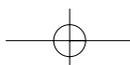
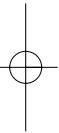
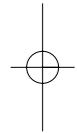


BLACK HISTORY MONTH SPECIAL - IS THE NHS INSTITUTIONALLY RACIST?

GUEST EDITORIAL HERE



The impact of ethnicity and diversity on doctors' performance and appraisal

A disproportionate number of ethnic minority clinicians working in the NHS are either suspended or referred to the General Medical Council.

What are the reasons for this? Does racism play a part?

In this article the authors consider the evidence as to whether the assessment and appraisal of clinicians can be influenced by race.

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by Aneez Esmail and Peter Abel

An analysis of clinician suspensions, undertaken by the National Clinical Assessment Service (2005) indicated that a disproportionate number of suspension cases involved ethnic minority clinicians.

What role does racism play in the performance assessment and appraisal of individuals prior to and during the suspension process? To try and understand this, we need to consider the concept of institutional racism and also how racism may impact on stress in clinicians.

We then look at how racism can affect individuals and how it can manifest itself in the appraisal process. Finally, we look at the role that organisations can have in mitigating the effects of racism.

Institutional racism

The MacPherson report (1999) into the racist murder of Stephen Lawrence found that the failure of the Metropolitan Police resulted from both incompetence and 'institutional racism', which was defined as the collective failure of an organisation to provide appropriate and professional services to people because of their colour, culture or ethnic origin.

The Blofeld Inquiry (2003) into the death of David "Rocky" Bennett described a culture of discrimination and institutional racism within the NHS.

Recognition of how institutional racism operates is critical to understanding the factors that can affect doctors' performance, but also in developing equitable appraisal programmes.

King (1996) provided a conceptual analysis of institutional racism within the medical sector. He showed that the con-

cept of institutional racism helps to distinguish between the actions of individuals who discriminate and racial stratification resulting from structural impediments and processes. Institutional racism is less an indictment of individuals working within institutions than of an institution's systematic operation.

The institutional racism paradigm emphasises the group, as opposed to the individual consequences of racial discrimination. It examines the impact of external factors, and incorporates history and ideology as major determinants of racial inequality.

This means that external issues (such as the perception of overseas-qualified doctors; the problems faced by overseas qualified doctors in career progression; and differentials in the allocation of discretionary awards) can exert an influence on the organisation and how its ethnic minority staff are perceived and how they perceive themselves.

Barriers to employment

Similar issues arise when considering barriers to employment for black and minority doctors which can exist at recruitment and promotion, and have been well-described in the literature.

The source of barriers is rarely overt bigotry, but rather more subtle and indirect forms of discrimination that might not even be recognised by its perpetrators.

However, the greatest problem with using the institutional racism paradigm to understand why ethnic minority doctors may be disadvantaged in the NHS is precisely because institutional racism is less overt, more subtle and less identifiable in terms of specific individuals.

Because it originates in the operation

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of established and respected forces in society, it receives far less public condemnation than individual racism.

This also does not mean that the actions and consequences, rather than intent, of individuals in positions of authority can be ignored in determining whether racism is a problem.

Dovidio and Gaertner (2000) described the rise of 'aversive racism', characterised by people who 'endorse egalitarian values, who regard themselves as non-prejudiced, but who discriminate in subtle rationalisable ways'.

Racism and stress

Findings in the UK Fourth National Survey of Ethnic Minorities suggested widespread experiences of racial harassment and discrimination among ethnic minority people.

Qualitative studies by Virdee (1995) and Chahal & Julienne (1999) in the UK found that many people experienced interpersonal racism as part of everyday life: their lives were constrained by fear of racial harassment, and that 'being made to feel different' was routine and expected.

The experience of ethnic minority doctors and staff is not different, and was confirmed in a DH-commissioned report by Lemos & Crane (2000)

Experiences of racism can also be associated with stress and work-related stress. The causal link between stress and burn-out has been well described by McManus et al (2002).

Post and Weddington (2000) described the nature of work-related stress related specifically to racism experienced by African-American family physicians. They described physicians' experiences with racism in medicine, which was exhibited as doubt and a strong desire to prove oneself in the medical environment. They underscored the importance of race and culture in the stress and coping processes.

In a survey of US women physicians, Corbie-Smith et al (1999) described the prevalence of racial harassment. Of the respondents, 62% of blacks reported having experienced harassment. Foreign-born doctors reported significantly more harassment during training and practice.

