Racism and Discrimination – the experience of primary care professionals in the Humberside region

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1. Executive Summary

Humberside LMC carried out a racism survey across primary care colleagues in the region in December 2020. This report sets out the findings of the survey in the context of a wider national picture. It provides evidence of the impact of racism in primary care, as experienced locally. The report outlines next steps for this project to ensure primary care in the Humberside region is anti-racist and supports racial equity for our colleagues and patients.

You are cautioned that offensive racist language from the survey is reproduced in this report.

The authors of this report have worked in partnership with colleagues from diverse backgrounds, and sought to reach a consensus view on acceptable terminology for the groups of people represented in this report. Collectively, we agreed to use the terminology "people who experience racism" above the multiple other phrases in common use. We recognise that this may not encompass the experience of everyone reading or responding to this report, but hope it will be considered as an acceptable approach. Other terminology may be used when primary sources have been directly quoted.

Thanks go to:

Dr Aigbokhai Ohiwerei and Dr Abu Mohammed.
Dr Bushra Ali, Dr Hisham Nobeebaccus and Dr Yasmin Zaidy.
Dr Margaret Ikpoh.
Jonathan Appleton and Simon Barrett.

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2. Introduction

In June 2020, Humberside LMC made a successful bid to launch a Wellbeing work stream aimed initially at GPs, funded by money from the General Practice Forward View (GPFV) and Integrated Care System resilience funds. This initially supported the establishment of a local mentoring service for GPs, but when a bid for further funding was successful, it allowed a broadening of the scope of the Wellbeing and Resilience work streams.

When I took up the role of Wellbeing Lead at Humberside LMC, it was in addition to the role of Medical Director. I wrote and designed our Wellbeing Strategy, and while it covered all aspects of those things that may affect the overall wellbeing of a colleague working in primary care, I'm embarrassed to say racism was not defined as a specific work stream in the beginning.

2.1 Background

The Humberside LMC Wellbeing Strategy focuses on addressing the six risk domains of burnout: workload, reward, values, control, community and fairness. (Maslach). While devising a strategy that addressed all 6 domains for primary care colleagues in our region, the LMC was contacted by Dr Aigbokhai Ohiwerei and Dr Abu Mohammed, two Black British GPs working in the south of England. Dr Ohiwerei is a GP in Fareham and a Wessex faculty board member. He has an MSc in Leadership in Health and Wellbeing and recently co-authored an Anti-Racism policy for his Primary Care network. Dr Mohammed (@Dr_Abu_M) is a GP in Hampshire and a Wessex Faculty board

member. He holds MRCGP and DRCOG qualifications and recently recorded three webinars on tackling racism in partnership with the RCGP. In May 2020, they contacted LMC chairs across England reflecting on the issue of racism in general practice and suggesting an action plan relevant to LMCs.

Humberside LMC shared their letter with our board of directors, secretariat and committee. There was unanimous support for the development of an anti-racism programme delivered with support from the LMC, and with its strong overlap to wellbeing it was added to the strategy as a parallel work stream.

Members of the LMC committee were asked to join a dedicated task and finish group to support delivery of the project, with the aim of a broader network for people who experience racism and white allies being developed. Our first step was to survey all colleagues working in primary care across Hull, the East Riding, North and North East Lincolnshire. This report summarises the findings of that survey, in the context of a broader national acknowledgement of racism in healthcare in the UK. It outlines next steps for this project to ensure primary care in the Humberside region is anti-racist and supports racial equity for our colleagues and patients.

2.2 The Wider Picture

The Equality and Human Rights commission produced the largest review into race equality in Britain in 2016, with key recommendations for the government about population wide interventions required to begin to address these gaps. These findings affect our patients and our colleagues, with those who experience racism in the UK likely to face challenges in education and employment.

The NHS is the single biggest employer in the UK, and the fifth biggest in the world. The Humberside region contains 117 GP practices, as well as allied services such as urgent care, out of hours and CCGs. The majority of these staff are not clinical – there are 3 times more admin staff than GPs, and 5 times more than nurses.

While it is easy to therefore think of challenges with racism and discrimination from a clinicians point of view, and certainly as an LMC this is usually our focus, the whole of the primary care team needs to be included. With the planned changes to commissioning structures at national and regional level, and the removal of CCGs, maintaining momentum and applicable local measures to tackle racism may be additionally challenging.

While racism in the NHS has always existed, 2020 brought a more public acknowledgement of its existence and the desire to address it. The NHS Workforce Race Equality Standard (WRES) was established in 2015 to tackle workplace inequalities. While its finding can be a useful indicator of the wider system, like the NHS Staff survey, it is only completed by hospital trusts and not primary care. The RCGP estimates that GPs carry out 90% of patient contacts in the health service; as a community based speciality this presents its own distinct set of challenges in respect to racism. The NHS Race and Health Observatory was therefore launched in 2020 to "*identify and tackle the specific health challenges facing people from BAME backgrounds*" although it has yet to report.

As the Covid-19 pandemic has progressed, its *"disproportionate mortality and morbidity amongst black, Asian and minority ethnic (BAME) people"* became quickly apparent. For those working in the NHS, the number of deaths and serious illness highlighted inequalities facing not just patients but frontline staff from ethnic minority backgrounds. The PHE report on disparities and outcomes of Covid-19 makes for a sobering read:

"An analysis of survival among confirmed COVID-19 cases and using more detailed ethnic groups, shows that after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British."

The Health Foundation called the examples of health inequality people who experience racism face in the UK as "many and shameful" while the Kings Fund report on Workforce race inequalities and inclusion in NHS providers warns "*We cannot continue to damage the lives of ethnic minority people in the workplace, we must act now and stay on the long road to lasting change*."

The BMJ published a special edition on racism and medicine, covering broad topics from medical school admission and the role of migrant doctors in supporting the NHS, to the impact on patients with neglect of older patients from ethnic minorities in research and the disparity between care during pregnancy and delivery experienced by black women, who are five times more likely to die from pregnancy complications than white women. The BMJ publishing group has removed all paywalls to their journal content on these issues and many more around equality and racism.

The GMC has published findings into its own referrals after a continuing difference between the referrals and outcomes for international medical graduates and those from a black and minority ethnic background. Bourne et al published on the increased risk of serious mental illness and suicide that occurs in those undergoing GMC investigation.

The Royal College of Nursing articulated the concerns of the nursing profession, with the Nursing Standard highlighting the challenges of working as a Black British nurse in the NHS.

Receptionists, administrators and managers in primary care are often on the front line in dealing with the impact of race and discrimination. The role of reception staff is widely acknowledged as key but how well equipped they are for this role is undetermined. UNISON continues to campaign on fairness and equality and, as the largest trade union for those working in the NHS, has specific groups aimed at addressing challenges for those with protected characteristics of all types.

Following widely reported examples, in 2019 the Secretary of State for Health and Social Care, Matt Hancock, shared a letter condemning racist abuse and advocating a "zero tolerance approach" - see Appendix B.

"No one is entitled to choose the colour of the skin of the person giving that healthcare."

Matt Hancock, Secretary of State for Health and Social Care,
5th November 2019

3. Survey response summary

Against a background of long standing racism and discrimination in the NHS, Humberside LMC with the support of Hull, East Riding, North Lincolnshire & North East Lincolnshire CCGs, shared a detailed survey with all primary care colleagues in the region.

