics alone but reflects differences in access to and transmission of valued forms of social and cultural capital. Within the NHS leadership field, these capitals facilitate access to influential networks, sponsorship and other resources that support leadership progression, while Black doctors appear to face higher thresholds of scrutiny and expectation when pursuing leadership roles. Together, these dynamics interact with the habitus and rules of the field, creating a synergistic mechanism that contributes to DA between Black and Asian doctors at senior leadership level. Moreover, these inequalities are further reinforced by the continued use of broad, homogenising ethnic categories e.g. BME/BAME, in NHS workforce data collection and monitoring, limiting visibility of important differences between minority ethnic groups.

6.3 Discussion & Implications of Research Findings

6.3.1 Research Questions (RQ)

This study is guided by three research questions relating to British or British trained doctors:

1. What are your perspectives on the DA between White majority and minority ethnic doctors in senior leadership positions within the NHS
2. What are your perspectives on the DA between Black and Asian minority ethnic doctors in senior leadership positions within the NHS
3. What are your perspectives on the health implications of DA at senior leadership level in the NHS for minority ethnic communities

6.3.2 Summary of the Themes from the Research and Related Research Question

Each research question and its associated themes are interpreted in relation to existing literature and foundational studies on DA among minority ethnic doctors, both broadly and within NHS leadership. They are also considered in relation to the statutory frameworks e.g. WRES, established to monitor and address workforce disparities along ethnic lines within the NHS.

This research found 9 main themes and 19 subthemes, detailed in Chapter 5. In the sections that follow, I examine the implications of the key findings—the *'so what'*—for individual doctors in, or aspiring to, senior leadership roles in the NHS, as well as for the organisation itself. In keeping with a RTA approach, themes are not treated as fixed categories but as interpretative constructions developed through engagement with the data and the research questions (Braun & Clarke, 2019). Consequently, the themes and subthemes are presented and discussed under more contextualised and theoretically informed headings

that better capture their underlying meaning and relevance to each research question **(Table D1 below).** I believe this approach facilitates a richer analytical narrative and demonstrates how the findings contribute to the broader conceptual framework of the study.

Table D1 - The contextualised headings used in this discussion chapter as relates to the original themes, subthemes and research questions (RQ)

RQ	Themes & Subthemes	Contextualised Headings for Discussion Chapter
1	**1. From Meritocracy to Marginalisation: Minority Ethnic Doctors' Career Progression in the NHS Leadership** 1.1. Relative Meritocracy in Early Career Advancement 1.2. Structural Filtering at Senior Leadership Transitions 1.3. Institutional Normalisation of Unequal Leadership Outcomes	• Relative Meritocracy and the Systemic Marginalisation of Minority Ethnic Doctors in NHS Leadership • Power, Networks, and Information Gatekeeping as Systemic Barriers to Leadership Attainment for Minority Ethnic Doctors in the NHS
1	**2. Power, Social Capital, and Informal Gatekeeping in NHS Leadership** 2.1. Informal Decision-Making Beyond Formal Structure 2.2 Affinity Bias and the Reproduction of Dominant Leadership Identities	• Conditional Inclusion and the Burden of Representation for Black Doctors in Senior Leadership
1	**3. Conditional Inclusion and the Burden of Representation** 3.1. Overperformance, Unequal Thresholds, and Hypervisibility 3.2. Conditional Belonging and Identity Negotiation	• Overperformance as a Prerequisite for Black Doctors in Senior Leadership Positions

2	**4. Inter-Minority Ethnic Hierarchies and Differential Leadership Trajectories** 4.1. Differential Progression and the Masking Effects of Ethnic Aggregation 4.2. Black Underrepresentation through Structural Exclusion and Racialised Stereotyping	• Inter-Minority Ethnic Hierarchies of Opportunities Contributing to Differential Attainment Between Black and Asian Doctors in Senior Leadership in the NHS • Cultural Habitus, Field and Leadership in Senior Leadership Positions in the NHS
2	**5. Organisational Mechanisms of Sponsorship, Visibility, and Opportunity Access** 5.1. Sponsorship as a Relational Mechanism of Leadership Progression 5.2. Representational Visibility and the Shaping of Leadership Aspiration	• Cultural Capital, Habitus, Field and DA between Black and Asian Doctors in Senior Leadership Positions in the NHS
2	**6. Cultural Capital, Identity and Belonging in NHS Leadership** 6.1. Unequal Access to Cultural Capital and Intergenerational Advantage 6.2. Internalised Leadership Ceilings and Self-Exclusion	• Identity, Belonging, Historical Legacies as Relational Aspect of Inter-Minority Ethnic DA at NHS Senior Leadership
3	**7. Minority Ethnic Leadership Representation as Structural Advocacy** 7.1. Relational Harm from the Absence of Minority Ethnic Leadership 7.2. Representation as a Mechanism for Community Health Improvement	• Minority Ethnic Leadership Representation as Structural Advocacy for Positive Health Outcomes for Minority Ethnic Communities

3	**8. Cultural Competence, Credibility and Patient Experience** 8.1. Relational Trust, Representational Credibility, and Healthcare Access 8.2. Cultural Understanding as a Mechanism for Reducing Bias and Inequality	• Relational Aspects of Representation, Cultural Competence, Credibility and Patient Experience
3	**9. Structural Inequality as a Driver of Health Inequality** 9.1. Leadership Inequality as a Determinant of Minority Ethnic Health Outcomes 9.2. The Limits of Representation Without Structural Change	• Structural Inequality, Health Inequality and the Relationship Aspect of Minority Ethnic Leadership

6.4 Discussion on RQ 1 – Perspectives on the DA between White Majority and Minority Ethnic Doctors in Senior Leadership Positions Within the NHS

This research question generated three main themes and seven subthemes, which I discuss under the four contextualised subheadings listed below. The key findings related to this research question centre on the notion of relative meritocracy within the NHS, which participants described as fundamental to their career progression and as shaping their understanding of the organisation and the challenges encountered throughout their careers. This informed two realisations. First, the significance of power structures and networks within organisations, often held by gatekeepers—predominantly White men. Second, the consequences of these power dynamics, which result in a form of conditional acceptance of minority ethnic doctors within these high-level spaces. Participants highlighted the challenges faced by the relatively few minority ethnic doctors who occupy such spaces as senior leaders. These include the physical, sociocultural, professional, and psychological burdens required to navigate and endure these environments.

The participants' narratives and the themes constructed through RTA are presented in relation to, and interpreted through the lens of, the research question. The implications of these findings are examined alongside my reflexive analysis using the four contextualised subheadings below. These capture the overarching theme and associated subthemes identified in relation to RQ1. They are as follows:

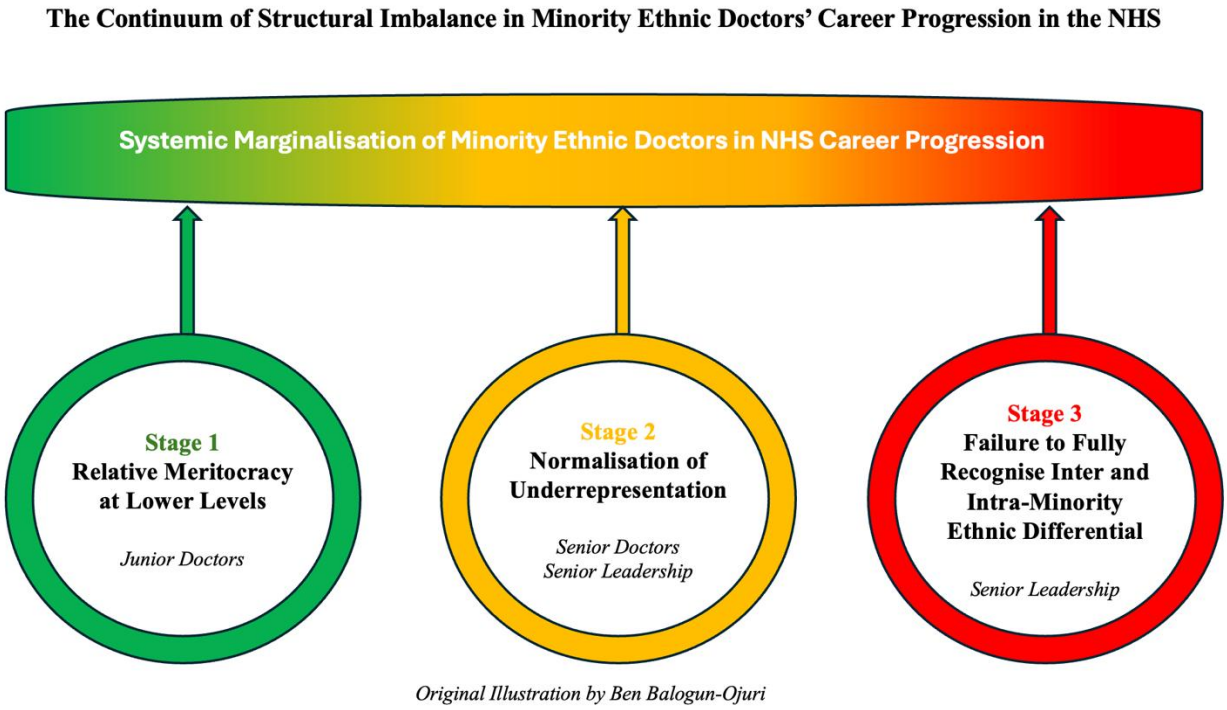
1. Relative Meritocracy and the Systemic Marginalisation of Minority Ethnic Doctors in NHS Leadership
2. Power, Networks, and Information Gatekeeping as Systemic Barriers to Leadership Attainment for Minority Ethnic Doctors in the NHS

3. Conditional Inclusion and the Burden of Representation for Black Doctors in Senior Leadership
4. Overperformance as a Prerequisite for Black Doctors in Senior Leadership Positions

6.4.1 Relative Meritocracy and Systemic Marginalisation of Minority Ethnic Doctors in NHS Leadership

The discussion here focuses on three areas identified from the findings related to this subheading. They each directly link to the central premise that the structural configuration of the NHS—organised around predominantly White norms—casts a long shadow, generating systemic challenges, disparities, and injustices in particular for those who are non-White and/or first-generation British. This structural imbalance significantly underpins the findings across the first theme and subthemes for RQ1, which can be understood as forming a continuum (**see figure D2**). Specifically, the perception of relative meritocracy at the lower levels of the organisation (stage 1)—particularly among junior minority ethnic doctors—diminishes as individuals progress through successive career stages. This occurs in the context of both inter- and intra-minority ethnic differentials, culminating according to the findings in this research, in lower representation at senior leadership levels (stage 2), where disparities between ME groups become even more pronounced. This continuum, as I've chosen to describe it in this study, ultimately leads to the normalisation of both the underrepresentation of minority ethnic doctors at senior leadership levels, and a failure to fully recognise the extent of intra-minority ethnic disparities at this level (stage 3) (Kline, 2025). As discussed, these patterns can be traced back to early stages of the career trajectory in the NHS, particularly for Black doctors.

Figure D2: The Continuum of Structural Imbalance in Minority Ethnic Doctors' Career Progression in the NHS



One of the most significant findings to emerge from this study, in relation to the first research question, is what may be described as a structural awakening among minority ethnic doctors in the NHS regarding their career progression within the organisation. This 'awakening' was described explicitly by participants in their narratives, reflecting a full realisation that the ideals of meritocracy in the NHS are hampered by numerous systemic constraints, described as *'unwritten rules'*, that disproportionately affect minority ethnic doctors throughout their careers. These constraints, which participants often found difficult to fully articulate, but which are rooted in systemic and structural discrimination, manifest in the DA described above. They are numerous and function as a series of obstacles or additional hurdles that minority ethnic doctors encounter throughout their careers in the NHS. This

suggests that there is almost no established blueprint for Black doctors in particular to follow in achieving success at this higher level, thereby adding further complexity to understanding the factors underlying this disparity.

Disparities between White and minority ethnic groups have been extensively documented in the literature (Kline, 2014; Esmail, 2007; Woodhams et al., 2024; Stockton & Warner, 2024). According to the NHS's own analysis, minority ethnic doctors—who make up 47% of the medical workforce (Stockton & Warner, 2024)—are less likely to secure training posts required to become specialists and consultants (Iacobucci, 2020). Those who do obtain training posts are less likely to progress successfully through the ARCP (Annual Review of Competency Progression) (Adebowale & Rao, 2020) and are more likely to fail postgraduate examinations (Linton, 2020), in part due to the need for greater decolonisation of the curriculum. Black doctors are also more likely to experience harassment, bullying, and abuse from colleagues (Edeh et al., 2022), are less likely to secure consultant and senior leadership positions (Kline, 2014; Stockton, 2024) and are more likely to face disciplinary procedures and receive harsher penalties (Majid, 2020). These constraints reflect the structural marginalisation of minority ethnic staff and the persistent lack of transformational change at senior levels, despite decades of statutory monitoring through mechanisms such as the Workforce Race Equality Standard (WRES). This is further compounded by growing political and international resistance to equality, diversity, and inclusion (EDI) initiatives risking a rollback of the modest gains achieved over the past decade (Kline, 2025). While some progress has been made—such as increased representation on non-executive boards and improved access to medical education through widening participation—these gains remain fragile.

Participants echoed these concerns, describing how they entered medicine expecting progression to be based on competence, hard work, and achievement, in line with the prevailing discourse of meritocracy in the NHS. However, many encountered organisational barriers, recognising that progression—particularly into leadership—is influenced by factors beyond performance alone. This often led to overperformance, excessive introspection, and burnout, driven by exclusion from opportunities, inconsistent sponsorship, and repeated unequal outcomes. Participants described this as a "loss of innocence", realising early in their careers that individual efforts—such as acquiring additional skills and qualifications—are insufficient to overcome entrenched structural barriers, particularly for Black doctors. These findings align with extensive research demonstrating persistent disparities in recruitment, progression, and leadership representation (Stockton & Warner, 2024; Kline 2014; Woolf, 2020). Kline (2014) highlighted the sharp decline in minority ethnic representation at senior levels, and a decade later, disparities remain, particularly in executive leadership (Kline, 2025). Participants' accounts extend this evidence by showing how inequalities are experienced cumulatively across careers, gradually challenging the belief that progression is merit-based. Participants also perceived a limited appetite for change among those in positions of power, alongside a lack of accountability for organisations despite longstanding monitoring. Interestingly, minority ethnic (ME) senior leaders in this study also expressed a sense of powerlessness in effecting meaningful change despite occupying influential positions. This suggests that representation at senior levels is not synonymous with the power or authority required to drive transformational change within predominantly White organisational spaces. Participants described concerns regarding their psychological safety and job security, highlighting the constraints that can accompany leadership positions for minority ethnic leaders (Ashraf, 2003).

Importantly, the findings suggest that structural disadvantage often remains obscured by the dominant narrative of meritocracy. Furthermore, as leadership appointments are framed as objective and fair, disparities can be attributed to individual shortcomings rather than organisational processes. This study found that this dynamic both conceals structural barriers and reinforces existing inequalities. Participants' accounts also challenge deficit-based explanations of DA. Historically, underrepresentation has often been attributed to individual characteristics such as confidence, ambition, or leadership capability. However, participants overwhelmingly rejected these explanations, instead emphasising the importance of opportunity structures, sponsorship, and organisational culture, with one participant suggesting "management need to reach out, find and nurture minority ethnic talents..." [A3] Their accounts suggest that the central issue is not a lack of aspiration among minority ethnic doctors, but unequal access to the mechanisms through which careers are advanced.

Furthermore, in the context of sustained operational pressures—exacerbated since the COVID-19 pandemic. This study found that Equality, Diversity and Inclusion (EDI) issues are often deprioritised. I believe this will further exacerbate the differential attainment at this high level and the ensuing implications across the minority ethnic workforce and their communities. For example, as the Chief Executive Simon Stevens concluded his tenure at the helm of England's National Health Service (NHS) by examining the direction of travel on racial equality under his leadership. He argued that "racial democracy"—that is, ethnic representation or diversity—has displaced efforts to address racialised injustice and inequality. Using the NHS as an example, he illustrates how the struggle against institutional racism has, under neoliberalism, been reduced to a mechanical quantification of inequality (Farah, 2021). These arguments resonate strongly with contemporary understandings of structural racism. Williams et al. (2019) argue that *"structural racism is the most important*

way through which racism affects health" (Williams et al., 2019, p 2). Structural racism refers not merely to individual prejudice, but to the ways in which institutions, policies, and practices produce unequal outcomes across racialised groups (Williams et al, 2019). In this study, participants rarely described overt racism. Instead, they highlighted subtle patterns of exclusion, differential treatment, and unequal access to opportunities that accumulate over time which impacts ME communities. However, in certain contexts—particularly in relation to patient care—participants identified more explicit racial disparities, for example in the provision of sickle cell services, which predominantly affect Black patients.

6.4.2 Power, Networks and Information Gatekeeping as Systemic Barriers to Leadership Attainment for Minority Ethnic Doctors in the NHS

A second important finding concerns the role of power, networks, and informal gatekeeping in shaping leadership progression. Participants consistently described advancement as dependent on access to influential relationships, professional networks, and sponsorship. While formal recruitment processes remained important, informal mechanisms were often perceived as decisive in determining who progressed, with one participant observing that *"at this level [senior leadership], the person who gets the job is often not a surprise" [B4]*, an observation echoed by participants in this study. These findings can be understood through Bourdieu's concept of social capital (Bourdieu, 1977), which posits that the value of social networks lies not simply in their existence but in the actual and potential resources they make available. For example, doctors with a multigenerational presence in the NHS or links to influential advocacy organisations such as BAPIO (British Association of Physicians of Indian Origin) may be better positioned to access information, sponsorship, connections, support, and opportunities through these networks. Participants' accounts suggest that these

resources are distributed unevenly, with some individuals benefiting from established relationships and informal networks that facilitate career advancement. This research found that between minority ethnic groups, those of Asian background, in particular Indian background, are more likely the benefit from this, which many suggest is a contributory factor to their presence at this higher level of the NHS organisation, rather than demography per se (Stockton & Warner, 2024).

Participants identified sponsorship as particularly important for leadership progression. Unlike mentoring, which primarily provides guidance and support, sponsorship involves active advocacy by influential individuals who use their position and influence to create opportunities for others. Participants described sponsorship as having had a direct influence on their attainment of senior leadership roles. While mentoring was generally perceived as accessible, sponsorship was described as limited and often difficult to secure. The importance of sponsorship is well established in the broader leadership literature (Chakravorty, 2021). Consistent with this evidence, the findings suggest that progression into senior leadership positions rarely depends solely on formal qualifications; rather, advancement often requires visibility, endorsement, and access to influential decision-makers. Participants frequently described the need to be *"in the know"* to be considered for opportunities—an access point that often depended on invitation and alignment with dominant organisational norms, including forms of socialisation shaped by White hegemony. Whilst the majority of the Black participants in this study had sponsors who were not ethnically congruent- often White, participants reported particular difficulty accessing support in leadership which remained predominantly White. However, participants also suggested that ethnic congruence with a sponsor is not a panacea. Indeed, ME participants suggested that, given the predominance of White leaders within senior NHS leadership,

access to influential networks often outweighs the importance of ethnic congruence in sponsorship relationships. Consequently, the priority is securing a sponsor with the social capital and organisational influence necessary to facilitate advancement. In contrast, ethnic congruence was perceived to be more valuable in mentoring relationships because of shared lived experiences, cultural understanding, and an appreciation of ethnicity-related nuances, including accents, traditions, and other cultural influences.