Their data confirmed other studies which identified that African-American, Asian and foreign-born residents were

more likely to report ethnic harassment, with prevalence as high as eight times that of white residents. They pointed to an emerging literature which describes the effect of perceived discrimination or harassment on mental health and higher levels of psychological distress. Their study also found that harassment was associated with severe work stress in Asian physicians.

Although we could not find any studies that showed a direct relationship between racism as a source of stress and its effect on performance, there is a strong theoretical basis for considering racism as an important contributory factor in an assessment of a physician whose performance raises cause for concern.

Individual experiences of racism

Research also shows that people's interpretation of what constitutes racism varies: whether an experience is seen to be a function of an individual's own position, or something else, will be a consequence of their own history of inter-group interactions, as well as a response to the 'objective' experience.

Research has shown that people report perceiving greater discrimination directed toward their group rather than toward themselves personally: the personal / group discrimination discrepancy.

Triple jeopardy

In terms of their experience in organisations, Landau (1995) described ethnic minorities as suffering from 'triple jeopardy'. They have to cope with negative racial stereotypes (e.g. in the UK, overseas qualified doctors from South Asia are frequently perceived to have inferior qualifications). They may be a minority or sometimes the only person in a work-group (less common in the UK, but a problem at senior NHS executive levels).

Finally, they may be regarded as tokens, having obtained their position solely due to positive discrimination. Possibilities for biased perceptions and evaluations of their performance of this kind may increase particularly if (contrary to the stereotypical belief) they are extremely high-fliers.

Racism and performance appraisal

In relation to performance appraisal,

'The source of barriers is not overt but rather more subtle and insidious discrimination that might be overlooked by its perpetrators'

'There is considerable evidence that whites evaluate job performance of blacks less favourably than those of whites when the raters are themselves white'

'race and gender were significant predictors of promotional ratings... there is considerable evidence that biased perceptions and stereotyping may be a barrier to promotion assessments'

there is considerable evidence that raters evaluate job performance of blacks less favourably than of whites, especially when the raters are themselves white.

Black managers often experienced restricted advancement opportunities, and Jones (1986) reported that they experienced extensive dissatisfaction and frustration with their careers.

The role of organisational experiences in producing these negative outcomes remains largely unexplored. In a meta-analysis of rater effects, Kraiger and Ford (1985) found that white raters assigned

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higher performance evaluations scores to other whites, than to ratees of other races, particularly in field studies where blacks were only a small percentage of the total workforce.

Landau's (1995) work showed that race and gender were significantly related to promotional ratings, controlling for age, education, organisational tenure, salary grade, and type of position and satisfaction with career support. This provides some evidence that biased perceptions and stereotyping may be influencing the promotional assessment process.

The role of organisational discrimination

Greenhaus et al (1990) examined relationships among race, organisational experiences, job performance evaluations and career outcomes for black and white managers. They found that compared to white managers, blacks felt less accepted in their organisations; perceived themselves as having less discretion in their jobs; received lower ratings from their supervisors on their job performance and suitability for promotion; were more likely to have reached career plateaux; and experienced lower levels of career satisfaction.

They developed the concept of 'treatment discrimination' to describe situations where the treatment of employees was based more on their subgroup membership than on their merit or achievements.

Such discrimination can affect not only such tangible phenomena as position assignments; training opportunities; salary increases; promotions and terminations; but also more subtle issues such as acceptance into work groups or the availability of career-enhancing support from supervisors.

In effect, subgroup members who are exposed to treatment discrimination encounter organisational experiences that are less favourable to their careers than the experiences of the dominant group.

Applying research findings on gender discrimination to racial minorities, Ilgen & Youtz (1986) suggested that minorities may experience treatment discrimination that can have dysfunctional consequences for their careers.

Treatment discrimination may reduce their job performance and career prospects, since they would have fewer opportunities to enhance work related skills and develop supportive relationships.

These lost opportunities may be reflected in the absence of a powerful sponsor. They can depress minority employees' motivation, and thereby diminish their performance.

In effect, they proposed that race differences in work performance could be explained, at least in part, by the differential treatment different groups experienced.

They further suggested that minority members may internalise an organisations negative evaluations of them and engage in 'self-limiting' behaviours, for example

refusing a challenging job assignment or declining an opportunity for additional training.

Appraisal of current job performance plays a significant role in organisations' assessment of an employee's suitability for promotion. Supervisors who hold a negative view of an employee's job performance evaluation may give that individual smaller salary increments, less interesting assignments and less recognition than other employees.

This has obvious implications for the assessment of physicians' performance. Because organisational systems can have a detrimental impact on an individual's performance, it is important that there is some assessment of the organisation when undertaking an assessment of an individual.

How to assess the problem of institutional racism: is the organisation racist?

