VIEWS AND REVIEWS

PRIMARY COLOUR

Helen Salisbury: Responding to racism

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I try hard, but I know that I make mistakes. I practise unfamiliar names to myself before calling patients in from the waiting room, and I ask to be corrected on pronunciation. I like to know where my patients are from, and I hope that asking this demonstrates my interest—but what if it's construed as intrusive or, worse, as questioning their right to be here seeing a doctor? Sometimes I ask, "Where is your name from?" which is more about heritage than personal history but still could be misconstrued.

The problem with privilege, which I undoubtedly have, is that I may be blind to getting things wrong: if I'm racially insensitive, most of the time nobody will tell me. There are many possible manifestations of discrimination. When consultations are complicated by the necessity of working through an interpreter, is there a risk that I'll fail to explore my patient's thoughts and fears because we're concentrating on the diabetes or hypertension numbers? Am I less likely to raise sensitive issues related to sex, drugs, or alcohol for fear of being culturally inappropriate? I hope not, but I do need to ask myself this.

As well as policing myself, I must respond when racism arises in the behaviour of others, including patients. A trainee at our practice, popular with young patients, was struggling to gain experience seeing older ones. This was a new problem, and we reluctantly concluded that his foreign sounding name was the reason older patients chose not to book with him. His solution was to issue a "pizza challenge" to the reception staff, rewarding them when they succeeded in booking older patients into his

clinic. After initial appointments the problem was solved, as his new patients usually chose to consult with him again.

One of the privileges I have is to work in a remain voting city with a diverse population: I rarely see overt racism, and it's still a shock when I do. Responding to patients who are abusive to our staff ought to be simple, as any level of racist abuse is unacceptable. Patients crossing this line should be asked to register elsewhere. In practice, however, this can be complicated, especially if a patient claims to have been misheard or misconstrued. Giving the patient the benefit of the doubt (in other areas, it's my usual instinct to give patients a second chance) could signal a lack of support for my team. And many patients with cognitive impairment lose the inhibitions that once prevented them from voicing unacceptable opinions. The impulse to support my colleague and to remove the patient from our list has then to be balanced against the patient's vulnerability. We need to ask and find out how it feels to the colleagues most affected—and discuss how we respond as a team.

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