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Smart, A. (2021) 'Protecting UK healthcare workers from patient racism', *Sociology of Health & Illness*, 43 (8), pp. 1826-1830.

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Protecting UK healthcare workers from patient racism

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The proportion of people admitting to racial prejudice in the UK has not dropped below 25% in the last 30 years (Kelley et al. 2017), with greater levels of hostility among older people and ‘less qualified working class young men’ (Ford 2008: 632). The long-recognised racist abuse suffered by UK healthcare workers from patients and visitors (Gunaratnam 2001; Jones et al. 2003, Pendleton 2017), is reportedly on the increase (itv.com 2019; Rimmer 2020). While discussions about how to address this problem have been advancing in the US (Rakatansky 2013; Paul-Emile, et al. 2016; Garrahan and Rasmussen 2019), this commentary focuses on the emerging UK debate. In particular, it contends that Sokal’s (2019) arguments about the fair treatment of racist patients obscure the unfair treatment of healthcare professionals and the responsibilities of healthcare organisations to protect employees from racism in the workplace.

The problem of patient racism gained attention following a news investigation which included the case of Radhakrishna Shanbhag, a trauma and orthopaedic surgeon who had been asked by a patient if they could be treated by a white doctor (itv.com 2019). The patient then complained to the relevant NHS trust¹ because care was not available from a white doctor (Rimmer 2020). The controversy prompted the Secretary of State for Health to assert that such abuse was unacceptable and that ‘a zero tolerance policy approach’ should be taken (Rimmer 2019). Subsequently, the NHS in England extended the ability of healthcare organisations to act on discriminatory behaviour. In the past, non-emergency patients could only be refused treatment if their behaviour was deemed aggressive or violent (Rimmer 2020). To broaden the grounds for the refusal of treatment, the NHS revised its Standard Contract² to state that: ‘a provider may withhold treatment where a patient displays behaviour which constitutes discrimination or harassment (within the meaning of the Equality Act 2010) towards staff or other patients’ (NHS England 2019: 9). One of ‘protected characteristics’ covered by the Equality Act (2010) is race, which it defines as including ‘colour, nationality, ethnic or national origin’. The Act proscribes, again among other things, direct discrimination such that a person is treated worse than another, and harassment, such that a person is treated in a way that violates their dignity, or that creates for them an ‘intimidating, hostile, degrading, humiliating or offensive environment’.

The North Bristol NHS Trust was in the vanguard of the new approach. Its ‘Red Card to Racism’ campaign was launched in November 2019 in response to increased staff reporting of racism on its wards. It stated that it would enforce ‘its zero tolerance policy against abusive behaviour’ which is applied to ‘anyone with mental capacity making racist or sexist language, gestures or behaviour’ (nbt.nhs.uk 2019). The ‘red card’ metaphor is adopted from the high profile anti-racist campaigning group *Show Racism the Red Card*, which originally started its work in football (football referees can show a player a ‘yellow card’ as a warning, with a subsequent offence resulting in a ‘red card’ and removal from the game). The Trust announced that abusive behaviour would first be ‘challenged’ and given a verbal warning. Incidents would be documented in patient notes and in the event of repeat behaviour ‘treatment would be withdrawn as soon as is safe’ (nbt.nhs.uk 2019).

In a response to the North Bristol NHS Trust campaign, *The BMJ* published a piece titled ‘Dealing fairly with racist patients’ by Daniel Sokal (2019), under his ‘Ethics Man’ byline. As *The BMJ* is a leading, high-profile journal that targets a wide-range of medical professionals, the viewpoints that it chooses to publish warrant attention. Sokal cast doubt on the workability of the policy, claiming it would only work if ‘all patients were uncomplicated bigots’. He notes that patients may have underlying health conditions (like dementia) that affect their behaviour, plus there is uncertainty about what counts as racism. In a ‘rapid response’ to Sokal in *The BMJ*, Ilangaratne (2019) counters

these objections by arguing that doctors are generally familiar with the notion of mental capacity, and that acts of discrimination are subject to the legal standards of the Equality Act 2010. It is also worth adding here that an offence is deemed racially motivated by the police and Crown Prosecution Service if it is perceived as such by the victim (cps.gov.uk 2020). US discussions about the issue have also engaged with these concerns. Accounting for a patient's decision-making capacity is a recommended part of a structured, step-wise approach for determining the correct course of action to take (Paul-Emile, et al. 2016, Rakatansky 2013). These US recommendations are less clear on the question of what constitutes racism, but they do discuss scenarios in which a race-based patient request for reassignment might be deemed clinically or ethically appropriate. To extend this, Garran and Rasmussen (2019: 501) have argued that organisations must provide training so that staff are 'motivated to provide non-discriminatory care, aware of - and sensitive to - the dynamics of racism' and capable of having the difficult conversations that will ensue.