In these contexts, informal networks appeared self-reinforcing, reproducing existing patterns of influence and opportunity. Participants described homophily—a preference for similarity—whereby those in positions of power tended to select and promote individuals who resembled themselves, thereby maintaining the status quo and often favouring White male candidates. Although this homophily encompasses characteristics beyond race, these characteristics nevertheless appear to be shaped by adaptation to, and socialisation within, structures associated with a White-dominant culture. Therefore, the issue was not the suitability or qualifications of those already in leadership roles, but rather the exclusion of others, particularly minority ethnic candidates. In this study, this process was frequently described as a *"vicious cycle",* whereby the relative underrepresentation of Black individuals limited access to the social capital necessary for career advancement, further reducing opportunities to enter these influential positions. The implication is that, without intervention, the marginalisation of Black doctors within these spaces is likely to persist. Participants' accounts also align with Kanter's (1977) theory of homosocial reproduction, defined as *"the tendency for workgroups to remain skewed over time by adding members that match the overwhelming demographic majority of the group"* (Ellen et al., 2025, p. 4). This process is often sustained alongside token levels of diversity, which can help preserve existing power structures through the selective inclusion of underrepresented groups (Ellen et al., 2025).

Importantly, this dynamic may extend beyond the White majority group to include sections of minority ethnic communities that have established a foothold within these spaces. Participants suggested that British Asian doctors may benefit from such established networks and forms of social capital that support continued access to influential roles, thereby contributing—intentionally or otherwise—to the reproduction of existing hierarchies.

A related issue identified in this study is tokenism. The presence of a small number of minority ethnic individuals in influential positions can, paradoxically, serve to reinforce existing inequalities rather than challenge them. This was reflected in the accounts of minority ethnic participants, one of whom stated: *"I don't want to be here [in a senior leadership space] as the token Black doctor … seen as someone's prized pig … never mind the 30 years of experience I have"* [B4]. This quotation highlights the tension experienced by individuals who attain senior positions but feel that their presence is valued primarily as a symbol of organisational diversity rather than for their expertise, experience, or professional contributions. As a result, representation alone may be insufficient to address structural inequities if it is not accompanied by genuine inclusion, influence, and recognition. This idea of tokenism may provide gatekeepers with a form of "psychological permission" (Ellen et al., 2025) to disengage from deeper scrutiny of organisational diversity, thereby perpetuating homophily. This suggests that organisations may point to limited diversity as evidence of compliance with legal or regulatory expectations while failing to address the underlying inequities in principle. This can result in the conscious or unconscious restriction of opportunities for other minority ethnic individuals (Chang et al., 2019). This study argues that this idea is a contributor to why there is persistent lack of significant improvement in minority ethnic representation at senior leadership as captured by the WRES data over the last decade. These findings further highlight the need for structural and cultural change at the

highest organisational levels. Without more fundamental interventions, including more equitable and proportionate inclusion, appointment decisions may continue to be justified on the basis of comparable credentials while systematically disadvantaging minority ethnic candidates, particularly Black candidates, as identified in this study.

A particularly notable aspect of participants' accounts was the subtle nature of gatekeeping. Explicit exclusion was rarely described by participants; instead, many describe a state where opportunities appeared to be distributed through informal interactions, personal recommendations, and social familiarity. Such mechanisms are difficult to challenge because they often operate beneath the threshold of formal scrutiny. Consequently, individuals may encounter disadvantage without being able to identify a specific discriminatory act. The implications for minority ethnic doctors are significant. Black minority ethnic participants in particular described a considerable psychological burden arising from these experiences, including self-doubt, frustration, and the questioning of personal agency. This finding is consistent with organisational research demonstrating that informal processes can reproduce inequality, even within organisations committed to equality and diversity (Adebowale & Rao, 2020; Adegoke et al., 2025). Moreover, as these processes are embedded in everyday practices, they often appear natural or inevitable rather than exclusionary. The findings therefore suggest that power within NHS leadership operates not only through formal structures but also through informal networks that shape access to opportunities. Understanding DA thus requires attention not only to recruitment outcomes but also to the social processes through which careers are developed and advanced.

Through a Bourdieusian lens, these findings suggest that access to NHS leadership is shaped not solely by formal meritocratic processes but also by the interaction of *field, habitus,* and *capital.* NHS leadership operates as a field in which informal norms and

relationships influence access to opportunities. Participants' accounts of opportunities being mediated through personal recommendations and social familiarity indicate the importance of social and cultural capital in navigating this field. For minority ethnic doctors, limited access to dominant networks may restrict the accumulation and mobilisation of valued capital, while repeated experiences of exclusion may shape habitus through the internalisation of self-doubt and diminished agency. Consequently, inequality is reproduced not through overt discrimination alone but through the routine operation of seemingly ordinary practices that privilege certain forms of capital and reinforce existing power relations within the senior leadership field.

6.4.3 Conditional Inclusion & Burden of Representation in Senior Leadership for Black Doctors

A prominent theme that emerged from the findings was the burden associated with being one of a small number of minority ethnic individuals in senior leadership positions, particularly for Black doctors who are least represented between the two groups—Black and Asian. Participants frequently described challenges that extended beyond attaining leadership roles, relating instead to the expectations, scrutiny, and responsibilities that accompanied heightened visibility. While representation was viewed as important, experiences were often characterised by a form of conditional inclusion, whereby acceptance within leadership structures remained contingent upon meeting additional unclear expectations not equally applied to White counterparts. Minority ethnic participants described feeling highly visible within organisations while simultaneously lacking genuine influence. This paradox of visibility without power is well recognised within the diversity and inclusion literature, where minority individuals may be symbolically included in leadership spaces yet excluded from

key decision-making processes (Kalra et al., 2009; Ashraf, 2013; Kline, 2014). Such experiences suggest that representation alone is insufficient to achieve meaningful inclusion, as diversity targets may be met without altering underlying power structures (Ellen et al., 2025). The implication of this further indicates that minority ethnic doctors in senior leadership roles often feel pressure to demonstrate exceptional competence to gain legitimacy.

Minority ethnic participants also described an expectation to act as representatives for wider minority ethnic communities. While many viewed community advocacy as an important aspect of leadership, they also recognised the burden of being expected to speak on behalf of diverse groups with differing experiences. This study found that such expectations can reinforce tokenism by positioning individuals as representatives of their ethnicity rather than as leaders in their own right. In this study, this burden was particularly pronounced among Black participants who had attained senior leadership positions, which they attributed, in part, to their relative underrepresentation at these levels. For example, although Black doctors comprise 9% of the NHS workforce, compared with 5% of the UK population (Stockton & Warner, 2024), they remain markedly underrepresented in positions of influence. Participants suggested that greater inclusion throughout the leadership pipeline could help reduce this burden by increasing access to peer support, role models, and network-based resources. This contrasts with the experiences described among some Asian minority ethnic groups, whose stronger presence in key career stages may confer greater access to such advantages. For example, at consultant level—the principal feeder grade for senior NHS leadership—Asian doctors constitute 32% of the consultant workforce, whereas only 3% are Black. Among UK-trained (British) consultants, this falls from 3% to 1% (Stockton &Warner, 2024). These disparities suggest that inequalities emerge well before entry into

formal leadership positions, shaping subsequent opportunities for advancement into higher level positions. The implication here is significant for Black doctors where they appear to be marginalised on the first stepping stone i.e. achieving a consultant grade, compared to British Asian doctors (Stockton & Warner, 2024). Therefore, unless there is adjustment at this stage, Black British doctors will continue to be significantly underrepresented at senior leadership roles in the NHS.

Furthermore, the lack of proportional representation led participants—particularly Black doctors—to feel constrained in their ability to advocate fully for their communities or to be their "authentic selves". Instead, some described adopting dominant organisational norms aligned with White cultural expectations, viewing this as necessary for career progression and longevity. There was also concern about being perceived as the "ethnic leader" who continually foregrounds race-related issues, particularly within a predominantly non-minority ethnic workforce. The findings further suggest that inclusion was often conditional upon conformity to dominant organisational cultures. Moreover, minority ethnic participants described adapting communication styles, leadership behaviours, and professional identities to align with established norms. While such adaptation was frequently viewed as necessary for progression, it was also associated with feelings of inauthenticity and identity conflict. These experiences align with for example theories of Identity Work which suggest that minority leaders engage in ongoing negotiation between professional expectations and personal identity (Caza et al., 2018).

Importantly, conditional inclusion appeared to operate through informal organisational expectations rather than explicit requirements. Participants rarely described direct pressure to assimilate; instead, they referred to subtle signals regarding what constitutes an acceptable leader. These cues were often conveyed through observations of

who succeeds, whose voices are valued, and which leadership styles are rewarded. Such dynamics reinforce dominant norms while constraining opportunities for alternative perspectives and approaches. These findings suggest that increasing diversity alone will not eliminate DA at senior leadership in the NHS. Unless organisations also address the conditions under which individuals are included and able to influence decision-making, ethnic minority leaders may continue to experience marginalisation despite occupying positions of authority. This distinction between representation and meaningful inclusion underscores the limitations of diversity initiatives that focus primarily on numerical targets rather than organisational culture and underlying power structures. Nevertheless, the findings suggest that numerical representation retains important symbolic and practical value, enhancing credibility, trust and legitimacy among minority ethnic NHS staff, while strengthening the perceived security and visibility of minority ethnic leaders and the communities they represent. From a Bourdieusian perspective, simply increasing the number of ethnic minority leaders does not necessarily alter the distribution of power within the field. While representation may change, the rules of the game may remain largely intact. New entrants may continue to succeed by acquiring and reproducing the dominant forms of cultural capital rather than challenging them. Consequently, diversity initiatives focused solely on numerical representation risk incorporating individuals into existing structures without transforming the underlying mechanisms through which legitimacy and influence are conferred.

A divergent view emerged from a small number of minority ethnic participants, including several White participants, who suggested that minority ethnic doctors aspiring to higher leadership roles should adapt to the dominant culture. They argued that the scope of responsibility associated with such positions necessitates this adaptation, particularly given

that Britain remains a predominantly White country. However, I contend that, while this is a legitimate consideration, these two principles are not mutually exclusive. Black senior leaders can maintain their authenticity and advocate for minority ethnic communities, while simultaneously recognising that the responsibilities associated with senior leadership extend beyond these groups to encompass the wider population. The view expressed by participants that minority ethnic doctors should adapt to the dominant culture can also be understood through a Bourdieusian lens. Within any field, actors frequently recognise the value of acquiring the forms of capital necessary for success. Adaptation may therefore represent a pragmatic strategy for navigating existing power structures. However, Bourdieu's framework also highlights how such adaptation can inadvertently reproduce the very norms that sustain inequality. The challenge is therefore not whether ethnic minority leaders should develop the capacities required for senior leadership, but whether the field itself remains sufficiently open to recognise and value a broader range of leadership dispositions and forms of cultural capital.

Overall, these findings suggest that power within NHS leadership operates less through direct exclusion and more through symbolic processes that define and legitimise particular forms of leadership identity. Through the interaction of field, habitus and capital, dominant norms become naturalised, rendering assimilation an implicit expectation and limiting the extent to which minority ethnic senior leaders can exercise authenticity and influence organisational change. Consequently, addressing DA at senior leadership levels in the NHS requires not only greater representation but also a critical examination of the power relations that determine whose forms of capital are recognised as legitimate within the leadership field.

6.4.4 Overperformance as Pre-requisite for Black Doctors in Senior Leadership Positions in the NHS

An important finding that emerged across participants—particularly among Black participants—was the perception of an unequal threshold for Black senior doctors seeking progression to the highest levels. This unwritten standard was widely recognised, with participants observing that Black leaders in these roles often appeared "overqualified" compared to their peers. This perception was most clearly articulated by Black participants, who linked it to early socialisation, including messages from family and community that they would need to overperform to be regarded as equal to their White counterparts. While not unique to Black individuals in the UK, this reflects a broader, lived reality shared across many minority ethnic groups.

Importantly, this study found that such expectations at senior levels were not only upheld by White and other minority ethnic leaders but were often reinforced by Black leaders themselves. Participants suggested that some Black leaders viewed aspiring Black candidates as reflections of their own credibility and legacy, creating a sense that individual achievements were closely interconnected. Participants described a perception that the success or failure of one Black leader could influence how others were viewed within the organisation at senior leadership. As a result, higher standards were sometimes applied to Black candidates seeking advancement. Indeed, some Black participants suggested that, in appointment processes, they would be more likely to support a White candidate for a senior role unless the Black candidate was considered 'excellent'. The implication here is that this dynamic may inadvertently reinforce elevated expectations and contribute to the persistence of higher thresholds for advancement among Black candidates. I argue that this is a form of internalised racism from Black doctors that contributes to marginalisation between minority

ethnic representation at higher levels of the NHS organisation. Black participants acknowledged this differential and its inherent inequity but contextualised it within the unique environment of senior NHS leadership, where gatekeepers and decision-makers are predominantly non-Black. Participants suggested that these gatekeepers, who often favour homophily, may use the perceived failure of a single Black individual to justify maintaining or reinforcing White-dominated leadership structures, thereby further marginalising Black doctors. Therefore, to justify this apparent injustice, some Black senior leaders appear to set higher thresholds for aspiring Black leaders than for their non-Black counterparts, according to the findings of this study.

This study found that Black doctors recognised this phenomenon, suggesting that Black candidates need to be demonstrably 'better' in order to be successful at this level and overcome the barriers. Participants also described a need to over-credential as a form of capital to counter these barriers, while others disengaged from leadership aspirations altogether due to a perceived lack of belonging. There was also evidence that some Black senior leaders internalised these heightened expectations, framing them as a form of internalised racism (Tucker, 2023). At the same time, they acknowledged that these perceptions are grounded in lived experience within a racialised organisational and societal context. This complex and multidimensional nature of the heightened expectations placed on Black doctors appeared to operate across racial and ethnic boundaries. Participants described this phenomenon in different ways, ranging from subtle and often unspoken assumptions to more overt forms of scrutiny. While some participants clearly recognised the phenomenon, others struggled to articulate it despite acknowledging its existence and effects. Drawing on these findings, I propose the concept of "Blackflation" as a theoretical lens for understanding this dynamic.

I define Blackflation in this context as:

> *"A form of conscious or unconscious bias, rooted in a Western hegemonic mindset and operating across racial groups—including among Black individuals themselves—whereby Black NHS doctors are expected to demonstrate disproportionately higher levels of skill, ability, competence, and credibility than their peers in order to achieve parity in the attainment of leadership roles, based solely on their visibly Black identity. The phenomenon is inflationary in that these expectations are continually elevated, making parity difficult to achieve through conventional measures of success alone."*

This definition is applied in this study specifically to the NHS. Blackflation as conceptualised from the findings of this research refers to the inflation of demands placed on Black doctors seeking or occupying leadership positions within the NHS. Existing literature has documented the over-education of UK immigrants (Lindley, 2009), differential unemployment among Black and minority ethnic graduates (Rafferty, 2012; Moore, 2026), and the perception that minority ethnic individuals are overqualified relative to available opportunities (Battu & Sloane, 2002; Ma & Lo, 2024). However, Blackflation represents a distinct phenomenon that extends beyond these existing explanations and is therefore examined through the theoretical framework outlined below. These amplified demands contribute to DA through both elevated entry thresholds and the self-exclusion of individuals who are unwilling or unable to meet such unequal requirements. The concept extends beyond technical and non-technical competence to encompass broader judgements relating to performance, credibility, legitimacy, conduct, and visibility. In doing so, it captures the cumulative burden of having to demonstrate exceptional ability in order to gain entry to, and acceptance within, positions of power and influence.

This concept emerged strongly from the findings as a meaningful way of describing a form of bias that appears to operate across racial groups and has not, to date, been explicitly conceptualised in the literature, particularly within the context of NHS leadership.

Importantly, participants' accounts suggested an inflationary dimension, whereby there is no clear or finite means of satisfying these demands. Additional qualifications, credentials, leadership experience, or organisational tenure were often perceived as insufficient to overcome the higher bar applied to Black doctors. Consequently, the threshold for acceptance appeared continually to shift, requiring sustained overperformance merely to achieve parity with others.

The concept draws on established social science theories, including Stereotype Threat (Steele, 1998), which describes how awareness of negative stereotypes about one's group can create anxiety and affect performance in evaluative contexts (Steele & Aronson, 2004; Brooks, 2023). It draws on Bourdieu's symbolic violence (Bourdieu, 1994) where he argues that that power is most effective when it is not recognised as power. Rather than imposing explicit demands for assimilation, organisations communicate subtle expectations that become accepted as common sense or professional necessity. This appears to have been internalised by the Black participants in this study and externalised by others who normalised this unequal threshold. In this study, participants rarely described direct pressure to conform or over credential; instead, they identified informal cues about acceptable leadership behaviour and qualities such as accents, sponsorship, etc. These cues exemplify what Bourdieu describes as *symbolic power*—the ability of dominant groups to define legitimate ways of thinking, speaking, and acting without those definitions appearing coercive. As a result, dominant leadership norms come to be perceived as objective indicators of merit rather than socially constructed preferences.

Blackflation also builds on McGee's theory of Stereotype Management, which suggests that Black individuals may invest significant effort in countering negative racialised assumptions about their competence and intelligence, often involving self-regulation and the suppression

of authentic identity (McGee, 2016; Leath et al., 2025). Together, these frameworks help to conceptualise how high-achieving Black professionals—in this case, senior doctors—are expected to maintain credibility within racialised organisational environments characterised by structural inequality and marginalisation.

In this study, Blackflation manifested in several ways. Participants consistently observed that Black doctors who reached senior leadership positions were often seen as "overqualified" compared to their peers, having accumulated relatively more qualifications, broader experience, or more demonstrable achievements for equivalent roles. White participants, at times, acknowledged processes such as homophily, confirmation bias, and unconscious bias, but also described a passive acceptance of the "exceptionalism" of Black leaders without questioning why such elevated standards appeared necessary. This lack of critical interrogation effectively normalised the expectation that Black candidates must exceed typical requirements. Among Asian participants, Blackflation was reflected in both implicit and explicit expectations, including perceptions that Black candidates needed to demonstrate higher levels of competence before being selected over others with comparable qualifications and experience, including other Asian doctors. Notably, Black participants themselves openly recognised and, in some cases, internalised these expectations. Many described deliberately over-credentialing—pursuing additional qualifications, leadership roles, and achievements—as a strategy to offset anticipated bias and demonstrate undeniable competence. The implication is that Black doctors are less likely to pursue senior leadership positions until they perceive themselves to be 'fully qualified', often acquiring additional qualifications and credentials beyond the stated requirements. By contrast, other candidates may apply having met only the minimum criteria, supported by social capital, privilege,

sponsorship, or established professional networks. This is likely to continue to exacerbate the differential between minority ethnic doctors at higher leadership levels in the NHS.