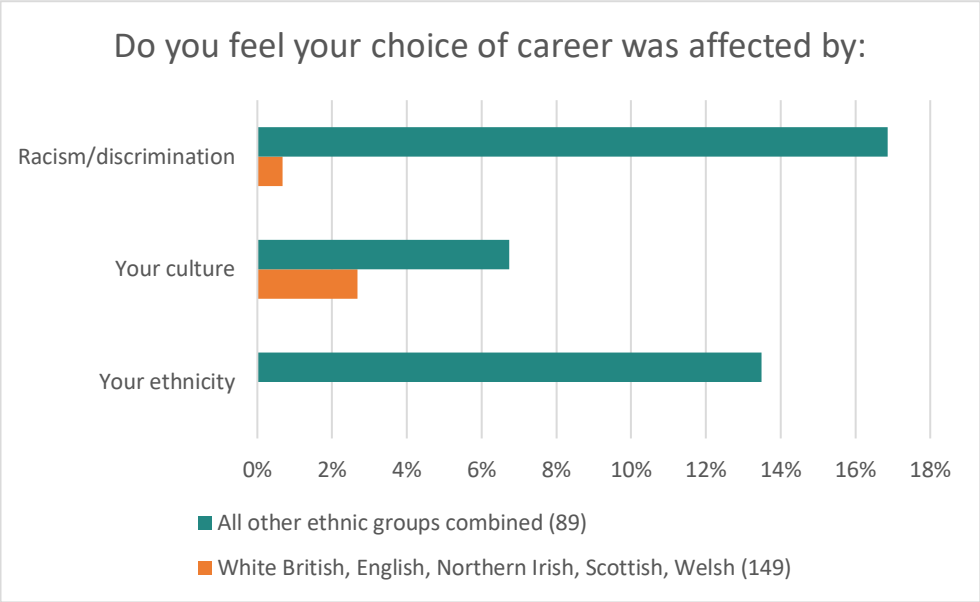
The survey was launched on 17th December 2020, with accompanying emails and newsletter content. It was discussed at LMC committee meetings both before and after it was live, and colleagues were encouraged to share it with all staff in primary care. 238 responses were received, which is higher than any previous survey conducted by the LMC.

An analysis of each section of the survey has taken place and we summarise here our findings.

3.1 Impact on career

This section asked respondents how their choice of career, ability to train, successful job applications, choice of working pattern and access to education or ongoing professional development has been impacted by their ethnicity or race.

5-7% of respondents overall felt their ethnicity, culture or race was a factor in their choice of career. The breakdown of this response is shown below.



In some cases this related to overt racism

> *"I felt I had to leave my primary choice of speciality training as I was told by the Dean for post graduate training then 'we do not want people who are not from around here'"*

and in others a systemic perception of an unequal playing field for people of colour

"Unable to get into hospital specialities….competitive specialities very difficult to get into…training posts would not have been available to someone of my ethnicity…discouraged by consultants from applying to certain specialities"

The overall perception of colleagues from ethnic minority backgrounds was felt to be negative:

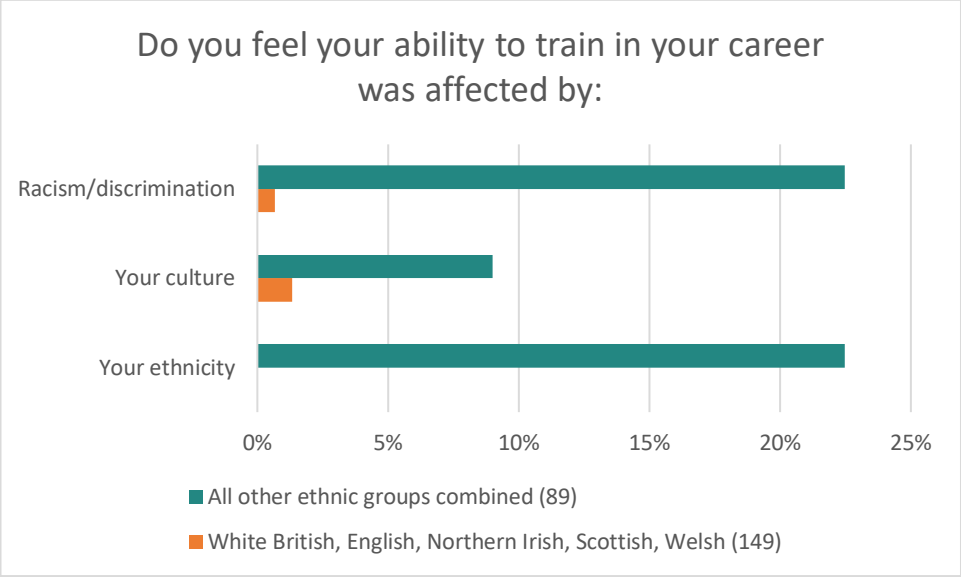
"Constantly made to feel like I had to work twice as hard as my non-BAME colleagues in hospital jobs and to prove that I do not fit the stereotype of BAME doctors (not a 'problem trainee' or an underachiever or a 'problem IMG')"

"Felt unduly pressured rather than supported…as though more was expected of me due to my background"

Others discussed more personal factors such as religious faith predisposing them to a caring career, family culture of valuing education or a personal desire to achieve.

3.2 Training, education and development

A higher number of colleagues felt that their ability to train in their chosen career had been affected by their ethnicity (9%), culture (5%) and racism or discrimination (10%). The figures are further broken down, below.



Some cited other barriers such as gender and socioeconomic status that limited their access to further training due to financial pressures. Different training routes led to discrimination in some cases, either because of undertaking training outside the UK or taking a different path to training. Experiences of discrimination varied within the UK itself:

"While I was in another part of the UK, I unfortunately did fell discriminated against. In England I have felt quite the opposite, I feel people have recognised me for who I am as a person and not a person from a particular background"

There were no examples of diversity being seen as a positive during training or in terms of career:

> *"Comments were made throughout my career that I was an inferior doctor…rather than seeing the positives- awareness of different cultures, languages and attitudes. My background was seen as a negative"*

> *"I would not get through an interview if competing against a White British person even if less qualified. The competition for an interview was only between similar doctors from non-white backgrounds"*

Specific issues with limitations in training opportunity due to patients' refusal to see a non-white doctor was highlighted:

> *"Patients often requested to be seen by a white doctor or a GP - these, therefore, limits the scope of my exposure as a trainee doctor"*

> *"patients often express preferences to be seen by a white Dr, which is usually honoured by the admin staff to my surprise. This restricted my opportunities to fulfil my educational needs - as I was only exposed to patients that didn't mind seeing a black doctor"*

The theme of patients selecting their carers based on their racial prejudices and preferences is one which continues throughout this survey. Training sessions sometimes served to perpetuate the myth that those who experience racism are less able to communicate with patients:

> *"During a…teaching session..a white GP trainer specifically picked on only brown trainees to do practice consultations in front of everyone. She kept on saying, 'you have to get better otherwise you will create more work for your GP colleagues'"*

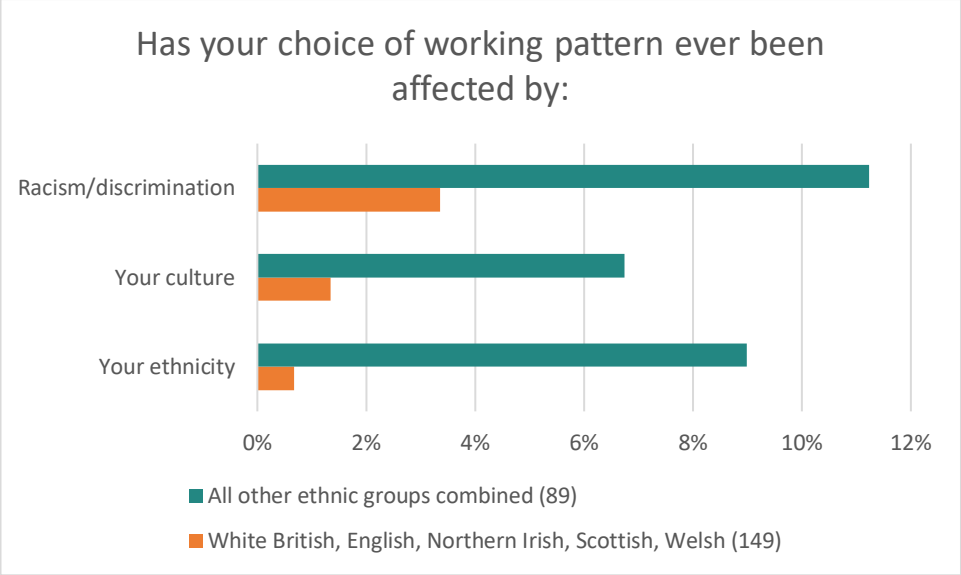
Access to education or professional development had been affected by ethnicity and racism in 5% of responses. There was felt to be a need for more support in understanding how training programmes and recruitment work, and looking at timing of events with evenings proving challenging for some colleagues. Those who needed to apply for study leave sometimes felt this was unfairly allocated.