Sokal also contends that allowances should be made for a patient's 'limited intellect'. He then argues: 'There may also be specific reasons for a patient's hatred of a particular race - such as a rape or other trauma inflicted by a person of that race - that while not excusing the racist behaviour may render the ordinary sanction disproportionate.' The claim that people who reason as such should be given allowances displays a problematic understanding of the nature of race, racism and anti-racism. The argument not only appears to rehearse the biologically unfounded idea that we can be categorised into 'a particular race' but also suggests we are somehow culpable for the acts of others who may be deemed of our race. It is worth specifically reflecting on Sokal's use of rape as an exemplar for his argument. This mixes violence and sex in a way that sits uncomfortably close to centuries old anti-Black racist tropes (Collins 2004), and is concerning given that some of the healthcare workers who are on the receiving end of racist abuse will identify as Black. As unthinking prejudice and stereotyping are at the heart of racism and are part of what anti-racist policies aim to challenge, it seems counter-productive to give allowances to people who use such thought processes to justify their discriminatory behaviour. Furthermore, accounting for a patient's 'reasons and motivations' has an attendant risk of victim-blaming. As another 'rapid response' to Sokal in *The BMJ* points out, rather than focussing on what is in the mind of the accused, it is 'the impact on the victim which matters most' (Ahmed 2020). In the US context, Paul-Emile, et al. (2016: 710) argue that the reasons for racism are relevant only in 'rare cases', which they exemplify using a patient whose reasoning is impaired by an anxiety disorder.

In his final analysis Sokal argues that '[c]linicians should be permitted to exercise their judgment in deciding what to do'. However, this leaves questions about how judgements are to be made when only some members of a care team are subjected to abuse. This is especially important where there are differences in professional status, not least because evidence suggests that nurses experience more abuse than doctors (Nieterman and Bourgeault 2015; NHS WRES 2019). In its statement of principles, the NHS notes that the statutory and contractual rights of employees help to ensure that, among other things, staff 'have healthy and safe working conditions and an environment free from harassment, bullying or violence' and 'are treated fairly, equally and free from discrimination' (Department of Health and Social Care 2015). NHS employees should not be expected to tolerate racism from patients while doing their job, and their employers have a responsibility to create working conditions that help to ensure that they do not have to. As such, healthcare organisations need processes for dealing with racist patients that address differences in the impacts of racism within staff teams, so that the rights of all employees are protected equally.

For many years, studies of nurses have shown that racism from patients is only one aspect of workplace prejudice and discrimination in healthcare, and importantly, racism persists despite the existence of the legal protections and policy interventions designed to prevent it (Likupe 2006; Xu 2007; Tuttas 2015; Walani 2015, Moyce et al. 2016; Pendleton 2017; Lin et al. 2018). In this body of

evidence, it has been found that laws and policies are inconsistently implemented; that attempts to confront racism can have detrimental impacts on those who speak up; and that mistreatment goes unreported. Prejudice and discrimination are not reported for a variety of reasons, including a lack of knowledge about the right to protection, a lack of faith that reporting will have an impact, a perception that it should be tolerated, concerns about how it might be perceived by other staff and a fear of the repercussions. It has recently been claimed that medical students are also not reporting racism, in part because they lack faith in the organisational processes for dealing with their complaints (Kmietowicz 2020; Adebowale & Rao 2020). It is telling that the North Bristol NHS Trust's 'Red Card to Racism' campaign was accompanied by posters and social media content that aimed to encourage staff to report incidents that they had experienced or witnessed (nbt.nhs.uk 2019). In this respect, concerns about the over-zealous application of policies to address patient racism appear misplaced. Instead, discussions should focus on how organisations can create a working environment in which staff are able to claim the rights and protections to which they are entitled.

Sociologically, the racism experienced by nurses has been theorised in terms of dominant vs. subordinate social group status (Tuttas 2015); colonialism (Braithwaite 2018); whiteness (Turritin et al. 2002; Garran and Rasmussen 2019); and, globalised neo-liberalism (Ahlberg et al. 2019). The operation of deep-seated discourses, social structures and power relations helps to explain resistance to anti-racist work, and why past attempts to address inequality and mistreatment have been judged unsuccessful (Pendleton 2017; Braithwaite 2018). Against this socio-historical context, politicised claims of zero-tolerance towards racism can ring hollow. However, campaigns like the 'Red Card to Racism' and the recent change to the NHS Standard Contract are important markers of intent. They reflect the legal responsibilities that employers have to protect their staff from racism. They have the potential to generate norms and expectations; to set standards for practice; and to create material evidence for documenting and evaluating cases. Nevertheless, a consistent message from research in this field is that healthcare organisations need to do more to ensure that laws and policy are actually applied and enforced in practice.

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¹ NHS trusts are organisational units that are responsible for the provision of healthcare services, and as employers, upholding the rights of employees.

² By altering its Standard Contract, the NHS is adjusting the usual terms and conditions under which it enters into a contract with healthcare organisations, like trusts, to provide services; effectively, the aim is to set new expectations in order to change organisational practices (in this example, in relation to patient behaviour).