Other examples of Blackflation from this study included participants describing how the failure of a single Black leader could be magnified and generalised, reinforcing caution among decision-makers (including Black decision makers) and raising the threshold for future Black candidates. Conversely, successful Black leaders were often framed as "exceptional", as though they had transcended their ethnicity rather than representative, further reinforcing the perception that only those who exceed standard expectations can progress. Some participants also reported self-exclusion from leadership pathways, perceiving the implicit bar as unattainably high or the environment as lacking belonging. Together, these examples illustrate how Blackflation operates as both an externally imposed and internally negotiated phenomenon. It not only raises the threshold for progression but also shapes behaviour, decision-making, and aspiration among Black doctors. In doing so, it contributes significantly to differential attainment in NHS senior leadership by embedding unequal expectations within both organisational processes and individual responses.

Furthermore, Blackflation can be understood as a form of prejudicial and biased treatment and, at its most extreme, racism. It operates across multiple levels: as internalised racism among Black individuals; as inter-minority ethnic prejudice, reflected in some of the expectations held by other minority ethnic groups towards Black candidates; and as institutional racism embedded within organisational structures shaped by dominant White norms. These dynamics may be further reinforced by differential stereotyping, whereby Black individuals are more likely to be subject to negative stereotypes, while some other minority ethnic groups (for example, Indian and certain East Asian groups) may benefit from more positive stereotypes, though not always. For example, participants suggested, for

instance, that the image of an Asian doctor is more readily accepted within British society, whereas that of a Black doctor is less aligned with prevailing social expectations. As a result, Black doctors aspiring toward NHS leadership may face additional scrutiny and higher thresholds of credibility, reinforcing the dynamics captured by the concept of Blackflation.

Importantly, Blackflation is not a one-off phenomenon; rather, my research findings argue that it persists throughout the career trajectory of Black doctors as they progress through training, leadership and senior leadership in the NHS. Even for those with exemplary records—where excellence is effectively a minimum expectation—there is little relaxation of this inflated standard. Instead, expectations remain consistently elevated, creating an ongoing "inflationary" dynamic. For Black doctors already in senior leadership, Blackflation continues to manifest through reduced psychological safety, limited job security, and constraints on authenticity. This is reflected in the paradoxical tension between the desire for more Black senior leaders to provide support and security within these spaces, and the risk that any perceived shortcomings among new Black leaders may result in punitive consequences for Black leaders collectively, thereby reinforcing expectations of exceptionalism.

Participants described an enduring pressure to overperform in order to maintain credibility, rather than simply to progress. As a result, Blackflation can be conceptualised as a self-perpetuating cycle—akin to a "hamster wheel"—from which individuals find it difficult to disengage. This has significant implications, as it helps explain a gap in the literature, where previous research has struggled to establish a clear causal relationship between DA and leadership progression. Instead, studies have typically identified the existence of DA and speculated on a range of multifactorial and often nebulous explanations. The absence of a clearly defined mechanism I believe has limited the development of effective

recommendations. By contrast, this study identifies and names a specific contributory factor—Blackflation—highlighting a distinct and cross-racial phenomenon that shapes the experiences of Black doctors within NHS leadership pathways. Recognising Blackflation, particularly among those in leadership positions, necessitates both reflection and action. It calls for a move beyond reliance on ostensibly objective standards, as the findings suggest that it is not solely the standards themselves, but their interpretation, that is problematic. These standards—whether formal or informal—are often applied to Black candidates through an inflationary lens shaped by bias, prejudice, and racism, both internalised and externalised. Addressing this requires active, targeted interventions and a willingness to interrogate how decisions are made, rather than assuming neutrality in existing systems.

6.5 Discussion on RQ 2 – Perspectives on the DA between Black and Asian Minority Ethnic Doctors in Senior Leadership Positions Within the NHS

This section addresses the second research question by examining the lack of differentiation between the two major minority ethnic groups—Asian and Black, in both the UK and the NHS workforce, particularly within senior leadership—where this study is situated. The question arises from the longstanding homogenisation of minority ethnic groups by the NHS and statutory bodies, often through the use of broad categories such as "BME" or "BAME". Such classifications are problematic, as they obscure important differences and can mask inequities, thereby potentially exacerbating injustice (Aspinall, 2021). Evidence is now beginning to recognise DA between these major minority ethnic groups within the NHS (Woolf, 2020; Woolf et al., 2011, 2023), although this remains limited by a lack of granularity in data collection. This narrative inquiry, based on the experiences of 25 NHS senior leaders, specifically examined these differences at senior levels of the organisation. While the study is focused on leadership, participants' accounts suggest that these dynamics are also evident at earlier stages of career progression, indicating broader implications for minority ethnic doctors across the NHS.

The following four subsections of this discussion chapter draw on Bourdieu's theoretical framework—particularly the concepts of cultural capital, habitus, and field—to contextualise the DA between two major minority ethnic groups, Black and Asian. In doing so, this study acknowledges the inherent tensions within UK ethnicity categorisation, particularly when applied to these broad groupings. Paradoxically, while the study seeks to critique homogenisation of minority ethnic groups e.g. use of BME/BAME, as a contributory factor to DA, it also necessarily employs the categories "Black" and "Asian" for analytical purposes. This involves a degree of abstraction that overlooks the considerable diversity and

range of nationalities within each group. This limitation is recognised and is discussed further in the study's limitations section. The four subsections are:

1. Inter-Minority Ethnic Hierarchies of Opportunities Contributing to Differential Attainment Between Black and Asian Doctors
2. Cultural Habitus, Field and Leadership in Senior Leadership Positions in the NHS
3. Cultural Capital, Habitus, Field and DA between Black and Asian Doctors in Senior Leadership Positions in the NHS
4. Identity, Belonging, Historical Legacies as Relational Aspect of Inter-Minority Ethnic Differential Attainment at NHS Senior Leadership

6.5.1 Inter-Minority Ethnic Hierarchies of Opportunities Contributing to DA Between Black and Asian Doctors in Senior Leadership in the NHS

One of the most significant contributions of this study lies in its exploration of differences within minority ethnic groups. Participants consistently challenged the tendency in workforce policy and research to treat minority ethnic staff as a homogeneous category. Instead, they described, in their narratives, distinct experiences of advancement, visibility, and exclusion across different ethnic backgrounds. Several participants perceived that Black doctors encountered greater barriers than some other minority ethnic groups. While acknowledging that DA affects multiple communities, they suggested that both the nature and magnitude of disadvantage vary considerably between groups. These findings support growing calls within the literature for more nuanced analyses of ethnicity and career outcomes.

Klara et al. (2009), in their report on leadership interventions for Black and minority ethnic staff in the NHS, highlighted that senior leadership does not reflect the diversity of

either the NHS workforce or the wider UK population and argued that this imbalance stems from structural inequality. The present findings broadly align with existing evidence of DA throughout medical careers (Klara et al., 2009; Woolf et al., 2011) and in leadership positions (Kline, 2014, 2024). However, this study further suggests that differences between Black and Asian doctors—particularly those of Indian origin—cannot be explained solely by workforce demographics. Instead, participants pointed to accumulated advantages, including legacy effects and intergenerational social capital, that appear more accessible to certain Asian subgroups than to Black doctors. Importantly, this study also suggests that the continued aggregation of racial and ethnic data within workforce monitoring contributes to institutional marginalisation by obscuring meaningful inter- and intra-minority ethnic differences. While evidence from the UK education system has long demonstrated disparities between ethnic groups from an early age (Demie & McLean, 2007), these distinctions have received comparatively limited attention within NHS career trajectories. This may partly reflect assumptions of meritocracy and the belief that qualifying as a medical doctor creates a level playing field. However, the findings in this study demonstrate that professional trajectories are shaped by complex and unequal socio-cultural factors that extend beyond qualification as a doctor. For example, Demie and McLean (2007) identified variation in attainment between Black African and Black Caribbean students at GCSE level, while Woolf (2020) reported persistent disparities affecting Black doctors. Despite decades of monitoring through statutory mechanisms such as the Workforce Race Equality Standard (WRES), there remains limited understanding of inter- and intra-minority ethnic inequalities at the highest organisational levels.

Historically, NHS workforce data have relied on broad categories such as “Black and Minority Ethnic” (BME). Although such classifications can identify general patterns of

inequality, they risk masking important differences between groups. Participants' accounts suggest that different minority ethnic groups occupy distinct positions within organisational hierarchies, shaped by factors such as migration histories, societal stereotypes, organisational culture, and perceptions of leadership suitability. Consequently, career outcomes cannot be fully understood through simplistic comparisons between White and minority ethnic groups. Participants also indicated that inter-minority ethnic differences influence access to opportunities, networks, and sponsorship. Although increases in the visibility of certain groups were viewed positively, concerns were expressed that aggregated diversity metrics can create an illusion of progress while concealing persistent disadvantage among specific communities. Accordingly, this study argues that current approaches to workforce data collection lack the level of disaggregation necessary to identify and address inequalities effectively. Insufficiently granular data may contribute to institutional marginalisation by concealing important differences both between and within minority ethnic groups. Participants further highlighted the potential for competition between communities in contexts of limited opportunity, where diversity initiatives may inadvertently foster perceptions of scarcity and reinforce, rather than reduce, inequality. The implication is that without greater disaggregation, interventions are unlikely to produce meaningful or equitable outcomes. Programmes may disproportionately benefit certain ethnic groups or nationalities within broader minority categories—for example, some Asian subgroups, particularly those of Indian origin—who may already possess greater cultural or social capital. In contrast, Black doctors may remain comparatively disadvantaged because of both organisational structures and wider societal influences, including negative stereotyping (Osbourne et al., 2021; Edeh et al., 2022; Woolf et al., 2008; Ahmed, 2012). Furthermore, gains arising from initiatives such as widening participation and contextualised admissions (Garlick & Brown, 2008; Gore et al., 2018), which have increased the number of minority ethnic students and

junior doctors (Stockton & Warner, 2024), may not be distributed evenly across all groups. There is therefore a risk of interpreting the increased visibility of some minority ethnic groups, such as Black and Asian communities, as evidence of overall progress, thereby obscuring persistent or widening inequalities affecting other minority ethnic population.

This study argues that meaningful progress requires systematic disaggregation of workforce data at both racial and ethnic levels, wherever practicable. The findings from this study suggest such approaches could involve distinguishing between South Asian, East Asian, and Southeast Asian populations, and between African and Caribbean groups, with further analysis proportionate to population size and NHS representation. Additional perspectives may include migration history, generational status, and proportional representation within the workforce. Although such categorisation presents methodological challenges, this study argues that these should not impede efforts to improve the precision of workforce monitoring. The implication is that failure to do so risks perpetuating inequities with substantial consequences for workforce experience, professional advancement, and community representation—issues that became particularly visible during the COVID-19 pandemic (Murali et al., 2023; Poole & Williamson, 2023).

Overall, these findings support a move away from broad ethnic classifications towards more nuanced understandings of DA. Future workforce policies should recognise the diversity of minority ethnic experiences and ensure that interventions are tailored to address the specific barriers faced by different groups.

6.5.2 Cultural Habitus, Field and Leadership in Senior Leadership Positions in the NHS

Bourdieu's concept of habitus refers to systems of durable, transposable dispositions shaped by aspirations, behaviours, perceptions, and decision-making (Bourdieu, 1977). Habitus develops through repeated social experiences, influencing whether individuals perceive certain opportunities as realistic, appropriate, and attainable (Bourdieu, 1977, 1986). Through this concept, Bourdieu sought to explain the relationship between structure and agency, recognising the influence of historical and external factors as both enablers and constraints (Webb et al., 2001). Habitus also encompasses the practical enactment of internalised beliefs and dispositions in social contexts (Huang, 2019). Within the NHS, habitus may influence the extent to which minority ethnic doctors aspiring to leadership perceive such roles as attainable, particularly within organisational contexts that have historically been dominated by White men. Minority ethnic participants, and Black participants in particular, described senior leadership spaces as environments in which they felt unable to be their *"authentic selves"* [B1], lacked a sense of *"psychological safety and security"* in their positions [B3], or risked being perceived as a *"single-issue senior leader"* [B2] when advocating for issues affecting their communities. Participants did not view advocacy for their communities and representation of wider organisational interests as mutually exclusive responsibilities. However, they perceived that senior White leaders frequently constructed these roles as competing or incompatible, thereby constraining the legitimacy of minority ethnic leaders' contributions and identities within senior leadership contexts.

In this study, intersectionality was also evident, particularly along gender and other protected characteristics. Participants noted that individuals who are visibly "other"—for example, through cultural or religious expression—were less likely to be represented within

senior leadership. One explanation for inter-ethnic differences between Black and Asian (particularly Indian) doctors lies in the role of habitus. These disparities cannot be explained solely by population differences within the NHS or wider UK society. Rather, they reflect historical and generational advantages, including inherited forms of capital, which shape confidence, aspirations, and a sense of belonging in leadership spaces. For some groups, career trajectories are informed by family histories in medicine, social status, and access to networks, which collectively reinforce habitus and facilitate progression. This is not to suggest that other minority ethnic doctors lack agency; rather, differences in habitus influence how individuals navigate organisational structures and opportunities at senior levels. An example from the findings was the perception among Black participants that the established presence of Asian doctors within senior leadership field increased the likelihood that those already occupying such positions would *"pull others up"* [B2]. This was viewed as particularly important at senior levels, where formal qualifications may be relatively similar across candidates and where access to informal networks, sponsorship, and other forms of social capital may play a decisive role in advancement. From a Bourdieusian perspective, habitus is shaped by historically accumulated social and cultural capital and influences individuals' perceptions of where they belong and what opportunities are attainable. Participants' accounts suggested that some Asian doctors benefited from access to more established professional and community networks that reinforced dispositions of confidence, legitimacy, and belonging within senior leadership spaces. In contrast, Black doctors more frequently described experiences of under-representation and isolation, resulting in a habitus that was less aligned with the norms and expectations of the dominant leadership field and making progression into, and navigation of, senior leadership positions more challenging.

Furthermore, Bourdieu's concept of *field*—a social space in which individuals compete for resources and influence (Grenfell, 2009)—further illuminates these dynamics. There is a relational interplay between habitus (dispositions) and field (position within a structure) (Maton, 2014), particularly in terms of how individuals deploy social capital within leadership environments. This interplay was evident in participants' accounts of networking and sponsorship. While some participants described how established Asian professional networks and senior role models facilitated access to leadership opportunities, Black participants more often reported isolation and under-representation at senior levels. These differences demonstrate how positions within the field influence access to social capital and, in turn, shape habitus by reinforcing or constraining perceptions of belonging, legitimacy, and opportunity. This study argues that at senior NHS leadership level, the field appears to reward forms of capital associated with strategic communication, political awareness, executive presence, and access to sponsorship. For example, participants described how the *"real decisions"* [B4] were often made *"outside formal meeting areas"* [A2], within informal networks and arenas of influence that could only be accessed *"by invitation"* [B3], highlighting the importance of social capital in navigating senior leadership environments. These attributes are not inherent to specific ethnic groups but are often acquired through prolonged exposure to, and inclusion within, established networks—frequently mediated by gatekeepers. These gatekeepers, often from majority White groups, and increasingly from certain minority ethnic groups, exert influence over access to opportunities. The study identifies a self-reinforcing cycle, whereby access to leadership spaces is controlled by those already within them—who are less likely to be Black—thereby perpetuating inter-ethnic disparities. As participants noted, leaders often *"lift their own as they rise"*, reinforcing patterns of representation and limiting access for those outside these networks.

6.5.3 Cultural Capital, Habitus, Field and DA between Black and Asian Doctors in Senior Leadership Positions in the NHS

Chakravorty et al. (2021), in their Bridging the Gap (BT21) report on differential attainment (DA) in the medical profession, identified five primary contributors across the medical career lifecycle: social class and deprivation, immigration status, geographical factors, and individual characteristics. The findings of this study broadly align with these factors but offer greater specificity within the context of British-trained senior leaders. As most participants had been educated and/or trained in the UK, factors such as immigration status—and to a large extent geography and deprivation—did not operate in the same way. Instead, the focus on Black, Asian, and White British doctors with shared training pathways enables a more nuanced and direct examination of DA between these groups. In this context, applying Bourdieu's concept of cultural capital is particularly useful. The assumption that the advantages held by later-generation British doctors—such as those from medical families with established networks and cultural capital—become irrelevant at senior levels is not supported by the findings in this study. Rather, it suggests that such advantages become more pronounced at higher stages of career progression, where formal qualifications are less differentiating and informal criteria gain prominence. This was exemplified by one participant's description of the "three Es": *Education, Experience, and Exposure*, with the latter two becoming increasingly important as doctors progress towards leadership roles. Participants suggested that these dimensions are often shaped not merely by individual effort, but by inherited or accumulated privilege, including access to networks, opportunities, and insider knowledge. This again challenges assumptions of meritocracy and objectivity at senior levels of career progression as described earlier in this chapter.

The implication of this study is that leadership development, selection processes, and policy interventions should account for these differential advantages across candidates, including along racial lines. At senior levels, where candidates are likely to meet both essential and desirable criteria, distinctions are often made based on less formalised attributes—such as networks, visibility, and perceived "fit", as described by participants in this study. These unwritten criteria, which are frequently shaped by existing power structures, play a significant role in shaping progression and must be more explicitly acknowledged and addressed. The findings of this study challenge the notion of meritocracy in advancement to senior leadership positions. The findings suggest that accumulated cultural and social capital, rather than merit alone, plays a significant role in selection, particularly at the highest levels of the NHS. Advancement therefore reflects both inherited and acquired advantages shaped throughout an individual's life course and professional career. These advantages are distributed unevenly across racial, ethnic, and gendered groups—for example, White men, Indian men, and Black African women—with varying degrees of privilege attached to each.

Overall, participants described a hierarchy of advantage, in which White candidates generally benefit from the greatest structural advantages, followed by Asian candidates and then Black candidates. Within this hierarchy, Black female doctors were not consistently perceived as occupying the most disadvantaged position in relation to access to senior leadership opportunities. This contrasts with findings from other organisational contexts, where Black women are often found to experience compounded marginalisation in leadership roles (Showunmi, 2021; Syster et al., 2023). Participants offered several possible explanations for this divergence. One suggestion was that Black female doctors in senior leadership positions within the NHS may be perceived as less of a "threat" to existing power structures and less likely to challenge dominant organisational norms. While this

interpretation reflects participants' perceptions rather than an objective finding, it highlights the importance of considering how race, gender, and leadership intersect in shaping opportunities for advancement. These findings suggest that experiences of advantage and disadvantage within leadership pathways are complex and cannot be understood through single-axis analyses of either race or gender alone.