> *"it seemed that people of some ethnicity never had any issue getting courses/leave sanctioned"*

These responses indicate that racism affects training and early career progression for those from ethnic minority backgrounds, having an impact prior to beginning work in primary care locally.

3.3 Working Patterns

7% of respondents felt that racism and discrimination had impacted on their choice of working pattern. This manifested itself in a variety of ways, particularly being expected to work around their counterparts. The breakdown of the 7% is shown below.



"Expectation that because other female GPs were happy to work in a certain way, that I would be too"

"..single and childless so unsociable hours and school holidays always seem to fall to me"

"expectation to cover Xmas (despite being from a Christian background) but assumption of being part Indian means you don't celebrate Christmas"

Colleagues who experienced racism felt they were put down for, or asked more often to work unsocial hours compared to other colleagues.

"assumption that people from minority backgrounds don't have a social life, hence should be offered more unsocial hours..."

"'they love the extra pay'... is the usual pun"

"Trainees that were non ethnic being given the benefit of the doubt whilst ethnic ones (were) not"

Social support outside work was also impacted by generalisations and a lack of consideration for people's religious or personal beliefs including *"socialising being based around alcohol".*

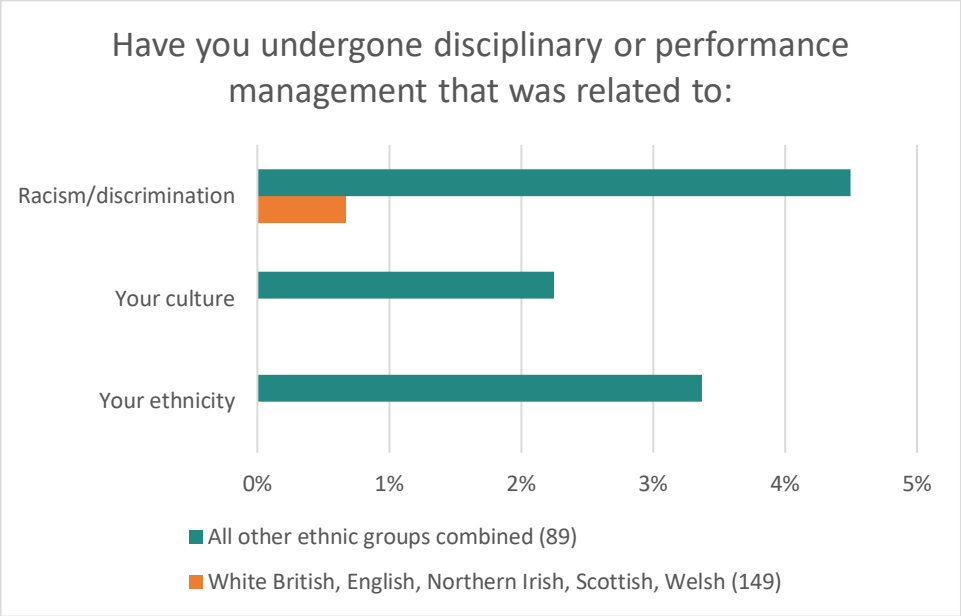
3.4 Racially motivated complaints

This survey asked about the experience of complaints from all respondents, and whether complaints from patients or colleagues were specifically related to race or ethnicity. Many examples were provided, in some, overt racism was shown and in others the colleague involved felt this was a motivating factor within the complaint.

21% of colleagues had encountered complaints from patients that were directly related to their ethnicity, culture and racism or discrimination. 16% had encountered similar complaints from colleagues.

It was impossible to separate examples where patients were making a complaint where racism was a factor, and when there was no complaint other than the colleague being from a different ethnic background. For this reason, we have considered any expression of dissatisfaction from a patient that included reference to the colleague's ethnicity as racism. All examples for which we have consent to share are listed in full in the appendix. The themes throughout are strikingly similar across all groups of respondents.

This provides local context to the national referral figures produced by the GMC and referenced in section 2.2. When patients complain more about colleagues who experience racism, these individuals are then disproportionately represented at further stages of complaints and performance procedures. Just under 3% of respondents had undergone a disciplinary or performance management process that they felt was related to their ethnicity, culture or due to racism and discrimination.



Complaints sometimes referred to perceived aggression on the part of the person of colour. A lack of understanding about how different cultures communicate seemed to play a part:

> *"I was accused of raised tone when it was my normal way of speaking , hand gesticulation is seen as aggressive; plenty about my attitude and outspokenness to think it is me not my culture"*

A theme where people of colour would be singled out even when there was shared responsibility in a complaint was articulated by a number of respondents:

> *"When a patient complained regarding a clinical issue affecting her, I was the only GP referenced although a British-born GP was also involved in her care"*

"I've received complaints from patients as the only black doctor involved in their care despite them seeing several other people before and after me. Patients usually got a lower threshold to complain when the doctors is not Caucasian"

"We end up answering loads of frivolous complaints from patient(s)…"

"Patients did not look at ease speaking with me. They prefer to speak to white receptionist though I speak perfect English"

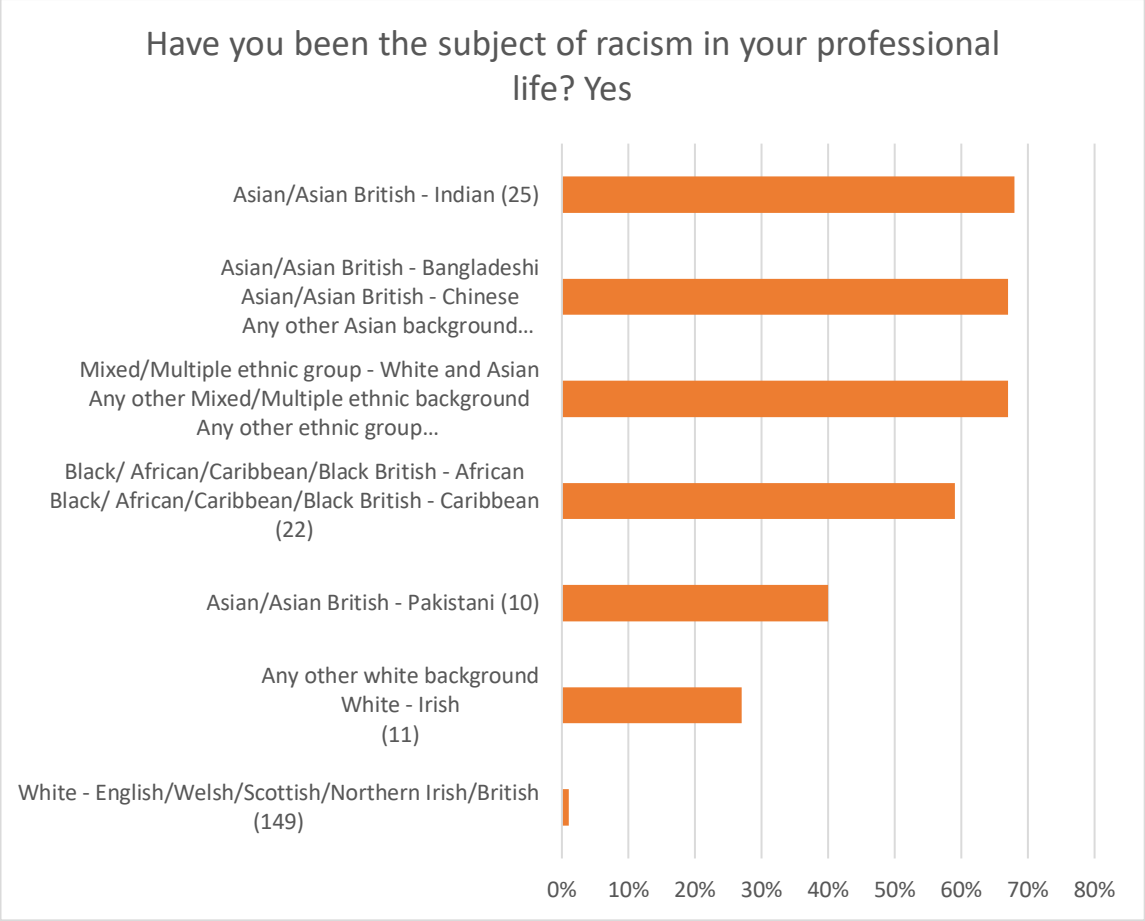
"Patient is always right seem to be the ethos of CQC and CCG in this country. It is sad, how unproductive this has made primary care services, instead of spending time developing skills and knowledge… I end up writing responses to patients and then…reflection for NHS England."

