

# Viewpoints



## Race and Racism in Primary Care

The *Black Lives Matter* campaign has highlighted issues of race and racism which are present in all parts of our communities and organisations. BJGP Open is inviting Viewpoints to document experiences of racism in primary care as a patient, practitioner, trainee, or researcher.

This initiative sits outside the usual BJGP Open framework for research and commentary, and has been created as a rapid access format for sharing information.

### What is your full name?

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### What is your role?

**NB** - GP Tower Hamlets & Head of School for General Practice, HEE, North Central and East London

**MR** - Medical Adviser, Workforce Race Equality Strategy Implementation Team, NHSEI, Co-chair Race Equality Public Action Group NIHR & Senior Clinical Fellow, Department of Primary Care and Public Health, Imperial College London

### Please describe the experience of race and/or racism that you would like to share

#### **Tackling racial disparities in general practice: now is the time**

General practice has been one of the most diverse medical specialties since the inception of the NHS in 1948, and has, like the rest of the NHS, drawn heavily on migrant labour from the Commonwealth and former colonies for not only doctors, but nurses and other support staff. Despite tightening immigration controls, a flow of overseas doctors was maintained throughout the 1960s and 1970s to ensure the smooth running of the NHS.

There was acknowledgment that the NHS could not function without migrant doctors, but widespread racism ensured that, regardless of their ambitions, they were concentrated in Cinderella specialities. These specialties included general practice and these migrant GPs were overwhelmingly located in parts of the country that locally trained doctors did not want to work in.<sup>1</sup> By the 1980s, 16% of the GP workforce had qualified in India, Pakistan,

Bangladesh, and Sri Lanka and this group was instrumental in the delivery of care in industrial and inner-city areas.<sup>2</sup>

We know that the ethnicity of a member of staff determines their experiences and opportunities.<sup>3</sup> Never has this been more apparent than in the disproportionate impact of COVID-19 on ethnic minority communities.<sup>4</sup> This should not have surprised us. Health inequalities have been widely acknowledged but have focused on deprivation and disadvantage, ignoring increasing evidence that at every level ethnicity is an independent risk factor to health outcomes.<sup>5</sup>

The Fenton report has highlighted racism, stigma, and distrust as underlying the existing inequalities experienced by Black and Minority Ethnic (BME) communities, and more specifically, key workers.<sup>6</sup> The fact is that 12 of the first 13 GPs to sadly die as a result of COVID-19 have been from BME backgrounds.<sup>7</sup> It is heartening to see the establishment of the new NHS Race and Health Observatory,<sup>8</sup> which aims to provide a much needed, proactive, drive towards closing long-standing inequalities experienced by BME communities, patients, and NHS staff.

Forty-one percent of the doctors in the NHS are from BME backgrounds. Current GMC data shows that this includes over 30% of GPs of whom half are international medical graduates (IMGs).<sup>9</sup> A substantial body of research evidence published during the last four decades has highlighted the racism and discrimination experienced by BME doctors, and IMGs in particular,<sup>10</sup> and has provided compelling justification for their inclusion in the strategy to address ethnic inequalities in the NHS workforce.

Indeed, there is differential attainment by ethnicity across all measures of career progression and opportunity in all medical specialties including general practice. Little has been done in past decades to address these differences with historic interventions focusing on a deficit model that cannot have the system-wide impact needed to counter the discrimination that is the root cause of differential attainment.

Alongside this, concerns regarding the racism faced by BME NHS Trust staff led to the development of the NHS Workforce Race Equality Standard (WRES) in 2015,<sup>11</sup> which requires NHS organisations to close the gap in workplace experiences and opportunities between BME and white staff, against a set of indicators. The WRES continues to be a powerful driver for organisational change in secondary care and while progress is being made on closing the ethnicity gaps on indicators such as recruitment, entry into formal disciplinary action, and on representation in leadership, more is needed to be done to address the needs of the medical staff.

Earlier this month, the WRES programme introduced the Medical Workforce Race Equality Standard (MWRES) to add the granularity required to ascertain a better understanding of race disparities in the medical workforce.<sup>12</sup> Of the eleven MWRES indicators, four reflect variation in career progression and pay, six represent medical staff perceptions of how they are treated by colleagues, employing organisations and patients, and one highlights the diversity of the councils and boards of medical institutions. It is a welcome start to the process of monitoring differential attainment and experience of NHS doctors and translating evidence into appropriate practice and policy to breakdown the structural barriers to race equality. However, MWRES will focus on medical students, doctors in training, and doctors in NHS Trusts<sup>13</sup> but is not designed to assess the pay and

career progression of GPs, so will not address the deep-seated and longstanding inequalities for this critical part of the NHS workforce.

The need for general practice to focus on this agenda is paramount. A recent study based in Lewisham,<sup>14</sup> surveying all general practice staff on four WRES indicators most applicable to general practice, found BME staff across general practice report high levels of racism from patients and significant levels of bullying from colleagues. In 22% of responders this led to a career change.

The challenges of shifting the dial of inequality are enormous; but following the resurgence of the Black Lives Matter Movement and the impact of COVID-19 on our BME communities, there can no longer be any denial of the impact of systemic racism on the opportunities and experiences of our minority communities and staff.

The NHS People Plan<sup>15</sup> has made a commitment to create a culture where everyone feels they belong. One of the challenges to overcome when implementing the Plan will be to shift the historic focus on secondary care to include general practice. As general practice moves to strengthen collaborative practice through primary care networks (PCNs) we need to ensure that the aspirations set out in the NHS People Plan are equally applicable in this crucial part of the NHS.

Race equality must remain a key priority for everyone with a leadership committed to anti-racism across all parts of the healthcare system, including in general practice. Improving the experiences and opportunities of BME staff has a positive impact on all parts of the workforce as well as on patient satisfaction, patient care, and overall patient experience.<sup>15</sup> To see meaningful and sustained change on this agenda, we need both demonstrable leadership and data-driven accountability. That is exactly why implementation of the WRES and MWRES is critical. General practice must be part of this journey.

#### Acknowledgements

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