Jeanquart-Barone & Sekaran (1996) developed a causal model for testing the precursors of institutional racism. They found three independent variables:

- supervisory support - help and career support given to employees
- procedural justice - fairness of compensation
- and indoctrination - the extent to which employees are expected to conform to the norms of the majority group in the system

as important measures of institutional racism in organisations.

The model that they described assesses the acceptance of minorities in the system, their participation in decision making and the extent to which cultural diversity is respected in the organisation. They also looked at the supportive climate of an organisation and the extent to which an atmosphere of mutual help, trust and psychological safety existed.

Although their analysis only covered 146 employees (a 12% response rate in a sample of 1,500), their work provides some important theoretical perspectives on the measurement of institutional racism.

They found that a lack of a supportive climate and perceived discrimination were significant direct paths to institutional racism and suggested that organisa-

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tions can reduce the extent of perceived institutional racism by providing an organisational climate that is conducive to the effective functioning of all employees and enforcing non-discriminatory standards.

If approximately 30% of the current NHS medical workforce is from ethnic minorities, what can health care organisations do to develop policies and practices which are non-discriminatory?

If we are to accept that assessing clinical performance is an important aspect of managing clinicians and that institutional racism can have an impact on that assessment, then it is important for us to consider how we can assess an organisation's competence in this area.

Research in this area is scarce. Equal employment requirements are the main driver of management policy and our experience of the NHS is that few organisations can claim to positively encourage diversity practice.

Brach & Fraser (2000) defined cultural competency as 'an ongoing commitment or institutionalisation of appropriate practice and policies for diverse populations'. If cultural competence is the goal, then diversity management is the process leading to culturally competent organisations.

Diversity management is therefore a strategically driven process whose emphasis is on building skills and creating policies that will address the changing demographics of the workforce and patient populations.

A survey by DeAnda et al (1998) on career attainment among health care executives across different races / ethnicity confirmed that there was considerable room for improvement in the cultural and diversity climates of healthcare organisations.

Research examining diversity management practice is scarce. Weech-Maldonado (2002) only identified three studies in the USA, which examined diversity management practice in healthcare organisations. These studies have focused on human resource issues in diversity management.

Each of the three studies found that relatively few hospitals had implemented diversity management programs even when hospitals considered such programs

an important organisational issue. Hospitals that were not actively implementing diversity management policies were primarily concerned with compliance-orientated strategies.

Culley (2002) reported similar observations in her study of equal opportunities policies in relation to NHS nursing employment.

Weech-Maldonado (2002) discussed some of these issues in a study carried out on the diversity management practices of Pennsylvania hospitals. Using a conceptual framework, developed by Dreachslin & Saunders (1999), he suggested a five-stage theoretical model for organisational change, from affirmative action to valuing diversity.

Each stage is characterised by different diversity management practices, or behaviourally-based performance indicators. These include indicators for: planning; stakeholder satisfaction; diversity training; human resources; health care delivery; and organisational change.

Health care organisations are expected to be at different stages of the change process, and a natural progression is expected from one diversity stage to another. Based on his survey results, which found that hospitals in Pennsylvania had been relatively inactive with respect to diversity management practices, he suggested four areas that merited special attention for hospitals seeking to adopt diversity management practices:

- Establishing diversity training programs for clinical and staff personnel.
- Instituting human resources practices aimed at recruitment and retention of minorities at all levels.
- Using structural mechanisms such as task force or quality improvement committee to monitor the racial/ethnic diversity climate.
- Implementing control systems that reward management and clinicians for meeting diversity goals.

Summary

We have argued that institutional racism can be an important factor in the assessment of clinicians. The reality is that racism is perceived as being a part of everyday life in the NHS, and this cannot be ignored.

Racism is an important source of stress and can affect the health of individuals. Because of the impact of racism, any assessment of an individual should also take into account the effect of interpersonal discrimination; the effects of institutional racism; and the extent to which the individual feels that they are part of a wider group subject to discrimination.

We have also shown how an organisation and its responsiveness to diversity practices can influence how an assessment is carried out. It is our contention that because of the potential impact of institutional racism, an organisational assessment may in some cases be an essential part of the overall assessment of a person's competence.

There is an increasing understanding of issues related to racism in the NHS and Esmail (2005) has summarised and evaluated the various NHS initiatives. Coker (2001) also provides a useful analysis of current policies and developments in relation to the NHS and medical organisations.

There is no doubt that the legal framework in the United Kingdom acts as an important driver for change. However it is also important to understand that organisational policies can have an impact on the performance and appraisal of individual physicians. UK healthcare organisations could learn useful lessons from the diversity management model outlined.