In terms of embodied cultural capital, the findings suggest that there is considerable value attached to socialisation into, and embodiment of, the behaviours, norms, and expectations associated with the White majority, particularly at senior leadership levels. Participants described informal socialisation practices—such as networking in social settings outside work—that facilitated relationship-building and access to opportunities. These forms of capital also extend to unwritten standards that act as proxies for leadership competence. Participants across racial groups identified valued attributes such as preferred communication styles, accents, vocabulary, and displays of confidence. These characteristics often require prolonged immersion in dominant cultural environments, shaped by formative experiences such as schooling and attendance at elite institutions. However, even among British-born and British-trained doctors, significant variation exists between the White majority and minority ethnic groups, as well as between minority ethnic groups themselves. Such differences reflect the uneven distribution of economic, cultural, and social capital, shaped by class, socio-economic background, and inherited privilege. At senior levels in the NHS, minority ethnic individuals may be evaluated not only on their communication abilities but also on the extent to which their accent, mannerisms, and style align with what are perceived as "acceptable" norms, such as Received Pronunciation.

Examples from both participant narratives and the reflexive thematic analysis (RTA) illustrate a spectrum of observable yet largely intangible forms of social and cultural capital.

These ranged from perceptions of embodied familiarity and confidence, exemplified by one participant's remark that *"I can tell a person who is from a medical family a mile off"* [B4], to accounts of how professional networks established through organisations such as BAPIO (British Association of Physicians of Indian Origin), founded over 30 years ago, facilitated access to influential relationships, sponsorship, and endorsement. Participants described how these networks contributed not only to attaining and sustaining senior leadership positions but also to fostering a sense of inclusion within leadership spaces where representation from their own minority ethnic groups was visible. In contrast, Black participants frequently highlighted their relative isolation within senior leadership structures, with one noting *that "often you are the only Black person at this level (senior leadership)"* [B2]. This perceived lack of representation appeared to reinforce a more individualised approach to career advancement, perhaps reflecting limited access to similarly established and influential ethnically aligned professional networks. Although organisations such as the Caribbean and African Health Network (CAHN), founded nine years ago, now provide support for healthcare professionals of Black heritage, participants suggested that these structures have not yet achieved the same level of institutional presence or influence described in relation to longer-established organisations such as BAPIO.

Crucially, embodied cultural capital cannot be acquired quickly; it requires time, exposure, and sustained socialisation. Findings from this research suggests that for many Black minority ethnic doctors in particular, access to these forms of capital may involve adapting or suppressing aspects of their identity, for example through code-switching (Grier, 2021) or the adoption of dominant cultural norms. Participants described this as a necessary strategy for both advancement and retention, with some perceiving that failure to conform could result in exclusion. In some cases, this extended to visible markers of difference, such

as religious attire, which were perceived as potentially limiting opportunities. Furthermore, participants suggested that those who "choose" to remain visibly different at this level do so at their own risk. The implications of these findings are significant. They point to the intersection of race, ethnicity, culture, religion, and identity in shaping access to leadership opportunities (Agbenyega, 2017; Adebowale & Rao, 2020). Rather than operating independently, these factors appear to interact and compound disadvantage, increasing the marginalisation of minority ethnic doctors whose identities or behaviours diverge from dominant White organisational norms. This finding underscores the importance of an intersectional understanding of leadership attainment, recognising that the pressures to conform may be particularly pronounced for individuals who embody multiple forms of difference simultaneously e.g. Black, female and visibly religious.

The findings also highlight differences in the accumulation of cultural capital across minority ethnic groups. For example, participants noted that some doctors—particularly those from families with established medical backgrounds (e.g. third- or fourth-generation doctors)—demonstrated greater confidence, familiarity with professional norms, and ease within leadership spaces. This contrasts with many first-generation Black doctors, who may lack access to these forms of embodied cultural capital. Participants described such confidence as a form of "currency", signalling belonging and legitimacy. Importantly, this form of generational or inherited cultural capital appears to provide advantages beyond formal qualifications. At senior leadership levels in the NHS, where degrees and professional credentials are expected of all candidates, these embodied attributes may become more significant differentiators. As a result, some Black participants described compensating through over-credentialing—accumulating additional qualifications as a form of

institutionalised cultural capital—while recognising that this may not fully offset deficits in other forms of capital.

Overall, these findings demonstrate how cultural capital functions as a key mechanism underlying DA among minority ethnic doctors aspiring to senior leadership positions. Unequal access to valued forms of social and cultural capital—resources that are highly prized within the NHS leadership field and often differentiate Black and Asian minority ethnic leadership aspirants—contributes to disparities in career progression and helps explain unequal outcomes both between and within ethnic groups.

6.5.4 Identity, Belonging, Historical Legacies as Relational Aspect of Inter-Minority Ethnic DA at NHS Senior Leadership

In this study, participants suggested a symbiotic relationship between cultural capital and belonging in facilitating advancement to senior leadership within the NHS. Importantly, cultural capital was associated not only with career advancement but also with a sense of belonging. Many participants described feeling like outsiders within leadership environments despite significant professional achievement, often experiencing a sense of being *"present but not fully included"* [A3]. This finding aligns with Bourdieu's concepts of capital, habitus, and field, which collectively shape the quality of belonging and individuals' capacity to navigate organisational power structures (Bourdieu & Passeron, 1990; Agbenyega, 2017). Participants' accounts suggest that belonging functioned both as an outcome of possessing valued forms of capital and as a mechanism through which further capital could be acquired. Those whose dispositions, behaviours, and identities aligned more closely with dominant organisational norms appeared more likely to gain acceptance, build influential networks, and access opportunities for advancement. Conversely, individuals whose identities or ways of

being diverged from these norms often described experiences of exclusion, despite occupying positions of authority.

Participants also highlighted the intersectionality of gender, ethnicity, and visible religious identity. For example, they suggested that being a visibly religious minority ethnic woman, whose forms of cultural expression and socialisation may diverge from dominant organisational norms, could operate as an inadvertent mechanism of exclusion. This was perceived to affect both an individual's sense of belonging within senior leadership spaces and the extent to which aspiring doctors with similar intersecting identities viewed such positions as attainable. This highlights the mutually reinforcing relationship between cultural capital and belonging, and their combined influence on leadership attainment among minority ethnic doctors.

In this study, belonging extended beyond representation to encompass feeling recognised, valued, and able to contribute authentically without suppressing aspects of identity. Participants' narratives, however, suggest ongoing tension between authenticity and conformity. This tension appear to carry significant psychological implications, including emotional strain, reduced psychological safety, and, in some cases, experiences consistent with moral injury—distress arising when individuals feel unable to act in accordance with their values (Litz et al., 2009). Minority ethnic leaders, particularly Black participants who were underrepresented at this level, often described feeling constrained in advocating for their communities. Instead, they reported prioritising acceptance and conformity, coupled with concern about being perceived as "single-issue" leaders focused on race. To navigate this environment, many described engaging in identity management strategies, such as code-switching (Grier, 2021), modifying communication styles, and carefully managing discussions around race and ethnicity. While often viewed as necessary for progression, these

adaptations carried emotional and psychological costs. These findings support existing literature suggesting that professional environments are not culturally neutral (Ahmed, 2012). Rather, organisational cultures privilege particular identities and leadership styles while marginalising others. Consequently, progression depends not only on competence but also on the ability to navigate and align with dominant cultural norms. The findings therefore suggest that DA cannot be fully understood without considering identity and belonging. Efforts to improve representation may increase numerical diversity, but without addressing organisational culture, they are unlikely to create genuinely inclusive leadership environments.

Ahmed (2012) provides a useful theoretical lens for understanding these dynamics. Her work shifts the focus from individual prejudice to the ways in which institutions are structured around particular bodies, identities, and norms. Institutions are not neutral; they are historically shaped by those who have occupied positions of power (Ahmed, 2012). This helps explain why barriers to progression persist despite organisational commitments to equality, diversity, and inclusion, and why ideals of meritocracy may become increasingly fragile at senior levels. Ahmed further argues that organisational spaces are oriented towards Whiteness, shaping norms of belonging and leadership. This is reflected in the findings of this study, which suggest that leadership continues to be associated with characteristics historically linked to White, middle-class professional identities—such as specific communication styles, "neutral" self-presentation, social confidence, and access to influential networks. Participants also highlighted expectations around demonstrating authority without challenging dominant norms, which may shape perceptions of suitability for leadership. Furthermore, as these norms are treated as universal rather than culturally specific, they often remain invisible to those who embody them (Ahmed, 2012). Consequently, minority ethnic

doctors—particularly Black doctors—may experience leadership pathways as more constrained, not due to a lack of competence, but because organisational norms privilege a narrower conception of who is seen to "naturally" belong in leadership.

6.6 Discussion on RQ 3 – Perspectives on the Health Implications of DA at Senior Leadership Level the NHS for Minority Ethnic Communities

In this study, the findings related to this research question were explored by most participants through the lens of the recent COVID-19 pandemic, which represented a seminal period for many of them. As individuals in senior leadership positions during the global pandemic, participants had first-hand experience of how systemic injustices and inequities—sustained by an unyielding NHS structure that is slow to change—respond under severe external pressure (Oskrochi et al., 2023; Bhaskar et al., 2020). Oskrochi et al. (2023) highlighted the unequal impact of the COVID-19 pandemic on minority ethnic communities, attributing these disparities to underlying systemic inequalities. Their findings showed that infection rates among Asian communities were up to twice those observed in the White British population. Additionally, both Black and Asian communities experienced excess mortality, with minority ethnic groups overall demonstrating a 23% greater risk of excess death compared with the wider population (Oskrochi et al., 2023). This context revealed the depth of long-established issues relating to race, inequality, and the underrepresentation of minority ethnic groups in leadership. In turn, it left a sequence of catastrophic consequences for both the minority ethnic workforce and the communities they serve (ADPH London, 2021).

The findings are discussed under the following three subsections:

- Minority Ethnic Leadership Representation as Structural Advocacy for Positive Health Outcomes for Minority Ethnic Communities
- Relational Aspects of Representation, Cultural Competence, Credibility and Patient Experience
- Structural Inequality, Health Inequality and the Relationship Aspect of Minority Ethnic Leadership

6.6.1 Minority Ethnic Leadership Representation as Structural Advocacy for Positive Health Outcomes for Minority Ethnic Communities

The importance of representation has been repeatedly highlighted within NHS workforce literature (Chakravoty, 2021). Despite comprising a substantial proportion of the NHS workforce, minority ethnic staff remain significantly underrepresented in senior leadership positions (Kline 2014, 2025). The Kline (2014) report identified striking disparities between workforce diversity and board-level representation, while subsequent evaluations have demonstrated only gradual improvement over time. Participants argued that representation matters because leaders shape organisational agendas. Decisions regarding recruitment, workforce development, service delivery, and resource allocation are influenced by those in positions of authority. Consequently, underrepresentation in leadership may limit the range of perspectives informing organisational decision-making. Importantly, participants did not suggest that minority ethnic leaders automatically advocate for minority ethnic staff or communities. Rather, they emphasised that lived experience could provide greater awareness of barriers, inequities, and exclusionary practices, thereby increasing the likelihood that these issues are recognised and addressed within organisational decision-making processes. This is a nuanced but important distinction, as well as a key finding of this research, highlighting the relational aspect of the presence of minority ethnic senior leaders and their representation of the communities they are perceived to serve.

In this study, senior NHS leaders reflected on their experiences during the pandemic as a lens through which to emphasise the significant role that minority ethnic leaders—when given power and voice—can play within both the NHS workforce and the communities they serve. This finding also resonates with my own experience as a frontline consultant during

the pandemic, particularly in relation to vaccine uptake among minority ethnic staff, as described in Chapter 1 of this study. Participants consistently described leadership representation as extending beyond symbolic diversity, instead framing it as a genuine driver of change in both healthcare uptake and the perceived legitimacy of the NHS, which has a duty to serve all populations, not only the majority White population. In addition, this study found that while representation was valued intrinsically, many participants emphasised its potential to influence organisational priorities, decision-making processes, and workforce experiences. This study argues that the implication of this are significant and suggest that if the NHS values its workforce—including career progression, health, and wellbeing—then proportional representation of minority ethnic staff becomes essential, both as a strategic tool to achieve these aims and as a mechanism to actively improve the welfare of both the workforce and the communities they serve.

These findings also contribute to the growing body of evidence regarding ethnically congruent healthcare provision, where improved health outcomes have been observed when care is delivered by ethnically congruent providers (Teal et al., 2025). This is not to suggest that only ethnically congruent healthcare practitioners can deliver high-quality care. Rather, care excellence is not mutually exclusive to any racial or ethnic group, and good care can be delivered by healthcare providers regardless of background (Paradies et al., 2014). However, there is important nuance. Although the principle of healthcare equity requires that all patients receive the same standard of care, this study suggests that cultural awareness, sensitivity, and shared lived experience may sometimes enable an ethnically congruent provider to develop a deeper understanding of a patient's experiences. This may be due to shared cultural understanding or a deeper contextualisation of socio-economic challenges faced by certain minority ethnic communities (Teal et al., 2025), as well as improved

communication during clinical interactions (Ashton et al., 2003). Nevertheless, evidence also suggests that such preferences are not universally sought among all minority ethnic patients (Walker et al., 2026). Many participants frequently illustrated these points using the example of sickle cell disease, a haematological condition that affects the shape of red blood cells and can result in severe painful crises requiring strong analgesia, often opioids. This condition predominantly affects individuals of Black African and some Mediterranean backgrounds. Participants described witnessing instances of suboptimal care—even from otherwise competent clinicians—including the mislabelling of patients as drug-seeking. Notably, findings—particularly from Black participants—suggested that lived experience, such as having a family member or community contact with the condition, positively influenced their clinical approach and was associated with better patient outcomes. Furthermore, as senior leaders, these individuals were able to influence organisational culture through education, awareness-raising, and advocacy, contributing to improved patient experiences. Other participants from minority ethnic backgrounds cited comparable examples, including disparities in maternity outcomes among minority ethnic women (MacLellan et al., 2022) and inadequate pain management in Black paediatric patients (Goyal et al., 2015). The experiences reported in this study are consistent with existing evidence on the disenfranchisement of Black and other minority ethnic patients within the NHS (Patel & Hanif, 2022; Sizmur & McCulloch, 2016).

Moreover, this study adds to the established argument that the healthcare needs of minority ethnic communities are more likely to be recognised and prioritised when there is representation at senior leadership and decision-making levels. These findings contribute to the growing body of post–COVID-19 literature highlighting the impact of insufficient minority ethnic representation in senior leadership on the health outcomes of both minority

ethnic staff and the communities they serve (ADPH London, 2021; Kline, 2024). Furthermore, these findings challenge simplistic understandings of representation as merely a numerical outcome. Instead, participants viewed minority ethnic leadership as a mechanism through which meaningful organisational change can occur. Participants suggest that leaders from minority ethnic backgrounds were frequently perceived as more likely to recognise inequalities, challenge exclusionary practices, and advocate for underrepresented groups.

Participants also highlighted the symbolic significance of representation. Visible minority ethnic leadership was seen as demonstrating that advancement is both possible and attainable. Findings from this study suggest that this was particularly important for junior staff, who often look to senior leaders as indicators of organisational opportunity, fairness, and inclusion. Participants' accounts suggest that representation within senior leadership extends beyond numerical presence. Through a Bourdieusian lens, seeing leaders who share similar ethnic, cultural, or religious backgrounds may strengthen feelings of legitimacy, belonging, and aspiration by demonstrating that such identities are recognised and valued within the field. In contrast, under-representation may contribute to a misalignment between an individual's habitus and the dominant leadership culture, reinforcing perceptions of exclusion and limiting access to the social capital necessary for progression.

Furthermore, participants suggested that leadership diversity is valuable even in areas with predominantly White populations, as it promotes a wider range of perspectives, experiences, and ideas. Evidence from a range of sectors has shown that diverse leadership can have positive organisational outcomes, including enhanced innovation, decision-making, and performance (Herring, 2009; Areiqat et al., 2020; Salomon & Schork, 2003). However, participants simultaneously recognised the limitations of representation alone, suggesting that diversity without influence was viewed as insufficient. Participants described organisations

that appeared diverse on paper, yet where key decisions continued to be concentrated among a relatively small group of individuals. This distinction highlights the importance of examining power and decision-making authority alongside representation.

Overall, the findings therefore suggest that leadership diversity should be understood not merely as an equality objective but also as a component of organisational effectiveness. While not exclusive to minority ethnic senior leaders, this study argues that diverse leadership teams may be better positioned to identify inequalities; challenge established assumptions and foster more inclusive approaches to decision-making. Consequently, meaningful inclusion requires not only diverse representation but also equitable access to influence, authority, and organisational power.

6.6.2 Relational Aspects of Representation, Cultural Competence, Credibility and Patient Experience

There is substantial evidence suggesting that racism is associated with pervasive health inequalities (Paradies et al., 2015). This is not limited to the NHS; it extends to both the minority ethnic workforce and the communities they serve. The literature also supports the relational importance of ethnically congruent or concordant healthcare provision, with evidence of improved healthcare outcomes for minority ethnic patients (Alsan et al., 2019). This highlights the need for workforce diversity not only at the lower levels of organisations—as is often observed within the NHS workforce (Stockton & Warner, 2024)—but also for proportional representation at the highest levels of leadership. In this study, an important extension of participants' discussions concerned the relationship between workforce diversity and patient care. Participants frequently linked leadership representation

to broader issues of cultural competence, organisational credibility, and patient experience, with many citing examples of increase vaccine uptake by both minority ethnic staff and patients when delivered by other minority ethnic staff during the COVID-19 pandemic. This cannot be overstated given the lifesaving impact of the vaccines during this period and along with associated heard immunity effect (Mesle et al., 2024). Participants suggested that leadership diversity influences how organisations understand and respond to the needs of increasingly diverse patient populations. Nevertheless, this study also found that minority ethnic doctors in leadership positions cannot be expected to bear the full burden of improving healthcare outcomes for minority ethnic communities. This responsibility must be shared across organisations, regardless of their composition.