"Systemic racism means that mistakes by ethnic doctors are likely lead to complaints. I've seen non ethnic doctors make similar mistakes without any patient complaints"

3.5 Experiences of Racism

You are cautioned that offensive racist language from the survey is reproduced in this report.

As well as asking about complaints related to race, we asked about racism that had been experienced or witnessed in a work setting. 23% of respondents had been the subject of racism in their professional life. Of this, colleagues from Asian, Mixed and Black backgrounds were most likely to have experienced this as shown below.



One respondent raised the concept that racism takes different forms, challenging our perception that racism is always overt; continual micro aggressions and the resulting disadvantage that these create was evident in the vast majority of the survey responses:

> *"In England racism is very subtle. Snide remarks, the odd joke etc. Workplace bullying and complaints against someone who is coloured due to trivial matters are common"*

> *"A relative asked me how I felt about a certain extremist group out of the blue during a palliative care consultation"*

> *"Casual racism by elderly patients, e.g. "Do you like it here in the UK? If you had said no, I'd have kicked you out of the house"*

We received a large number of examples of patients refusing to receive care from staff members who were non-white or had surnames considered linked to another ethnicity. Patients either complained about communication and inability to understand, or fundamentally objected to the idea of a non-white member of staff.

British-born ethnic colleagues for whom English is their first language were not exempt from this discrimination. Racist comments made by patients in their presence were commonly followed by:

> *"but of course we don't mean you!"*

Racism towards white colleagues from other countries or cultures was reported, with broad generalisations made and a perception from both victim and perpetrator that this wasn't racism as it didn't involve a person with a different skin colour.

> *"Does your dad look like Stalin?", "Are you a communist?", "Oh your country is run by the mafia right? Do they attack people?"…plenty of jabs about being a catalogue bride or asking "Why not marry someone from your own country?" when I mention that my other half is British"*

> *"I think that people forget that being "white" doesn't protect you from discrimination. When talking about these things I've been told "But you're white, you're fine." and think that some comments are more acceptable if you're European"*

3.6 Micro aggressions

Micro aggressions are defined by the Oxford Lexico as

"A statement, action, or incident regarded as an instance of indirect, subtle, or unintentional discrimination against members of a marginalized group such as a racial or ethnic minority."

Psychologist Derald W. Sue has a more encompassing definition:

"…more than just insults, insensitive comments, or generalized poor behaviour. They are the kinds of remarks, questions, or actions that are painful because they have to do with a person's

membership in a group that's discriminated against or subject to stereotypes. They happen casually, frequently, and often without any harm intended, in everyday life."

While racially aggravated abuse or harassment is experienced by colleagues locally, micro aggressions make up a significant and more frequent part of their experience of racism.

> *"Where are you from Dr? Oh but you don't sound like someone from Nigeria; I must say, I am very impressed by your thorough assessment and your Queen's English"*

One colleague elaborated about patient comments:

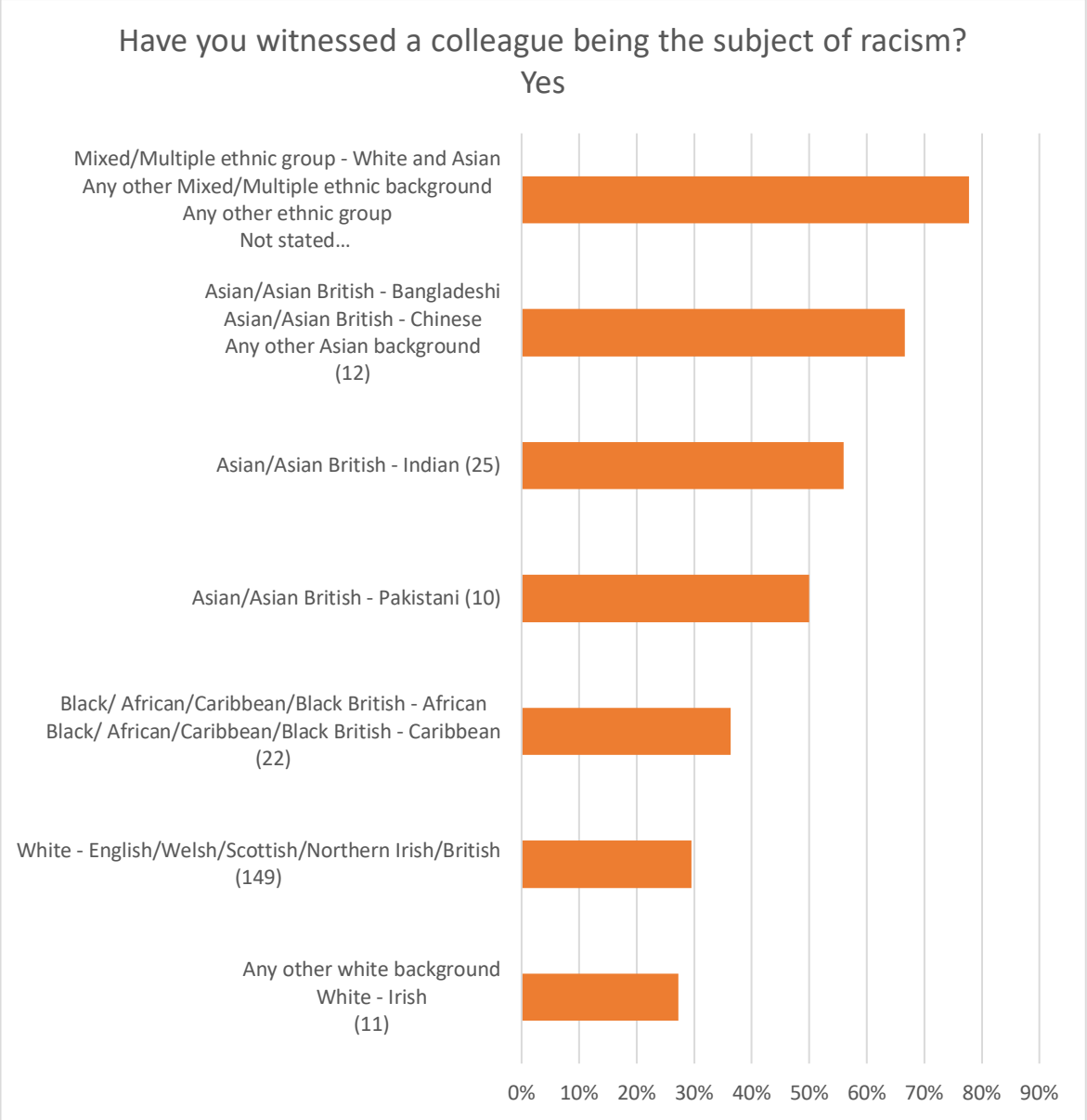
> *"saying they are surprised how good my English is … statements like this may have been intended as a compliment, but no thanks - it is perceived (as) condescending by anyone of an ethnic minority - as though we are expected to be substandard"*

3.7 Defensive othering

The concept that racism is not exclusively perpetrated by white people and can be caused by those of any ethnicity, may be an unfamiliar concept. This is termed defensive othering and is described particularly to highlight that racism is equally damaging regardless of the ethnicity of the perpetrator. Examples were given of racism from within the same ethnicity, and across ethnicities where the presence or absence of an accent when speaking, of international rather than UK training, and of religious prejudice all played a role. This affected interactions with patients from different backgrounds as well as colleagues. Those who reported it felt it was a distinct entity from other forms of racism.

