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THE BOTTOM LINE

Partha Kar: To tackle racism, the NHS needs policies with teeth

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I had to read through the email a few times to digest what a consultant had written to me. "Conflating covid with institutional racism amongst your friends and colleagues is utterly shameful," it said. "Nobody knows the genetics of covid, but you see fit to suggest that its predilection for BAME [black and minority ethnic people] is down to racism. Your views nauseate me—there is no room for them in today's NHS."

The email was in response to my column in May for *The BMJ*,[1] in which I discussed whether racism was a factor in the increased mortality rate from covid-19 among people from ethnic minority backgrounds. Subsequently, further investigations and a report from Public Health England[2] have established that racism and discrimination may have contributed to the increased risk of death from covid-19 among ethnic minority groups. Yet, for the consultant who sent me that email, it was hurtful to even suggest that there may be racism in the NHS.

The incident made me reflect on a wider problem—and an analogy with sexism. When the MeToo movement began, many men responded indignantly: "We can't all be tarred with this brush," "I have many women friends," or "I'm a very liberal man." They missed the point that the movement wasn't about them. It was about being quiet, listening to the examples raised, and reflecting that there may be many colleagues whose views you have not picked up on, not acted on, or ignored. It was about being vocal against the issue when observed. About being allies for women facing sexism and trying to bring an end to such a culture.

Racism in the NHS is not much different. You indeed may not be racist, but to then suggest that no one else is, and to be indignant at the notion of the NHS having a race bias, may simply reflect your ignorance or the bubble you inhabit, where people don't make any judgments based on colour.

However, it's this sort of ignorance from well meaning individuals, more than the views of outright racists, that propagates the problem. Such views mean that, when people see something that jars, they remain silent or try to explain it away with some "scientific" reasoning: cue the debate about vitamin D and that being the sole reason for greater mortality in the BAME population, rather than acknowledging the existence of discrimination and racism. If you can't even accept that there could be a problem—that there could be racism and discrimination in the amazing NHS—why would you want to try to solve it?

At an individual level, it's time to be antiracist, to speak up, and to be allies. At a policy level, it's time for the NHS to start affirmative action. It needs to introduce something like the Rooney Rule, a US National Football League policy that requires teams to interview ethnic minority candidates for head coaching jobs and other senior roles.

So far in the NHS, all attempts at cajoling or nudging have achieved little beyond tokenism. Data in the 2019 Workforce Race Equality Standard showed that white applicants were still "1.46 times more likely to be appointed from shortlisting compared to BME applicants."[3] How many more reports or data do we need before we realise that simply "shining light on the data" makes no difference without targets and penalties to improve things? We do know that the NHS responds to targets and associated penalties: look at the four hour target or waiting times for cancer treatment.

Another big step would be to ditch terms such as B(A)ME, which turn discrimination into a simplistic discussion about white and non-white communities. The issues influencing differences in attainment and socioeconomic deprivation are fundamentally different for someone who is black than for someone who is Indian, just as they're different for someone from Bangladesh than for someone from China.

There is no better or more opportune moment to shift the dial from conversations and cajoling to clearer data collection, open access to data based on area and authority, and a commitment to a concept similar to the Rooney Rule. The "Seacole Statute" has a ring to it, and it would be a way to pay homage to a titan and pioneer in the world of fighting for equality in healthcare. It's certainly worth thinking about.

Competing interests: www.bmj.com/about-bmj/freelance-contributors.

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1 Kar P. Partha Kar: Covid-19 and ethnicity-why are all our angels white? *BMJ* 2020;369:m1804. doi: 10.1136/bmj.m1804 pmid: 32371436
2 Public Health England. Beyond the data: Understanding the impact of COVID-19 on BAME groups. Jun 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf.
3 NHS. NHS workforce race equality standard. Feb 2020. https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/workforce-race-equality-standard-2019-report/.

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