Ahmed (2012) highlights the burden of representation placed on minority ethnic leaders, noting that they are often expected to undertake diversity work on behalf of institutions. Indeed, in some NHS organisations, it is not uncommon to see that the only senior roles occupied by minority ethnic individuals are those with an equality, diversity, and inclusion (EDI) remit. While these roles are important, responsibility for addressing inequality must extend beyond individual actors and symbolic representation. Ahmed (2021) further argues that the invisible labour undertaken by these individuals is often insufficiently recognised or rewarded. Moreover, these individuals may be implicitly made responsible for resolving organisational problems they did not create, often in the absence of genuine institutional commitment to meaningful change. These findings align with evidence demonstrating links between workforce experience and patient outcomes (Kline, 2014). Research has shown that organisations in which minority ethnic staff experience discrimination often report poorer patient experience scores (NHS England, 2026). Furthermore, staff engagement, inclusion, and organisational culture have been consistently

associated with the quality of care and patient satisfaction (Chakravorty, 2021). Participants argued that leaders from diverse backgrounds may bring unique perspectives regarding cultural needs, barriers to access, and experiences of healthcare inequality. In this study, such perspectives were viewed as particularly valuable in organisations serving ethnically diverse communities.

Overall, the findings also suggest that representation contributes to organisational credibility. Participants described situations in which patients and communities questioned whether healthcare organisations genuinely understood their experiences. Visible diversity within leadership was therefore perceived as signalling organisational commitment to inclusion and responsiveness. This finding is particularly significant given the growing recognition of the importance of culturally competent healthcare (Anderson et al., 2003). Effective healthcare delivery requires an understanding of the social, cultural, and structural factors influencing health behaviours, healthcare utilisation, and patient experience. Leadership diversity may therefore contribute indirectly to improved service design and delivery.

6.6.3 Structural Inequality, Health Inequality and the Relationship Aspect of Minority Ethnic Leadership

The final, and arguably most important, theme related to this third research question concerns the relationship between workforce inequality and health inequality. Participants consistently linked their experiences of DA to broader societal patterns of inequality, suggesting that workforce and health disparities are interconnected rather than separate phenomena. Again, many framed this within the context of the COVID-19 pandemic, which revealed at scale the impact of structural health inequalities on minority ethnic communities, including the

minority ethnic NHS workforce. Participants described personal accounts of colleague mortality, which they partly attributed to inadequate risk assessment for minority ethnic staff, particularly those working on the frontline. This finding represents one of the most significant contributions of the study, as it illustrates the interplay between structural and systemic issues, their impact on minority ethnic staff and communities, and the potential beneficial role of congruent leadership in both identifying and mitigating health risks.

Mertens' (2007) transformative framework is instructive here, emphasising that knowledge is not neutral but is shaped by interests, power, and social relationships, particularly in relation to marginalised groups, including racial and ethnic minorities (Sweetman et al., 2010; Mertens, 2007). This framework underpinned the study and informed the interpretation and discussion of the findings throughout, even where not explicitly stated. This research was conducted in line with this framework, following its key stages, including defining the problem in context, research design, and participant selection—specifically focusing on individuals in positions of influence with the capacity to enact change. These elements align with the criteria outlined by Mertens (2007) for transformative research. While considerable attention has been given to DA within medical careers, less focus has been placed on how leadership inequalities may influence broader health outcomes. Participants frequently argued that who occupies leadership positions matters, as leadership shapes organisational priorities, policy development, and resource allocation. These findings also support a relational understanding of inequality, whereby workforce inequality and health inequality appear mutually reinforcing. This study argues that underrepresentation in leadership limits the diversity of perspectives informing decision-making, while health inequalities affecting minority ethnic communities may remain insufficiently recognised or addressed. Participants frequently described leadership diversity as a mechanism through

which health inequalities could be challenged. They argued that leaders with lived experience of marginalisation were more likely to recognise structural barriers affecting patients and communities, though not exclusively. Consequently, increasing representation was viewed not merely as a workforce objective but as a potential strategy for promoting health equity. These findings align with broader public health literature emphasising the social determinants of health e.g. socioeconomic factors (McKee et al., 2021) which suggests health outcomes are shaped not only by clinical interventions but also by social, economic, and institutional factors. Workforce diversity and leadership representation form part of this wider ecosystem, influencing organisational responsiveness to inequality. Therefore, this study suggests that addressing DA in NHS senior leadership has significance beyond individual career trajectories. It asserts that leadership inequality represents a broader organisational and societal issue, with implications for workforce wellbeing, service quality, patient experience, and population health.

6.7 Chapter Summary and Conclusion

Taken together, the findings support a fundamental shift in how DA within NHS leadership is understood. Participants consistently rejected explanations centred on individual capability, ambition, or effort. Instead, they described a complex system of structural, organisational, and cultural mechanisms that shape access to opportunities, career progression, and inclusion, with consequences not only for minority ethnic staff but also for the health outcomes of the communities they serve. The study demonstrates that minority ethnic senior leadership progression is influenced by access to social and cultural capital, informal networks, sponsorship, and organisational norms which is a likely contributory factor inter and intra-minority ethnic differential. These mechanisms frequently operate beneath the surface of formal recruitment and promotion processes, making inequalities difficult to identify and challenge. Consequently, differential attainment emerges not as a series of isolated incidents but as a cumulative and systemic phenomenon. The findings further suggest that representation alone is insufficient. While increasing diversity within leadership structures remains important, meaningful progress requires attention to inclusion, influence, and organisational culture. Without such changes, this study suggests that minority ethnic leaders, particularly Black doctors, may continue to experience conditional inclusion despite occupying senior positions.

In the next chapter, I present recommendations for policy, practice, and future research arising from this study, aimed at reducing DA and promoting equitable leadership progression within senior NHS leadership. The chapter will also address study limitations, and further reflexivity.

PART V: RECOMMENDATIONS & LIMITATIONS

Chapter 7 Recommendations and Limitations

Overview

The previous chapter discussed the findings of the narrative study, including their implications for minority ethnic doctors aspiring to senior leadership positions within the NHS, their wider communities, and the NHS itself. In this chapter of the thesis, I present the recommendations arising from the study, which centre on the need for structural and transformative change within NHS organisations rather than focusing on individual-level interventions. This chapter also addresses the limitations of the research.

7.1 Principles Underpinning the Recommendations

Before outlining specific actions, it is important to state the principles that underpin this chapter. First, the recommendations I suggest are guided by the view that equity is not achieved through passive fairness, which was a strong thread which emerged from the study participants. The study found that formal equality of opportunity is insufficient when individuals enter leadership pathways with unequal access to support, visibility, networks, and institutional recognition. Second, the proposed recommendations assume that representation matters but asserts that representation alone is insufficient to influence meaningful change. Therefore, I believe that diversity at senior levels in the NHS must be accompanied by meaningful authority, influence, and the capacity for minority ethnic doctors to help shape organisational decisions. Third, the findings add to the body of evidence suggesting that aggregated approaches to ethnicity are inadequate. Therefore, I believe that any effective strategy must recognise variation within and between minority ethnic groups, particularly the distinct barriers experienced by Black doctors. Fourth, this chapter adopts the position that organisations, rather than individuals alone, must change. Participants

repeatedly described adapting themselves to existing cultures in order to progress. While such adaptation may be pragmatically necessary in the short term, I believe it should not be the primary mechanism through which equity is achieved. Moreover, the study found that it takes psychological toll on minority ethnic doctors. Finally, the recommendations are informed by the theoretical frameworks I used throughout the study – cultural capital and transformative worldview, which are intended not only to describe problems but also to support structural change, challenge inequity, and improve outcomes for both minority ethnic staff and the communities served by the NHS.

7.2 Recommendations

Both the literature review and discussion chapters highlighted that recommendations to address DA among minority ethnic doctors have traditionally focused more on individual-level factors. However, this study adds to growing evidence that meaningful change requires addressing the structural and systemic factors operating within NHS organisations and senior leadership. NHS organisations, workforce bodies, and policymakers should therefore move beyond representation-focused initiatives and prioritise transparency, accountability, sponsorship, organisational culture, and equitable access to leadership capital. However, this study acknowledges the intrinsic value of increasing ME representation in senior leadership, both in fostering trust and credibility among the NHS's diverse minority ethnic workforce and as a mechanism for improving health outcomes within minority ethnic communities.

Sustainable progress is unlikely to be achieved through individual interventions alone without reforming the organisational processes that perpetuate leadership inequalities. The study's recommendations are therefore grounded in this principle. It also argues that more granular ethnic categorisation can enhance organisational transparency and legitimacy in

leadership appointments and career progression. Improved ethnicity data collection would support more robust research, evidence-informed policymaking, and the development of targeted interventions to address persistent inequalities. This study therefore proposes the following two key recommendations:

1. Stratification of senior leadership based on workforce and community ethnic demography
2. Improve data collections and monitoring through greater granularity in ethnicity categorisation

7.2.1 Recommendation 1: Stratification of Senior Leadership Based on Workforce and Community Ethnic Demography

This study recommends that representation within senior leadership should be aligned proportionately with the ethnic composition of either the local workforce, the surrounding community, or national population demographics. The central premise of this recommendation is that meaningful progress towards equity requires structural change through the reconstruction of leadership structures at the top of organisations, rather than relying solely on the cumulative effects of numerous small-scale interventions at lower organisational levels. While initiatives aimed at widening participation, increasing diversity within medical schools, and supporting the progression of minority ethnic professionals are important, their impact may be limited if existing leadership structures remain largely unchanged. Therefore, I believe that structural reconstruction at senior levels is necessary to ensure that the benefits of inclusion throughout the educational and professional pipeline are ultimately reflected in organisational leadership. This recommendation should not be interpreted as advocating for the appointment of less qualified or less competent individuals.

On the contrary, existing evidence demonstrates that there is a substantial pool of highly qualified minority ethnic candidates capable of occupying senior leadership positions (Kalra et al., 2009). The issue is therefore not one of capability but of equitable access to opportunities. This recommendation is grounded in the principle of equity rather than equality, recognising that achieving genuine diversity and inclusion may require structural reforms that challenge longstanding organisational arrangements. This study argues that small-scale interventions alone are unlikely to dismantle entrenched structures that continue to reproduce inequalities in leadership representation. This proposed stratification can be conceptualised across three levels **(Figure A):**

Level 1: Workforce-Based Representation

At the organisational level, the proportion of minority ethnic individuals occupying senior leadership positions should broadly reflect the ethnic composition of the workforce. For example, if 30% of employees within an NHS organisation identify as belonging to a minority ethnic group, then approximately 30% of senior leadership positions should be occupied by individuals from minority ethnic backgrounds.

Level 2: Community-Based Representation

At the regional or local population level, senior leadership representation should reflect the demographic composition of the communities served by the organisation. For example, if minority ethnic groups comprise 50% of the local population, this proportion should be reflected within the organisation's senior leadership. However, this principle should not be applied rigidly. In areas where the local population is relatively homogeneous, I believe organisations should still recognise the intrinsic value of diversity in leadership. As highlighted in the discussion chapter, there is a

substantial body of evidence that suggest that diversity contributes positively to organisational effectiveness, innovation, decision-making, staff wellbeing, patient experience, and institutional performance (Gomez & Bernet, 2019; El Chaarani & Raimi, 2022). Consequently, even where workforce or community demographics would result in relatively low levels of diversity, organisations should make deliberate efforts to ensure diverse representation within senior leadership teams.

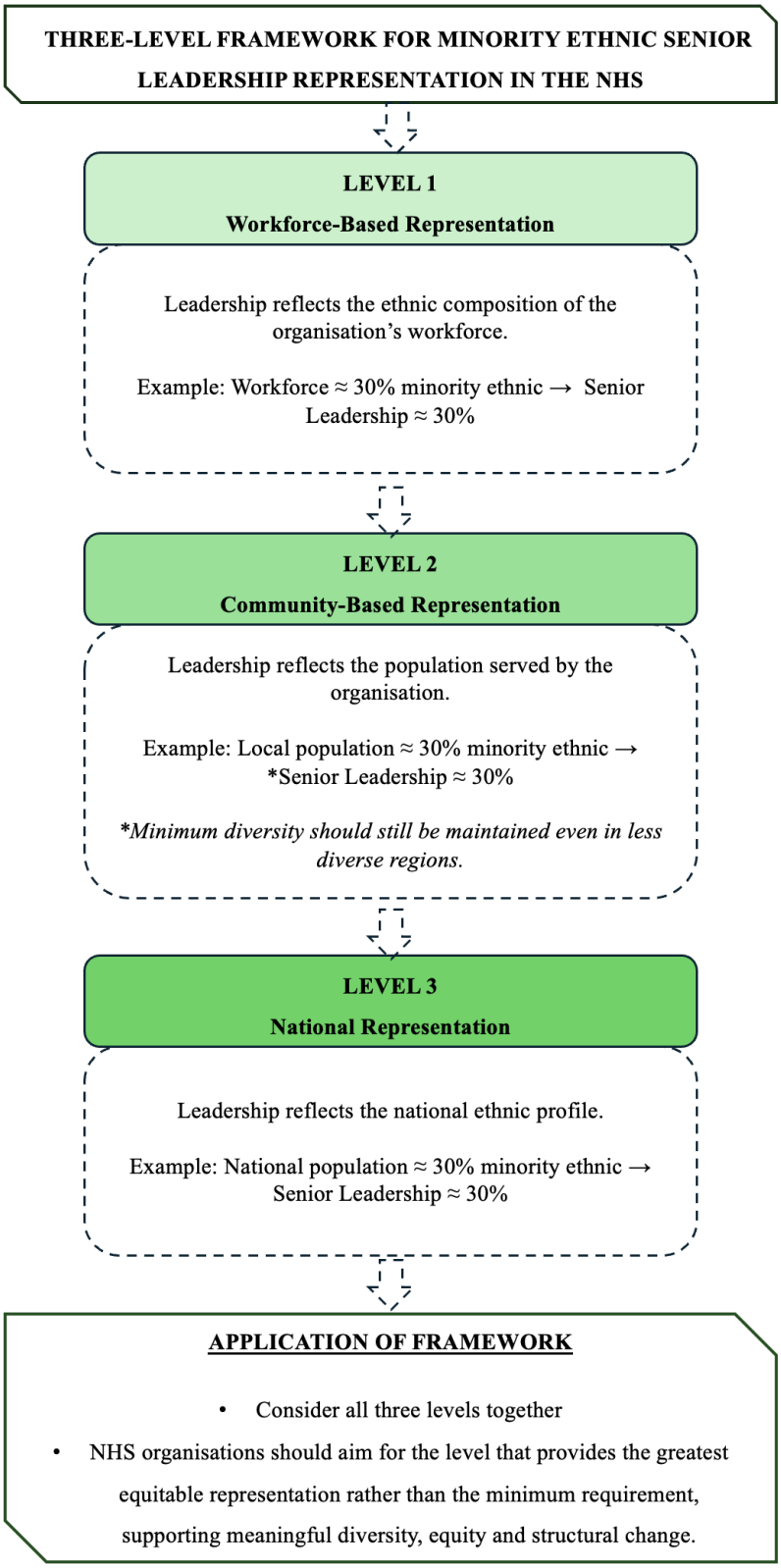
Level 3: National Representation

The third level considers representation based on national demographic patterns. Under this model, the proportion of minority ethnic individuals in senior leadership roles should reflect the overall proportion of minority ethnic groups within the national population. For example, if minority ethnic groups constitute 30% of the national population, a similar proportion should be reflected within leadership positions across NHS organisations.

Applying the Three-Level Framework

These three levels should not be viewed as mutually exclusive. Rather, they should be used collectively as a framework for informing leadership representation targets. NHS organisations should consider all three measures and aim to achieve the level that produces the greatest degree of equitable representation, rather than defaulting to the minimum requirement or adopting tokenistic approaches to diversity. Such an approach would demonstrate a genuine commitment to equity, inclusion, and structural transformation within NHS leadership.

Figure A: Visual Representation of the Three-Level Framework for Minority Ethnic Representation in NHS Senior Leadership – Original Illustration by Ben Balogun-Ojuri



7.2.2 Recommendation 2: Improve Data Collection and Monitoring Through Greater Granularity in Ethnicity Categorisation

This study supports calls for greater granularity in the collection and categorisation of NHS workforce ethnicity data to better understand DA and workplace inequalities (Aspinall, 2021; Kline, 2019; Woolf et al., 2011) and particularly as senior leadership level in the NHS. The findings challenge the continued use of broad categories such as BAME and BME, including within NHS monitoring systems such as the Workforce Race Equality Standard (WRES). They also encourage researchers informing NHS policy to reconsider reliance on such aggregated classifications. The study found that limited differentiation between minority ethnic groups, particularly Black and Asian doctors, contributes to DA in senior NHS leadership. Broad ethnic categories can obscure important differences in experiences, outcomes, and progression, potentially masking or perpetuating inequalities within minority ethnic groups themselves. Consequently, this study proposes a more stratified and inclusive approach to ethnicity data collection and monitoring based on the following principles.

1. Cessation of Homogenising Acronyms

Based on the findings regarding the need for greater granularity in minority ethnic categorisation, this study recommends the discontinuation of broad collective terms such as BME and BAME in NHS workforce data collection, reporting, and monitoring. This recommendation applies not only to NHS organisations but also to statutory and regulatory bodies that collect, analyse, and utilise ethnicity data for workforce planning and policy development. Furthermore, researchers working in the fields of equality, diversity, and inclusion should avoid the use of such homogenising categories where more detailed ethnic classifications are available. Continued reliance on broad ethnic groupings risks obscuring

important intra-group differences and may inadvertently exacerbate inequalities by failing to identify the specific challenges faced by different ethnic communities within the NHS workforce.

2. Recognition of Diversity Within Minority Ethnic Groups

Participants consistently highlighted the significant differences that exist between ethnic groups, differences that are often obscured when minority ethnic staff are treated as a homogeneous population. Workforce monitoring and organisational strategies should therefore recognise the heterogeneity of minority ethnic groups and avoid assuming shared experiences, opportunities, or barriers.

Where feasible, NHS organisations should:

- Analyse workforce data using more granular ethnic categories – as suggested below **(Table R1).**
- Examine differences in leadership progression and career development experiences across ethnic groups, with focus on inter and intra minority ethnic differences e.g. between Indian, Pakistani, Bangladeshi, Black African, and Black Caribbean doctors, rather than treating them as a single "minority ethnic" group. For example, research could compare rates of promotion to Clinical Director, Medical Director, or Board-level positions, access to sponsorship and mentoring opportunities, and experiences of discrimination or inclusion across these groups. Such analysis could identify important inter-ethnic differences (e.g. between Black African and Black Caribbean doctors) as well as intra-ethnic differences within broader categories such as Asian or Black doctors.

- Design interventions that are responsive to the specific needs and contexts of different communities for example by recognising social, cultural capital and wider societal challenges that may disproportionately affect specific minority ethnic group e.g. positive versus negative stereotyping.
- Monitor differential attainment and leadership and senior leadership representation at a more detailed level to identify previously hidden disparities at both individual and systemic levels.