> *"my trainer asked if I had something against that (ethnic minority) patient's culture because I am a Muslim"*

Unsurprisingly, when respondents were asked if they had ever witnessed a colleague being the subject of racism, 40% said yes. When broken down by ethnic group, colleagues from all types of white backgrounds were least likely to report they had seen this behaviour. There are several possible explanations for this including the majority of primary care colleagues in the region coming from white backgrounds, failure to recognise racist behaviour as such or a genuine lack of racism being witnessed.



3.8 Racism between colleagues

This took several forms, with frequent generalisations based on ethnic background, as well specific racist incidents. A lack of support for people who experience racism to ensure fair access to training and fair distribution of workload was articulated.

> *"One very senior colleague commented – 'You lot should not be entitled to receive maternity pay' referring to the fact that I moved to UK from India"*

> *"Colleague made racist comments about how they felt my culture had an adverse effect on my lifestyle"*

> *"I have had instances where colleagues assumed that I don't understand English, or have been standoffish because they think it's difficult to talk to somebody foreign. A friend at an*

old job once let it slip that 'They don't know how to talk to you because they think you won't be able to understand'. It was more of a problem when I was younger and my accent was thicker. Some people have also exaggerated about not being able to understand if I mispronounced a word, or said something wrong, or berated me if I used a phrase that was 'American'"

"During my training some people I worked with would make derogatory comments about 'Muslims, Foreigners, Immigrants'"

> *"A white GP colleague said that 'our Indian brethren are all the same', implying laziness and incompetence"*

"There was a doctor who used to wear a Bindi (vermilllion powder) on her forehead. A sign of a devout Hindu. The secretaries used to call her 'Smudge'"

"Colleagues who have an accent or 'funny name'. Usually it's 'I can't understand them' although they speak better and clearer English than me"

"You Asians are terrible at ...."

Some examples included personal observations as well as religious discrimination

"My husband and children are of mixed race and religion so colleagues sometimes bring this up"

"Being told by a consultant that I should take part in (a) termination and that we are all working together. She assumed because of my ethnicity that I would object when in fact I was dealing with the women and actively taking part in the process"

"My colleague reported that one consultant said to her 'thank god she was white and assisting him in theatre and not one of the foreigners'"

Even when colleagues reported they were now working in a positive and supportive environment, the impact on their professional confidence long term appeared to be significant:

"Colleague undermining my authority and also diminishing confidence of my patient in my ability"

3.9 Discrimination against patients

While this survey focuses on the experience of staff in primary care in the Humberside region, we also wanted to explore the extent to which patients were being impacted by racism. While this is challenging to quantify, when asked the question "*Have you witnessed a patient being the subject of racism?*" 17% of respondents said they had. Those respondents from all types of white backgrounds were less likely to report witnessing racism against patients. The examples given included both clinicians and support staff working in primary care:

> *"Multiple times I have seen patients stereotyped and pigeon holed. I have seen accents being mocked, cultures being disrespected and micro aggressions on show through my training and career."*

Patients who did not speak English, or required the support of an interpreter were reported as encountering particular challenges.

> *"white British experienced GP consulting with a black woman with a subpar command of English. He barely listened to her - wrote her a prescription and handed it to her right after her presenting complaint…perhaps he felt it would be too much hassle making any further enquiries given the language barrier…"*

> *"patient with English as a second language was given care not up to standard as they could not communicate effectively"*

> *"patients have been denied access to interpretation services because the medical staff couldn't be bothered"*

> *"a comment from a receptionist saying something along the lines of 'it would be easier if s/he could speak English properly, and if I could pronounce his/her name' - in relation to a patient of Polish origin"*

> *"Receptionists treating patients differently if they do not speak English as a first language, sometimes shouting questions - these patients are not deaf, they require you to speak slower!"*

> *"One patient from an ethnic minority complained about a doctor, the way was this concluded showed an element of racism" (against the patient)*

> *"regularly see hostility towards non-English speakers from reception staff and from some nursing/ other healthcare staff"*

The impact this has on clinical care is challenging to quantify, although particular examples regarding pain and religious stereotyping were given:

> *"Eye rolling and judgmental assumptions made by colleagues. Not trusting assessment of pain level and ability to work due to ethnic background."*

> *"I have also experienced [Health Care Assistants] and [Midwives] be less empathetic towards a black woman requesting pain relief"*

> *"In hospital medicine the use of the term 'Mrs Begum' to denote BAME ladies especially if symptoms not easily explained"*

"generic passive (aggressive) comments by all grades of staff"

"From my experience - staff would have been more proactive should that patient had been white."

"Recent...letter raised possibility of female genital mutilation and forced marriage based only on patients Islam religion without any other facts given…Colleagues discussing if patients are 'terrorists' based upon their colour of skin. "

"Patients are also subjected to racism by other patients 'why do THEY get to be seen before ME'"

Given these are a sample of experiences reported by those working in primary care, and was not the main focus of this piece of work it is highly likely that if patients were asked directly about their experience of racism the numbers would be higher.

However a number of these incidents happened "behind the scenes" between staff members so may be more visible to colleagues. Patients are far from unaware however, with one respondent saying:

"I have received a complaint from a patient who felt that NHS services were institutionally racist although she was unable to specifically say why she felt this way."

3.10 Enablement of racist views

The concept of enablement of racist views was reported in several ways – firstly by failing to recognise what constitutes racism in primary care; secondly if it was recognised, a total or partial failure to address it; lastly, collusion with racism by inaction.

Patients' refusal to be cared for by a person of colour, or on the basis of the colleagues name or surname were frequently reported (see section 3.5). These requests were usually granted.

> *"Patients asking for a doctor from a different ethnicity to attend to them is one which comes to mind and rather than address the patient for the obscene behaviour, their wishes are complied with."*

"I think my worst experience of racism is when racist patient comments (whether intentional or not) are brought to another member of staff - especially receptionists and practice managers - who feel they owe no responsibility to correct or condemn these statements, and simply honour patient's racist demands. This is probably the worst of it all - as it not only affects ones morale at the job, it also taints your perception and relations with your

colleagues. Silence, a British expression of politeness is then perceived as tolerance and support of these racist comments"

"My trainer told me he thought there was no racism in the NHS and thought it had been eradicated"

*"A senior partner at my training practice used the term 'n***** in the pile' at a practice meeting with me present. Nobody objected…"*

"Use of abusive language and physical aggression towards reception colleague from BAME background. Not managed well by senior partner, in fact brushed off as the patient being in distress due to being unwell."