References

- Blofeld J (2003) Independent Inquiry into the death of David Bennett. Norfolk, Suffolk and Cambridgeshire Strategic Health Authority
- Brach C, Fraser I (2000) Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. [Review]. *Medicare Care Research and Review* 57(1 Suppl): 181-217
- Chahal K, Julienne L (1999) 'We can't all be white!': Racist victimisation in the UK. York Publishing Services Ltd
- Coker N (2001) *Racism in Medicine. An agenda for change*. King's Fund, London
- Corbie-Smith G, Frank E, Nickens HW, Elon L (1999) Prevalences and correlates of ethnic harassment in the U.S. Women Physicians' Health Study. *Academic Medicine* 74(6): 695-701
- Culley L (2001) Equal opportunities policies and nursing employment within the British National Health Service. *Journal of Advanced Nursing* 33(1): 130-7

- De Anda J, Dolan TC, Lee-Eddie D, Elision E, Honkawa Y (1998) A race/ethnic comparison of career attainment in healthcare management. *Healthcare Executive* **13**(3): 28–33
- Dovidio JF, Gaertner SF (2000) Aversive racism and selection decisions: 1989 and 1999. *Psychological Science* **11**(4): 315–9
- Dreachslin JL, Saunders JJ (1999) Diversity leadership and organizational transformation: Performance indicators for health services organizations / Practitioner application. *Journal of Healthcare Management* **44**(6): 427–39
- Esmail A, Abel P, Kalra V (2005) A critical review of leadership interventions aimed at people from black and minority ethnic groups. A report for The Health Foundation http://www.health.org.uk/uploadedfiles/document/2_113_BME%20report%20exec%20summaryFINAL.pdf
- Greenhaus JH, Parasuraman S, Wormley WM (1990) Effects of Race on Organizational Experiences, Job Performance Evaluations, and Career Outcomes. *The Academy of Management Journal* **33**(1): 64–86
- Ilgen DR, Youtz MA (1986) Factors affecting the evaluation and development of minorities in organizations. In: Rowland K, Ferris G eds. *Research in personnel and human resource management*. JAI Press, Greenwich, Conn: 207–31
- JeanQuart-Barone J, Sekaran U (1996) Institutional racism: An empirical study. *Journal of Social Psychology* **136**(4): 477–82
- Jones EW (1986) Black managers: the dream deferred. *Harvard Business Review* **64**(3): 84–93
- King G (1996) Institutional racism and the medical/health complex: a conceptual analysis. [Review] *Ethnicity & Disease* **6**(1–2): 30–46
- Kraiger K, Ford JK (1985) A meta-analysis of race effects in performance ratings. *Journal of Applied Psychology* **70**(1): 56–65
- Landau J (1995) The Relationship of Race and Gender to Managers' Ratings of Promotion Potential. *Journal of Organizational Behaviour* **16**(4): 391–400
- Lemos & Crane (2000) Tackling Racial Harassment in the NHS: Evaluating Black and Minority Ethnic staff's Attitudes and Experiences. Department of Health, www.dh.gov.uk/raceharassment
- MacPherson W (Sir) (1999) The Stephen Lawrence Inquiry - Chapter 6. Racism. Presented to Parliament by the Secretary of State for the Home Department by Command of Her Majesty. London, TSO. Cm 4262-I
- McManus IC, Winder BC, Gordon D (2002) The causal links between stress and burnout in a longitudinal study of UK doctors. *The Lancet* **359**(15): 2089–90
- Berrow D, Faw L, Jobanputra R (2005) NCAS Evaluation, Research & Development. Analysis of the first 50 NCAS assessment cases. National Clinical Assessment Service
- Post DM, Weddington WH (2000) Stress and coping of the African-American physician. *Journal of the National Medical Association* **92**(2): 70–5
- Virdee S (1995) Racial Violence and Harassment. Policy Studies Institute, London: 1–95
- Weech-Maldonado R (2002) Racial/ethnic diversity management and cultural competency: The case of Pennsylvania hospitals. *Journal of Healthcare Management* **47**(2): 111–24

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Key points

- There is an over-representation of ethnic minority clinicians who are either suspended or being investigated by the General Medical Council and the National Clinical Assessment Service.
- Racism may be a factor in the assessment and appraisal of these clinicians.
- Understanding the impact that racism may have, requires consideration of the role of institutional racism, the way that racism can lead to stress and the role that organisations can have in both inadvertently accentuating the problem but also in mitigating its effects.
- Diversity management provides a model for change which has direct relevance for healthcare organisations in the UK.