3. Stratified Ethnicity Categorisation Based on Diasporic Origin

One of the main objectives of this study was to examine the effects of homogenising minority ethnic doctors within the NHS. The findings support the need for greater granularity in ethnicity categorisation and, consequently, recommend the disaggregation of broad racial and ethnic categories using the 2021 UK Census framework (Cabinet Office, n.d.). However, I am mindful of the tensions inherent in adopting more granular ethnic classifications. While disaggregation can reveal heterogeneity obscured by broad categories (Aspinall, 2021), it may also position ethnic groups within comparative hierarchies of achievement, disadvantage, or adaptation (Song, 2004). Participants in this study described both positive and negative stereotypes linked to structural racism, whereby for example, doctors of Indian heritage were often perceived as the accepted norm within British society, whereas doctors of Black Caribbean heritage had historically not occupied such spaces. Furthermore, evidence of educational or occupational success among some minority ethnic groups may be appropriated to challenge the existence of institutional racism and attribute inequalities to group-level differences rather than structural barriers (Tomlinson, 2005). I therefore approach disaggregated analyses with caution, recognising that ethnic categories are socially and

politically constructed and that any observed differences should be interpreted within their broader social, economic, migratory, and historical contexts. This reflexive stance seeks to balance the analytical value of granular categorisation with an awareness of its potential both to illuminate and reproduce inequalities.

As such, this study recommends the adoption of a more descriptive and stratified approach to ethnicity categorisation that recognises diasporic origins and the cultural nuances associated with different ethnic identities. This is particularly relevant for ethnic minority populations in Britain, which comprise individuals from first-generation through to multi-generational diasporic communities whose experiences, social capital, and cultural identities may differ substantially. The Office for National Statistics (ONS) currently classifies ethnicity into five broad categories, each containing several subgroups. These categories provide an important foundation for ethnicity monitoring. Therefore, this study proposed the following categorisation which is intended to reflect both the demographic composition of the NHS workforce and the distinct experiences of major ethnic groups, particularly those from Black and Asian backgrounds, while recognising important variations within these populations.

The recommended 20 categories are shown in **Table R1** below:

1. Asian Indian	2. Asian Pakistani
3. Asian Bangladeshi	4. Asian Chinese
5. Asian Other	6. Black African
7. Black Caribbean	8. Black Other
9. White English	10. White Scottish

11. White Welsh	12. White Northern Irish
13. White Irish	14. White Other
15. White Irish Traveller/Roma	16. Mixed White & Asian
17. Mixed White & Black	18. Mixed Other
19. Arab	20. Other Ethnic Group

The purpose of this categorisation is not to create further division among ethnic groups but rather to enhance the accuracy, transparency, and utility of workforce data. I believe that more granular data would strengthen research, improve the monitoring of DA and career progression, and support the development of more targeted and evidence-informed policies aimed at reducing ethnic inequalities within NHS leadership.

7.3 Reflexivity

Reflexivity was an integral component of this study and was maintained throughout the research process. Within interpretivist and constructivist paradigms, researchers are not viewed as detached observers but as active participants in the co-construction of knowledge. Consequently, my professional background, personal experiences and social positioning inevitably influenced the research process, including the questions asked, relationships formed with participants and interpretation of findings.

As a minority ethnic doctor working within the NHS and holding leadership responsibilities in medical education, I occupied an insider position in relation to many participants. I believe this offered several advantages, including shared professional experiences facilitated rapport and trust, allowing participants to discuss sensitive topics such as discrimination, exclusion, organisational culture and leadership progression in considerable depth. Participants often appeared comfortable discussing experiences that may have been more difficult to articulate to researchers unfamiliar with NHS structures or the realities of medical careers. However, this insider status also presented challenges. For example, I believe that shared assumptions and experiences risk creating blind spots within the research process. In addition, certain organisational practices, cultural norms or experiences of exclusion could be perceived as self-evident and therefore insufficiently interrogated during interviews or analysis. This came through during supervision with my supervisors where I had made assumptions or not been explicit about observations which may not be obvious to someone who is unfamiliar with the NHS practices. There was also a risk that personal experiences might shape interpretation of participants' accounts, particularly where narratives resonated with my own observations of leadership and career progression within the NHS. However, rather than being viewed as a threat to objectivity, I used

reflexivity as a mechanism for enhancing the transparency and trustworthiness of the research.

7.4 Limitations

7.4.1 Methodological Issues

Several methodological challenges were encountered throughout this study. Narrative inquiry required participants to retrospectively construct coherent accounts of complex professional experiences recalling decades worth of experience, introducing the possibility of selective recall and post hoc sense-making. Furthermore, the integration of narrative inquiry with reflexive thematic analysis required a careful balancing of individual narrative integrity with the identification of cross-cutting themes, while also acknowledging the influence of my own interpretation and positionality. Narrative inquiry prioritises chronology, plot, meaning-making, and individual stories, whereas reflexive thematic analysis focuses on identifying patterns across a dataset. Moving from individual narratives to cross-cutting themes therefore required careful consideration to ensure that participants' stories were not fragmented, decontextualised, or stripped of their narrative coherence, which was challenging for me as a novice researcher.

In addition, maintaining narrative integrity while generating broader thematic insights required ongoing reflexive engagement throughout the analytical process. My insider position as a minority ethnic doctor working within the NHS, I believe, simultaneously facilitated rapport, trust, and contextual understanding while necessitating continuous reflexive scrutiny of my own assumptions and interpretations. I was also mindful of the potential influence of my positionality on participant recruitment, recognising the possibility that individuals who agreed to participate may have shared similar worldviews or held particularly strong views regarding DA and leadership inequalities experienced by minority ethnic doctors within the

NHS. This is a source of potential bias, which I tried to mitigate through the inclusion of broader participant recruitment beyond my immediate contacts, including national recruitment. Moreover, the challenge of recruiting this hard-to-reach group meant that I relied on introductions from the initial participants who may have recommended other with similar worldview and perspectives. Finally, the diversity of experiences represented within the broad category of minority ethnic doctors highlighted the challenge of generating overarching thematic insights without obscuring important differences between participants. However, I believe these challenges are not unique limitations of this study but rather reflect broader methodological tensions inherent in narrative research that seeks to explore issues of identity, power, and organisational inequality.

7.4.2 Novice Researcher

As this study formed part of my DPhil, I was undertaking qualitative research as a relatively novice researcher. While I brought extensive professional experience as a clinician, educator and leader within the NHS, my experience of conducting narrative inquiry and qualitative analysis was less extensive than that of established qualitative researchers. This presented both opportunities and challenges throughout the research process. One challenge concerned developing confidence in managing the complexity and ambiguity inherent within qualitative research. Unlike quantitative approaches, narrative inquiry requires researchers to make interpretive decisions throughout data collection and analysis. I found that determining which aspects of participants' stories to foreground, how to preserve narrative integrity and how to move from individual narratives to broader thematic interpretations required ongoing methodological learning and critical reflection (Clandinin & Connelly, 2000).

Furthermore, as a novice qualitative researcher, I was mindful of the risk of either over-interpreting data by imposing meaning prematurely or under-interpreting data through

excessive reliance on participants' explicit accounts. Recognising this possibility, I ensured the analytical process was deliberately iterative, involving repeated engagement with transcripts, reflective memo-writing and continual revisiting of emerging interpretations. At the same time, I believe my novice researcher status may also have offered advantages. For example, I approached the data with curiosity and openness, which I believe encouraged close engagement with participants' narratives and reduced the likelihood of relying on established assumptions or predetermined theoretical explanations. I believe this facilitated an inductive exploration of participants' experiences while remaining attentive to unexpected findings and contradictions within the dataset. Consequently, while my relative inexperience as a qualitative researcher represented an important consideration, I believe this was mitigated through reflexive practice, methodological transparency and ongoing supervisory support. Consistent with the interpretivist foundations of the study, the objective was not to eliminate researcher influence but to critically examine and make visible how interpretations were developed.

7.4.3 Trustworthiness & Credibility

Moon (2019) identified authenticity, internal analysis, credibility, and follow-up interviews as important criteria for trustworthiness in narrative inquiry. Although follow-up interviews and member checking of re-storied narratives were originally planned, participants' senior leadership roles made further engagement impractical. To address this, I sought to develop a thorough understanding of participants' perspectives during interviews through probing questions that clarified meanings and explored issues in greater depth. Detailed descriptions of the data collection and analytical procedures were also provided to enhance transparency

and enable readers to evaluate the credibility of the findings. Furthermore, Belotto (2018) suggested that trustworthiness can be strengthened through independent analysis of the dataset. As an individual DPhil project, this was not feasible and is acknowledged as a limitation. To mitigate this, I adopted a reflexive approach throughout the research process, remaining attentive to the researcher–participant relationship and critically examining my assumptions, decisions, and interpretations during data collection and analysis (Mertens, 2014). This ongoing reflexive engagement helped strengthen the rigour and trustworthiness of the study.

7.4.4 Transferability

Narrative inquiry does not seek statistical generalisation; instead, it aims to generate rich, contextualised understandings of lived experience within specific social, cultural, and organisational contexts (Clandinin & Connelly, 2000). This made it well suited to exploring DA among senior minority ethnic leaders in the NHS. However, several factors may limit the transferability of the findings. Participants were purposively selected as senior NHS leaders who had successfully navigated career progression. Their experiences therefore cannot be assumed to represent those of all minority ethnic doctors, healthcare professionals, organisations, or leadership contexts. The study also recognised the diversity of minority ethnic communities, meaning findings regarding leadership representation and its perceived benefits may not apply equally across all ethnic groups.

Although the sample of 25 participants was appropriate for a DPhil-level narrative inquiry, most were recruited from large urban teaching hospitals in London and South-East England. Their experiences may differ from those of doctors working in other regions, healthcare settings, or systems. In addition, participants' narratives were rooted in the NHS

and broader British social context, limiting the extent to which findings may transfer internationally.

Transferability is further influenced by the co-constructed nature of narrative inquiry. Participants' accounts were shaped by the interview context, my research questions, and my interpretive lens. The inability to undertake member checking of re-storied narratives I believe represents an additional limitation. Participants also reflected on experiences occurring during particular periods in NHS history, including the COVID-19 pandemic, and findings should therefore be interpreted within their historical and organisational context.

A central finding of the study was the heterogeneity of minority ethnic experiences, including inter-minority ethnic hierarchies and unequal access to opportunities. Consequently, the experiences reported cannot be assumed to apply equally across all minority ethnic groups. Rather than providing broadly generalisable conclusions, the findings offer insights into processes of inclusion, exclusion, and career progression that may be relevant to other contexts, while recognising that these processes are likely to manifest differently across organisational, geographical, cultural, and professional settings.

7.4.5 Dependability

Dependability refers to the consistency, transparency, and traceability of the research process (Ahmed, 2024). In narrative inquiry, exact replication is neither expected nor aligned with its interpretivist epistemology, which views knowledge as co-constructed between researcher and participants (Clandinin & Connelly, 2000). Similarly, reflexive thematic analysis recognises that findings are generated through the researcher’s engagement with the data rather than objectively discovered (Braun & Clarke, 2019). As a novice qualitative researcher, I acknowledged that my developing experience of narrative interviewing and analysis could influence methodological and interpretive decisions. To enhance

dependability, I maintained an audit trail documenting methodological decisions, analytical development, and theme generation. Reflexive memo-writing and regular supervisory discussions supported critical reflection and helped ensure alignment between the study's philosophical assumptions, methodology, and findings. Transparency was further strengthened through detailed reporting of the research design, data collection, analytical processes, and reflexive considerations. Together, these measures enable readers to understand how interpretations were developed and strengthen the study's dependability and overall trustworthiness while acknowledging the inherently interpretive nature of qualitative research.

7.4.6 Ethnicity Categorisation

Race and ethnicity were central considerations in this research. One of the key premises underpinning the study was the need for greater granularity in ethnicity data collection among doctors working in the NHS. Rather than employing homogenising acronyms such as BAME/BME, I adopted the ethnicity categorisation used by the UK Government, as described in the methodology chapter. While I believe this approach provided a distinction between ethnic and national groups than broad umbrella terms, I recognise that considerable heterogeneity remains within these categories. For example, important differences may exist between Black British individuals of African origin and those of Caribbean origin, including document differential attainment (Demie & McLean, 2007; Demie, 2007). Furthermore, there may be significant variation within these groups, such as between individuals of West African and East African heritage. In addition, as highlighted in the discussion chapter, there is considerable diversity in the social and cultural capital of minority ethnic doctors in Britain. Some individuals are first-generation immigrants, while others belong to fourth- or

later-generation British families. I believe these differences shape access to opportunities, professional networks, and experiences of leadership progression, and may therefore have influenced participants' perspectives, whether consciously or unconsciously.

Furthermore, I recognise the importance of intersectionality and the ways in which multiple social identities interact to shape individual experiences. Factors such as gender, religion, sexuality, socioeconomic background, and ethnicity may intersect in complex ways. For example, the experiences of an Asian Muslim doctor, a Black gay female doctor, or a White Irish female doctor may differ significantly from those of individuals who share only one aspect of these identities. While such intersectional differences undoubtedly exist across both minority ethnic and White majority groups, they were not explicitly explored within this study and may have influenced participants' narratives and interpretations of their experiences. Consequently, although this study sought to move beyond overly broad ethnic classifications, I acknowledge that any system of categorisation inevitably simplifies complex and multifaceted identities. The findings should therefore be interpreted with an appreciation of the diversity and intersectionality that exist both within and between ethnic groups.

7.5 Summary

This chapter outlined the limitations and recommendations arising from the study, drawing on the findings and discussion explored through the lens of the research questions. The next and final chapter presents the study's contribution to knowledge, discusses implications for future research, and provides the overall conclusion of the research.

Chapter 8: Conclusion, Contribution to Knowledge & Implication for Future Research

Overview

This final chapter synthesises the key findings of the study, highlights its contributions to knowledge, and considers the implications for policy, practice, and future research.

8.1 Conclusion

This study explored the experiences of minority ethnic doctors in relation to senior leadership progression within the NHS with a focus on Black compared to Asian doctors, examining how participants understood, navigated and interpreted their leadership journeys. Through narrative inquiry and reflexive thematic analysis, the findings revealed that career progression was rarely perceived as a straightforward meritocratic process. Instead, participants described leadership advancement as being shaped by a complex interplay of organisational structures, informal networks, cultural expectations and power relations. Across the narratives, participants highlighted the importance of social and cultural capital, access to influential networks and the ability to navigate organisational norms which were contextualised as instruments of power. Furthermore, this has been argued to be a contributory factor underlying the disparity between Black and Asian minority ethnic doctors in senior leadership positions, with the latter group benefiting from greater social and cultural capital and a more established habitus owing to their multigenerational presence in the NHS. In addition, while minority ethnic participants described some positive experiences of support and sponsorship, many recounted barriers associated with exclusion, from informal decision-making processes, limited access to opportunities and the need to continually demonstrate competence and legitimacy. The findings also revealed important differences within and between minority ethnic groups, challenging assumptions of a uniform minority ethnic

experience and highlighting the influence of inter-minority ethnic hierarchies on leadership opportunities.

8.2 Contribution to Knowledge

First, this study contributes to the growing body of evidence highlighting the significance of inadequate ethnicity data collection as a contributor to the DA experienced by minority ethnic doctors in achieving senior leadership positions within the NHS, with a focus on inter-minority ethnic differential. The findings suggest the need for a more granular approach to ethnicity data collection by researchers investigating DA and awarding gaps in postgraduate medical education, as well as by NHS organisations, regulatory bodies such as the General Medical Council (GMC) and the Workforce Race Equality Standard (WRES). Greater disaggregation of minority ethnic data would facilitate a more nuanced understanding of DA and awarding gaps, both between and within ethnic minority groups. Such an approach would enable the development of more targeted recommendations, interventions, and policy decisions. This contribution highlights the heterogeneity of minority ethnic experiences. Rather than treating minority ethnic doctors as a single homogeneous group, participants described differing experiences of inclusion, exclusion and opportunity, revealing the existence of inter-minority ethnic hierarchies and variations in access to leadership capital. These finding challenges broad ethnic categorisations frequently used within workforce research such as BME/BAME and supports calls for more nuanced understandings of ethnicity within studies of NHS leadership and organisational inequality. A significant contribution of this study is its demonstration of the heterogeneity of minority ethnic experiences within the NHS. Specifically, it highlights how the aggregation of minority ethnic groups within workforce data and policy frameworks can mask important differences

in experiences and outcomes between ethnic groups. By revealing disparities in leadership attainment between Black and Asian doctors in senior leadership, the study challenges prevailing approaches that treat minority ethnic staff as a homogeneous category. In doing so, it contributes new insights into how existing systems of data capture, reporting, and policy intervention may inadvertently sustain or exacerbate both inter- and intra-minority ethnic inequalities in career progression and senior leadership representation within the NHS.

Second, drawing on Bourdieu's concepts of field, habitus, and capital as theoretical lens, this study argues that, unlike Black British doctors in the NHS, the perception is that British Asian doctors benefit from a multigenerational presence within the organisation and the wider medical profession. Over time, this presence appears to have enabled the consolidation and development of social and cultural capital, professional networks, sponsorship opportunities, and increased visibility in leadership spaces. These achievements have, in part, resulted from efforts by earlier generations of Asian doctors to establish and maintain representation in positions of influence within a British society that historically excluded them. Contemporary generations continue to benefit from and build upon these established networks and forms of capital. This study argues that comparable opportunities have not historically been available to many Black British senior doctors, who are more likely to be first generation doctors. As a result, they have had fewer opportunities to accumulate similar forms of social and cultural capital, limiting access to influential networks and sponsorship relationships that facilitate progression to senior leadership roles. Furthermore, this study found that there is no expectation that established minority ethnic groups—mainly British Asian—occupying leadership positions should or will relinquish hard-won influence or representation in favour of other minority groups e.g. Black minority ethnic, particularly when such positions remain scarce. Consequently, minority ethnic

competition for these leadership spaces may inadvertently perpetuate inequalities in access and progression, with significant implications for both individual careers and the communities these leaders represent. Therefore, this study makes a significant contribution to the differential attainment literature by moving beyond the conventional framing of disparities between White and minority ethnic groups and instead examining inequalities within minority ethnic groups. In doing so, it provides a more nuanced understanding of how race, professional networks, social and cultural capital, and historical patterns of organisational inclusion and exclusion interact to shape leadership outcomes. This contribution advances both the theoretical and empirical understanding of ethnic inequalities in NHS leadership and workforce progression.

Third, a key contribution of the study is its identification of leadership progression at higher level as a structural and relational process rather than solely an individual achievement. Participants' accounts challenge dominant meritocratic narratives by illustrating how access to leadership opportunities for minority ethnic doctors in the NHS is influenced by informal networks, sponsorship, organisational culture and access to social and cultural capital. In doing so, the study extends existing understandings of DA and workforce inequality beyond formal recruitment and promotion processes to include the less visible mechanisms—such as informal sponsorship, access to influential networks, gatekeeping practices, cultural fit assessments, and differential access to leadership development opportunities—through which leadership trajectories are shaped.