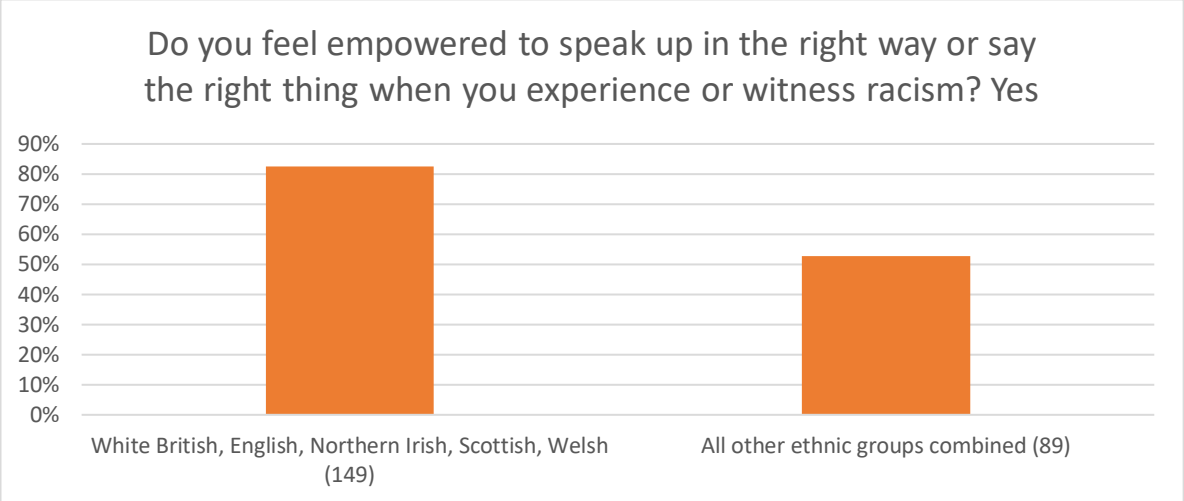
"Patient abuse of colleagues, reported beliefs about colleagues, racist language about Colleagues all said to me because they believed I would sympathise with their feelings because I am 'one of them'"

"I witnessed a patient being verbally racially abused by another patient based on the tone of her skin. I called the police who attended, but declined to arrest the abuser or to take further action other than to ask him to leave the premises"

"I don't think it's malice, but people just assume that if you have an accent then your English is bad. I've had a fair share of comments about my country"

3.11 Challenging racist views

77% of those who responded to the survey said they felt empowered to speak up in the right way, or say the right thing when they witnessed or experienced racism. The breakdown of this question, below, suggests that colleagues from White British, English, Northern Irish, Scottish and Welsh backgrounds felt more empowered than colleagues from all other ethnic backgrounds.



Some gave decisive examples of how they had dealt with a particular situation:

"where the patient concerned had capacity, these opinions were addressed by explaining the colleagues role and professional qualifications and that they would be the Doctor/Physiotherapist etc. who would be providing their care"

"Had to report and remove a patient from the practice list, as they called a trainee 'you black people, come into this country and take our jobs'."

"I have witnessed direct racism with a GP in another surgery, (patient) directly using anti racial language that I was very uncomfortable with. This was duly reported through the correct and appropriate channels at the time and the patient was dealt with accordingly."

"Always call people out on it, make it very clear that I do not share their beliefs and my room is not a "safe space" to express them"…"I always challenge patients if they use racist language and so does the practice"…"all practice staff are empowered to challenge in appropriate comments, warning letters sent"

But many others pointed to the barriers they felt to raising concerns. These included fear of being labelled as a "trouble maker", "overly sensitive" or "pulling out the race card", and individuals being disarmed by being included within the comments being made on the side of the protagonists.

"As a minority, I feel that I have to blend in and not 'make a big deal' out of things related to my culture or race. This includes not starting an argument/debate/fight when I hear colleagues making casually racist comments about immigrants (who are of a different race, ethnicity, and culture to them). …..Given the British culture of being polite (which I really do appreciate), I try not to take it personally as I understand they don't mean harm. It doesn't mean that racism does not exist, it is just a simmering pot waiting to boil over"

"The Registrar who was an ethnic minority didn't have the courage to raise the problem with the consultant"

Some were afraid of causing complaints if they challenged patients, or that the patients' anger might be redirected at them. When asked whether they felt empowered to speak up if they saw racism, one colleague simply replied:

"Never- Job loss, fear of harassment"

This failure extended to other instances of abusive behaviour towards those who experience racism, with concerns similarly dismissed:

"When I was a trainee, during consultation a male patient tried to squeeze my breasts. I swiftly moved away, I was very upset later. When I brought it up in front of the 3 male, white GP partners they laughed it off. I was not supported in any way….I was made to believe that I was making an issue out of nothing."

Some colleagues admitted they struggled to tackle racism when they saw it, saying their actions would depend on the circumstances, and whether they felt able to have a private conversation with the patient. A number of respondents identified that micro aggressions are particularly difficult to deal with.

> *"I find it harder to know how to respond to comments about not being able to understand*

someone, and how to understand the challenges my BAME colleagues face”

“If I received overt racism or see a colleagues experience this I feel comfortable speaking up however on most occasions racism tends to be covert and come in the form of micro aggressions and this can be much harder to speak up about.”

“It is harder to know how to tackle comments like 'oh good you're English' or 'oh I'm pleased you speak English' or 'I saw a doctor at the hospital, he was a black man' which imply racism, I try to ask 'is that important?'”

“When the racist one is the patient I am not always sure what to do. I frequently tell patients that their language is not acceptable when they use racist terms about colleagues (when the colleague is not there). I am never sure that this is enough but escalating also can seem out of proportion and would likely lead to complaints”

Despite the apparent positive message from 77% of respondents, there were several examples in the free text comments throughout the survey when racist incidents were described, with the preface “not racist but…/not racist per se…”. The ability to identify an action or phrase as racist confidently seems to be an area colleagues need further support with.

3.12 Other Types of Complaint

While this survey did not specifically ask about discrimination experienced due to other protected characteristics, responses highlighting similar concerns about sexual orientation and gender of clinician were also received.

4. Discussion

The final question in our survey asked respondents to indicate who they felt needed to be particularly involved in addressing racism in primary care locally. While all options were selected by at least 60% of participants, patients and the wider public scored most highly with 81% and 85% respectively. While clinical colleagues, PM and reception/admin staff all received support, this makes it clear that any work done within primary care locally must be complimented by a co-ordinated approach aimed at patients and the public collectively.

Areas highlighted for development were:

- a unified approach,
- staff training,
- involvement of community groups,
- education on what racism is and micro aggressions,
- how to be a white ally,
- the need for increased visibility of ethnic minority colleagues in leadership positions
- a zero tolerance approach to racism from patients.

We asked for any further specific suggestions and responses included the use of online training, religious tolerance, and the involvement of secondary care and patient representatives. Ensuring that any future work included all primary care staff, not just clinicians and those from all ethnic backgrounds was widely supported. The need for clearly identifiable goals, and possible issues around other types of protected characteristics were raised. The avoidance of tokenism, and those who do not experience racism leading future work was highlighted as especially important.

This is the first survey of its kind carried out in primary care in our region. As with all research, there are methodological limitations. These include insufficient sample size, absent representation from some ethnicities, and additional questions for future study that have been highlighted by the results. This survey was never intended to be a highly powered statistically analysed piece of work; it was intended to open a window onto the lived experiences of our colleagues and patients so that we can start to address these together.

5. Next Steps

This survey provides a limited but significant insight into the lived experiences of those working in all roles across primary care in the Humberside region. The next steps proposed below are divided into those directed towards our own organisation, Humberside LMC, and those constructively suggested to other local stakeholders. The LMC has no direct remit over other local partners but we hope these suggestions are taken in the spirit of collaborative working to improve the lives of our colleagues and patients across the area.

