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Ethnic minority staff and patients: a health service failure

A call for papers for a special theme issue of The BMJ

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This autumn *The BMJ* will publish a special issue to reflect the working lives of doctors from ethnic minority backgrounds and the healthcare experiences of ethnic minority patients. Why? Because despite decades of evidence of disparities in health outcomes related to ethnicity and differential attainment among clinical staff, there has been little action. We want to highlight discrimination and health inequalities related to race and ethnicity, and we invite submissions on how to better characterise the problems, air debate, and find solutions.

Discrimination in health and healthcare is multifaceted. The direct effects of acts of discrimination on physical health are measurable, as first shown by the work of David Williams, a Harvard professor of public health who launched the everyday discrimination scale in 1997.[1] In a 2016 TED talk he explained that the scale "captures ways in which the dignity and the respect of people who society does not value is chipped away at on a daily basis."[2] The scale has enabled researchers to link discrimination to an increased risk of a broad range of diseases, including heart disease, mental health, and obesity, as well as to low birthweight infants and premature mortality.[3 4]

In the UK, mapping differences in healthcare outcomes by ethnicity is hampered by poor quality data.[4] A 2018 report commissioned by Public Health England aimed at promoting effective action on ethnic health inequalities found "very little information" on the ethnic differences in health.[5] Sample sizes are small, and the variety of categories used to define different ethnicities has not helped to optimise data collection.

However, the available data do point to disparities. One of the starkest examples is maternal mortality. In the UK, black women are five times more likely to die in pregnancy than white women, with Asian women twice as likely to die as white women.[6] Data also show that infant mortality is higher among some ethnic minority groups,[5] and studies, including one on hepatitis B in Chinese groups,[7] have shown that the NHS is slow to respond to health problems that disproportionately affect particular ethnic minority groups.

There are also disparities in access to health services. Ethnic minority patients experience delayed treatment for myocardial infarction, despite their having similar awareness of symptoms as white patients.[5] Management of hypertension and diabetes among ethnic minority patients in primary care is also suboptimal.[5] As McKenzie and Bhui described 12 years ago in an editorial in *The BMJ* on mental healthcare, these disparities and the delays in tackling them seem to satisfy the definition of institutional racism.[8] The rapid growth in digital technology and health apps offer new ways to access services, but oversight to ensure they are inclusive and do not widen inequalities is lacking.

Another issue is inherent prejudice towards NHS staff. About a third of doctors working in the NHS identify as being from an ethnic minority background,[9] against a UK ethnic minority population of 14%.[10] Ethnic minority doctors hold 57% of staff grade posts and are less likely than white doctors to be shortlisted for, and appointed to, consultant posts. They are also more likely to report being bullied and harassed, have poorer wellbeing, face a disproportionate number of official complaints and disciplinary actions, and earn 4.9% less than their white consultant counterparts.[11-13]

The UK has made efforts to try to remove this unfairness. The 2004 NHS race equality action plan aimed to tackle discrimination but met with limited success. A decade later, the NHS Equality and Diversity Council agreed action to end discriminatory practices in the workplace. And the Workforce Race Equality Standard was launched in 2015 to track progress.[14] It found that in 2018, just 16% of the NHS's 231 trusts had a medical director from an ethnic minority background, despite 39% of hospital doctors identifying as belonging to an ethnic minority.[15] The proportion of ethnic minority staff experiencing

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discrimination had increased to 15% that year, up from 13% in 2017.

This environment affects us all. When doctors do not feel valued patient satisfaction tends to be lower.[16] Similarly, enhancing diversity at the top of organisations aims to promote diversified thinking, without which there is an increased risk of groupthink and an acceptance of the status quo.[17]

The current reality for ethnic minority patients and staff in health services is unacceptable. Health systems must consistently and competently meet the needs of the whole population.[16] The evidence is clear on the discrimination and prejudice against patients and staff from ethnic minorities. What is less clear is the appetite of health systems in the UK and around the world to tackle age-old health inequalities based on race and ethnicity. It is a scandal that is understood, tolerated, and paid lip service, but it cannot be allowed to continue.

What are we looking for?

We welcome submissions across all article formats, including research, analysis, education, and opinion. Here is a selection of topics we are interested in:

- Reliable data on access to healthcare and health outcomes by ethnicity, including for mental health
- Underserved and under-represented diseases and conditions
- How the current status of ethnic minority doctors and patients is affecting wider NHS objectives for patients, staff, and citizens
- NHS initiatives to measure and reduce racial and ethnic health inequalities
- International examples of measuring and tackling racial and ethnic health inequalities
- Differential attainment by ethnic background
- Workforce planning
- The effect of new digital technologies on racial and health inequalities
- Increasing diversity and inclusion in clinical leadership, health policy, patient partnership, and research

The themed edition will be guest edited by Victor Adebowale and published in autumn 2019. We welcome submissions via our website at submit.bmj.com. All submissions will be subject to our usual review processes. The last date for submissions for research is 2 August 2019.

To discuss ideas and suggestions, please contact Zosia Kmietowicz, zkmietowicz@bmj.com

This article has been reposted to include a closing date for submissions.

Competing interests: We have read and understood BMJ policy on declaration of interests and declare that MR is medical adviser to NHS England on Workforce Race Equality.

Provenance and peer review: Commissioned; not externally peer reviewed.

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