Fourth, this study introduces the original concept of *'Blackflation'*. Grounded in Bourdieu's theory of symbolic violence and informed by other sociological frameworks discussed in previous chapters, *Blackflation* captures the cumulative and compounding effects of a range of experiences reported by participants, including those from minority

ethnic backgrounds. The concept encompasses overt and internalised forms of racism, higher and often shifting expectations, unequal standards of assessment, and the normalisation of these inequities—a form of symbolic violence. Collectively, these dynamics create elevated barriers and unequal thresholds that Black British doctors must overcome to attain parity in progression to senior leadership positions within the NHS. While none of these experiences are individually unique to Black doctors aspiring to senior leadership positions within the NHS, having been identified in previous studies (Chakravorty, 2021; Kline, 2025), this study demonstrates that their cumulative and synergistic effects constitute a significant mechanism underpinning DA among Black British doctors. This finding advances the literature by moving beyond the identification of discrete barriers to show how multiple, interconnected experiences interact to shape leadership trajectories and reproduce inequalities in progression to senior leadership roles.

Fifth, this study contributes conceptually by demonstrating the interconnected relationship between leadership representation, organisational culture and health inequality. Participants frequently described minority ethnic leadership representation not merely as symbolic inclusion but as a mechanism for advocacy, cultural understanding and organisational change. The findings therefore suggest that leadership diversity may have implications that extend beyond workforce representation, potentially influencing organisational responsiveness, minority ethnic staff experience and patient care outcomes.

Lastly, methodologically, the study contributes to the growing body of qualitative research examining race, leadership and organisational inequality within healthcare in general. The combination of narrative inquiry and reflexive thematic analysis I believe enabled both the preservation of individual experiences and the identification of broader structural patterns across participants' accounts. This approach offers a framework through

which complex issues of identity, power and leadership can be explored in a manner that captures both personal and organisational dimensions.

Overall, the principal contribution of this study is the development of a more nuanced understanding of how senior leadership inequalities in the NHS are produced and experienced between White majority and minority ethnic doctors, and crucially within minority ethnic doctors. By shifting analytical attention away from individual deficit explanations and towards the structural, cultural, and relational mechanisms that shape leadership progression, this study advances contemporary understanding of DA among minority ethnic doctors in the NHS. Its primary contribution lies in extending the DA literature beyond descriptive accounts of underrepresentation to illuminate how power, privilege, and accumulated forms of capital operate within leadership pathways. Furthermore, the study makes an original contribution by examining inter-minority ethnic differences between Black and Asian doctors in senior leadership. Drawing on Bourdieu's concepts of field, habitus, and capital, it also demonstrates how generational advantages, inherited social and cultural capital, and greater relational proximity to the dominant White leadership culture may differentially influence opportunities for leadership progression and attainment within the NHS. In doing so, it may provide an empirical foundation for future research, policy development, and organisational interventions aimed at promoting equity and inclusion within healthcare leadership.

8.3 Implication for Future Research

This study provides insight into how minority ethnic doctors understand and navigate leadership progression within the NHS. However, the findings also highlight several areas requiring further investigation.

First, future research should explore the experiences of a broader range of healthcare professionals and leadership groups to determine whether the structural and organisational mechanisms identified in this study are similarly experienced across different professional contexts. Comparative studies involving nurses, allied health professionals and healthcare managers may help establish whether the barriers identified are unique to doctors or reflective of wider organisational processes within the NHS.

Second, the findings suggest that minority ethnic doctors do not experience leadership progression uniformly which becomes more pronounced at senior leadership level. Future research should move beyond broad ethnic categorisations and examine differences between specific ethnic groups, recognising the potential for intra-minority ethnic hierarchies e.g. Black African compared to Black Caribbean doctors, and varying access to social and cultural capital. Such work may provide a more nuanced understanding of how ethnicity intersects with leadership opportunities and organisational experiences.

Third, several participants described the importance of informal networks, sponsorship, mentorship and organisational culture in shaping career progression. Future studies could explore these mechanisms in greater depth, particularly through organisational case studies or mixed methods approaches that examine how leadership opportunities are distributed and accessed within NHS institutions.

Fourth, while this study focused on the experiences of individuals who had attained senior leadership roles in the NHS, future research may seek to include those who have disengaged from leadership pathways, left the NHS or experienced stalled career progression. Such perspectives may provide valuable insight into the processes through which talented

individuals become excluded from leadership trajectories. This was a particular concern from the Black doctors in this study.

Finally, future research should examine the relationship between minority ethnic leadership representation and organisational outcomes, including staff experience, workforce inclusion, patient trust and health inequalities. Given participants' accounts of leadership representation as a mechanism for advocacy and cultural understanding, further investigation is needed to explore whether increasing diversity within senior leadership translates into measurable organisational and patient benefits. More broadly, future research should move beyond documenting disparities in leadership representation towards understanding the structural processes through which inequalities are produced, maintained and challenged. Longitudinal and organisationally focused studies may be particularly valuable in examining how leadership careers evolve over time and how institutional cultures, policies and power structures influence access to leadership opportunities. I believe such work may have the potential to inform both organisational practice and policy interventions aimed at promoting equity within NHS leadership.

8.4 Final Summary

Whilst the study has several limitations, including its context-specific sample, the interpretive nature of narrative inquiry and the challenges associated with researching complex issues of race, identity and leadership, measures were taken to enhance trustworthiness through reflexive practice, methodological transparency and a systematic analytical approach. The findings should therefore be understood as a credible and contextually grounded interpretation of participants' experiences rather than a definitive account of minority ethnic senior leadership progression within the NHS. Ultimately, this study argues that improving minority ethnic representation within NHS senior leadership requires attention not only to individual development but also to the structural, cultural and organisational conditions that shape access to leadership opportunities. By foregrounding the voices and experiences of minority ethnic doctors, the study contributes to a deeper understanding of how leadership inequalities are experienced and sustained, while identifying areas where NHS trusts may intervene to promote more equitable and inclusive leadership pathways. In doing so, it offers both an empirical contribution to the literature on NHS senior leadership and a foundation for future research and policy development aimed at addressing persistent inequalities within healthcare leadership.

Overall, through narrative inquiry and analysis, I was able to simultaneously capture the complexity and nuance shaping the DA of Black doctors in particular within minority ethnic representation at senior leadership level in the NHS. I believe this study therefore provides particular insight for Black doctors aspiring to senior leadership, enabling a deeper understanding of the complexities involved in navigating this career pathway and recognising that individual effort alone is not deterministic. While there is evidence of the power of collective endeavour, as observed among some subsets of Asian doctors. This study found

that progression is more fundamentally shaped by structural and systemic institutional barriers. However, although these barriers are pervasive, findings from this research suggest they can be navigated through increased awareness, sustained perseverance, and, crucially, through the education of gatekeepers and a broader organisational commitment to structural transformation.

9 Appendix

9.1 Appendix I – RTA Participant Coding & Thematic Mapping Showing Theme and Subtheme

Sample of participants coding document showing iterative process of coding, including semantic, latent, in vivo, and interpretive coding. ***(HC healthcare; ME Minority Ethnic)***

Line	Data Item	Coding 1 (semantic)	Coding 2 (semantic)	Coding 3 (semantic or "in vivo")	Coding 1 (latent)	Coding 2 (latent)	Coding 1 (interpretive)	Coding 2 (Interpretive)
1	*"However, structural discrimination continues to exist, and that does affect people's access to good services."*	social disadvantages and structural inequalities are major determinants of health outcomes for minority ethnic people	social disadvantages and structural inequalities	Marginalisation through poor access	structural deprivation	poverty and deprivation are major drivers of poor health outcomes in black community	socioeconomic determinants of health foreground over race or ethnicity	Systemic bias and structural challenges
2	*"The way in which they're treated etc. Black people in Britain are poorer and if you are poor, if you are socially disadvantaged"*	social disadvantages and structural inequalities are major determinants of health outcomes for minority ethnic people	social disadvantages and structural inequalities	Differential treatment of ME	structural deprivation	poverty and deprivation are major drivers of poor health outcomes in black community	socioeconomic determinants of health foreground over race or ethnicity	Systemic marginalisation of ME
3	*"People still think it's about racism. Race is important, but not in this direct way at all."*	racism does not fully account for overrepresentation of black people in some institutions	racism does not fully explain overrepresentation	socio determinants drive disparities	complexity of causality	overrepresentation not solely attributable to racism within the workforce	sociocultural practices around healthcare are significant drivers of poorer outcome in minority community	differences in health beliefs and practices differ within same minority ethnic group
4	*" Lived experiences and representation in not the only factor. If only it were as simple as that. it's such a lazy kind of trope."*	leadership requires more than lived experience	Leadership required a wide range of skills and experience which includes but not limited to live experience	Holistic mindset to leadership	anti-essentialism	Minority ethnic representation alone is insufficient to combat ME health inequalities	Lived experience in ME leadership is only partly advantageous	Leadership effectiveness not reducible to shared ethnicity only

5	*" I'm so glad you're just so good. You're a very good [specialist]. Do you know something? You're the first black person I've ever met who isn't a patient."*	society expect little from black people	black senior doctors patronised	black people are not expected to be as competent or as skilled	Racialised judgement	black senior leaders experience microaggressions and tokenistic perceptions	society racialised professional competence through lens of whiteness	professional credibility is racialised
6	*" If you were the only black consultant and saw a new black consultant, you would think, I really hope they're good because they reflect on us"*	black doctors worried about how the competence of other black doctors reflects on them	black doctors feel judged regardless of competence	competency anxiety between black leaders	collective burden	High burden of representational pressure among black leaders	higher level competence compared to others affect cohesion of black leaders in white spaces	Individual performance of one black leader tied to group identity in general
7	*"In my experience as a black leader, you were the ambassador and you represented all the black people because oftentimes you're the only black person that someone had ever, ever met."*	black doctors worried about how the competence of other black doctors reflects on them	black doctors feel judged regardless of competence	competency anxiety between black leaders	collective burden	High burden of representational pressure among black leaders	higher level competence compared to others affect cohesion of black leaders in white spaces	Individual performance of one black leader tied to group identity in general
8	*"Us black people big ourselves up as a group. But there's very much more of a kind of what I need to do is care about me and my family, not you."*	black people may be more single minded about their achievement	perceived focus on personal advancement primarily	individualistic advancement	structural exclusion fosters competitive survivalism	individualistic advancement pursued by black leaders over than group success	individualism vs collective advancement may impact black leaders negatively	larger cultural pressure and higher expectation of black leaders produce a competitive survivalism mentality above group success
9	*"I mean it is a generalisation that Asian people tend to welcome others – though there might be some differences within the nationalities e.g. India and Pakistan related to this."*	Asian senior leaders more welcoming to other Asian leaders	suggest Asian leaders are more welcoming of other Asian leaders	Racialised stereotype	intra-minority variation	Intra-ethnic group variation between minority ethnic leaders	Perception of greater intra-group support within Asian community in general including in leadership contributing to group success	

10	*" I observe the disappointment in other black people's faces who are equally in that senior position because they actually liked being the only black person there and do not welcome the addition of other black people"*	Black senior leaders concerned other black leaders may diminish them	Black leaders concerned about being diminishment	*"Liked being the only one"*	token status preservation	sole representation in white space linked to prestige for the black leader	Individualism vs solidarity negatively impacting black presence in leadership	Concern new Black leaders reduce individual distinctiveness of current black leader already in the space
11	*"Sometimes we just want to be the only one. someone else coming diminishes your achievements, that other minority groups don't necessarily feel that way."*	Black senior leaders concerned other black leaders may diminish them	Black leaders favour exclusivity	exclusivity among leaders	Internalised racism	Lack of security in white spaces	Homophily and internalised racism	Intra ME internalised racism
12	*"Every black doctor is driven by different motivations. And for some people, they do need to see somebody there who looks like them."*	black doctors are not a monolith	minority heterogeneity	visibility of minority ethnic leaders is important	identity complexity	Some divergence of motivations for black doctors who purse leadership	Individualistic mindset	
13	*"I observe the disappointment in other black people's faces who are equally in that senior position because they actually liked being the only black person there "*	tension between black leaders in senior leadership positions	Black leaders feel disappointed or sense of rivalry in senior roles	"Diminishes their achievement"	scarcity dynamics	leadership rivalry among black leaders	limited positions intensify competition	
14	*"In fact, for some people, it's probably like I want to be the first, you know – rather than seeing some like them already in that senior role."*	black doctors are not a monolith	Homogenisation	*"Want to be the first"*		Need for ethnic disaggregation	black doctors have varied aspiration which may not include leadership, while other value being the first rather than following precedent	rejection of homogenisation
15	*"Regarding the black community as a whole and health outcomes and impact, I*	black people in leadership position makes a difference	Representation improves health	*"Absolutely makes a difference"*	structural leverage	Leadership diversity impacts community HC outcomes	Representation in leadership makes a	leadership diversity linked to agenda influence

	think it absolutely, make a difference if you have black people senior management and leadership positions in the NHS"		outcomes for ME communities				difference to ME communities	
16	*"So, if you're not visible then they don't know about you - community."*	visibility of minority leaders is important for their community	visibility of leadership offers hope and challenges false assumptions	visibility inspires hope	symbolic modelling	Symbolic and practice impact of minority ethnic leadership to their communities	HC outcomes of minority ethnic communities have direct correlation to representation at decision making levels	representation as a tool to reshape aspirations of ME community
17	*"there's something about being able to put that challenge in and challenge any false or incorrect assumption about your community but only if you're present in the room"*	visibility of minority leaders is important for their community	visibility of leadership offers hope and challenges false assumptions	visibility inspires hope	symbolic modelling	Symbolic and practice impact of minority ethnic leadership to their communities	HC outcomes of minority ethnic communities have direct correlation to representation at decision making levels	representation as a tool to reshape aspirations of ME community
18	*"I would say that being as a black female chief exec, I think that gives courage, Inspiration, Support and Voice to other both black and other minority ethnic groups - staff and patient populations."*	positive aspect of representation for minority ethnic community	representation impacts ME community positively	empowerment through representation	role modelling	Role modelling and inspiration is important for future ME leaders	Empowerment through representation and visibility of other black leaders	representational leadership expands voice of ME
19	*"The only people that they did stereotype are the Pakistanis and the Muslims."*	negative stereotypes of other non-black minority ethnic groups	Negative stereotypes and stigma vary between ME groups	Negative stereotyping of some Pakistanis and Muslims worse than other Asian groups	ethnic prejudice	Black people are generally more negatively stereotyped in society which impacts the community as a whole	Ethnic prejudice linked to wider societal narratives--stereotyping and stigmatisation--disproportionally affects black people and their status in society	bias in HC experienced by all ME community targeting cultural identity, beliefs and protected characteristics
20	*" If you're good at music, that's good because you're black. But if you're black and*	British society expectation of black	societal stereotypes shape expectations	negative societal expectations	internalised narratives	internalised and structure prejudice impacting HC	black people are not expected to be academic	

	you want to be something that is educationally guided, they will start saying, well, do you think you should. And that does things to people's heads."	people are stereotypical and prejudiced				outcome of ME communities negatively		
21	*"We're bombarded by negative connotations and negative influences of black people. And therefore, unless you're really understanding what's being going on and the complexities, you start to believe it."*	British society expectation of black people are stereotypical and prejudiced		*"Bombarded by negative connotations and negative influences of black people"*	internalised narratives	identity shaped by discourse	Media narratives influence self-perception and opportunities of black people	
22	*"As a black doctor who took up the vaccine, the cleaners, the porters, the healthcare assistant who had questions and hadn't taking the vaccine. I'd go and talk to them, one to one, and ask them if they had. They'd say Doctor I'm taking it if you have."*	representation builds trust with minority ethnic people	relational trust	trust through representation	relational concordance	Ethnic concordance improves engagement in HE for minority communities	building community trust through representation in leadership	ethnic alignment builds trust and improves uptake in HE for ME community
23	*" I was undecided as to whether to take the vaccine because there wasn't any research on it and because if you look at the historical things done to black people around this have not really been in the best interests of the population"*	history suggest systemic injustices against black people	Historical injustices affect black healthcare outcomes	historical injustice legacy	collective memory	Historical injustice legacy against black people in healthcare	mistrust of healthcare system embedded in history against black communities	past injustices and harms to ME community mediates present mistrust in system
24	*" If they come to the hospitals and see that the majority of the people looking after them does not reflect the composition of their*	lack of representation impacts ME outcomes	bias and stereotyping of ME people in HC	underrepresentation affects care	structural bias	lack of representation within healthcare providers affects health outcomes for minority ethnic people	structural bias among HC providers negatively affects ME people	Workforce composition and diversity influence care and impacts

	community, this can affect how they access healthcare and their trust in the healthcare they receive."							trust in HC providers
25	*" Health outcomes for those that are non-white are going be poor, If the decisions made are mainly made by people that are white."*	minority ethnic healthcare needs may not be addressed even if it affects a large group	minority needs no addressed	homogenous decision making without ME representation	homogeneous power	Minority needs may be overlooked without representation	Decision making bias when leadership lacks diversity	representation positively influences healthcare access decisions
26	*"In heavy minority areas where a significant number of people are from say Asian background, the health priorities can be very clear and hard to ignore even if the senior management don't come from the same minority ethnic background"*	senior leaders cannot ignore minority needs that affect a large group	Minority needs hard to ignore in high density ME areas	demographic pressure shapes agenda		Demographic size of ME communities influences health priorities of leaders regardless of ethnicity	Demographic pressures shape agenda	density forces recognition of ME needs and HC disparities
27	*" If we need to have somebody of colour in a room to have that conversation, then we should. We've got a lot of work to do as a society, haven't we?"*	ME leader is important for change	Leaders should be educated broadly	Collective leaders' education about ME HC needs	shared accountability	need to educate all leaders about minority ethnic communities needs without representation	Equity responsibility beyond minority leaders' ethnicity	Societal duty to embed awareness of ME community HE needs in leadership regardless of ethnicity
28	*"But I'm here primarily to be the good doctor and I don't want to be a distraction because I don't want everything to be about my ethnicity"*	duality of being a black senior leader in a white space	duality in white spaces		professional duality	Balancing identity and professionalism	identity negotiation for black leaders	tension for black leaders between personal endeavours and community expectation
29	*"I don't deserve to be in the target sites of everybody just because I happen to do this job now and I'm black."*	duality of being a black senior leader in a white space	feels unfairly targeted for being a black leader	hypervisibility targeting	professional duality	Balancing identity and professionalism	identity negotiation for black leaders	tension for black leaders between personal endeavours and community expectation