Actions for Humberside LMC

By Jan 2022, we will have:

- Reviewed the make-up of our committees, board and secretariat to clarify whether they reflect the demographics of our constituents and report on this to our constituents and wider stakeholders
- Reviewed the processes and procedures for elections and appointments to roles within Humberside LMC and worked to improve fairness for all colleagues
- Reviewed our constitution with recommendations to committee to reflect measures put in place to address any issues highlighted by the above. This new constitution should articulate that we are an anti-racist organisation and that we seek to be an ally to all colleagues.
- Extended our existing equality, diversity and inclusion training to include more robust and challenging content with support from recognised experts in this field.
- Invited our provider, commissioner and community stakeholders to join us in this extended training
- Reached out to local colleagues who hold roles with responsibility for equality, diversity and inclusion in their own organisations and seek mutual support
- Reviewed the wellbeing workstream to ensure continuation of this piece of work; we recognise that identifying a problem is only a small part of solving it.
- Promoted the Freedom To Speak Up guardian role that the LMC now offers to all our primary care constituents, with a focus on ensuring colleagues know this includes offering help if they encounter racism or discrimination.
- Shared our work and experiences with all LMCs across the UK, and our stakeholders in the area.

- Sought to improve our communication and visibility to our colleagues from all backgrounds, and articulate our support offer to them.
- Facilitated the formation of a network for those who experience racism; Primary Care Against Racism (PCAR) network.
- Worked with stakeholders within the ICS to promote high quality, relevant training on anti-racism and allyship for all colleagues working in primary care.
- We will lobby at local and national level for the consideration of diversity, equality and inclusion as a standard part of any decision making process.
- We will develop an anti-racism charter for Humberside LMC
- We will sign up to the Race at Work charter and undertake its recommendations

Suggested actions for our provider, commissioner and community stakeholders:

- Use this as an opportunity to trigger reflection and review of your own organisation.
- Educate yourself on the challenges racism creates for our colleagues and patients by reviewing the resources in this document and sharing them with your teams.
- Critically review your current training offer for staff at all levels on these issues.
- Accept the offer of joint training with Humberside LMC colleagues to build on your existing equality, diversity and inclusion training
- Read this excellent short article on becoming anti-racist by Dr Louise Taylor of Oxford Brookes University How can we become anti-racist? A guide | Advance HE (advance-he.ac.uk)
- If you deliver a patient facing service, involve them in the conversation including the adoption and promotion of a zero tolerance approach to racism.
- Sign up to the Race at Work Charter Race at Work Charter Signatories - Business in the Community (bitc.org.uk) and use their guides on anti-racism and allyship as the first step in the conversation Anti-Racism and Allyship in the Workplace: A Brief Guide - Business in the Community (bitc.org.uk)
- Support the formation of the proposed Primary Care Against Racism network; offer your support and expertise to ICS colleagues
- Develop an anti-racism strategy – the Chartered Institute for Professional Development has an excellent toolkit Developing an anti-racism strategy | CIPD

This piece of work has involved challenging reflection both personally and for us as an organisation. I have read and heard heart-breaking examples that make me ashamed of my profession and my patients. This is the start of a lot of difficult and uncomfortable conversations for us locally; you have taken the first step by reading this; please share it. Listen to what your colleagues are telling you – this is their lived experience. If you have ever thought racism isn't an issue in Humberside, I am sure you have had your eyes opened.

Spend a moment trying to put yourself in the shoes of those who have shared their experiences with you. However uncomfortable and awkward you may find it, it is nothing compared to the daily challenges they encounter simply because of their name, the colour of their skin, or their accent. Rather than disbelieving, or pointing to your own lack of racism, recognise that it is no longer acceptable to stand by. We all have a duty to look for racism, to call it out in all its forms, and to be actively anti-racist.

Appendices

A. **References**
B. **Matt Hancock letter**
C. **Racism and Discrimination Survey questions.**

A. References

Maslach, C.; Jackson, S.E. (1981). "The measurement of experienced burnout". *Journal of Occupational Behavior*. **2** (2): 99–113

Race report statistics | Equality and Human Rights Commission (equalityhumanrights.com)

The NHS workforce in numbers | The Nuffield Trust

Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk)

NHS Workforce Race Equality Standard (WRES) wres-2019-data-report.pdf (england.nhs.uk)

The National Health Service (rcgp.org.uk)

NHS Race and Health Observatory NHS England » NHS England and NHS Confederation launch expert research centre on health inequalities

Coronavirus » Addressing impact of COVID-19 on BAME staff in the NHS (england.nhs.uk)

Disparities in the risk and outcomes of COVID-19 (publishing.service.gov.uk)

Health Foundation statement on racial inequalities in health and health care | The Health Foundation

Workforce race inequalities and inclusion in NHS providers (kingsfund.org.uk)

Racism in medicine | The BMJ

Reports | NPEU (ox.ac.uk)

Supporting equality and fighting racism for a healthier world | BMJ.

Fair to refer - GMC (gmc-uk.org)

The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey | BMJ Open.

Racism hurts our entire profession| Blogs | Royal College of Nursing (rcn.org.uk)

Racism in the NHS is hiding in plain sight – and we can all do something about it | RCNi

How should I deal with a racially motivated incident? 958216 (bmj.com)

Fighting for fairness and equality | What we do | UNISON National

https://www.lexico.com/definition/microaggression

microaggressions_by_derald_wing_sue_ph.d._.pdf (uua.org)

B. Matt Hancock letter, 5th November 2019

Department of Health & Social Care

From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

5th November 2019

Dear Colleagues,

I love our NHS. It's there for us at some of the best and worst times in our lives and is an institution we should all be incredibly proud of.

The NHS is what it is thanks only to the hard work and dedication of each and every one of you. Our incredible staff make the NHS great. Without you, our wonderful NHS would not be able to deliver for millions of people across our country in the way it does.

So I was horrified last week to see accounts of the abuse that many of you face whilst doing your job. Abuse of any member of NHS staff is completely unacceptable. It is absolutely appalling that many of these incidents are racially motivated.

Like me, you may have seen the shocking testimony of Radhakrishna Shanbhag, a hard-working doctor who has committed more than 20 years of his life to the NHS. In an exceptionally moving interview this week, he described the racial abuse that he had been subjected to whilst working as a part of the NHS. Racial abuse that made him feel worthless. Abuse so foul that it made him reconsider his position in the NHS.

I have seen for myself racist abuse of staff, on night shifts in hospitals. Such racism is awful, and something that no staff member should have to endure. Especially troubling is the feeling among some staff that they need to accept this humiliation because they can't be sure they will be backed up if they challenge it.

So I want to send a clear message, from the very top of our health and care system, with the strong support of the entire national leadership of the NHS: this sort of abuse is unacceptable and we will not tolerate it.

If you face abuse, do not accept it. If you see a colleague being abused, do not ignore it. If you know of an employee facing this, do not stand for it. This government takes

a zero-tolerance approach to dealing with racist abuse whenever it arises. Things should be no different in our NHS.

If a patient asks to be treated by a white doctor, the answer is "no". Your management must and will always back you up. We are very proud that everyone in the UK is entitled to healthcare at the point of delivery, according to need not ability to pay. No one is entitled to choose the colour of the skin of the person giving that healthcare.

Those working on the frontline dedicate themselves to delivering world-class care for their patients and it is unacceptable that anyone would want to harm or abuse them for whatever reason – but especially on the basis of their race. Staff of all backgrounds should rightfully expect to work in an NHS that exhibits a healthy, inclusive, and compassionate culture: a culture where abuse and violence have no part. We all need to act to ensure racism in our NHS is eradicated. It is not the responsibility of those who suffer racist abuse to challenge it alone.

You will be aware that the interim NHS People Plan, published in June 2019, set out the initial framework for how the NHS will become the best place to work, to achieve the fantastic workplace culture that all NHS staff deserve. As a part of the interim People Plan, each NHS organisation must continue their work to improve the wellbeing of their staff in this regard. The national bodies of the NHS must also continue to support NHS trusts to meet the right of staff to work free from violence and abuse, as set out in the NHS Constitution and enshrined in law.