30	*"It's about me being a good clinician and a hard worker and a good team person that I can share with everybody"*	duality of being a black senior leader in a white space	Lack of security	Imposter syndrome	professional duality	Balancing identity and professionalism	identity negotiation for black leaders	tension for black leaders between personal endeavours and community expectation
31	*"Representation at the top can help change the culture. But there is a price you pay as that minority individual particularly if you are the minority black person in that space."*	cost of being a black senior leader	cost of representation	*"Representation at the top can help change culture"*	psychological toll	Cost of representation not insignificant for minority ethnic leaders	Psychological toll of being a ME leader	
32	*"I don't want to be portrayed as being someone's priced pig. Let's forget the 30-40 years I've been working hard to reach this senior position."*	black senior leaders' skills and experience undervalued	black leaders' merit overshadowed by their race and ethnicity	merit delegitimised	quota narrative	Perception of skills undervalued for ME leaders	Tokenistic framing undermines merits and career effort of ME leaders	black leaders' competence delegitimised
33	*"So, broadly we need to think about how we design systems that actually culture appropriate."*	cultural inclusive health system	culturally appropriate systems		structural embedding	cultural inclusive systems beneficial for ME communities	System redesign needed to improve health outcomes	culturally appropriate health care design improves outcome for ME community
34	*"There's no doubt that when I was trying to get people to vaccinated, being a black vaccinator was a big deal."*	representation at all levels impacts minority ethnic trust in health system	representation is linked to trust	representation at all levels	distributed visibility	frontline concordance matter to ME community	representation at all points of health care delivery is important to health outcomes of ME community	culturally appropriate health care design improves outcome for ME community
35	*"Black people let me vaccinate them and not necessarily anybody else because we had the conversation. That's just about being the right person."*	representation at all levels impacts minority ethnic trust in health system	representation is linked to trust	representation at all levels	distributed visibility	frontline concordance matter to ME community	representation at all points of health care delivery is important to health outcomes of ME community	culturally appropriate health care design improves outcome for ME community

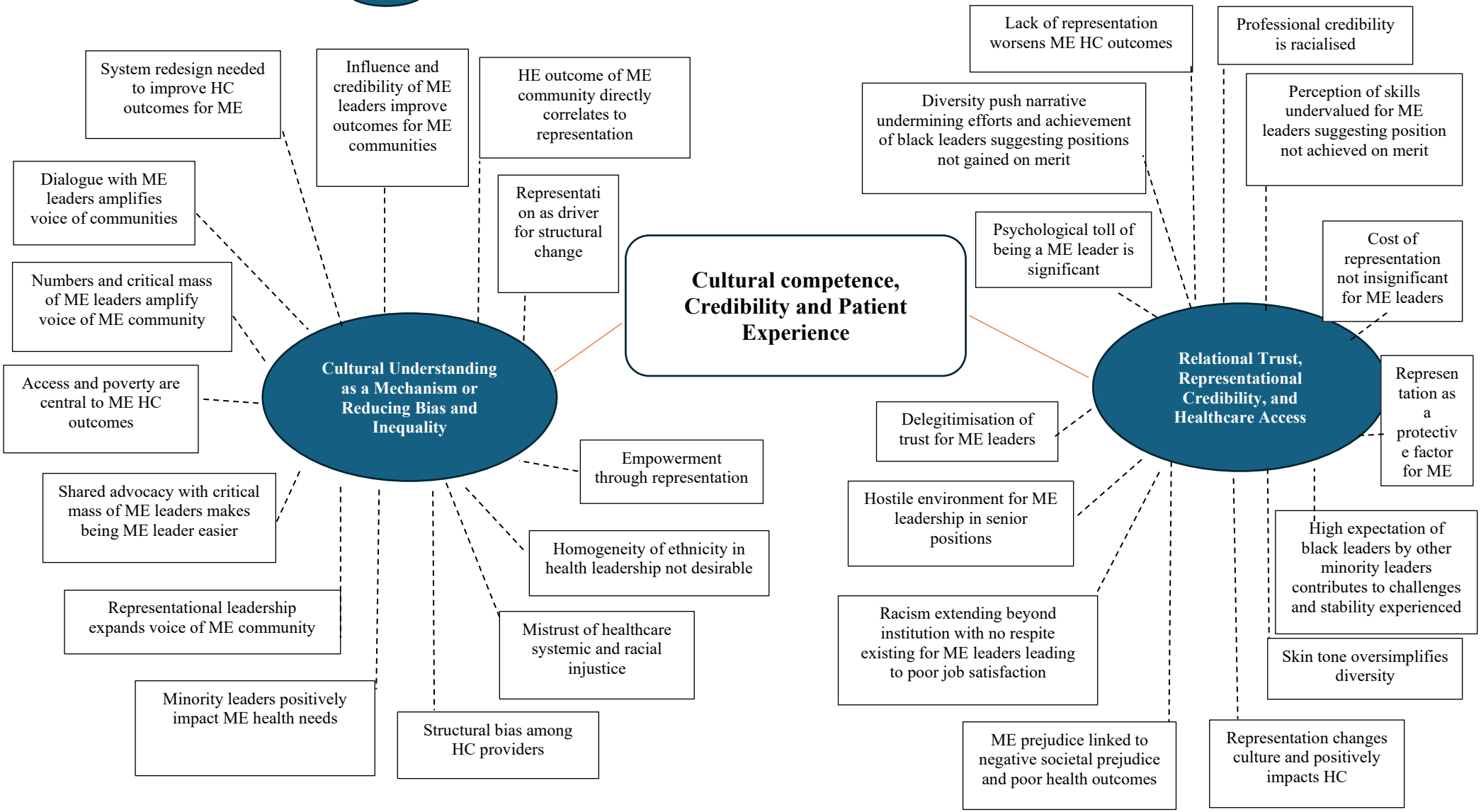
36	*"The worry though is that just having one black person at the top is unlikely to make much difference."*	overall numbers of black leaders matter to improve health outcome		critical mass advantage	collective agency	critical mass of ME leaders reduces burden on them while improving the HE outcomes for their community	Shared advocacy makes being a minority ethnic leader easier	numbers amplify voice of ME community
37	*"I think that representation at the top can help change the culture."*	lack of minority ethnic leaders impact health of their communities	lack of leaders impacts health		cultural influence	culture is shaped by representation	representation helps change culture	leadership shapes norms
38	*"I not sure if minority ethnic people think that other minority staff can better take care of their needs or understand their needs better it depends on the doctor."*	quality of care not dependent on ethnicity of provider	Cultural credibility		individual competence	care quality not dependent on ethnicity of care giver	health carer competence more desirable than ethnicity	rejects automatic concordance benefit
39	*"It helps us address our assumptions, prejudices and biases, you know, yes, human beings, because that's what we've grown up with."*	Lived experience in leadership is important to minority community health outcome	Cultural credibility		experiential authority	advocacy through representation impact care provision for ME people	Lived experience of healthcare providers positively correlates to the quality of care received by ME community	
40	*"we've missed conditions black patients because we didn't have the education. Undoubtedly some stuff is going to be harder to spot in black skin anyway, isn't it just, you know."*	black people should expect errors from healthcare providers due to their skin colour	Diagnostic challenges in dark skin patient from poor medical education	diagnostic errors on dark skin	training deficit	Educational gaps in healthcare training compounds health inequalities for ME community	training deficits and curriculum bias is linked to differential health treatment for ME community	curriculum bias creates risk
41	*"You need people and doctors to advocate for their communities and bring nuance and lived experience because of the credibility of the science behind it"*	doctor as community leader holds more credibility	doctors in leadership make for credible advocate	doctor credibility in advocacy	authority amplification	professional status of doctors enhances advocacy of ME needs	professional status of doctors together with lived experience offers a positive synergistic effect on enhance ME ethnic outcome through advocacy	

42	*"Why on earth would I take someone off Afro Caribbean heritage and think genetically they are somehow related to someone of East African heritage where the difference that separates those continents is enormous "*	lack of nuance within minority ethnic group and associated health concerns	lack of nuance in ethnicity between ME community	Homogenisation of ME	overgeneralisation	Simplistic attributions of disease by ME groups should be avoided	overgeneralisation of disease burden of ME community	
43	*"And yet I somehow are happy to lump together these communities, based upon a shade of skin tone, which of course is wrong."*	lack of nuance within minority ethnic group and associated health concerns	lack of nuance in ethnicity between ME community	*"Lump together communities"*	overgeneralisation	Simplistic attributions of disease by ME groups should be avoided	overgeneralisation of disease burden of ME community	skin tone oversimplifies diversity
44	*" I think a lot of the differences have nothing to do with the colour of someone's skin, but a very strongly different driven by Health deprivation - access to healthcare."*	factors influencing health disparities other than ethnicity	access inequality	*"Nothing to do with colour"*	access inequality	deprivation drives HE disparities	access and poverty are central to ME health outcomes	deprivation central mechanism
45	*"We need to have more representation. You got to be in the room where it happens."*	lack of representation causing adverse health outcomes for minority ethnic patients	underrepresentation of ME leaders in COVID worsened outcome	*"Be in the room"*	advocacy absence	Devastating consequences for ME community of lack of ME leadership	lack of representation worsens ME health outcomes	representation as protective factor
46	*"So, they treat them differently."*	poor care due to lack of lived experience	poor care of ME community from lack of lived experience from leaders		experiential gap	differential treatment of ME compared to majority group		distance fosters bias
47	*"Or actually, no, there is this thing to consider about us"*	local and cultural knowledge can have positive health outcomes for minority communities	bespoke provision for ME community	*"There is this thing to consider about us"*	contextual insight	contextual insight through lived experience is important in leadership representation for nuanced MC HC provision	Insider knowledge can help shape policy fit for ME for better HC outcomes	
48	*"Someone who sees diversity as an asset, not a deficit I*	What makes a good leader	understanding variation in ME needs	*"Diversity as an asset"*	intersectional competence	Leaders who embody diversity as an asset	leadership requires nuance	cultural humility central

	think often people who have lived experience may be more attuned to that, but they're not unique in that."					and understands the nuance between ME community and effect on HC needs		
49	*"I don't think that having a minority ethnic leaders will guarantee equity."*	Minority ethnic leaders do not guarantee equity	anti-tokenism	*"Equity not guaranteed"*	anti-tokenism	symbolic vs structural change in ME leadership determine the quality of change	structural change required	
50	*"I think it's not just children. I think just generally for the black community."*	Differential treatment applies to black people in general	differential treatment exists in medical practice	systemic bias in pain management affects black people disproportionately	systemic bias	Patterned racialised mismanagement disproportionately affecting black community	patterned racialised mismanagement	

Example of a thematic map – RQ3 (Theme 8)

KEY: Theme ▭ **Subtheme** ⬭ **Link to sub-theme**- - - **Link to theme** ——



9.2 Appendix II

9.2.1 Participant Information Sheet

Primary Investigator: Dr Ann Childs
Ann.childs@education.ox.ac.uk

Department of Education
University of Oxford
15 Norham Gardens
Oxford
OX2 6PY
United Kingdom

Researcher: Ben Balogun-Ojuri, DPhil student
ben.balogun-ojuri@wolfson.ox.ac.uk

Differential Attainment of Black British Doctors within the minority ethnic representation of senior leadership in the NHS: Individual Perceptions and Implications at Micro Level.

PARTICIPANT INFORMATION SHEET

Central University Research Ethics Committee Approval Reference: **EDUC_C1A_24_145**

1. **Introductory paragraph**

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

2. **Why is this research being conducted?**

This research is being conducted by myself (Ben Balogun-Ojuri) and supervised by Dr Ann Childs. I am conducting this research as part of my DPhil in Education from the University of Oxford. This project will investigate the Differential attainment of black doctors within the BAME representation at senior management within the NHS.

I am seeking to understand, from the perspective of those already in these positions, the drivers for attainment as well as ideas about the disparities which exist within the BAME group.

I am only interested in your opinion on these issues and there is no need for you to research anything before our discussion.

3. **Why have I been invited to take part?**

You have been invited to participate in this research as you someone who has attained this position within the NHS structure. You have unique knowledge and experience that may be useful with

regards to the research questions, and I would very much like to know more about. I am recruiting around 25 participants for this project.

4. Do I have to take part?

No. It is up to you to decide whether or not to take part. You can withdraw yourself from the study, without giving a reason and without any negative consequences, by advising me of this decision. The deadline by which you can withdraw any information you have contributed to the research is 1st April 2025. If you decide to withdraw, any data which has already been collected will be permanently deleted.

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

This section explains what will be involved in participating in this research in the order you will experience it:

- As the primary researcher, I (Ben Balogun-Ojuri) will contact you to schedule an online (via Microsoft Teams) interview.
- You will be provided with a consent form prior to the interview, and you will be asked to sign the consent form prior to the interview which indicates that you have read and understood this information sheet. You may contact me at any time prior to the interview to ask questions or discuss the project further.
- At the start of our interview, I will verbally review the key points of the consent form which you have signed, and offer another opportunity for you to ask questions.
- You will be interviewed once, and the interview will last between 45 and 60 minutes. Generally, I will be asking questions about your experience in your role. The questions I will ask are firstly a general one about your journey and experience to attaining your senior management position in the NHS and then these four others around four key areas, with a focus on your area of expertise:

1. What is your experience regarding differential attainment of White doctors compared to the minority ethnic doctors, at senior management level in the NHS?

2. What is your perception about the differential attainment of black doctors at senior management level in the NHS, compared to Asian doctors?

3. What are your concerns about these disparities with regards to your community and potential health outcomes?

The interview can remain unstructured and somewhat casual, and the conversation can move to reflect your experiences and opinions.

- With your consent, I would like to audio record the interview to provide accurate record of our conversation, and so I can distil important direct quotations when the research is being written up.
- You may ask to pause or stop the interview at any time, without having to give a reason.

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

If you take part in this study, it may provide an opportunity for reflection on your journey and experience, as well as how a story that can help shape the experiences and futures of those to come after you. It may also help contribute to widen participation, equality and diversity agenda in their various NHS organisations. The research will be conducted semi-anonymously. We will record your audio during the interview and this will be discarded after transcription. We will also endeavour to remove any identifiers, comments or contributions that could reveal you or your place of work.

7. Expenses and payments

There will be no payment for taking part in this study.

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

Consent forms and contact details will be collected via Microsoft Word documents emailed from my University of Oxford's student Microsoft email account. Downloaded copies will be stored on Nexus 365 OneDrive for Business, again provided via the University of Oxford. Local and physical copies will not be kept for increased security.

Online interviews will be conducted using Microsoft Teams, provided via the University of Oxford's student Microsoft account. Audio recordings of the online meetings will be collected and uploaded to Nexus 365 OneDrive for Business the day they are recorded via my personal phone/laptop, with local copies being deleted after upload.

Transcripts of audio recordings will be completed on my personal laptop and will only be saved on Nexus 365 OneDrive for Business.

I (Ben Balogun-Ojuri) and my supervisor (Dr Ann Childs) will have access to the research data.

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. Participants will not be directly identifiable from the outputs.

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

A copy of my thesis/ dissertation will be deposited both in print and online in the Oxford University Research Archive where its access will be restricted. There is a possibility that I will share my research through a journal publication, a conference presentation, a report or on a website.

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 study. 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 at https://compliance.admin.ox.ac.uk/individual-rights.

11. Who has reviewed this study?

This study has received ethics approval from a subcommittee of the University of Oxford Central University Research Ethics Committee. (Ethics reference: **EDUC_C1A_24_145**

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

If you have a concern about any aspect of this study, please contact me (Ben Balogun-Ojuri – ben.balogun-ojuri@wolfson.ox.ac.uk) or my supervisor (Dr Ann Childs – ann.childs@education.ox.ac.uk), and we will do our best to answer your query. We will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with.

If you remain unhappy 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.

13. Further Information and Contact Details

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

Ben Balogun-Ojuri
ben.balogun-ojuri@wolfson.ox.ac.uk

Department of Education, University of Oxford
15 Norham Gardens
Oxford
OX2 6PY
United Kingdom

9.2.2 Ethics Approval – CUREC

SOCIAL SCIENCES & HUMANITIES
INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
DEPARTMENTAL RESEARCH ETHICS COMMITTEE

Department of Education
15 Norham Gardens, Oxford OX2 6PY
student.curec@education.ox.ac.uk; staff.curec@education.ox.ac.uk

Ben Balogun-Ojuri
Department of Education, Social Sciences Division
University of Oxford

8 May 2024

Dear Ben,

Research ethics approval

Research title: Differential Attainment of Black British Doctors within the BAME representation of Very Senior Management (VSM) in the NHS: Individual perceptions and implications at micro level.

Research ethics reference: EDUC_C1A_24_145

The above application has been considered on behalf of the Education Departmental Research Ethics Committee (DREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to confirm that, on the basis of the information provided to the DREC, ethics approval has now been granted for this study.

Please note the following:

Personal data: It is the responsibility of the PI to ensure that all personal data collected during the project is managed in accordance with the University's guidance and legal requirements.

In-person activities: Any data collection involving in-person interactions with participants must have an up-to-date fieldwork risk assessment in place; further guidance is available from the Safety Office's website.

Amendments: Please notify the committee if you intend to make any amendments to the information in your ethics application as submitted at date of this approval, as all changes must receive ethical approval prior to implementation. The amendment form is available on the SSH IDREC webpage.

We welcome feedback on your experience of the ethical review process and suggestions for improvement. Please email any comments to staff.curec@education.ox.ac.uk / student.curec@education.ox.ac.uk or ethics@socsci.ox.ac.uk.

Yours sincerely

S. Cadwallader

Dr Stuart Cadwallader, DREC Member

9.2.3 Consent form

Primary Investigator: Dr Ann Childs
Ann.childs@education.ox.ac.uk

Department of Education
Univeristy of Oxford
15 Norham Gardens
Oxford
OX2 6PY
United Kingdom

Researcher: Ben Balogun-Ojuri, DPhil student
ben.balogun-ojuri@wolfson.ox.ac.uk

Consent to take part in:

"Differential Attainment of Black British Doctors within the minority ethnic representation of senior leadership in the NHS: Individual Perceptions and Implications at Micro Level."

Central University Research Ethics Committee (CUREC) approval reference: **EDUC_C1A_24_145**

Purpose of Study: This study will interview doctors who have attained senior leadership positions within the NHS, exploring their attainment journey and experiences so far, but also their perceptions on representation at this level.

	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 September 1st, 2025, 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 project.	☐

I understand that I will not be directly identifiable from any publications or other research outputs here, including presentations.	☐
I consent to being audio recorded.	☐
Use of quotations: Please indicate your preference (select *one* option): a) I do not wish to be quoted directly but accept being quoted if I am not directly identifiable. **or** b) I agree to the use of quotations in research outputs	☐
I give permission for you to contact me again to clarify information.	☐
I understand how to raise a concern or make a complaint.	☐
I agree to take part.	☐

_____	dd / mm / yyyy	_____
Name of participant	Date	Signature
_____	dd / mm / yyyy	_____
Name of person taking consent	Date[1]	Signature

[1] *To be signed and dated in the presence of the participant. Once this has been signed by both parties the participant should receive a copy of the signed and dated participant consent form. The original signed and dated consent form should be kept with the project's main documents, which must be kept in a secure location.

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