Making the NHS the best place to work must extend beyond the eradication of racial abuse, to fully supporting people from BAME backgrounds in all aspects of their career in the NHS. The Workforce Race Equality Standard is a fundamental component of the support BAME staff receive and should be implemented by each NHS trust. NHS Trusts must also continue to demonstrate to the local commissioner, staff, CQC and its Board that it is making progress against any locally-led improvement targets related to Workforce Race Equality Standard.

To those of you in senior management positions within Trusts, I would be grateful if you would reiterate to your hard-working and dedicated staff that we consider the racial abuse of NHS staff to be completely unacceptable. I therefore expect that all appropriate steps are taken by organisations to ensure their staff know they can come to a workplace that is free from abuse and harassment. It must be clear to everyone who works for the NHS have that they have the full support of the government and NHS in tackling racism towards staff.

And to all of you working every day to improve the lives of patients across our country, please know that you have my full support in challenging racism and discrimination wherever you see it. No person should ever feel worthless because of racial abuse. Particularly the extraordinary individuals, like Radhakrishna Shanbhag, who have dedicated their lives to improving the lives of others.

Yours ever,

MATT HANCOCK

C. Racism and Discrimination Survey Questions

This survey is part of a Humberside-wide strategy to address racial inequalities and barriers, and provide support for all those staff from ethnic minority backgrounds working in primary care. It is supported by our colleagues in the Humber region CCGs. This is the start of a conversation where you can share experiences anonymously if you choose to do so; it is not compulsory, and there will be other opportunities in future.

This survey is aimed at everyone working in primary care in Hull, East Yorkshire, North and North East Lincolnshire, of any ethnicity. Please answer all questions as fully as you can to help us know how we can better support all colleagues. This survey is quite detailed, and will take between 5-15 minutes to complete.

For more information on how we process data please see the privacy notice on our website www.humbersidelmc.org.uk.

1. Which ethnic group do you most identify with? Choose one option that best describes your ethnic group or background. (From ONS Measuring equality guide 2016)

☐ White - English/Welsh/Scottish/Northern Irish/British
☐ White – Irish
☐ White - Gypsy or Irish Traveller
☐ Any other White background, please describe
☐ Mixed/Multiple ethnic group - White and Black Caribbean
☐ Mixed/Multiple ethnic group - White and Black African
☐ Mixed/Multiple ethnic group - White and Asian
☐ Any other Mixed/Multiple ethnic background, please describe
☐ Asian/Asian British – Indian
☐ Asian/Asian British – Pakistani
☐ Asian/Asian British – Bangladeshi
☐ Asian/Asian British – Chinese
☐ Any other Asian background, please describe
☐ Black/ African/Caribbean/Black British – African
☐ Black/ African/Caribbean/Black British – Caribbean
☐ Any other Black/African/Caribbean background, please describe
☐ Arab
☐ Any other ethnic group, please describe:

2. What religion do you most identify with?

☐ No religion
☐ Christian
☐ Buddhist
☐ Hindu
☐ Jewish
☐ Muslim
☐ Sikh
☐ Any other religion (please describe)

3. If you actively practice your religion, does your role create a barrier to this? E.g. being unable to attend religious services or observe festivals, or not feeling able to request this.

☐ Yes
☐ No
☐ N/A

Comments:

4. What is your age group?

☐ 18-25
☐ 26-35
☐ 36-45
☐ 46-55
☐ 56-65
☐ 66-75
☐ 76 or older

5. What is your main role in primary care?

☐ Admin/reception
☐ Clinical staff including trainees – nurse, ANP, GP, paramedic, physiotherapist, pharmacist
☐ Manager – practice or CCG
☐ ARRS role
☐ Other - please specify:

We want to understand how you feel your work and personal life are affected by racism and discrimination. For each of the following, please choose if you feel your ethnicity, your culture, or racism and discrimination have impacted on these areas of your life. There is a free text box beneath each question if you wish to expand your answer.

6. Do you feel your choice of career was affected by:

☐ Your ethnicity
☐ Your culture
☐ Racism/discrimination
☐ N/A

Comments:

7. Do you feel your ability to train in your career was affected by:

☐ Your ethnicity
☐ Your culture
☐ Racism/discrimination
☐ N/A

Comments:

8. Has applying for a job ever been affected by:

☐ Your ethnicity
☐ Your culture
☐ Racism/discrimination
☐ N/A

Comments:

9. Has your choice of working pattern ever been affected by:

☐ Your ethnicity
☐ Your culture
☐ Racism/discrimination
☐ N/A

Comments:

10. Has access to education or professional development ever been affected by:

☐ Your ethnicity
☐ Your culture
☐ Racism/discrimination
☐ N/A

Comments:

11. Have you ever received patient complaints that were related to:

☐ Your ethnicity
☐ Your culture
☐ Racism/discrimination
☐ N/A

Comments:

12. Have you received colleague complaints that were related to:

☐ Your ethnicity
☐ Your culture
☐ Racism/discrimination
☐ N/A

Comments:

13. Have you undergone disciplinary or performance management that was related to:

☐ Your ethnicity
☐ Your culture
☐ Racism/discrimination
☐ N/A

Comments:

14. Has your ethnicity ever been linked to the following:

☐ Hinting you were dishonest
☐ Not trusting you
☐ Hinting you must be lazy
☐ Hinting you must not be clean
☐ Made you feel like an outsider because of your appearance
☐ Exclusion from social activities
☐ Negative interactions on social media
☐ Hinting you must be violent
☐ Not taking you seriously because of your ethnicity
☐ Treated you differently to your colleagues
☐ Thought you couldn't do things/handle a job due to your ethnicity or country of birth
☐ None of these

15. Have you been the subject of racism in your professional life?

☐ Yes
☐ No

If you feel able to share examples, please do so below:

16. Was this from a patient or colleague?

☐ Yes
☐ No

If you feel able to share examples, please do so below:

17. Can an anonymised version of this be shared to help support learning?

☐ Yes
☐ No
☐ N/A

18. Do you feel it was dealt with appropriately?

☐ Yes
☐ No

19. Have you witnessed a colleague being the subject of racism?

☐ Yes
☐ No

If you feel able to share examples, please do so below:

20. Do you feel it was dealt with appropriately?

☐ Yes
☐ No

21. Can an anonymised version of this be shared to help support learning?

☐ Yes
☐ No
☐ N/A

22. Have you witnessed a patient being the subject of racism?

☐ Yes
☐ No

If you feel able to share examples, please do so below:

23. Do you feel it was dealt with appropriately?

☐ Yes
☐ No

24. Can an anonymised version of this be shared to help support learning?

☐ Yes
☐ No
☐ N/A

25. Do you feel empowered to speak up in the right way or say the right thing when you experience or witness racism?

☐ Yes
☐ No

If you feel able to share examples, please do so below:

26. Can an anonymised version of this be shared to help support learning?

☐ Yes
☐ No
☐ N/A

We want to work towards this area being actively anti-racist place, and a safe place to work for all staff. We don't expect anyone to have a single answer to the best way to do this, and this is a long term project. But we do want your opinion based on your personal experience. This isn't asking you to solve the problem of racism, but it will help us work out where to take the first steps.

27. Who do you feel particularly needs to be involved in addressing racism locally? (select all that apply)

☐ Clinical colleagues
☐ Reception/admin staff
☐ Practice managers
☐ Patients
☐ CCG
☐ NHSE/I
☐ Wider public

Comments:

28. The LMC will be supporting the development of a BAME and allies network, working alongside all 4 CCGs and with support from regional HEE and NHSEI colleagues. We'd like your thoughts on what this might look like – who should be involved, what should it focus on, how to reach as many colleagues as possible.

Please enter any thoughts you have:

29. If you would like to be kept up to date with this and how you can get involved, please enter your email address below: