Anti-Racist Nursing and Midwifery. A Resource for Students, Practitioners, Educators, and Activists.

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This book exposes institutionalised and inter-personal racism in healthcare and its impact on the lives of Black and Brown people. It is based on the experiences and actions of a group of nurses and midwives who came together as a result of the research project Nursing Narratives: Racism and the Pandemic (UKRI/AHRC).

Racism in healthcare damages us all and is a matter of social justice. It affects staff retention, staff health and well-being, and the quality of patient care. In this book, nurses and midwives narrate their experiences of racism and reflect on the successes and difficulties of challenging racism within healthcare institutions. With the overall aim of empowering others, including providing white allies with a deep understanding of how racism operates, the book gives opportunities for critical reflection and encourages us to think about how we can bring about progressive change in practice.

The book is an invaluable resource, helping health professionals and students understand the patterns of racism in the health workplace.

Anandi Ramamurthy is Emeritus Professor at Sheffield Hallam University and led the research project Nursing Narratives: Racism and the Pandemic. She has authored five books on racism and culture.

Sadiq Bhanbhro is Senior Research Fellow at the Centre for Applied Health and Social Care Research (CARe) at Sheffield Hallam University and a member of the Nursing Narratives team.

Ken Fero is Assistant Professor at Regent's University London and founder of the radical film activist collective Migrant Media. His award-winning films include *Injustice* (2001) and *Ultraviolence* (2020). He produced the documentary *Exposed* (2022) for the Nursing Narratives research project.

Rachel Ambrose is a Registered Mental Health Nurse (RMN) and Specialist Community Public Health Nurse (SCPHN). With a nursing career spanning 20 years, she brings extensive expertise to her work in CAMHS and School Nursing. She is committed to inclusive practice in health and education and lectures at Oxford Brookes University.

'*Anti-Racist Nursing and Midwifery* is a powerful and deeply moving book that exposes the realities of racism within the nursing and midwifery profession. Through the courageous testimonies of Black and Brown nurses and midwives, it evokes a wide range of emotions—pain, anger, heartbreak, and, importantly, hope. The narratives illuminate the strength, resilience, and perseverance required to continue providing care in the face of injustice. This book provides valuable guidance for practitioners worldwide.'

Lucinda Canty *PhD, CNM, FACNM, FAAN, FADLN, Founder of Overdue Reckoning on Racism, US*

'This work marks a groundbreaking shift away from damage-centered research, which too often focuses solely on stories of pain and positions racially marginalized participants as victims. Instead, it engages and centers the perspectives of Black, Brown and migrant care workers—particularly nurses—who have been rendered less than human and less worthy of care by neo-colonial/racialized systems of knowledge and power relations, a reality made especially evident during the COVID-19 pandemic. It delves deeply into the subversive waters of creative resistance to bring individual and collective stories of agency to the surface, and to enable self-determined and transformative knowledge creation and mobilization. In a European healthcare context where racism is considered a silent/silenced phenomenon, this work contributes to breaking that silence by offering a compelling and necessary resource for reflection and action. It identifies critical areas for institutional change, and underscores the broader power structures that must be addressed in order to advance equity and justice in nursing. The book is vital reading for policy makers, professionals, students, and activists alike.'

Tanja Gangarova, *National Monitoring of Discrimination and Racism (NaDiRa) DeZIM Institute, Berlin*

'This brilliant book makes for difficult but essential reading for nurses and those managing and leading health services in England. The fact is, the NHS needs nurses and midwives from all backgrounds to shore up and deliver high quality services for an aging and growing population. It therefore has a responsibility to take note of the harrowing experiences of nurses and midwives in this book and consider ways of mitigating the impact of racism on this very important part of the NHS workforce. It will be my go-to book for lots of information on ethnic minority nurses and midwives working in the NHS.'

Yvonne Coghill, *Former Director, Workforce Race Equality Standard, NHS, board member of NHS Race and Health Observatory*

'An indispensable book for those looking to see how the persistence of racism in all parts of British society results not only in micro-aggressions but the deprivation of life itself! Health care workers bore the brunt of a biological virus that was super-charged by the virulent, vicious racism that pervades the NHS. These awe-inspiring testimonies bear witness to the utmost resilience

and humanity of Black and Brown staff faced with the intensification of everyday racial harassment and inequality. Ending with an urgent manifesto for change this is a tool for educators and activists alike, it stands along with the accompanying film as a testimony to all those who gave their lives, without discrimination, in the battle against Covid-19.'

Virinder S. Kalra, *Department of Sociology, University of Warwick*

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Routledge
Taylor & Francis Group
LONDON AND NEW YORK

Designed cover image: Gabs Iozzi/nursingnarratives.org

First published 2026
by Routledge
4 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

and by Routledge
605 Third Avenue, New York, NY 10158

Routledge is an imprint of the Taylor & Francis Group, an informa business

For Product Safety Concerns and Information please contact our EU representative GPSR@taylorandfrancis.com. Taylor & Francis Verlag GmbH, Kaufingerstraße 24, 80331 München, Germany.

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

ISBN: 978-1-041-05428-3 (hbk)
ISBN: 978-1-915713-96-4 (pbk)
ISBN: 978-1-041-05427-6 (ebk)

DOI: 10.4324/9781041054276

Typeset in Galliard
by Newgen Publishing UK

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Contributors

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Dusu G. Dung is a Doctoral Researcher in public health and social research whose work focuses on healthcare disparities. He has over four years' experience as a healthcare assistant in the UK.

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Zoe Malcolm trained as a nurse. She is a qualified English teacher currently working in an inner-city alternative provision setting, where she is focused on improving students' functional literacy.

Fatimah Mohamied is a Muslim, mother, and midwife – an alloy of Britain, Egypt and Bengal. She advocates for marginalised and vulnerable groups. Her work tackles patriarchy, white supremacy, and capitalism.

Benash Nazmeen is a midwife, academic, and activist. Her work centres on structural inequalities in maternity care, with a particular focus on migrant and racially minoritised communities.

Gemma Newbold is a registered nurse with a background in community and children's nursing. She uses her voice to advocate for justice, identity, and lasting change within healthcare and beyond.

Roseline Sanni-Ajose is a theatre and critical care nurse, as well as an international actress, producer, and writer. Her films focus on the needs of the community in Nigeria and the diaspora.

Preface

In March 2020 as the country went into lockdown, I was filled with stress, scrolling news bulletins. It was Al Jazeera's article 'Muslim Minority Doctors, First to Die in the Pandemic' that had an profound impact on me. The photograph accompanying the article, of four Black men with the kindest of smiles, gone forever, hit me. The articles kept coming. Thomas Harvey, who had worked for the NHS for 20 years, was given gloves to look after COVID+ patients and was failed by the ambulance service. Mary Agyapong, heavily pregnant 'felt pressured' to work, and John Alagos, just 23 years old was not allowed to leave his shift early despite having COVID, went home never to return.

I was burning inside. The media discussion on racism was muted, and the discourse was centred around wider social vulnerabilities and even genetics. But what about racism? In collaboration with Ken Fero, an activist and filmmaker, and Sadiq Bhanbhro, a colleague at Hallam, we submitted a proposal to UK Research and Innovation's (UKRI) Urgent Covid Call through the Arts and Humanities Research Council (AHRC) and were successful. We wanted to amplify the voices that were being ignored and ensure that the research reached a wide audience, so we decided to make a film about the experiences of Black and Brown nurses. As we began working on the research, we expanded our scope to include a wider array of staff, such as midwives, healthcare assistants, and allied health professionals. Their experiences of racism and discrimination were similar. We were also interested in ensuring that our participants were not portrayed solely as victims, so we highlighted the individual and collective acts of resistance in their stories.

There were many people who supported us along the way, Kanlungan Filipino Consortium joined our advisory panel. We extend special thanks to Susan Cueva and Nyel Camilion at Kanlungan, who supported us in meeting and interviewing several Filipino nurses and reflecting on the core issues and concerns. The African Caribbean Health Network also came on board, Charles Kwaku Odoi joined our advisory panel, and Faye Ruddock became a co-investigator on the project. Her extensive networks enabled us to get in touch with many nurses and midwives in the North West. Shanaaz Ali, Michelle Cox, and Dr. Aneez Ismail also provided us with valuable insights

into their experiences of challenging racism in the NHS. We also thank Steve Ford from the Nursing Times, who helped publicise the project and its concerns. Special thanks to Freya Collier Smith, our research assistant without whom the project launch event could never have happened.

There were numerous nursing groups that invited us to meet their members, but they were concerned about speaking out on film because of the targeting they may be subjected to. This makes us all the more in awe of those who took part in our film *Exposed* and were not afraid to speak up: Esther Akinpelu, Rachel Ambrose, Nafiza Anwar, Olanike Babalola, Neomi Bennett, Rosetta Binu, Rona Codero, Susan Cueva, Estephanie Dunn, Fatima Ezzahra, June Green, Dawn Hutchinson, Felicia Kwaku, Abhinav Kolilagadda, Zoe Malcolm, Fatimah Mohamied, Benash Nazmeen, Gemma Newbold, and Roseline Sanni-Ajose. Without their bravery, we would not have been able to create the impact that we did. Thank you to Felicia Kwaku, who circulated the Anti-Racist Manifesto for Change through dozens of nursing associations, which all signed up to display a collective determination to change the status quo. Thanks to Estephanie Dunn for organising more than one screening of the film at the Royal College of Nursing, Neomi Bennett for her invaluable insight from her work in Equality for Black Nurses both during the initial project and in the development of this book.

After the film was released, we were approached by Critical Publishing (now absorbed by Routledge) to produce a book that would provide a resource for professionals, students and activists. Many of the participants were excited at the idea. Rachel Ambrose, as an early career academic, came on board as an editor and her personal experience of the workplace and as an activist has been invaluable.

We hope the book can be a useful resource for those that are impacted by the issues that are covered in the stories and also a guide for those who want to support the struggle for equality and change.

Anandi Ramamurthy, June 2025

Introduction

Anandi Ramamurthy

Black, Brown, and migrant health workers make a critical contribution to the NHS and social care. Yet, their experiences at work paint a devastating picture of racism and discrimination at all levels. There have been numerous reports on the racism and discrimination faced by both staff and patients in UK healthcare, yet little has changed. In 1999, the Macpherson report recognised institutional racism. It made recommendations for all UK public institutions to address disparities in public service delivery and carry out a review of policies, practices, and training programmes to eliminate discrimination (Macpherson, 1999). Yet the NHS only began to collect data to measure experiences by ethnicity in 2015. Despite the Workforce Race Equality Standard (WRES) data collected by the NHS since 2015, after years of campaigning by those seeking to challenge discrimination, there has been little change in practice. The lack of opportunities for progression for Black and Brown staff has maintained the snowy white peaks of the NHS, and higher incidences of bullying and harassment continued and increased during the pandemic (NHS England, 2020). Numerous reports have also highlighted the poorer health outcomes that Black and minority ethnic communities experience when accessing healthcare. (Kapadia, 2022).

During the coronavirus pandemic, the impact of racism and discrimination was lethal. In the first month of the UK lockdown, Cook et al. concluded that 72% of the NHS and social care staff who died were from Black and Brown communities.[1] In the early months of the pandemic, Black males had a mortality rate 3.3 times higher than white males, while Black females had a rate 2.4 times higher than white females. Men from Bangladeshi and Pakistani ethnicity had mortality rates twice that of white males (Cook et al., 2020). It is noteworthy that the figures of healthcare staff deaths by ethnicity during the pandemic have never been released. A Public Accounts Committee in February 2021 recognised that the government 'does not know enough about the experience of frontline staff, particularly BAME staff'. It asked the government to consider the 'extent to which (and reasons why) BAME staff were less likely to report having access to PPE and being tested for PPE and more likely to report feeling pressured to work without adequate PPE' (House of

DOI: 10.4324/9781041054276-1

Commons Public Accounts Committee, COVID-19 2021). The October 2021 Lessons Learned report noted that 'the higher incidence … may have resulted from higher exposure to the virus' (House of Commons, 2021). Yet neither report explicitly referenced racism and the government's Commission on Race and Ethnic Disparities, chaired by Tony Sewell, denied the persistence of racism in national institutions (Commission on Race and Ethnic Disparities, 2021). Yet the blatant disparity in impact of the coronavirus pandemic on Black and Brown communities and the outcry over this led the government to establish the Race and Health Observatory in 2021. Tasked with investigating health disparities, to date, the observatory has focused on the experiences of the population as patients rather than on the workforce.

This book brings together a collection of stories of racism, resistance, and resilience from nurses, midwives, and healthcare assistants who contributed to the Nursing Narratives: Racism and the Pandemic project (nursingnarratives.org). Funded by UK Research and Innovation and the Arts and Humanities Research Council (UKRI/AHRC) as an urgent COVID-19 Call research project, our aim was to create a space where nurses and other healthcare workers could speak out about their experiences of racism both during the pandemic and previously in their working lives. We decided to focus on the experience of nurses and midwives since doctors have often had more opportunities to share their perspectives, because of their status. While statistical data on racism collated in the WRES has been important to enable us to understand the breadth of the problem, stories of experience can help us to better understand how racism impacts individuals in everyday life. These stories indicate that racism is not just experienced as a series of isolated incidents. As an accumulation of experience, it can have a profound impact on individuals, their networks, and their patients that are greater than the individual isolated events.

Given the multitude of reports that have been written, we decided it was more valuable to make a film and employ eye witness testimonies harnessing emotion as a tool to elicit memory (Archibong and Dar, 2010; Kline, 2015; Kline, 2024; RCM, 2012; West et al., 2017). Our film *Exposed* explored the experiences of 19 nurses and midwives (Fero and Ramamurthy, 2020). Every participant had stories of mistreatment but also of resistance. The film narrative was influenced by 25 audio interviews that we also carried out at the time of our research to enable us to understand the patterns of experience that existed for staff on the frontline.

This book aims to provide deeper narratives that we could not cover in a film. We hope it will enable students, practitioners, and educators to understand the cultures of racism that exist in the health service in order to challenge the patterns of oppression that continue. We hope it will support Black and Brown staff to understand their experiences and prevent gaslighting and the internalisation of racism. We hope that the stories will enable allies to recognise racism in their own workplaces and stand up for colleagues that are being treated unfairly, both in individual and recognisable incidences, but

also through the perpetuation of cultures of exclusion. We also hope that the stories will highlight the need for government and regulatory bodies to take action to remove the environments and practices that foster and cultivate racist exclusions, attitudes, and behaviours.

In Chapter 1, 'The Realities of Racism', we explore the overall data that we collected for the project from both oral and video interviews. The interviews collectively enabled us to understand the key ways in which racism operates in the health workplace. These established cultures of racial discrimination impacted on treatment in the pandemic and the disproportionate consequences for Black and Brown staff.

To evaluate the cumulative impact of racism on healthcare professionals and how this reflected on their treatment in the pandemic, we believed it was essential to privilege and make space for the voices of Black and Brown healthcare professionals. To understand why so many Black and Brown staff died, we needed to look historically at how both everyday and systemic racisms operated in the health workplace to make Black and Brown health staff so vulnerable.

The remainder of this book gives space to 17 stories of experience written by nurses, midwives, and healthcare assistants. Listening to the narratives of people's lives, we can appreciate the cumulative impact of racist discrimination and the toll that this takes mentally and physically – a racial weathering as it has come to be described. Most importantly we also learn the ways in which people have resisted and navigated racism at work. For the participants, speaking out about racism is a form of resistance. They ask us to listen and learn.

The chapters have been written by two senior managers, as well as nurses, midwives, and healthcare assistants on the frontline. The majority of the chapters were written by healthcare workers who were participants in the initial research. We also include a chapter from Michelle Cox, who sat on our advisory committee, but was unable to give an interview at the time of the research due to her ongoing racial discrimination case against NHS England, a case she later won. The other additional chapter is from a doctoral scholar whose research will develop knowledge on discriminatory workload allocation, an aspect of racialised work practices that we highlighted in the Nursing Narratives research, an issue that has been poorly discussed in existing research on racism in health.

The chapters do not need to be read in any order, although we start with a chapter by Estephanie Dunn, the Regional Director of the Royal College of Nursing (RCN) North West at the time of writing. Her chapter, "Navigating Power", provides a long view of the NHS through reflections on a career that lasted nearly 50 years. As a senior manager and later regional director of the RCN, her chapter highlights early experiences of support, discrimination and exclusion. She reflects on the resistances that she faced when trying to challenge inequalities in health outcomes, as well as recognising what is possible when leaders support visions for improvement. Her chapter provides examples

of the ways in which racist stereotyping can have serious impacts on management decisions, affecting health outcomes for whole communities. Her narrative reflects on a range of initiatives to combat racism and represent staff in the RCN, emphasising the need for allies in the struggle against racism.

Zoe Malcolm's chapter "Stand Your Ground, but Not at Any Cost" takes us to the beginning of the nursing journey, their training. The racist bullying and harassment that she faced meant that she was never able to complete her nursing degree. Her story highlights the racism of both her placement institutions and the university, from whom she should have received pastoral support. For Zoe the entrenched nature of racism in the health service has led her to believe the most effective response to force change is for Black people to withdraw their labour until they are treated with the respect that they deserve.

Riel Alfonso's chapter "Don't Suffer in Silence" provides an example of a nurse who acted on what Zoe feels. He left the NHS due to racist and homophobic bullying. His story is the first in the book by an internationally educated nurse. Riel's experiences highlight the systemic racism of the health service that fails to recognise the qualifications of overseas nurses, leading to nurses being undermined by white staff through interpersonal racism, exploited due to their immigration vulnerabilities and denied opportunities to use and develop their skills and careers. Riel's story also provides evidence of intersectional oppression and highlights the emotional impact of a system that feels as though it is designed to undermine the self-worth of migrant nurses. His chapter begins the evidence of unfair treatment and neglect of Black and Brown nurses in the pandemic, during which time he sought support from Kanlungan, an independent Filipino organisation who campaigns for migrant workers' rights.

Two further chapters by Rona Cordero and Olanike Babalola provide further evidence of both systemic and interpersonal racism faced by migrant nurses who are mothers. Rona Cordero highlights how different forms of discrimination intersect. The systemic racism of no recourse to public funds forced her to work nights while her husband worked in the day. The refusal by her managers to recognise this straitjacket left her open to victimisation. Rona's experiences as a staff governor highlight a management that often pays lip service to the voice of its workforce. She provides evidence of unfair treatment in the pandemic and highlights the importance of Black and Brown staff speaking out together as the safest way to advocate for change. Olanike Babalola's story narrates the difficulties of a Nigerian nurse who is impacted by the brutality of the immigration system, skyrocketing fees, and having no recourse to public funds. Her experiences of everyday racism highlight the ways in which Black nurses are often treated as though they are incompetent, despite qualifications and skills, stifling career development. She also gives evidence of the struggle for safe working in the pandemic. As a union organiser, she turned to the RCN, who supported her right to a safe working environment.

A number of the nurses whom we spoke to chose to work as agency nurses. Roseline Sanni was one of them. Roseline's story emphasises her resilience and refusal to be treated as second-class. She gives evidence of the unfair treatment of Black nurses in the pandemic, who were invariably sent to the red zone. As a multi-talented individual – actor and nurse – Roseline has not allowed the racism of the health service to curb her potential. Committed to improving the health of her people, she has employed her filmmaking talents to provide public health education to the Nigerian community.

There were very few healthcare assistants who spoke with us during our research despite attempts to reach out to them. Janice Baptiste is one of the few who did. Although first speaking in confidence for fear of reprisals, she later decided she wished to join the nurses who spoke out in public, recognising the importance of truth to power. Janice's story tells of a Black woman who was insufficiently supported as a student when struggling due to the personal loss of family members. Like Zoe Malcolm and at least one other nurse who we spoke to, she was failed at the end of her degree. Janice settled with being a healthcare assistant. She reflects on how speaking out has led her to be framed through the racist stereotype of the angry Black woman. Her experience in the pandemic gives evidence of moral injury at work that caused lasting trauma. Delegated a workload that made it impossible to care safely for her patients, her historical experience of racism led to her own fear that she would be victimised as a result of a patient's death, rather than first recognising that she had been ill-treated. Speaking out after the death of George Floyd and joining a Black workers group gave her strength, confidence, and a belief in her value.

Dusu Dung's story reflects on the experiences of migrant healthcare assistants (HCA). As a Black member of staff at the lower end of the NHS hierarchy, he was often treated as second class and delegated the worst tasks to carry out. Dusu highlights the intersectional nature of his oppression as a male Nigerian support worker. He is now focussing on research as a method to highlight racism.

The next three chapters narrate the experiences of midwives. Their stories highlight resistance to both colour-based racism and Islamophobia. Benash Nazmeen's story reflects on the culture of workplaces that marginalise racialised minorities. Seeing the failures of maternity care to support South Asian Women adequately, she helped set up the Association for South Asian Midwives to enable midwives like her to come together to speak out to improve their working lives and the outcomes for South Asian birthing mothers. Benash, like a number of the contributors to Nursing Narratives, has chosen to enter academia, aiming to make change through research and curriculum development. Fatima Ezzahra Ghaouch highlights the different nature of racism in Italy and England. Black Lives Matter was a critical moment for her to speak out and share her experiences of racism with colleagues. After working in a senior position and facing resistance to change, she too has entered academia hoping to ensure that midwives are better equipped to care for mothers from

all ethnic and religious backgrounds. The urgent need to challenge racism in midwifery training and practice is highlighted through Fatimah Mohamied's recent experience as a student nurse, a newly qualified midwife, and a birthing mother. She emphasises the impact of colonialism and white supremacy in health institutions and academia, where she experienced repeated attempts to silence any challenge to the status quo. For Fatimah, the care of all birthing mothers must be of concern to midwives. In the context of the current devastation of Gaza, Fatimah speaks out for the rights of mothers in the Global South, including in Gaza, through her published writing. She calls for others to do the same.

The flight to academia from nurses who have experienced discrimination and wish to create change is also present in Rosetta Binu's chapter. Having experienced isolation and harassment as an internationally educated nurse, she moved into academia to achieve promotion and meaningful direction by supporting new internationally educated nurses through their OSCE training.

Chapters 14 and 15 focus on racism, mental health, and well-being. Gemma Newbold's chapter exposes appalling everyday racism and discrimination that must be understood as an institutional responsibility when it is not challenged by management. Gemma reflects on the cost of racialised experiences for her own mental health and how speaking out was a powerful moment in gaining confidence and improving her well-being. Rachel Ambrose's chapter reflects on racism within mental health and learning disability services, drawing on both her personal family experiences and her professional work within the mental health system. As an active trade unionist, Rachel highlights the importance of Black staff organising and speaking out on both racism and wider workforce issues. She too has moved to academia to work towards changing the curriculum in mental health nursing.

The final three chapters develop insight into the work of nurses who have made direct challenges to racism in institutions, through legal frameworks and campaigning. Michelle Cox's story of tirelessly seeking to create inclusive systems, yet being treated with exclusion and discrimination led to her landmark racial discrimination case against NHS England.

Neomi Bennett and Esther Akinpelu's chapters provide narratives of resistance to racism through independent Black-led organisations. Black Lives Matter was a galvanising moment for Neomi Bennett, who set up Equality for Black Nurses following racist treatment in the pandemic and the broadcast death of George Floyd. Neomi's focus is not just the racism of the workplace but the racism of regulatory bodies such as the Nursing and Midwifery Council (NMC). Esther Akinpelu's treatment as a Black nurse highlights anti-Black racism towards both patients and staff. Discrimination in progression led her to leave full-time employment and work as an agency nurse in order to create space to support the work of Equality for Black Nurses. The nurses and

midwives in our study chose to organise both inside and outside the system, sometimes using both avenues to try to push for progressive change.

We asked all the health workers that we spoke to highlight the changes that they wanted to see for the creation of an anti-racist health service. The reflections that they made were then discussed collectively to create the 'Anti-Racist Manifesto for Change' that is published at the end of the book. The Manifesto is the result of their experiences of struggle which have been condensed into catalysts for action. The call by health workers for a compassionate health service was resounding, along with the demand to be treated with dignity and respect. Health workers chose a variety of strategies to try to achieve change but the recognition that trusts, universities, government, and regulatory bodies all held responsibility along with individuals was clear. All must take action if we are to create an anti-racist health service fit for the future.

Note

1 We have adopted the terms Black and Brown to recognise the continued impact of colour-based racism despite the intersection of discriminations based on other markers of ethnicity.

References

Archibong U & Dar A (2010). *The involvement of Black and minority ethnic staff in NHS disciplinary proceedings*. University of Bradford, Centre for Inclusion and Diversity.

Commission on Race and Ethnic Disparities (2021). The Report of the Commission on Race and Ethnic Disparities. GOV.UK. https://assets.publishing.service.gov.uk/media/6062ddb1d3bf7f5ce1060aa4/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf

Cook T, Kursumovic E, & Lennane S. (2020). Exclusive: Deaths of NHS staff from COVID-19 analysed. *Health Services Journal*.

Fero and Ramamurthy (dir) (2020). *Exposed*. [Film] Nursing Narratives: Racism and the Pandemic. https://nursingnarratives.org/

House of Commons (2021). *Coronavirus: Lessons learned to date: Sixth Report of the Health and Social Care Committee and Third Report of the Science and Technology Committee of Session 2021–22*.

House of Commons Public Accounts Committee, COVID-19 (2021). *Government procurement and supply of personal protective equipment*. Forty-Second Report of Session 2019–21.

Kline, R. (2015). *Beyond the snowy white peaks of the NHS*. Race Equality Foundation. https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/Health-Briefing-39-_Final.pdf

Kline R & Warmington J. (2024). *Too hot to handle: Why concerns about racism are not heard … or acted on*. brap. https://27aa994b-a128-4a85-b7e6-634fb830ed15.usrfiles.com/ugd/27aa99_9a9468c5e4da43288da375a17092d685.pdf

Macpherson, W. (1999). *The Stephen Lawrence inquiry. Cm 4262-I*. The Stationery Office.

NHS England (2020). *Workforce race equality standard 2019*. www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/workforce-race-equality-standard-2019-report/

RCM (2012). *Freedom of information request: Midwives and disciplinary proceedings in London*. Royal College of Midwives.

Chapter 1

The realities of racism

Anandi Ramamurthy, Sadiq Bhanbhro, Rachel Ambrose, and Ken Fero

This chapter brings together our understanding of the realities of racism faced by nurses, midwives, and other healthcare workers in the National Health Service (NHS) through individual audio and video narrative interviews (n = 45), a survey (n = 308) conducted between 2019 and 2020, as well as two further chapters by health workers produced for this book. (see Appendix A.1). Although our study participants included nurses, midwives, and healthcare assistants (HCAs), after watching our documentary *Exposed*, other health professionals, including doctors and allied health professionals, revealed how they had experienced the same systemic racisms. Our research adopted a Critical Race Theory (CRT) framework, recognising racism as systemic, a socially constructed entity, not a biological reality. CRT argues that racism is pervasive, making it an ordinary experience for most people of colour. It emphasises that its influence lies not just in explicit acts of race hatred but in the 'more subtle and hidden operations of power that have the effect of disadvantaging one or more minority ethnic groups'. CRT also argues against colour-blindness, holding that it is only through race consciousness that we can challenge racism (Baum, 2015; Delgado & Stefancic, 2017; Gillborn, 2015; Iheduru-Anderson & Alexander, 2022).

Through the stories that we heard, we found extensive references, historically and contemporaneously, to pervasive cultures of racism in the workplace. It was recognised that everyday racism, including microaggressions, stereotyping, and exclusion, was a pervasive element of working life. Such cultures fostered an environment where Black and Brown staff were less cared for, making space for differential work allocation, victimisation, neglect, and exclusion, and as a result, restricting space for progression and career development. These practices cannot be attributed to individual prejudices or 'unconscious bias' that can be taught out of the system. They must be seen as a result of policies, practices, and legal frameworks such as the immigration laws that demand differential treatment of Black and Brown healthcare workers, entrenched through the treatment of its migrant workforce, to maintain the NHS in a system embedded in racial capitalism (Sowemimo, 2023), where a

DOI: 10.4324/9781041054276-2

racial division of labour is required and enforced, through differential treatment and rights.

This chapter draws on all the interviews that we conducted. Here, we quote and emphasise specific experiences from participants who did not write their own chapters later in the book. Alongside this, we reference the narratives published in the second half of this book, where nurses and midwives share their own stories of both racism and resistance.

The chapter is organised into two sections. The first section explores the roots of racism. It considers the impact of colonialism on racial stereotypes and white supremacy/privilege, as well as the institutionalisation of racism through immigration laws, highlighting the consequences in the workplace. The second section explores three pervasive ways in which racism is practiced: exclusion and neglect; over-scrutiny and victimisation; and unequal work allocation. Together, these policies and practices create exploitation and victimisation of Black and Brown workers, with extreme vulnerability for overseas staff leading to devastating consequences in the pandemic.

The roots of racism

To understand the patterns of racism in the health workplace, we need to explore the historical roots of racism. Both slavery and colonialism as political and social practices were central to the development of capitalism in Europe. Capitalism relied on racism as an ideology to maintain the colonial belief in Europe's right to exploit the peoples, land, and wealth of Africa and Asia, leading to:

> The enslavement and transportation of millions of people, the direct appropriation of resources, the extraction of surpluses through taxation, exploitation and unequal trade, and the shifting of resources away from productive activities and the creation of enforced deindustrialisation.
>
> (Wilson, 2012, p. 19)

Despite the exploitation and brutality of colonialism in both Asia and Africa, colonial rule was constructed as 'the white man's burden' and viewed as a moral duty of Europe (Lugard, 1911).

Skin colour was a primary signifier of difference and was used to consolidate ideas of racial hierarchy and white supremacy for the benefit of Europe. Racial hierarchies were constructed to argue that white people were more intelligent, more sophisticated, morally superior, and more beautiful (Césaire, 1955; Fanon, 1952). As such, they were seen as better able to lead and organise societies. Asians and Africans were perceived as childlike and, therefore, unruly, disorganised, and in need of supervision, or as overly emotional, lacking in morality, and thus less able to make rational or sound judgements (Hall, 1997;

Hall, 2021; Said, 1978). At its most extreme, Africans and Asians were seen as less human, and therefore less deserving of the full range of rights that European Enlightenment theory (developing at the same time as the transatlantic slave trade and colonial forms of capitalist accumulation) afforded the individual. However, as Wilson argues, 'Enlightenment "universalism" was from the outset based on multiple exclusions with only the white property-owning man ultimately defined as capable of rational thought and action and therefore fully human and entitled to rights' (2012, p. 20).

Stereotypes of Black and Brown people as less intelligent, less able, uneducated, irrational, lacking in morals, emotional, aggressive, and lazy all have their roots in colonial policies and practices. For example, a school history book from 1911 described Black inhabitants of the West Indies as:

> Lazy, vicious, and incapable of any serious improvement, or of work except under compulsion. In such a climate a few bananas will sustain the life of a negro quite sufficiently; why should he work to get more than this? He is quite happy and quite useless and spends any extra wages which he may earn upon finery.
>
> (CRL Fletcher and Rudyard Kipling, School History of England 1911 in Home Office, 2024, p. 15)

A tea planter's diary of life in Assam, similarly, described coolies as 'lazy and requiring a lot of looking after' (Barker, 1884). These stereotypes served the interests of plantation owners who attempted to extract the maximum amount of labour from their enslaved workforce. It was also convenient to think of slaves and indentured labourers as not requiring much in terms of living needs to reproduce his/her labour. Any resistance to their treatment was seen as proof of innate Black aggression, suggested in the school textbook above through the term 'vicious'. African, Asian, and Arab cultures and literatures were disregarded as worthless, as exemplified in Macaulay's statement that 'a single shelf of a good European library was worth the whole native literature of India and Arabia' (Macaulay, 1835). The scholarship and knowledge of both continents were collected, stored, and reshaped by colonialists to construct East and West as opposites, entrenching white supremacy (Richards, 1993; Said, 1979). All such stereotypes and their repetition through media and culture continue to impact how Black and Brown healthcare staff are treated (Akala, 2019; Baker, 1998; Ramamurthy, 2003; Smedley, 1993). In this section, we explore three contexts to understand racism, using examples of everyday interactions in the healthcare workplace.

Colonial stereotypes

It is easy to see how racist tropes of African and Asian people as lazy and incompetent have impacted the over scrutiny and lack of trust with which Black and

Brown staff in the NHS have been treated (Brathwaite, 2018). Feroza recalls how a white nurse manager did not trust that she was working:

> She (the manager) would be shouting my name out all the time. Where are you, Feroza? … she thinks I'm hiding somewhere. I can hear her, but I'm here. I'm with a patient. So, I can't go because I'm busy doing something.

Staff spoke about trying to prove that they were not lazy. It led to staff who were shielding in the pandemic 'overcompensating' when working from home to 'prove' they were working: 'I used to feel like I had to work more, almost like to prove that I wasn't just sitting at home watching TV ….' (Maria).

The stereotype of Black and Brown people as inferior in culture and intelligence also impacted day-to-day treatment. Staff worked with an awareness that 'they rarely trust that Black people can do things as well as white people' (Janice). Luna, a Filipino nurse, commented: ' … some relatives would … actually divert their attention towards non-qualified (white) nurses rather than speak to foreign qualified nurses'. These experiences are elaborated in Olanike, Roseline, and Esther's chapters (Chapters 6, 7, and 18, respectively).

For Feroza, the management's attitude that she was incompetent meant that her actions were frequently questioned. A simple act of phoning relatives of a dying family during the pandemic was heavily scrutinised. The stereotype of Africans and Asians as untrustworthy and as liars (Moore-Gilbert, Stanton, & Maley, 1997; Said, 1978) has also contributed to the lack of trust afforded to Black and Brown workers. As Olanike recounts, the lack of trust meant she had to get support from her union to protect her family during the pandemic (Chapter 6). For Iris, the stereotype of Asians as untrustworthy had severe consequences. She was poorly supported by her trust when she had long COVID because her swab tests never came back positive. Di Angelo argues that the unspoken network of norms and actions that consistently create advantage for whites and disadvantage for people of colour, 'include basic rights and benefits of the doubt, purportedly granted to all but which are only consistently afforded to white people' (2018, p. 43).

White supremacy/white privilege

Sara Ahmed has discussed the way in which institutions, including the NHS, built through colonial wealth and power, are oriented around some bodies and spaces more than others, with some bodies recognisable as strangers—as bodies 'out of place' (2007). Her essay on whiteness highlights the way in which whiteness is invariably invisible and unacknowledged—an unmarked norm. It is this claim to the universal that gives whiteness its power. Fatima's visceral response to feeling out of place highlights how racism cannot always be identified as incidents that can be catalogued: 'You can feel it in the air.

I can see it in a look; I can feel the tone of the voice. I can really feel it deep in my skin' (Fatima).

White privilege, as a location of structural advantage and a set of cultural practices that are often unnamed or unacknowledged in society, serves as an absent centre against which others appear only as deviants or points of deviation (Dyer, 1997; Fanon, 1952; Frankenberg, 1993). Many staff members spoke of marginalisation, a feeling that even affected the physical spaces they occupied. As Benash discusses, Black and Brown midwives were more likely to be physically sat outside the group and were not welcomed when they entered a room (see Chapter 10). Mushtaq commented, '[white] people, mostly, didn't talk to us … they go on a break at different times, … they had priority, … it was like, from the tiniest things to all major things, you were always subordinate … not human'. These reflections highlight the pervasive impact of white privilege. Mushtaq and Benash both highlight the operations of white supremacy that scholars have identified as permeating institutions. 'If to be human is to be white,' as Sara Ahmed has reflected, 'then to be not white is to inhabit the negative: it is to be "not". The pressure of this "not" is another way of describing the social and existential realities of racism' (2007, p. 156).

The denial of basic humanity—the experience of everyday racism—was a shock to overseas nurses and health workers. Many spoke of being ignored. Divya recalled how she would say 'good morning' to everyone at the hospital, but would receive no response. She described it as 'a culture shock'. However, greetings are common courtesy in the UK. It is a social process through which, in learning the ropes in Britain, migrant workers had to learn to accept white supremacy and racism. On placement, Divya describes being 'talked down' to and how she was assigned to do 'all the horrible jobs'. There were also occasions when people made monkey noises when she approached the table. These experiences mirror those of Zoe, Olanike, and Gemma (see Chapters 3, 6, and 14).

As Sara Ahmed reflects: 'It is not just that there is a desire for whiteness that leads to white bodies getting in. Rather, whiteness is what the institution is oriented around, so that even bodies that might not appear white still have to inhabit whiteness, if they are to get 'in''. (Ahmed, 2007:158) Yet whiteness is invisible only to those who inhabit it, or to those who become so accustomed to its presence that they learn not to see it, even when they are not part of it. By recognising the differential space afforded to Black and Brown bodies in institutions where whiteness remains the normative centre of power, we can understand how, for example, Muslim staff were left without anywhere to pray in Ramadan, and no provision was made for fasting, as Divya recalls. For as Ahmed argues, 'What is reachable is determined precisely by the orientations we have already taken' (2004, p. 55).

Without orientation towards Black bodies, white supremacy permits differential behaviour and exploitation. Maria recalled, 'You'd see on the rota, you don't have a choice. When you try to make requests, there's an excuse why

you can't have what you ask, you just get what you're given'. As bodies 'out of place', tolerated rather than accepted, Maria was told she could not talk to a friend who joined the workforce as a security guard, causing intolerable stress:

> I remember being so terrified. I would actually say I'm sorry, I can't talk to you, despite other members of staff, white members of staff, being able to hug each other when they came on board. They used to be able to just talk to whoever. ... But I wasn't allowed to talk to (my friend) on duty.

Staff also commented on a general lack of respect. This led to standard workplace practices, such as confidentiality, being disregarded (see Chapter 10). Mustaq found that his visa and application process were not kept confidential, and when he experienced a health issue, this was also treated without regular confidentiality protocols. After he visited occupational health, he was surprised to find a letter about him on a desk in a communal area where everybody could read it. 'She (the manager) didn't care that this was a confidential letter. … Nobody cares. Your confidentiality really doesn't matter. They can say anything about you'.

In another serious case, a young midwife disclosed to her manager that she wanted to leave home due to domestic abuse. This escalated from being private knowledge to being shared knowledge, with her affairs being discussed at handover, a space where only patients' health should have been discussed. 'Everyone in the unit knew my business. And from there, I was the source of gossip in the hospital' (Humera).

In our research, racism and white supremacy often appeared to be positioned as acceptable parts of life. As Estephanie highlighted, in some institutions, migrant nurses were briefed to expect racism (see Chapter 2). Moreover, in health education, for example, the dehumanising and racist practices of colonial medicine continue to be brushed over, as Benash (see Chapter 10) and other staff highlight (Curtis et al., 2019; Lokugamage et al., 2021).

Institutional racism and the immigration laws

Even after the political decolonisation of former colonised nations in the post-World War II period, racism has continued to operate through both behaviours and structures of power across Europe and America. 'Racism—like sexism and other forms of oppression—occurs when a racial group's prejudice is backed by legal authority and institutional control' (DiAngelo, 2018). In the post-war period, people from Britain's former colonised nations heeded calls to work in Britain's factories. 'It suited Britain', as Sivanandan argues, 'to import the workers it needed from its colonies and ex-colonies: it was the quickest way of getting the cheapest labour at minimum (infrastructural) cost' (1976,

p. 348). Nurses, particularly from the Caribbean, the Windrush generation, were among those who migrated (Beula, 2021).

In 1976 the Race Relations Act outlawed racism in Britain. Sivanandan argues that the British state institutionalised racism at this time, through immigration legislation that sought to control the migration of labour from the former colonised nations, discriminating 'against a whole people, irrespective of class' (1991, p. 358). In this process, Sivanandan highlights how the state 'achieved for capital the best combination of factors for the exploitation of labour', atomised the working class and 'created hierarchies within it based on race and nationality' and 'confirmed racism within the city walls' of society (1976, p. 358). For the health workforce, we can see how immigration legislation has continued to play a role in singling out migrant workers, primarily from the global south, for particularly harsh exploitation. In 2024, it led to dozens of members of parliament (MPs) highlighting the racism of the immigration laws (Gentlemen, 2024). Immigration legislation through the 21st century has progressively limited the rights of migrant workers, through high visa fees, the health surcharge, limited rights to a family life, and the denial of any recourse to public funds at a time of crisis.

While all Black and Brown workers are subject to racism, the immigration laws and the work permit system that tie migrant workers to a hospital or care home, consolidate an environment of extreme vulnerability, because the worker is not free to take his or her labour elsewhere. As Mushtaq highlighted:

> You are extremely vulnerable, because you are on a work permit system, … they can take away our right to work … we didn't know the system, we came on our own, … no network to guide us. … They forced us to work extra shifts. You were just an extra person filling in the gaps. Regardless of whether you had an adequate rest or not. … this was complete psychological and physical exploitation … in this well-developed country, which talks about liberation and freedom of individuals.

Mushtaq's comments elucidate how 'capitalism is dependent on racial practice and hierarchy' (Gilmore, 2022) as well as administrative violence (Melamed, 2019). The liberal rights which Western democracies hail are not afforded to all peoples, both globally or locally. Immigration legislation and policy create systemic forms of violence. As an employer, if you know that a worker cannot leave due to visa regulations, it is sometimes not necessary to afford them the same rights in training or promotion to ensure that they stay, as they have no choice. As Abby, an Indian nurse manager, reflected:

> I managed to progress after I got my indefinite leave to remain. It's noteworthy that none of the 33-member cohort who came with me from India

were able to progress before they got their indefinite leave to remain. And many remain Band 5 nurses after nearly 20 years.

In a state and institutional system that renders overseas workers vulnerable through policy and law, any point of failure or difficulty can be viewed as a problem for the overseas nurse and makes them a target. When a university encountered problems regarding the authenticity of entry qualifications for some overseas nurses, Deedar proved his credentials, but the investigator discovered that the university had inappropriately assigned him a mentor without a degree. Told he would have to repeat his degree, Deedar refused and said he would rather go home, citing injustice. He was fortunate to have a course tutor who was sympathetic to his predicament and agreed to mentor him herself, to enable him to continue. The administrative violence of laying blame at the door of individual overseas nurses is evident more recently in the treatment of Nigerian nurses following evidence of fraud at a Nigerian test centre. With the wholesale rejection of hundreds of applications, dozens of nurses feel 'thrown out in the cold' despite passing their Objective Structured Clinical Examination (OSCE) and all competencies (Devereux, 2024).

The most devastating consequence of draconian immigration legislation and the deliberate state policy of creating a 'hostile environment' for migration to Britain is the poverty in which some families of overseas nurses are forced to live. Poor wages, no recourse to public funds, along with visa fees and health surcharge fees, can create severe hardship for the very individuals who enable the health service to operate (see Chapter 6). Rani also described how, being an overseas student with fees to pay and limited to 20 hours of work, she could only eat bread to survive

The vulnerability that migrant staff face makes many fear not doing well (see Chapter 4). The quest to prove oneself is also built into the system, as all overseas nurses are treated as newly qualified. De-classed, the racialised dismissal of their experience and qualifications was a bitter pill that made many feel wronged. Abel described it as 'demeaning' and 'disrespectful'. Others exploited themselves in a quest to prove their worth. 'I remember clerking most of the patients, when we had other nurses, English nurses there, HCAs who could do the job … almost in a quest to prove that I'm here, I'm qualified, and I've got the skill' (Abby).

The violence of the system structures overseas workers who are mostly not white as not entitled to the full range of civil rights. In this system, 'Whiteness endures as a marker of identity for being able to exercise the capacity to possess and stands in contrast to Blackness and indigeneity as social markers of disposability' (Melamed, 2019). As Olanike reflected, 'at the end of the day, I'm just a number. Because if anything happens to me or happens to my family, it's not going to be so long before you take someone else to replace me …'

Patterns of racism

The legacy of colonialism and entrenched white supremacy has impacted the culture of racism in the health workplace, leading to three significant patterns of behaviour—exclusion, victimisation, and exploitation. It has structured the experience of Black and Brown healthcare workers. While all staff can be vulnerable to such practices, the reproduction of colonial attitudes and the vulnerability engendered by the immigration laws, structure Black and Brown workers, especially the migrant workforce, as the most vulnerable. This was more evident in the pandemic.

Exclusion and neglect

Exclusion and neglect were among the most widely recounted experiences by staff. As bodies 'out of place' (Ahmed, 2004), the testimonies that follow show how exclusion and neglect operate as racialised mechanisms of control, systematically denying access, recognition, and support to Black and Brown staff. They were tolerated rather than respected and embraced. Racism is expressed not only through silences and omissions but through epistemic violence that manifests through the active withdrawal of care, opportunity, and legitimacy to maintain white supremacy (Spivak, 1988).

Institutional invisibility and silencing

Staff consistently described experiences of being unseen, unacknowledged, and deliberately erased from workplace dynamics. Abby recalled, 'I was invisible', a feeling that persisted even when she advanced into management. Being ignored, excluded, and sidelined were experiences highlighted by everyone, from student nurses to Band 8s. A Black African Equality, Diversity and Inclusion (EDI) lead described 'people on the phone in tears because they have just been so pushed out'. Susan, a Filipino community worker, extended this beyond the workplace: 'As a community, we felt that we've been completely invisibilised in British society'. This form of institutional erasure was particularly acute when staff challenged norms. Riaz, for example, described being met with 'cold hostility' and avoidance after raising concerns. Even praise could lead to silence and social punishment, as Maria experienced:

> There was a nice piece written about me in a local newspaper. A patient complained about the hospital, but she said that the nurse who admitted her was really nice, very friendly, and looked really pleased to do her job. Not one person said, congratulations, well done. No nothing. It just made them ostracise me even more.

These narratives demonstrate how invisibility operates not passively, but as an active strategy of marginalisation. It punishes dissent and reinforces white normativity by rendering racialised contributions illegible.

Excluded from knowledge and learning

Opportunities for learning and development were routinely withheld from Black and Brown students. Feroza described being consistently overlooked during her nurse training: white students were mentored and allowed to administer medication. At the same time, she was relegated to menial tasks, making it harder for her to achieve her competencies. Maria and Zoe echoed these experiences, noting how mentors and institutions did little to address the inequity (Chapter 3). Feroza described an inertia when it came to supporting Black and Brown students. She spoke of a 'willingness to teach' white students, while she was 'ignored'. Many spoke of mentors doing 'nothing' when they raised concerns (Ramamurthy et al., 2023).

Neglect from both practice placement mentors and universities meant some were either prevented from completing their degrees or were forced to repeat placements (see Chapters 3 and 8). Usma was forced to repeat a placement after a mentor did not sign off on her competencies. As Usma questioned: 'If she had those concerns, she should have raised it by week two, week three, not when I'm just about to qualify'. The repeated failing of Black and Brown students at the end of their degree suggests a politically motivated disgust that is weaponised to legitimise exclusion (Nussbaum, 2010).

Sam, a migrant nurse, was denied essential resources to prepare for her OSCE. Only through the informal support of another racialised colleague did she receive what she needed. The denial of mentorship and learning was a pattern of calculated obstruction. Feroza witnessed history repeating itself when she saw a Black nursing student suffer similar exclusions to herself on the ward where she worked.

Obstructed in progression

Career advancement was also persistently blocked. Black and Brown staff who were academically and professionally qualified were denied permanent roles and promotion. Humera, despite a first-class degree and having trained students who later outpaced her, remained on temporary contracts for years. She was told that she was 'thinking too big' and that 'her face didn't fit', attitudes that confirm whiteness as normative and Black bodies as 'out of place'. Anita was unable to get a permanent job in the NHS and was forced to turn to the private sector for her first permanent role.

Many racialised health workers found internal promotion to be not just difficult but systematically obstructed. Their experiences reveal a pattern where institutional mechanisms and workplace cultures combine to deny

advancement, not based on ability, but through racialised interpretations of competence, suitability, and belonging. Mustafa trained a white nurse who was promoted to a position he had applied for before his own interview had even occurred. Olanike and Rosetta's experience (see Chapters 6 and 13) suggests the widespread practice of denying advancement.

Humera was told she could not be promoted to a Band 6 role due to her domestic situation, despite having completed all competencies and already working at that level. Instead of offering support for her personal circumstances, her stressful domestic situation was used to justify keeping her in place. This pathologising of racialised staff, especially women, reflects how white institutions deflect accountability by turning systemic exclusion into a personal deficit.

For some, the only way to progress was through explicitly racialised routes. Anita was promoted through a BAME[1]-focused specialist midwife pathway. While her success was symbolically significant—'I wasn't aware how a change of uniform was such a big deal within the trust'—it also revealed the broader stagnation. Black and Brown colleagues came to her saying, 'Oh, you've made it', highlighting how rare such success was. Many had stopped applying for promotions altogether, resigned to the knowledge that they would not be supported.

These accounts show that progression in White institutions like the NHS is not always determined by merit but mediated by racialised gatekeeping. Promotion depends not just on skill, but on being seen, supported, and selected, conditions often withheld from Black and Brown staff.

Withholding of support and communication

Black and Brown staff members repeatedly described being denied the basic support necessary to perform their roles effectively. This withholding was not merely administrative oversight; it reinforced racialised, institutional hierarchies of power.

Sam, newly qualified, was left without a uniform for weeks. When she requested support on the ward, she was routinely dismissed with phrases like 'Google it' or 'she's busy'. Felicia, despite her seniority, was excluded from meetings and communications at times—an experience echoed by Michelle Cox, whose racial discrimination case against NHS England included evidence of being intentionally left out of critical information loops designed to undermine her credibility and authority (see Chapter 16). These forms of institutional exclusion and neglect signalled more than disorganisation; they communicated that Black and Brown presence was unwelcome and undervalued.

Staff highlight exclusion from both formal and informal communication networks. Maria noted that white HCAs under her supervision regularly received ward information before she did: 'it was quite prevalent'. Also, though her accent was

Anglicised, colleagues routinely pretended not to understand her. Felicia recalled entering rooms that would abruptly fall silent, reinforcing her outsider status.

Many staff spoke of being denied access to paid professional training. Maria, Riel, Mushtaq, and Divya all reported being told to fund their own development, while their White colleagues were supported through departmental budgets (see Chapter 4). Some, like Saima, were initially offered support that was later withdrawn without explanation. Others were caught in endless deferrals. In *Exposed*, staff describe being told repeatedly to 'wait their turn', highlighting the persistent, racialised obstruction to leadership pathways. These denials did not simply hinder individual advancement; they systematically redirected opportunity away from racialised staff and towards their white peers (Fero and Ramamurthy, 2022).

Abby's experience further illustrates this sabotage. When she applied and was accepted by the trust for an MSc course, her manager tried to block her by questioning her eligibility. Though she successfully challenged the decision, she was left without a mentor and feared asking for help from staff who had already tried to undermine her. The absence of support became an effective tool for punishing her assertiveness.

Rachel's account of discriminatory pay highlights how this exclusion can be both economic and emotional. When she was accepted onto a training course, she was informed that she would have to relinquish her Band 6 position and accept a pay cut. She later discovered that a white colleague on her course, with considerably less experience, had remained in a higher pay band. (Chapter 15) Pay disparities in the NHS continue to disproportionately affect Black and Brown staff, reflecting long-standing inequalities rooted in colonial legacies (Appleby, Schlepper, & Keeble, 2021; Ashiagbor, 2021).

Professional dismissal

Black and Brown staff repeatedly described having their professional expertise dismissed, overlooked, or actively undermined. This was not simply a matter of poor communication—it was a form of epistemic violence, in which their knowledge, innovation, and authority were rendered illegitimate unless validated by whiteness (Razack, 1998; Spivak, 1988).

Saima proposed an early warning score system for maternity patients—a crucial intervention that could help identify women at risk. The head of midwifery dismissed her suggestion as 'unfeasible'. Later, in an unrelated meeting, she discovered that the exact same system was being used in Accident and Emergency (A&E). 'Somebody else wants to take the credit for that', she said. 'Not that I want credit—but the fact that my idea was dismissed …'

Divya suggested a COVID-19 safety intervention: creating a dedicated dining area to reduce the risk of infection. Her idea was rejected as premature. A week later, it was implemented after being suggested by a white colleague. 'It just felt like they were waiting for someone else to say it', she explained.

Felicia, a senior nurse, described the cumulative impact of being routinely ignored, even by junior colleagues. 'I've wanted to put my contribution forward, and I've just been ignored', she said. 'Then someone else—who might be junior, less experienced—their contributions will be accepted'. She was often misidentified as a junior staff member, despite her leadership role. 'You have to keep repeating who you are and what your position is'.

These experiences reflect a broader pattern where whiteness operates as the gatekeeper of credibility. Ideas are dismissed not on their merit, but on who proposes them. The result is a culture that erases the intellectual and clinical authority of Black and Brown professionals while co-opting their innovations. As Sherene Razack argues, 'truth is established in ways that render Indigenous and racialized people's ways of knowing invalid, irrational, or 'cultural' rather than factual or legal' (Meer & Modood, 2009; Razack, 2002, p. 7). Instead, racialised staff are positioned as 'bodies' that need to be managed, corrected, or silenced, and rarely as authoritative subjects who generate legitimate knowledge. It has also led to the erasure of their historical contributions to the NHS (Simpson, 2018; Simpson et al., 2010).

Neglect that harms patients

Practices of exclusion and neglect could sometimes escalate to compromise patient safety. White HCAs were described by Black and Brown nurses as sometimes ignoring their requests for support. This was not simply stressful but could impede nurses from doing their job. As exclusion escalated, Deedar was pressured to carry out a two-person task alone, an action that could result in gross misconduct. When he filed a safety report instead, he was further ostracised by staff, who refused even to greet him. He eventually resigned and filed a case of racial discrimination. Sam also left her job and returned to the Philippines after she witnessed a staff nurse put a patient at risk while bullying her.

Staff are both workers and users of healthcare, and Saima's experience in maternity led her to realise the serious consequences of racialised neglect. Despite her own professional knowledge as a midwife, when in a maternity hospital, her concerns were ignored in a life-threatening crisis.

> I had an erupted ectopic. I said, life's going to come, life is going to go, I have no control over that. But the fact that I am ignored. I can't let go of that. How many more women like myself go through this?
>
> Saima

June reflected on her mother's experience, a Black State Registered Nurse from the Windrush generation. She had worked all her life in the NHS, tolerating the racism of white patients yet continuing to care for them, taking her duty as a nurse very seriously. But when it came to her own health, she did

not get the treatment that she deserved: 'they only did blood tests 6 months before she died … they care less for us. And in fact, nothing's changed. And it gets me so angry' (June).

The examples above highlight neglect as systemic for both Black and Brown patients and staff. As Mushtaq said, 'Public health institutions are made for white people'—both white workers and white users.

Pandemic as a mirror of institutional neglect

COVID-19 made the institutional disregard for Black and Brown staff undeniable. Many were deployed to high-risk wards without adequate PPE. Many nurses described feeling that hospitals and health centres did not care about them (see Janice's Chapter 8). Abby recalled how her managers parroted policy instead of acting to protect lives, particularly in areas with high ethnic minority staff:

> I sat with my manager in a corporate, … and she just said, well, they're just following PHE guidance … 'we can't do anything', but we didn't see any of them on the floor … because I worked in a very ethnic minority heavy area, I felt a lot more angry because I felt like you are just letting them die. It doesn't matter because they're all ethnic minorities.
>
> Abby

Felicia, chair of the Black and Minority Ethnic Chief Nursing Officer Strategic Advisory Group, documented the disproportionate deaths among Black and Asian healthcare workers, an outcome that the system initially neither acknowledged nor acted upon. The institutional neglect seemed to mirror wider systemic neglect, as Felicia noted:

> We started to hear that the first 10 doctors who died from COVID were Black and Asian, one of them was my colleague. … the information wasn't very transparent … I did my own count. And I had a list around April or May of 200 staff that had died. And then I looked at the nurses, and I counted over 70 nurses, and barring three, they were all Black or Asian nurses and midwives. … But there was no clamouring from the system, there was no clamouring from the nurse and midwifery communities. And then, although we're known as a BME advisory group, we actually started getting calls. Nurses were telling us that they were absolutely terrified.

Neglect was also apparent in how staff were treated when they were ill with COVID. Riel and Rona describe how managers were only interested in when they would return to work (see Chapters 4 and 5). Feroza also noticed how patients were treated differently during the COVID-19 pandemic. When a white person was dying, their relatives' visits were not limited. However, when

a woman from Iran was dying, her friend was refused entry. 'This woman was crying and screaming, ringing the buzzer, "Please let me in, let me say goodbye to my friend … . She's like my sister". I tried so hard. The response was that she's not a blood relative, but they were very, very close'. For an overseas person with few relatives, friends become your family and sole support, but systems and protocols disregard such realities and leave people to die alone.

This indifference reveals the truth of Ahmed's assertion: to be Black or Brown in white institutions is to be 'not', to be made peripheral even at the point of life and death.

Victimisation and over scrutiny

While exclusion often works through silence or neglect, excessive scrutiny and punishment are more overt and hostile ways that racism is enacted in the workplace. Like exclusion, these responses often follow when Black and Brown staff speak out, succeed, or behave in ways that challenge the norms of white institutions. Rooted in colonial ideas of incompetence, unreliability, and threat, these forms of discipline take shape through micromanagement, public humiliation, and targeted intimidation. For many, these intersect with other aspects of identity, such as gender, religion, age, or migration status, compounding their effects. The impact on well-being is significant. Felicia, a senior nurse, reflected:

> I've had staff who have ... been at the point of self-harm, because of the degree of bullying and harassment. I've been in meetings where some staff have wanted to call the police due to the behaviour of managers. … I've accompanied people to hearings or meetings, where some of the allegations that the managers have presented have no factual or evidence base at all. … and through COVID, that was very, very amplified.

Humiliation and harassment

Sam described being repeatedly put down in front of patients in ways that made her look incompetent: 'to make it look as though I did not know how to do my job'. For Uzma, the pressure from her mentor left her feeling like she 'couldn't even breathe'. She recalled being undermined for asking basic questions, even about a patient's care: 'She made it so difficult for me. Even asking parents, "What's normal and abnormal?" She made me feel I couldn't ask for anything'. This kind of treatment was not isolated. Uzma was also deliberately asked questions in front of patients that she was unlikely to know the answer to—what another nurse (see Chapter 14) called being 'set up to fail'. These patterns of public questioning weren't about learning—they were about control and humiliation.

For Muslim nurses and midwives, harassment around religious identity was also common (see Chapters 10, 11, and 12). Feroza, a Bangladeshi nurse, believed that her age, religion, and ethnicity intersected to shape how she was treated (Cannon, 2023; Church, 2024). Her mentor told her she would 'never become a nurse' and repeatedly asked her to remove her hijab. When Feroza later requested a reference, her matron told her she would only receive one if she put in writing that she wouldn't file a grievance.

Even institutional moments of care or recognition could be turned against racialised staff. When Black and Asian workers were prioritised for COVID-19 risk assessments—as a response to disproportionate deaths—as well as during attempts to address disproportionate mortality in Black and Brown women in materinity (Knight et al., 2018), Humera remembered being told, 'Don't you wish you were treated just like everyone else? Why are you special?'.

These testimonies make evident how quickly support or neutrality can shift into punishment and resentment. For Black and Brown staff, success, visibility, or even protection can be perceived as a threat.

Unequal consequences and gaslighting

When Black and Brown staff made mistakes—or were suspected of wrongdoing—they were often treated with greater suspicion, more severe penalties, and little room for explanation. Humera was suspended after visiting a home alone, where there were concerns about domestic violence. As she reflected:

> There are other staff that are white, that have in my eyes caused patient harm ... . There was no suspension. Now, for me, it was suspected that I went to this house alone, and that was a suspension. It wouldn't have happened if I was white.

Feroza recalled being disciplined after two minor errors. After working for the trust for five years, she realised other white nurses were treated with much more leniency and understanding: 'Why was I put on a disciplinary? I've seen young white girls make mistakes—it's a slap on the hand for them, but for me, it was a disciplinary' (Lewis & Dyer, 2021). Zoe, Riel, Fatima, Rosetta, and Esther all describe experiences of harassment and attempted punishment (see Chapters 3, 4, 12, 13, and 18, respectively). Some staff were also victimised through referral to both the Nursing and Midwifery Council (NMC) and the police without substantive evidence. Victimisation could sometimes escalate due to unfair treatment from the regulatory body itself (see Chapter 17).

These unequal consequences were often accompanied by gaslighting—efforts to make staff doubt their own experiences and perceptions. When

Abel reported being hit multiple times with a trolley by a white colleague, his matron responded: 'I don't think he's doing it intentionally'. This dismissal was common. Racism was framed as 'a perception'. Emotional responses were described as overreactions and in Riel's case intersected with homophobia and transphobia (see Chapters 4 and 12). The testimony of Black staff was also not valued. Zoe, for example, was required to provide evidence from white witnesses for her experiences of racism to be believed (see Chapter 3).

As Razack (1998) argues, white institutions refuse to recognise racialised staff as knowers. Instead, they are treated as problems to be managed. In these environments, the ability to name and challenge racism is itself turned into a vulnerability—something to be scrutinised, not addressed.

Weaponised bureaucracy

Many of the staff members interviewed described how institutional procedures—such as performance plans, development reviews, and human resource (HR) processes—were used against them. These systems became tools of control.

Fatimah was placed on a performance plan instead of receiving a preceptorship (see Chapter 12). When Cynthia raised concerns and became a Freedom to Speak Up Guardian, she was placed on a development plan. Her professional concerns were undermined as subjective attitudes, and she was labelled 'pro-Black'. 'It was a development plan with no development', she reflected. 'It wasn't about improving me', she reflected. 'It was about controlling me'. As a consequence, she described having to bring her 'A+ game every day' just to survive, because of constant scrutiny.

Divya applied for a Band 8 role and was told outright that she wouldn't get it. A member of staff made it clear: 'As long as they're around, they'll make sure I never progress beyond a Band 7'. When she was later offered a band 8 role after succeeding at the interview, she was called into several meetings to question her integrity. Eventually, the pressure led her to withdraw her application. When Esther requested feedback after an interview, she had to escalate her concerns to the Chief Nurse to get feedback. When it was finally given, the manager filled a legal requirement rather than really offering support. She read a pre-prepared script on a Teams call with the camera off.

Some of the most severe forms of punishment came when staff raised concerns about safety, discrimination, or inequality. Michelle (see Chapter 16) was targeted after raising ethical concerns about procedures. Abby, the Indian nurse manager who reported patient safety concerns, was accused of unprofessional behaviour and of trying to 'rally nurses' against a white manager.

Staff who raised concerns often faced being performance-managed out of their roles. Divya, for example, was accused of prioritising her studies and

failing to complete tasks. However, she was studying in her own time and had completed more tasks than her white colleagues. She reflected on how every person she knew who had escalated concerns was eventually pushed out of the organisation.

These patterns of behaviour reflect how institutions protect themselves and how racism is not just present but maintained through fear and intimidation. These forms of bullying are not individual aberrations; they are part of the normal functioning of institutions that continue to centre whiteness and punish those who challenge it.

Bullying and victimisation in COVID-19

COVID-19 exacerbated both overscrutiny and punishment. Estephanie, Rona, and Olanike, through their union roles or staff representative positions, all highlight experiences of harassment that they, or people they supported, faced during the pandemic (see Chapters 2, 5, and 6). Many spoke of not being given adequate personal protective equipment (PPE) and being forced to work in COVID-19-positive environments (see Chapters 4, 7, and 17). Others highlighted how white staff were left in their original roles and Black staff were sent to COVID-19-positive environments.

The systemic racism in the NHS made migrant workers particularly vulnerable to victimisation during the pandemic. Work visas that tied their right to work to particular trusts made it difficult for them to challenge delegation to COVID-19-positive work environments. Migrant workers spoke of being threatened with losing their jobs and visas if they did not accept redeployment to COVID-19-positive environments (see Chapters 4, 5, and 9). While Abel noted that contracts allowed for redeployment, in practice, the policy was not applied equally across the workforce. Sam reflected with bitterness: 'They would just tell you, you are hired to work here. Just work; I don't care if you die or not, I don't care if you're sick or not, just work'. Racism, as Mbembe (2019) argues, creates conditions for disposability.

Workload allocation and the racialisation of labour

The unequal distribution of labour within healthcare cannot be understood without recognising the impact of colonialism and slavery, during which Black and Brown bodies were positioned as sources of labour rather than knowledge (Behal, 2010; Razack, 1998; Rodney, 1972). These perceptions and histories have shaped the expectations on staff, workloads, and institutional behaviours in the NHS. From the Windrush generation to today, Black and Brown health workers continue to be delegated to physically and emotionally demanding roles, denied rest, frequently deskilled, or asked to work above their grade without recognition or compensation.

Racialisation of labour

It is well documented that Black nurses from the Windrush generation were frequently delegated to specific areas of care, such as older people's care, where the work tended to be much 'heavier' (Howells, 2025). As Dawn reflected on her training:

> All the Black nurses ended up on the elderly wards, where it was the harder, more labour-intensive (work). We all had to do six months of post-training. And I think we all went to the elderly wards.

Older nurses also describe how they were excluded from roles, such as midwifery, and steered towards nursing roles or nursing training due to their ethnic background. June, for example, was repeatedly denied the chance to practise as a midwife. It was also an expectation that Black nurses would work harder, as Felicia recalled,

> From the beginning, you always know if you are a person of colour, that there are certain expectations and you know that you have to work doubly, or triply hard.

In our research, the practice of allocating Black and Brown healthcare staff to 'heavier' work and riskier settings was highlighted by both staff who had just begun their careers and those who had worked for decades in the health service. Nurses describe being delegated to more labour-intensive work or being allocated more complex or riskier patients to manage (see Chapter 3). This was reported by HCAs, nurses, and midwives. Riel, Benash, and Fatima (see Chapters 4, 10, and 11) all describe the heavier and more difficult patients that they would be allocated, in comparison to their white colleagues. Rani, an HCA, also explained how she would be delegated more complex patients, 'the patient in a wheelchair with multiple sclerosis', for example:

> It was difficult to manage them. That kind of patient was always given to me, or to us Asian people, to deal with. Especially taking them to hydrotherapy, where you have to really get physical, and you know, do some lifting and support them. So yeah, all the work that is physical and you know, exhausting was given to us.
>
> Rani

These allocations weren't just physically demanding—they had material consequences for professional development. Several staff described being deskilled as a result of their work allocations, a pattern discussed by O'Brien (2007). Mushtaq, an overseas-trained worker, described how his adaptation period was prolonged unnecessarily:

> They made us work as carers, rather than working effectively with our own skills. They were not concerned about our supervision or adaptation. My supervision was supposed to be finished in three months, and it took around a year to complete.

Precious similarly described being reassigned to roles that did not allow her to practise her skills. Delegation patterns didn't just reinforce labour expectations—they blocked the advancement of racialised staff. Adelaide described how on her oncology ward, there were two sides: the chemo side, requiring technical skill, and the adverse reactions side, requiring constant physical and emotional labour. The division of labour was clear: 'All Black and Brown support workers, nurses, and students—including myself—are on the heavy side. And all of the white support workers and students are on the light side'.

These examples point to an enduring racial logic that views Black and Brown workers as more suited to hard, physical labour and less entitled to rest, recognition, or professional growth.

Flaunting of labour rights

Black and Brown staff, particularly overseas staff, reported exploitation that flaunted basic labour rights. Many staff described being refused breaks or asked to return early from breaks. Sam recounted how she was frequently denied rest after physically and emotionally demanding shifts:

> Some managers would not care if I had eaten or not. They would come to the kitchenette when I was eating lunch and make me return to the ward without proper food and a rest. I just had twelve patients transferred to other wards, and then here comes my break, and you're going to allocate me another six patients who are really acutely ill.

Deedar reported working with no break '70% of the time'. Mushtaq recalled how white staff get a priority to go on a break and are permitted to take longer breaks without consequence, whereas he and his overseas colleagues could not imagine taking 'one extra minute or otherwise, we will be in the office'. Overseas nurses also highlighted the failure of management to inform them of break policies.

Such neglect of the welfare of migrant staff in particular was common. Neglect and victimisation operated hand in hand. Sam recounted both a lack of support from her manager, but also how her manager would disturb those who were not white to do something for her, even when there were white staff sitting around not doing anything.

For Rani, the ward didn't seem concerned about what she was contracted to do. She described being consistently asked to perform tasks outside her role.

Employed as an activities coordinator, she was repeatedly reassigned to HCA duties and shift work. It placed her in a constant state of uncertainty:

> I was in the middle of patients and staff. And it affected me badly. I was the only foreign person, and they saw me as a target, like, 'Oh, we can use her to do whatever we want on the ward'.

Entrenched racist attitudes led to a nurse working with Gemma to retort, 'it beats being a slave' when she mentioned she was tired or had an unequal workload (see Chapter 14). Such comments highlight an underlying belief that Black and Asian people should work harder and are not entitled to the same treatment as white staff.

Several staff members also described taking on responsibilities that were well above their pay grade without receiving compensation. Abhi only received a promotion after raising repeated concerns. Olanike was only given a Band 6 post after pointing out that all other staff doing the same role were Band 6. Precious acted as a ward manager for eight weeks but was never paid. Others in her workplace were paid for acting up, but she was not.

Work allocation in the pandemic

The practices of delegating Black and Brown staff to heavier and riskier work were deadly in the pandemic. Dozens of staff spoke about the unfair allocation. Estephanie, Rona, Roseline, Janice, Neomi, Dusu, and all speak about Black and Asian staff being unfairly delegated to work in COVID-19 positive environments, frequently without protection (see Chapters 2, 5, 7, 8, 17, and 9). Many described being the first to be sent. As Luna reflected: 'We were chosen to be exposed'. Every Filipino in her hospital became ill with COVID-19 at the beginning of the first lockdown due to exposure to the virus without adequate protection.

Their stories highlight exploitation during the pandemic that not only exposed them to COVID-19, but also created intolerable working environments where they were expected to do both the 'heavier' and riskier work with little support, leading to some staff being traumatised (see Chapter 8). Abel too recounted how he was left on his own in a recovery ward during the COVID-19 pandemic with an inexperienced support worker and with six or seven IV patients who were awake, really anxious, and afraid. As he explained:

> I can deal with three or four coma patients because then nothing's gonna happen as long as their drips are done, they'll be fine. But if you have three or four patients who are awake, trying to take their masks off, and you're encouraging them to go on their tummy because that was the most effective manoeuvre we could do for COVID. It is really hard. And they would put Asian nurses mostly there, because we tend not to speak up. We

> are resilient. But in terms of the fairness of the allocation, they wouldn't put their precious English nurses there, because they would literally say I can't cope. No, it's not fair.

The treatment of migrant staff in the COVID-19 pandemic made them acutely aware of how dehumanised they were (see Chapter 4). This feeling was strongest amongst migrant nurses. Sam summed it up:

> They look at overseas workers as commodities, whom they buy through recruitment from other countries to get to their land to work as their slaves. We are nothing but a disposable commodity.

Both Riel and Sam left the UK.

Conclusion

This chapter offers an understanding of the roots of racism and the multiple ways in which racism is pervasive in the health workplace. It provides a conceptual framework through which we can appreciate the narratives of experience written by healthcare professionals in the second half of this book. The chapters that follow help us to understand the cumulative effect of racism on people's working lives as well as the ways in which nurses and midwives have sought to stand up, be heard and challenge racism in the health system, through both navigating inside healthcare institutions and challenging practices outside them.

The impact of racism on the physical, psychological, and emotional health of nurses and midwives is better understood through the narratives in the chapters that follow. They enable us to understand the impact of racism as not just a series of incidents but a pattern of experience, a racial weathering, that can have profound lifelong consequences (Geronimus, 2023). In both the audio and film interviews, nurses and midwives spoke of the devastating experience of racism. In our survey, 59% said that they had experienced racism during their working lives that had made it difficult for them to do their job; 52% of overseas nurses who answered our survey felt that work visas had made them more vulnerable to racism and exploitation.

The stress of racism can take its toll on both physical and mental health. As June described:

> … and when you get so broken, broken to bits, you don't look after yourself. You don't look after your health because you're told that you don't matter, and because they care less for you, you almost care less about your own health. There's a danger of you believing that you're not good enough. And always having to prove yourself.

Feroza went so far as to describe nursing as 'a cruel profession' for Black and Brown nurses. She repeated the word cruel three times. Cynthia spoke of how she had 'to gird my loins' and 'grow a thicker skin' (Cynthia).

In our survey, 53% of respondents said racism had impacted their mental health (see Chapters 3, 13, 14, and 18). This frequently resulted in staff leaving their job and/or taking sick leave. Of the 308 survey respondents, 33.4% had been forced to take sick leave as a result of racism. 36% said they had left a job as a result of racism during their working lives. As Abel reflected 'this bullying culture in our unit has persisted, and it's difficult to uproot. That's why I'm going to uproot myself'.

The healthcare workers who participated in the Nursing Narratives: Racism and the Pandemic project stood up and spoke out to effect change, engaging in various forms of individual and collective resistance. Many spoke of 'this sense of responsibility, when you are a person of colour around injustice' (Felicia). They reflected on the difficulties of challenging racism in the system and felt inspired by the power of solidarity that Black Lives Matter exhibited. It gave them an opportunity to confront their colleagues, a space to speak what had been unspoken, a collective chance to question the systemic and pervasive racism in their workplaces. The pandemic saw a proliferation of both independent nursing advocacy groups and the consolidation of existing networks. Some of these included Equality for Black Nurses (E4BN), the Filipino Nursing Association, the Uganda Nurses and Midwives Association UK, Nurses of Colour (now disbanded), the British Indian Nursing Association, and later the Association of Senior Keralite Nurses. Other relatively new organisations have consolidated, such as the Zimbabwean Nursing Association (Mbiba et al., 2020) and the Association of South Asian Midwives (https://asamidwives.co.uk). The proliferation of so many independent groups highlights the failure of the internal structures in the NHS to support the needs of Black, Brown and migrant nurses effectively.

E4BN, in particular, has developed independent grassroots support for nurses and midwives facing victimisation, unfair dismissals, and racist referrals to the NMC. They have supported both Black and Asian nurses through their expertise, recognising racism as a shared experience that can best be challenged through solidarity. Rather than focusing on the diversity management approach, which, as Razack highlights, reinforces a crucial epistemological cornerstone of imperialism: 'the colonized possess a series of knowable characteristics and can be studied, known, and managed accordingly by the colonizers, whose own complicity remains masked' (Razack, 1998, p. 10), E4BN has spoken out about institutional power (Ola, 2025a, b). As Gunew (2007) highlights, we cannot all 'be innocent subjects, standing outside hierarchical social relations, who are not accountable for the past or implicated in the present'.

The nurses and midwives who participated in Nursing Narratives sought to share their experiences of racism and challenge it, by highlighting the

profound impact it has on our society and demand change. Nineteen individuals spoke out in our film, *Exposed,* to raise awareness of racist treatment during the pandemic and in their working lives (Fero & Ramamurthy, 2020). Reflecting on her participation, Gemma described how standing together and speaking out 'had a positive impact on my confidence and drive to keep raising awareness and action to fight racism'. Many spoke of committing to action for change. However, as Estephanie reflected, 'it takes great effort to keep the screenings focused on the film and the manifesto for change, including what is expected of the organisation'. Neomi and Esther describe how fighting racism has become their central concern (see Chapters 17 and 18). Screening the film often led to audiences relaying their own experiences of racial trauma (Ramamurthy & Fero, 2024).

All 45 health workers who participated in the project collaborated to produce 'An Anti-Racist Manifesto for Change' (Nursing Narratives, 2022), which is published at the end of this book. Dozens of health organisations endorsed the manifesto, highlighting the responsibilities of individuals, institutions, and the state to challenge racism. Throughout the remaining chapters of this book, nurses, midwives, and support workers engage with specific points in the manifesto that are important to them, supporting the reader to reflect on their own actions for change.

Note

1 A moniker which stands for Black, Asian Minority Ethnic

References

Ahmed, S. (2007). A Phenomenology of Whiteness. *Feminist Theory*, *8*(2), 149–168. https://doi-org.hallam.idm.oclc.org/10.1177/1464700107078139.

Ahmed, S., & Ahmed, S. (2005). *The Cultural Politics of Emotion: Tenth Anniversary Edition* (1st ed.). Routledge. https://doi.org/10.4324/9780203700372.

Akala (2019). *Natives: Race and Class in the Ruins of Empire*. John Murray Press.

Appleby, J., Schlepper, L., & Keeble, E. (2021). The Ethnicity Pay Gap in the English NHS. Nuffield Trust. Available at: www.nuffieldtrust.org.uk/sites/default/files/2021-04/nuffield-trust-ethnicity-pay-gap-web3.pdf.

Ashiagbor, D. (2021). Race and Colonialism in the Construction of Labour Markets and Precarity. *Industrial Law Journal*, *50*(4), 506–531. https://doi.org/10.1093/indlaw/dwab020. Available at: https://academic.oup.com/ilj/article/50/4/506/6421414.

Baker, L. D. (1998). *From Savage to Negro: Anthropology and the Construction of Race, 1896–1954*. University of California Press.

Barker, George M. (1884). *A tea planter's life in Assam / by George M. Barker*. Calcutta : Thacker, Spink

Baum, B. D. (2015). *The Post-Liberal Imagination: Political Scenes from the American Cultural Landscape*. Oxford University Press.

Behal, R. P. (2010). Coolie Drivers or Benevolent Paternalists? British Tea Planters in Assam and the Indenture Labour System. *Modern Asian Studies*, *44*(1), 29–51. www.jstor.org/stable/27764645.

Beula, J. (2021). *Nursing a Nation: An Anthology of African and Caribbean Contributions to Britain's Health Services*. Nu Jak Media Publishing.

Brathwaite, B. (2018). Black, Asian and Minority Ethnic Female Nurses: Colonialism, Power and Racism. *British Journal of Nursing*, *27*(5), 254–258. https://doi.org/10.12968/bjon.2018.27.5.254.

Cannon, C. (2023). Muslim Women in the Workplace and the Equality Act 2010: Opportunities for an Intersectional Analysis. *International Journal of Discrimination and the Law*, *23*(3), 185–215. https://doi.org/10.1177/13582291231176513.

Césaire, A. (1955). *Discourse on Colonialism*. Monthly Review Press.

Church, E (2024). *What it's like to be visibly Muslim in the NHS, 2 May*. Nursing Times. [online] Available at: www.nursingtimes.net/workforce/what-its-like-to-be-visibly-muslim-in-the-nhs-02-05-2024/.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why Cultural Safety Rather Than Cultural Competency Is Required to Achieve Health Equity: A Literature Review and Recommended Definition. *International Journal for Equity in Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3.

Delgado, R., & Stefancic, J. (2017). *Critical Race Theory: An Introduction* (3rd ed.). New York University Press.

Devereux, E. (2024). Nigerian Nurses Suffering Following NMC Fraud Allegations. *Nursing Times*. www.nursingtimes.net/professional-regulation/nigerian-nurses-suffering-following-nmc-fraud-allegations-05-12-2024/.

DiAngelo, R. (2018). *White Fragility: Why It's So Hard for White People to Talk About Racism*. Beacon Press.

Dyer, R. (1997). White: Essays on Race and Culture (1st ed.). Routledge. https://doi.org/10.4324/9781315003603.

Fanon, F. (1952). *Black Skin, White Masks*. Grove Press.

Fero K. & Ramamurthy A (dir) 2020 *Exposed*. [Film] Nursing Narratives: Racism and the Pandemic. https://nursingnarratives.org/

Frankenberg, R. (1993). *White Women, Race Matters: The Social Construction of Whiteness* (NED-New edition). University of Minnesota Press. www.jstor.org/stable/10.5749/j.ctttsnhh.

Gentlemen, A. (2024). *UK Immigration Laws 'Cannot Be Uncoupled From Racism', Say Minority Ethnic MPs, 8 October. The Guardian*. www.theguardian.com/uk-news/2024/oct/08/uk-immigration-laws-cannot-uncoupled-racism-minority-ethnic-mps.

Geronimus, D. A. (2023). *Weathering: The Extraordinary Stress of Ordinary Life on the Body in an Unjust Society*. Little, Brown Book Group.

Gillborn, D. (2015). *Intersectionality, Critical Race Theory, and the Primacy of Racism: Race, Class, Gender, and Disability in Education*. *Qualitative Inquiry*, *21*(3), 277–287. https://doi.org/10.1177/1077800414557827.

Gilmore, R. (2022). *Geographies of Racial Capitalism with Ruth Gilmore, Antipode Films*. https://mapping.capital/wp-content/uploads/2022/04/geographies_of_racial_capitalism_with_ruth_wilson_gilmore.pdf;https://antipodeonline.org/geographies-of-racial-capitalism/.

Gunew, S. (2007). Rethinking Whiteness: Introduction: Introduction. *Feminist Theory*, *8*(2), 141-147. https://doi.org/10.1177/1464700107078138 (Original work published 2007)

Hall, S. (1997). The Spectacle of the Other. In S Hall (ed) *Cultural Representations and Signifying Practices*. Routledge.

Hall, S. (2021). The Whites of Their Eyes: Racist Ideologies and the Media' (first published 1981). In Gilroy P and Gilmore *R*. (Eds.), *Selected Writings on Race and Difference*. Duke University Press.

Home Office (2024). The Historical Roots of the Windrush Scandal: Independent Research Report. Government of UK. www.gov.uk/government/publications/the-historical-roots-of-the-windrush-scandal.

Howells, C. (2025). You called and we came: remembering nurses of the Windrush generation, Black History Month. https://www.blackhistorymonth.org.uk/article/section/the-windrush-generation/you-called-and-we-came-remembering-nurses-of-the-windrush-generation

Iheduru-Anderson, K. C., & Alexander, G. R. (2022). Critical Race Theory: A Framework for the Re-Education of American Nurses. *Creative Nursing*, *28*(3), 177–183. https://doi.org/10.1891/CN-2022-0021.

Knight M., Bunch K., Tuffnell D., Jayakody H., Shakespeare J., Kotnis R., Kenyon S., Kurinczuk J. (eds) (2018). Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland. Confidential Enquiries into Maternal Deaths and Morbidity 2014–16. www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Web%20Version.pdf.

Lewis, H., & Dyer, C. (2021). Ethnic Minority NHS Staff Face Unequal Disciplinary Action. *BMJ*, *375*, n2675.

Lokugamage, A. U., Rix, E. L., Fleming, T., Khetan, T., Meredith, A., & Hastie, C. R. (2023). Translating Cultural Safety to the UK. *Journal of medical ethics, 49*(4), 244–251. https://doi.org/10.1136/medethics-2020-107017

Lugard, F. D. (1965). *The dual mandate in British tropical Africa*. [Hamden, Conn.] :Archon Books,

Macaulay, T. (1835). Minute on Education. https://home.iitk.ac.in/~hcverma/Article/Macaulay-Minutes.pdf.

Mbembe, A. (2019). *Necropolitics*. Duke University Press.

Mbiba, B., Chireka, B., Kunonga, E., Gezi, K., Matsvai, P., & Manatse, Z. (2020). At the Deep End: COVID-19 Experiences of Zimbabwean Health and Care Workers in the United Kingdom. *Journal of Migration and Health*, 1-2, 100024. https://doi.org/10.1016/j.jmh.2020.100024.

Meer, N., & Modood, T. (2009). Refutations of Racism in the 'Muslim Question'. *Patterns of Prejudice*, *43*(3–4), 335–354. https://doi.org/10.1080/00313220903109250.

Melamed, J. (2019). *Operationalizing Racial Capitalism: Administrative Power and Ordinary Violence, lecture*. Yale University. www.youtube.com/watch?v=o3Z9sOGf6BA&ab_channel=YaleUniversity.

Moore-Gilbert, B., Stanton, G., & Maley, W. (1997). *Postcolonial Criticism*. Longman.

Nursing Narratives (2022). An Anti-Racist Health Service: A Manifesto for Change. https://nursingnarratives.org/anti-racist-manifesto/.

Nussbaum, M. C. (2010). *From disgust to humanity: Sexual orientation and constitutional law*. Oxford University Press.

O'Brien, T. (2007). Overseas Nurses in the National Health Service: A Process of Deskilling. *Journal of Clinical Nursing*, *16*(12), 2229–2236. https://doi.org/10.1111/j.1365-2702.2007.02096.x.

Ola, A. (2025a). Systematic Expulsion of Black and Overseas Nurses: How Employers Are Weaponising the NMC Referral Process. *Equality for Black Nurses*, 8 March. www.equality4blacknurses.com/post/systematic-expulsion-of-black-and-overseas-nurses-how-employers-are-weaponising-the-nmc-referral-pr.

Ola, A. (2025b). Race and Regulation: When Regulation Becomes Racial Weapon. *Equality for Black Nurses*, 25 June. www.equality4blacknurses.com/post/race-and-regulation-spotlight-when-regulation-becomes-racial-weapon-the-case-of-an-e4bn-nurse-agai.

Ramamurthy, A., (2003). Imperial Persuaders : images of Africa and Asia in British advertising. In *Imperial persuaders : images of Africa and Asia in British advertising* Manchester University Press.

Ramamurthy, A., Bhanbhro, S., Bruce, F., & Collier-Sewell, F. (2023). Racialised Experiences of Black and Brown Nurses and Midwives in UK Health Education: A Qualitative Study. *Nurse Education Today*, *123*, 105840. https://doi.org/10.1016/j.nedt.2023.105840.

Ramamurthy, A., & Fero, K. (2024). Empowering Obstinate Memory—The Experiences of Black, Asian and Migrant Nurses Before, During and After the Pandemic. In Cooper, F. & Fitzgerald, D. (Eds.), *The Pandemic and Beyond*. Manchester University Press.

Razack, S. (1998). *Looking White People in the Eye: Gender, Race, and Culture in Courtrooms and Classrooms*. University of Toronto Press.

Razack, S. (2002). *Race, Space, and the Law: Unmapping a White Settler Society*. Between the Lines.

Richards, T. (1993). *The Imperial Archive: Knowledge and the Fantasy of Empire*. Verso.

Rodney, W. (1972). *How Europe Underdeveloped Africa*. Bougle L'Ouverture.

Said, E. W. (1978). *Orientalism*. Pantheon Books.

Simpson, J. M. (2018). *Migrant Architects of the NHS:* South Asian Doctors and the Reinvention of British General Practice (1940s–1980s). Manchester University Press.

Simpson, J. M., Esmail, A., Kalra, V. S., & Snow, S. J. (2010). Writing Migrants Back into NHS History: Addressing a 'Collective Amnesia' and Its Policy Implications. *Journal of the Royal Society of Medicine*, *103*(10), 392–396.

Sivanandan, A. (1976). Race Class and the State: The Black experience in Britain. *Race and Class, 17*(4), 347–368.

Sivanandan, A. (1982). *A Different hunger : writings on black resistance*. Pluto.

Smedley, A. (1993). *Race in North America: Origin and Evolution of a Worldview* (2nd ed.). Westview Press.

Sowemimo A. (2023). Without a Care: Racial Capitalism Is at the Heart of the National Health Service. *HealthcarePapers*, *21*(3), 36–42. https://doi.org/10.12927/hcpap.2023.27193

Spivak, G. C. (1988). Can the Subaltern Speak? In Nelson, C. & Grossberg, L. (Eds.), *Marxism and the Interpretation of Culture* (pp. 271–313). University of Illinois Press.

Wilson, K. (2012). *Race, Racism and Development: Interrogating History, Discourse and Practice*. Zed Books.

Chapter 2

Navigating power

Estephanie Dunn

Summary

This chapter explores Estephanie's diverse experiences challenging racism and discrimination through decades of service in the National Health Service. It brings attention to the difficulties that Black women have faced in trying to enter midwifery, as well as highlighting the resistance staff have faced trying to further the equalities agenda. Estephanie's experiences highlight the importance of working where you are appreciated, as well as the changing pattern of racism. She reflects on experiences in the pandemic of witnessing disproportionate deaths, advocating for worker's rights and anti-racist approaches to the disproportionate impact of the pandemic on Black workers. She traces initiatives to establish networks in the Royal College of Nursing (RCN) since taking part in the Nursing Narratives project and screening *Exposed* at the RCN.

They saw me as a bit of hope

Whilst I was training, I was not personally exposed to racism, but I did witness it; notably when I returned to London from Jersey. Racism was inherent in the system. Black or Brown nurses were rarely visible as registered nurses and senior managers. Most qualified nurses who were Black were enrolled nurses. They were predominantly older women who came to the United Kingdom (UK) during Windrush and worked to establish the newly formed National Health Service (NHS) (Campbell, 2018). They expected to train and become state registered nurses (SRN) but were forced into the enrolled nurse programme. This compromised their opportunities for career progression despite them being capable and ambitious. They were very supportive of me and I suspect that they saw me as a bit of hope – a Black student nurse who one day is going to be an SRN and maybe a ward sister. I only came across two ward

DOI: 10.4324/9781041054276-3

sisters who were Black at that time in a London teaching hospital. Most of the Black faces were in enrolled nursing, auxiliary nursing roles (now Nursing Support Workers) and domestic or other ancillary roles. But for some reason, I was not conscious of being singled out for any differential or abusive treatment and for the most part, I enjoyed my training. It was very traditional. It was the 'old' SRN training, very much aligned with the apprenticeship model in operation today. It was very good for understanding and adhering to the fundamentals of nursing care (Brookfield and Nicol, 2020). But it was also very disciplined. We weren't allowed to challenge or question. There was a clear hierarchy.

After I qualified as a registered nurse, I got an exciting role working as a staff nurse on a medical renal unit and was often in charge. I only stayed there for six months, as I applied to a hospital in Newcastle upon Tyne to train as a midwife. On completing my midwifery training, I applied for and was offered a job as a midwife on night duty. Then, for some unexplained reason, they decided they were going to take that job away from me and give it to somebody else. They offered me day duty instead, but I didn't want to work on days. It was a personal choice. I was pretty offended by having the job taken from me without any justification. I decided to leave and get a job elsewhere. They were horrified when I sought an explanation and the restoration of the written offer in my possession and threatened me with, 'If you leave, you will never work in the northeast again'. I said it was fine. It's a big country. So, I left. I felt very strongly that I was not going to be bullied into accepting something, especially when I did not fully understand the reason for it – whether it was cronyism or whether it was cheaper to have an enrolled nurse on nights – fundamentally, it felt wrong. It might have been my race; I genuinely do not know. My name must have been on a list as I did not get a nursing role in the region and returned to work in London after three months of searching and working in non-nursing roles. I subsequently secured a job working in Newcastle, and I returned home to work as a night sister in a specialist hospital. Following this, I commenced health visitor training. I experienced discrimination at an interview when first applying for a place at the then Newcastle Polytechnic. I stood up for myself when a doctor on the panel asked, 'How did you get into Kings College Hospital?' They said they had worked there and obviously could not conceive of a person like me getting into their prestigious place of work. On my second application, I applied to and was accepted at a college in Durham and went on to work as a health visitor in an inner-city area. Ironically, I became a senior lecturer at the first establishment after it became a university.

As a health visitor, I do not recall ever knocking on a door and being refused entry by a family because of my race. And I am not in denial about any of those things. In the northeast of England, I experienced people as generally welcoming, despite the demographic profile showing low levels of diversity. I had

a large caseload, and they would come to see me at the clinic when invited or be available when appointments were made for a home visit. I also worked well alongside my health visitor colleagues and staff from other agencies involved in children's services.

However, there were communities within which I could see that the people who used our services were living in environments and communities where racism was an issue (Williams and Mohammed, 2009). It was challenging for them to address the systemic and structural issues that they faced. These challenges continue to exist (The NHS Race and Health Observatory, 2025). I was compelled to support them in a situation where employment and affordable housing were hard to find. Social housing became increasingly difficult to access as industrial decline and homelessness coincided with a shift in housing policy. More social housing was being sold, few, if any, affordable homes were being built, and market forces drove up rents, which excluded the most disadvantaged. I was aware of the impact of this situation on the physical and psychological safety and emotional well-being of individuals and families, forced to live in and navigate a space where their race became a key feature in the lack of access to decent housing. Consequently, they experienced poorer health outcomes. The city I worked in had extremes of poverty and wealth. The loss of traditional industries, coal mining, shipbuilding, and the associated industries left a significant number of families experiencing poverty and disadvantage. It was a short leap for some to find individuals or groups to blame, and in some streets and communities, people who were visibly different became targets (Back, 2002). In my role and in the context of supporting people in their own homes, the underlying social policy and architecture that sustained poorer health outcomes and societal inequalities were magnified. Being exposed to these issues and equipped with public health, sociological, and social policy education, I was determined to do something about them.

I believe the biggest challenge for me in my career was working out where I wanted to be whilst grappling with imposter syndrome (Clance and Imes, 1978). When I reflect on moving forward in my career and the obstacles I faced, much of it was related to doubting myself and my abilities. I always felt I had to be so much better and know so much more. Eventually, I recognised that I knew enough and had to take control. If I waited for somebody else to help me make my career, I would be waiting a long time. I was fortunate to be supported in accessing training and development. I was also unafraid of finding people who could help me by giving advice. I was not too proud to ask my Director of Nursing or Chief Executive for advice. That was when my career progressed. I taught nursing at the local university and then became a lecturer practitioner in child health. This was my gateway into management, and it came at a time when we had a series of health reforms. The introduction of the 'purchaser–provider split' introduced business and general management principles into the NHS, and this created a level of bureaucracy in the system

that required business management knowledge and skills to address the transactional relationships across the system effectively (Le Grand et al., 1998). I worked as the senior nurse/business manager in the children's directorate for some years before moving into a city-wide general manager position in a service for people who had learning disabilities. In this role, I witnessed and worked to address the inequalities faced by this client group and their family carers. In circumstances where race was an intersectional issue, the impact on the service user and family was amplified.

Challenging institutional discriminations

When I worked as a senior nurse business manager in an inner-city area, data and observation told me that very few children from Black or other ethnic minority backgrounds used our inpatient service even though they were present in the community. It was almost like a cure for child illness. I wanted to find out why and what the barriers were to people from different ethnicities and cultural backgrounds accessing our services. I applied for and received funding from the health authority to design and deliver some cultural awareness training across the trust. The conversation I had with a particular paediatrician about this funding was, 'Well, I wouldn't waste your money doing something like that. Why don't you do something more important?' They were very dismissive of my idea and paid no attention to unmet needs as they went on to say, in the presence of the white ward manager, that when they worked in a different part of England, 'the Black patients were dreadful'. I just looked at them as they clearly forgot my race and said, 'Can you just stop and tell me why we are such difficult patients?' And there was a look of horror on their face when he remembered that I was also Black. But he just shifted to say, 'Actually, all the P**'s were the worst'. It was my turn to be horrified and looked at them, then said, 'I think you need to put the shovel down right now, … it doesn't really give me any comfort for you to say that, out of the two ethnicities, there's one worse than us'. That conversation told me more about this man than anything he previously said or presented about himself. I was convinced that the work needed to be done.

When I asked the paediatrician to explain why he believed that Black and Asian patients were 'difficult to manage', he said, patients don't turn up for appointments and don't take medicines as prescribed. I wanted to understand why. Was there a cultural or social dimension? Was English as a second language at play here? Giving someone a leaflet or written instructions does not always ensure comprehension and then compliance. I believe we need to recognise where structural and systemic racism exists. People who design and provide services make assumptions about access and accessibility. The dominant view is that the service is here. If you choose not to take it, it's down to you. Despite this deeply held view, they proudly label their service as person or family-centred. I used the funding from the local health

authority, in partnership with community groups and leaders, to design and deliver cultural awareness training relating to six of the main cultural groups living in the community we served. The fundamental difficulties in accessing healthcare impacts every one of us to some degree (The King's Fund, 2023). It destroys lives and costs society much more in sustaining people who endure poorer futures and who die far earlier than they should. For me that experience really shone a light on personal, institutional, and systemic racism and how it affects victims and perpetrators. It sharpened my focus, attention, and commitment to the whole issue of inequality, equity, and natural justice.

When the Race Relations Amendment Act (Race Relations (Amendment) Act, 2000) came into force, I was a general manager in a mental health and learning disability service across a city with 300,000 people. Again, there was an underrepresentation of people from those communities working in mental health services and across the learning disability system. I was keen to understand the demographic profile of people accessing our services. We got a new director of mental health and learning disabilities, and one of the first things she said to me on her arrival was that when she trained as a mental health practitioner, the consultant psychiatrist who was delivering their training told her cohort that 'Black men were madder and worse than white men'. I was speechless and tried to work out the motivation for her saying this to me in such a casual manner. I had a Black father, brothers, and Black male friends. I challenged her. Such opinions was responsible for the over-representation of Black men in mental health institutions under sections and with significant diagnoses and those incarcerated in the criminal justice system. I went to deliver a presentation to the board with an action plan on how to address inequality across the organisation. The same director was present. In the middle of my presentation, she repeated her racist trope about Black men. I was in despair. I challenged her in front of the chief executive, the chair, the rest of the directors, and non-executives. When we as a system, society, or thought leader create a narrative around any scenario or group of people, repeat it often enough, and say it with the authority ascribed to our position or status, it becomes true (without evidence) – 'a social fact' (Durkheim, 1982). I could not change that individual's opinion, but I challenged her repetition of such stereotypes in front of the board. It was interesting watching the expressions of the people on the board. I felt it was important that the board didn't believe what the director of mental health and learning disabilities was saying. They saw that there was another explanation.

Work where you can make a difference

As the general manager of a learning disability service and later as a director of nursing, enabling access to services, challenging injustice and inequalities have been at the heart of my work. I was fortunate to have a supportive chief

executive. However, I encountered resistance from some of the non-executive members of the board when I presented a report on inequalities and institutional racism. One individual believed that by accusing the organisation of being institutionally racist by default, I was suggesting that they were racist. I had to spend some time emphasising that this was not about the people around the table, but the need to be assured that we are not being institutionally/systemically racist because of the way in which we designed and delivered our services. I gave the example of working with a local group of Muslim women who struggled with receiving obstetric, gynaecological, and other female-specific services from male medical staff. In terms of public health initiatives, these women could not access the swimming baths because of cultural practices. My director of public health was incredibly supportive and understood that we needed to think differently, so we organised women-only swimming and other exercise sessions. It was much more challenging to address the issue of access to female medical teams and service delivery because of the financial and human resources available to the system.

I was fortunate to work with people who were prepared to listen. If some disagreed, they kept silent so we could do our work. If I found myself in a system where they weren't prepared to listen, respond, or do anything to improve the quality, access, and safety, I would eventually leave. In one independent sector organisation, where I was employed as a consultant, they were telling new international recruits who joined that they had to expect racism when they got here, because of the nature of the client group. My response to the director of HR was that if you could manage to deliver a costly, challenging behavioural programme to address serious offences and risks to the public (Equality and Human Rights Commission, 2011), indeed, you can work to educate individuals and change how they treat and speak to Black staff. That was one of the places where I did not stay very long.

Changing patterns of racism

Racism changes how it manifests itself. What starts off as a germ, a little tiny piece of behaviour, or maybe a big aggressive piece of behaviour, left unchecked, it spreads, like a virus. anti-racism is a positive choice we make in our organisations and as individuals as opposed to being non-discriminatory. I think when you start to shine a light on things that are racist, whether that be language, behaviours, policies, and practices that disadvantage those from different races and cultures, the perpetrators of those acts shift either subtly or significantly. They go underground. They develop policies, they develop practices, they develop closed groups, and they rely on their power base to maintain the status quo. This sustains their thinking while demoralising the victims of this unfair and unlawful practice. They go out of their way to maybe avoid detection. But it's still there; the actual problems that people face in the workplace and the communities haven't gone away.

Royal College of Nursing

As a regional director at Royal College of Nursing (RCN), I worked as the co-chair of the England Equality, Diversity and Inclusion (EDI) Steering Group. I have tried to support the development of staff to ensure that they support our members effectively when they face discrimination in the workplace. There's a lot of work to be done, and it is not work that should be regarded as 'once and done'. Generations of discriminatory thought, language, and behaviour will require intergenerational work. It is often hidden in plain sight, with perpetrators failing to take responsibility and systems failing to demand accountability and proportionate consequences. I consistently see perpetrators claim to be the victims, or argue it's just banter that means nothing. In reality, it means a great deal, and the system/institution acquiesces.

The RCN has consistently expressed concern about the lived experience of members and service users who suffer from the impact of racism and other discrimination. The evidence of the differential treatment of individuals who have protected characteristics is undeniable. Racism is endemic despite decades of published reports (The NHS Race and Health Observatory, 2022, 2025), data gathering, training, and the producing of action/improvement plans. Promises to learn lessons, change, and do better fail to make a difference for the members and communities we serve. The reality is that casework in this area is increasing as members speak up and demand justice. At the same time, the system narrative denies that racism is a problem, and accusations of 'wokery' and wasting public money are used to create a smoke screen that obscures the reality of the impact of racism on people and the system they work in. The Director for England decided to introduce inclusive leadership training for regional directors as a mechanism to develop a shared understanding of the issue and potential solutions across the leadership team. This training stimulated several conversations and actions aimed at developing and embedding our approach to support members more consistently and effectively.

Plans continue to evolve, and a revised organisation-wide strategy for members was launched at RCN Congress 2024 (Royal College of Nursing, 2024). Work on a strategy for staff continues. I recognise that we are all in different stages of learning about and developing confidence to operate effectively in this space. This is reflective of society as a whole, and we need to be resolute in our determination to become the anti-racist organisation announced at RCN Congress 2023. I still overhear conversations that tell me some people do not understand racism, what it takes to be anti-racist, and why this is important. In addition to this, some choose not to apologise and take meaningful steps to learn and change their behaviour. This is the real battleground as change through policy, strategy, and development is slow, and victims become frustrated and feel marginalised by slow progress. I believe that we need to be leading the way as we strive to engage with external stakeholders to challenge

their practices and lack of progress on behalf of our members and people who use health and care services. Pace and embedding change are imperative.

Ensuring that racism is not dismissed remains a challenge. Our staff and members are products of a society where a range of views emerge and are held dear. I often hear that we are focusing too much time and attention on 'race'; I respond by saying it is the house that is on fire right now and has been burning for decades; why are we unable to put that fire out? Why are people denying that racism exists? Most significantly, how are they racialised in the first instance, and why do they consistently ask for data to prove that it exists? However, I see evidence of many people wanting to fight for change, many white people, white allies, who really do want to work in this space.

When we start talking about equity, equality of opportunity, and fair and just access to career progression within a diverse community and workforce, there is an assumption that people at the top will potentially think that it could be their job that they have to compete for. They may become defensive. This, coupled with people at the lower end who think, 'what about me?' There are white people in deprived communities who don't believe they have privilege. When we talk about white privilege, they don't feel privileged. But the reality is, alongside their Black counterparts in the same community, they are less likely to be stopped and searched, they are less likely to be followed around a supermarket and made to prove that they have paid for the goods in their shopping bags. Their children are less likely to suffer the indignity of personal and inappropriate searches by the police. I do not think they would ever appreciate that opportunity to go about one's business without fear of indignity or unlawful intervention is a privilege. When a Band 6 nurse with a BSc, MSc, and PhD is unable to achieve a Band 7 or higher and a less-experienced white colleague is promoted to manage them, questions need to be asked. whilst they may live in equally deprived communities and feel similarly disadvantaged, their lived experiences differ. So, there are all sorts of things that we need to remain mindful of when focusing on ridding ourselves of discrimination and disadvantage for our Black communities. We can make everybody's life better in that community by not fighting each other and doing so using policies and processes to dismantle the architecture that sustains racism.

The pandemic

When the pandemic started, the RCN immediately began lobbying for personal protective equipment (PPE), making sure we had the proper masks and that people who needed them were tested correctly because it's no good just giving somebody a mask that was unsuited to their level of exposure and risk. We were getting members of Black and ethnic minority nurses saying 'I must take my PPE when I go into work in this care home because there isn't any, or I am being declined PPE to work on a COVID ward'. And then you start to see images of the people who died, you know, healthcare professionals who died

from COVID. To begin with I though it was just me, just me because I am Black, only noticing the Black faces that were coming up on the news. But there were just more and more and more Black doctors, Black nurses, Black support workers.

One of the things that we were clear about in the college, working with our equalities lead, was that this isn't because Black people are biologically different. You know, there was something else going on. We were fighting on many fronts, trying to get the right equipment for our nurses in all the care sectors, trying to ensure that proper risk assessments were done and that the disproportionality in risk was addressed. We were getting numerous calls from our Black and Brown members to say that if somebody needed to move to a COVID area, it was invariably one of us. We had a situation where a nurse on a Saturday was speaking to one of my team members who was really distressed because she was singled out to go to a COVID ward; she asked for a risk assessment and was told that she was too young to need one, and she had to go to the COVID ward. She phoned the RCN, thankfully, and although it was a Saturday, a member of the team and I got involved. I think this member advocating for herself was powerful. Not many people have that kind of courage. She did eventually get a risk assessment. And she should not have been moved to a COVID ward because of her circumstances. None of that would have been identified had she not dug her heels in and contacted us.

There were examples of good practice where chief executives and senior teams were doing their best to ensure that PPE was being adequately distributed. There was also a lot of work that had to be done to gain confidence and trust. When the vaccine appeared, we saw a lot of vaccine hesitancy. I remember Black members saying to me, we're never first in the queue when there's anything good going, so why are they allowing us to have the vaccine first? Are we human guinea pigs? I believe that calling people vaccine refusers felt punitive and inappropriate. People were just hesitant. If you're going to be injecting something unknown into your body, you do need to work out what the risks and implications are. More evidence-based education was required, and this was slow in coming. We witnessed policies that threatened staff with dismissal if they refused the vaccine. What was not evident was the prosecution of employers and systems that failed to provide adequate and appropriate PPE.

We were fighting for benefits from work-related injuries. Employers were arguing that people could have got the infection in supermarkets, even though they worked extensive hours caring for people who had COVID-19 and, by default, would be exposed to a higher COVID load than colleagues in non-COVID environments. It was hard to prove, but several of our members, in the first wave, when we ran out of masks, were being forced to wear masks that were not fit for purpose. So, these were the sorts of things that we were fighting daily. It's been exhausting. I think it's been really an emotional journey. At the back of it is fear, fear of the unknown, you know, this invisible virus, and

the knowledge that you would be the first to be deployed to care in a COVID ward if you were Black or Brown.

Speaking out in *Exposed*

My reasons for becoming involved in the Nursing Narratives project are numerous. I watched helplessly as news programmes depicted a growing number of global majority staff in health and social care and again more widely across other public sector and essential services succumb to the virus. I was fortunate enough to be able to shield and work from home during this pandemic. Intuition told me that this experience would be airbrushed and that history would not show the disproportionate impact on the global majority of people. Lessons must be learnt from this dreadful period. There were many opportunities to learn from other systems as the virus spread across the globe to prepare effectively to reduce, contain, and control the spread on this island. It didn't happen.

My value base drove me to accept the opportunity to participate in the film *Exposed* and speak out on behalf of staff and service users who were not served well yet gave so much; for many, this was their life. They should never be forgotten, and this lack of preparedness should never be allowed to happen again.

We screened *Exposed* at Congress in Glasgow in 2021. We organised a fringe event to screen a shortened version of this film about racism and the pandemic and provided an opportunity for questions and answers (Q&A). It had a powerful impact on the audience, and many were moved to return to the main debating hall and asked for the film to be shown to all delegates. This led to a lengthy debate as organisers argued that there was insufficient time on the agenda. Their request was denied, and several members from the northwest region approached me to ask if we could support them in developing a multi-cultural nursing network. I agreed to explore the request and that it would be a member-led initiative with some support from staff and free access to our conference room for meetings, etc. We have also screened the film to RCN Staff Race and Culture Network. This led to a wide-ranging debate among staff members who were not clinically trained about living through the period of COVID-19. They were exposed to some of the traumatic experiences of global majority staff, who experienced an escalation of racism during the pandemic and the aftermath of the very public killing of George Floyd in the USA.

Establishing new RCN networks

Industrial action delayed the launch of the planned Multicultural Nursing Group in the northwest until November 2023. It is the only established group in RCN England. Members agreed on terms of reference and decided to align their work plan to the NHS England North-West Regional Assembly's

Anti-Racism Work Plan. The rationale behind this is because our group members work across the three ICS systems, and they can engage with local action to improve systems and outcomes for most global members and service users. It is in its infancy, and we have enormous ambitions for success in this space.

We are working with NHSE to develop lessons from the landmark employment case in which we supported our member, Michelle Cox. In addition, I have been successful in my application to join the Northwest Leadership Academy Talent Board, where we are currently focusing on career progression for most staff. I co-chair RCN England's EDI group, and we are working on developing a range of approaches to recruit, develop, and retain people with the right attitudes and value base who align their thinking and actions to support members consistently and effectively. We are also focusing on skilling staff to be more confident when engaging with system leaders and organisations. We are working to learn from complaints, develop learning from onboarding, and work with organisational development to produce learning to support representation and allyship. We are using data from our systems to identify where intervention is required and working with members to ensure that their lived experiences, both positive and negative, can be shared appropriately for learning. One essential change I would ask the government would be to 'reinstate third-party discrimination into legislation', as we have highlighted in the Anti-Racist Manifesto (Nursing Narratives, 2022). We need courage, determination, consistency, accountability, and the willingness to fight for the right thing.

Reflective questions

1 What steps can managers take to challenge racism and discrimination?
2 What can be done to challenge imposter syndrome and who is responsible for this?

References

Back, L. (2002) *Out of Whiteness: Color, Politics, and Culture*. London: Verso.

Brookfield, C. and Nicol, N. (2020) *Foundations of Nursing Practice: Fundamentals of Holistic Care*. 4th edn. London: Macmillan International Higher Education.

Campbell, J. (2018) *Nursing the Nation: A History of Gender and Governance in British Nursing*. Manchester: Manchester University Press.

Clance, P. R. and Imes, S. A. (1978) 'The Imposter Phenomenon in high achieving women: Dynamics and therapeutic intervention', *Psychotherapy: Theory, Research & Practice*, *15*(3), 241–247.

Durkheim, E. (1982) *The Rules of Sociological Method*. Translated by W.D. Halls. New York: Free Press. (Original publication: 1895).

Equality and Human Rights Commission (2011) *How to Prevent Harassment and Victimisation: Guidance for Employers*. [Online]. Available at: www.equalityhumanrights.com/guidance/sexual-harassment-and-harassment-work-technical-guidance (Accessed: 26 May 2025).

Le Grand, J., Mays, N., and Mulligan, J. A. (1998) *Learning to Compete: Markets, Ethics, and Health Care*. New Brunswick, NJ: Transaction Publishers.

Nursing Narratives (2022) *Anti-Racist Manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (Accessed: 7 June 2025).

Race Relations (Amendment) Act (2000) *Race Relations (Amendment) Act 2000 (c. 34)*. London: The Stationery Office.

Royal College of Nursing (2024) *How to Talk About Race Equity at Work: A New RCN Resource*. Available at: www.rcn.org.uk/news-and-events/news/uk-how-to-talk-about-race-equity-at-work-241024 (Accessed: 26 May 2025).

The NHS Race and Health Observatory (2022) *Patient Experience and Trust in NHS Primary Care*. [Online]. Available at: https://nhsrho.org/news/patients-report-alarming-lack-of-trust-in-nhs-primary-care-providers/ (Accessed: 26 May 2025).

The NHS Race and Health Observatory (2025) *The Cost of Racism*. [Online]. Available at: www.nhsrho.org/wp-content/uploads/2025/03/NHS-RHO-Report-Cost-of-Racism-March-2025.pdf (Accessed: 25 May 2025).

The King's Fund (2023) *What Are the Experiences of People From Ethnic Minority Groups Using Health and Care Services?* [Online]. Available at: www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england (Accessed: 26 May 2025).

Williams, D. R. and Mohammed, S. A. (2009) 'Discrimination and racial disparities in health: Evidence and needed research', *Health Affairs*, *28*(2), 580–590.

Further reading

Melson-Silimon, A., Spivey, N., and Skinner-Dorkenoo, L. (2024) 'The Construction of Racial Stereotypes and How They Serve as Racial Propaganda', *Social and Personality Psychology Compass*, *18*,12862. [Online] Available at: https://compass.onlinelibrary.wiley.com/doi/10.1111/spc3.12862 (Accessed: 10 December 2024).

National Health Service Confederation (2022) Shattered Hopes Black and Minority Ethnic Leaders' Experiences of Breaking the Glass Ceiling in the NHS. Reflections on the Lived Experience of Senior Black and Minority Ethnic Leaders in the NHS. [Online] Available at: www.nhsconfed.org/publications/shattered-hopes-NHS-BME-leaders-glass-ceiling (Accessed: 10 December 2024).

Chapter 3

Stand your ground, but not at any cost

Zoe Malcolm

Summary

Zoe Malcolm's story highlights the pernicious racism faced by a student nurse. Her story recounts her personal struggle to challenge the discrimination she faced and the unwillingness of institutions to implement anti-racist policies effectively. She highlights the failure of both universities and hospitals to challenge racism. Her consistent refusal to accept racism and bullying beh her aviour led to her being victimised. It led her to be unable to pursue her nursing career. She advocates for radical action from Black and Brown nurses in order to remove whiteness as a normative standard and demand change.

It is the NHS, and you do not get to choose who treats you

I had been working in Sainsbury's retail stores for 15 years, and I felt stuck in terms of my future progression. I was looking at my options for a career change, but I was also aware that there were quite limited choices for a Black person to be in a respected profession. A friend told me about some access to health and social care courses to help me get into nursing, so I enrolled on one. I did well; I really enjoyed it, especially the voluntary work. I got some good grades, and then I got a fully funded place at the University of Nottingham, which was brilliant; I was elated. I made a few friends on the course; everything was fine, and then we got our placements through. We were all excited. I was allocated to Ripley Community Hospital, which I had never even heard of. I Googled it. The first thing that came up was that Ripley was the most racist town in Britain. The entire placement was awful; within the first week, a patient was assigned to me, and he did not want me to treat him because I was Black. The nurses supervising me there said, 'He does not want you, so you will have to take another patient instead'. I was just so, so hurt by

DOI: 10.4324/9781041054276-4

that. I was thinking, 'It is the NHS, and you do not get to choose who treats you'. I am here, I am here to care for you, and I am going to do it properly, and you do not want me to do that because I am Black? I think what was more hurtful than anything was the fact that no one stuck up for me. From then on, it continued to go downhill with the staff and with more patients. Derogatory comments were made in the staff room; nurses would go and sit somewhere else if I sat next to them. It was a tough period.[1]

Hostile mentoring

That was an eight-week placement, and when I went back to the university I told myself that if I got another placement like that, I was not going to go. I would demand a placement within the hospital because it would be better there. It was not. I was placed in a hospital surgical ward, and I had a mentor who absolutely hated me. She would set me pieces of work to be completed the next day. I was working from 7 am to 7 pm, followed by a 25-mile drive back home to Birmingham, and then I had to go pick my kids up. On top of that, I was expected to write a 2000-word essay on pancreatitis. She said, 'If you do not do what I ask of you, then I am going to fail you. You are not going to graduate and be a nurse'.

I remember that one day, the weather was awful. The mentor sent all the white students to their homes, but the only other black student nurse and I were held back until the end of the day. I went out for my usual break, and later, when I checked my phone, I received an email from the university office saying that they were disappointed to hear that I had been absolved of' my placement and that I was acting in a very unprofessional way. Someone from the ward had phoned the university to say that I had walked out. I was put under investigation, but I had my signed timesheets, which proved that I had done nothing wrong. All I received was a one-line apology. I was told that as a student nurse, I had to accept that I was right at the bottom. That has never been my life. I am never going to accept to be right at the bottom. I was already 30 years old with children, my own house, my car. As time went on, the more I started to complain about what I saw as wrong in the workplace, the more my grades were going down. Down, down, down, down every time. It was just challenging and stressful. It got so bad that when I went to have a shower every morning, clumps of my hair were falling out. My nose was bleeding every day; it was absolutely ridiculous. It got to the point where I did not eat because when I went into the staff room, everyone stopped talking or walked out. It was the most horrible, isolating experience.[2]

Work was never allocated fairly. The Black students were left cleaning down the rooms, cleaning the blinds, sanitising, flipping the mattresses, and washing the patients. While we were doing that, a lot of the time, the white students would be in the staff room or the office eating pizza with their feet up. It was just ridiculous. We were doing a 12-hour shift, from 7 to 7, and they would

be let go at 3 o'clock in the afternoon. As soon as I even got close to sitting down, it was 'right, you need to go and do this; you need to go and do that' (Sivanandan, 2008). I had, had white student nurses, who were in lower years than me, telling me what to do. The supervisor would tell them to tell me what to do. How do you complain in this situation? I do not understand why, when I have a problem with racism, I constantly have to go to a white person to report it, and they decide whether I am experiencing racism or not.[3] They close ranks on you. They withdrew me from the course three times, and each time, I challenged them, and I got reinstated, but I think they knew they were never going to let me finish that course. That was my punishment for challenging them.

Blaming the victim

In another incident, we had a patient that we had to move in their bed, and, in the process, I hurt my back; it was just poor manual handling by the team. The supervisor noticed the following day that I was in pain and could not do some things and told me that I needed to go off sick. I was off for two weeks, but I got a doctor's note and came back. The supervisor would not speak to me. She just ignored me; then she told me that she was not happy with me. She said I should not have gone off sick, I should have phoned her every day, and that I had gone against policy. I decided to check it out, and I was correct; that was not the policy at all, but I never got an apology.

I raised the unfair treatment repeatedly, and then I began to be treated as the problem rather than the racism I faced being the problem. Their strategy was to avoid me, taking ages to respond to my emails, and nothing was dealt with properly, and there were none of the complaints. The response was always, 'You just need to get on with it, Zoe'. They were blaming the victim (Ryan, 1971).

Ironically, the last placement was at Ilkeston Community Hospital the district nurses were brilliant. They were incredible. The difference there was that the staff were young, and I got treated well by the matron. They cared about me. I remember once it was snowing heavily, and she insisted that I go home early as she knew I had a long drive; no one had ever done that for me before. I was working with a Polish woman with whom I am still friends. She was really good at her job and really lovely, but the patients would make comments about her behind her back; they would say, 'Oh, you know, I do not like it when she comes' or 'Do not send her to revisit me; she is too rough', but they were excellent. They were better than some of the qualified nurses on the ward that I had worked in terms of applying dressings and wound care; they were outstanding and so dedicated to the role. Despite this, the patients were hostile, and the main reason that they were nitpicking was because, at the time, there was the Brexit referendum, and the anti-immigrant feeling towards migrants was very high. The room would go silent when I walked in, and

I knew it was because they were discussing Brexit, and they did not want to talk about it in front of me. There was one time when they were talking about it, and the conversation was very anti-European. When it came around to me to say something, even before I opened my mouth, everyone got up, and one of them just said, 'Well, we all know what you think, Zoe'. I was sick of it. At the same time, I had made an appeal to be readmitted to my course under extenuating circumstances, which means they considered mitigating factors, but that was rejected. It meant that I could not finish the course, and I only had eight weeks to complete it; that was the end of it. I still tried to fight it. I contacted the Office of the Independent Adjudicator for Higher Education, but they were unable to do anything for me.

Anti-racist policies need implementing

In terms of improvements to structural racism, there is nothing new that needs to happen. We need to start implementing the policies that are already in place, but that is not going to happen. I know that what I am going to say now is controversial, but I do not think any Black, Asian, or ethnic minority people should go and work for the National Health Service (NHS). Let us withdraw our labour instead of being a constant stream of employees. If we say 'No', I do not want to be part of this racist system, then they are going to have to do something about it, but now all we are doing is feeding the system. A system that was not made for us but was made on our backs. For people who want to go into nursing, I say do not do it, do not do it. Not until the situation is resolved.

I think there is another reason why I was not allowed to complete my studies: my dissertation was about racism in the NHS, and I was writing it from a personal perspective. I feel disappointed in how I was treated. It made me think about loads of things that I have never even thought about. Where do I belong? Am I British? After my kids have finished school, do I still want to be here? If this is how we are being treated, then I do not want to be here.

During my nursing journey, I tried to find various outlets to tell my story. Nothing really came of it, but my friend found out about the Nursing Narratives project during the pandemic and encouraged me to speak out. It has really helped me to speak my truth to free myself from the burden of racism that I was subjected to by letting everybody know the reality of what some student nurses go through. Speaking out is liberating.

I have to speak out and keep fighting because our parents came to this country for a reason, so I do not want to waste the opportunity. I also want my kids to do well and get into decent schools. We are not going to eradicate racism; my children are going to have to challenge it as well, but I want to make it better for them so that whiteness is not the benchmark for everything. One of the most important points of the Anti-Racist Manifesto for Change to me (Nursing Narratives, 2022) is 'Remove whiteness as the benchmark in training

and organisational culture of the NHS'. This needs to be implemented; otherwise, nothing will substantially change for student nurses (Cordrey, 2021).

Since being forced out of nursing training, I have made a move into education. I am now a secondary school English teacher working across different schools through an agency. Racists drove me out of the NHS, but I do not think it means the racists have won at all because they need us. I think now, it is worse for them because I am teaching their children.

Reflective questions

1 How should organisations support staff that have challenged incidents of racism in the workplace perpetrated by patients?
2 How can you support colleagues who are being victimised by their line manager?
3 What should universities do to ensure that student nurses who experience racism are supported and not victimised further?

Notes

1 Racist abuse from patients including the refusal of care from Black nurses is a long-standing issue (Smart, 2021). The British Geriatrics Society (2021) published a survey looking at the impact of racism for those working in an older persons service in London with the shocking statistic that 67% of staff had witnessed a patient request for a different ethnicity of healthcare staff to look after them.
2 There have been several studies examining the link between the experience of racism and physical health decline including a longitudinal study by Stopforth et al. (2022) tracking the effects of racism overtime. A study by Paradies et al. (2019) argued that racism increases stress levels leading to hypertension and a weakened immune system.
3 The power dynamic inherent in having someone who has no lived experience judging the validity of a Black person's truth, creates space for invalidation and minimisation of lived experience, a concept termed racial gaslighting (Christensen & Evans-Murray, 2021).

References

British Geriatrics Society (2021) *NHS Staff Experiences of Racism from Patients and Carers: Survey from a London Older Persons Service*. Available at: www.bgs.org.uk/nhs-staff-experiences-of-racism-from-patients-and-carers-survey-from-a-london-older-persons-service (accessed 29 May 2025).

Christensen, M and Evans-Murray, A (2021) Gaslighting in Nursing Academia: A New or Established Covert Form of Bullying?. *Nursing Forum*, *56*(3), 475–477. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/nuf.12588?saml_referrer (accessed 25 May 2025).

Ramamurthy, A, Bhanbhro, S, Bruce, F, and Collier-Sewell, F (2023) Racialised Experiences of Black and Brown Nurses and Midwives in UK Health Education: A Qualitative Study. *Nurse Education Today*, *126*, 105840.

Ramamurthy, A, Bhanbhro, S, Bruce, F, Gumber, A and Fero, K (2022) *Nursing Narratives: Racism and the Pandemic*. The draft report was submitted to the UKRI-Covid Rapid Response Call Project. [online] Available at: https://shura.shu.ac.uk/29860/1/NN%20Report_Final_EDIT.pdf (accessed 5 December 2024).

Ryan, W (1971) *Blaming the Victim*. New York: Pantheon Books.

Sivanandan, A (2008) *Catching History on the Wing*. [online] Available at: https://irr.org.uk/article/catching-history-on-the-wing/ (accessed 18 October 2024).

Smart, A (2021) Protecting UK Healthcare Workers From Patient Racism. *Sociology of Health & Illness*, *43*(8). Available at: https://onlinelibrary.wiley.com/doi/10.1111/1467-9566.13279 (accessed 29 May 2025).

Stopforth, S, Kapadia, D, Nazroo, J and Bécares, L (2022) The Enduring Effects of Racism on Health: Understanding Direct and Indirect Effects Over Time. *SSM – Population Health*, *19*, 3–4. Available at: www.sciencedirect.com/science/article/pii/S2352827322001963#sec1 (accessed 29 May 2025).

Further reading

Allina, E (2015) 'Transforming 'Beasts into Men': Colonialism, Forced Labour and Racism in Africa'. [online] Available at: www.opendemocracy.net/en/beyond-traf ficking-and-slavery/transforming-beasts-into-men-colonialism-forced-labour-and-racism-in-afr/ (accessed 18 October 2024).

Cordery, S (2021) We Must Confront Structural Racism in Our Ranks. *The BMJ*. Available at: https://blogs.bmj.com/bmj/2021/05/04/saffron-cordery-we-must-confront-structural-racism-in-our-ranks/ (accessed 1 June 2025).

Deacon, M (2011) How Should Nurses Deal with Patients' Personal Racism? Learning from Practice. *Journal of Psychiatric and Mental Health Nursing*, *18*, 493–500.

Grewal, S, Khan, B, Panesar, K, Asher, S and Mehan, N (2024) Exploring BAME Student Experiences in Healthcare Courses in the United Kingdom: A Systematic Review. *Journal of Advances in Medical Education & Professionalism*, *12*, 8.

Hackett, K (2021) Reporting Racism: 'Students Fear They Won't Be Believed'. *Nursing Standard, 36*, 19–21.

Nursing Narratives (2022) *Anti-Racist Manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (accessed 7 June 2025).

Paradies, Y, Ben, J, Denson, N, Elias, A, Priest, N, Pieterse, A, Gupta, A, Kelaher, M and Gee G (2015, 23 September) Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLoS One*, *10*(9), e0138511. doi:10.1371/journal.pone.0138511.

Chapter 4

Don't suffer in silence

Riel Alfonso

Summary

Riel's story highlights racism and homophobia faced by a Filipino nurse in the National Health Service (NHS), both before and during the pandemic. His experience shows how racism can lead to both neglect, exploitation, as well as bullying and harassment. He highlights the dehumanisation, dismissal, and lack of respect that he faced as a migrant nurse, leading to neglect and a general lack of care for his welfare during the pandemic. He reflects on the vulnerability of migrant nurses which led to them being unfairly exposed to COVID-19 in the pandemic. His experience is valuable in understanding the intersectional nature of oppression. He also reflects on the importance of tackling racism to ensure that the NHS can retain staff.

Unsupported in adaptation

I have worked in the Middle East for ten years, but because of my sexuality, it proved to be difficult, so a good friend of mine encouraged me to apply as a nurse in the United Kingdom (UK). I was hesitant because I had applied ten years ago, but after being accepted for an interview, they changed their mind due to changing visa laws. Then, some years later, when I tried again, I lost £1000 to a fraudulent agency based in the UK, which was supported in linking my confirmed hospital placement with a UK university but never did. Although my Filippino agency filed a police case, nothing was ever investigated. These experiences made me hesitant. Friends encouraged me, and with my sexuality, I thought that the UK would be a bit more of an open and accepting place to work.

However, when I arrived, the hospital ward did not even know I was coming to work for them. They said, 'We thought you were coming next year'.

DOI: 10.4324/9781041054276-5

They did not have anything prepared. I was not even given information about how to open a bank account, which led to my wages being delayed. I was lucky to have a little money with me to survive. I was just told, 'You're gonna work as a Band 3'. During that time, I did not have a registration code called PIN issued by the Nursing and Midwifery Council (NMC). So, they just told me, 'We are going to send you to a senior nurse in critical care'. They also just gave me a schedule. So, I worked there. The hospital that sponsored my visa was responsible for having a programme particularly curated towards international nurses. The NMC upholds standards for people joining the register. It required overseas nurses to sit for an Objective Structured Clinical Examination (OSCE) and successfully pass it to obtain the PIN and enter the register. However, no proper adaptation programme was organised, and my name was left out of the email communication for study days, which resulted in me not being able to participate. This left me with no other choice but to pay for a private review centre to help me with my NMC registration.

When I did get my registration, I was told that I would be treated as a newly qualified nurse. This was very demeaning and insulting to me because I thought that I was hired because of my experience, but clearly, experience did not matter. I sent them all my qualifications. I sent them the critical care course that I have done in the Philippines, but it was not valued. I needed to start from the bottom. Those courses, those experiences that I did, did not matter. I was treated as a newly qualified nurse. I could only look after high-dependency patients, not critical care patients. Yet it was ironic that they (employers) would do a complete 180-degree turn when they were desperate. Their system had no consistency; it was as if anything goes when you are understaffed and hopeless, often blurring the lines of duties and responsibilities. One day, I could be taking care of critically ill patients and helping them with the dialysis machines, and the next day, I would be told not to touch those machines as I did not have training for them. I started questioning myself. Am I really not qualified to do this job? Why are there days that they actually support me? And then, days that they are just treating me as if I do not know anything? Then, there were days when they needed help, and they would come to me if they had problems with the dialysis machines. I told them that I had been trained to use those machines. So, when they were desperate and busy, they allowed me to help, but the next day, I was not allowed to even touch those machines.

Yet even though they treated me as newly qualified and told me that I was not supposed to have Level 2 or 3 patients, I would often get combative and delirious patients. These patients were hard to care for and had the tendency to jump out of their beds, making it next to impossible to calm them down alone, but my fellow nurses did not offer to help me.

They wanted me to stop feeling and just work

My first experience of bullying and racism happened in my first few months working in critical care; I was not given breaks for my 12.5-hour shift. They would often say, 'Oh, sorry, we did not remember', or 'Oh, we did not know that you needed one', or you needed to cut your break short because the other white nurses needed their breaks.

It was also then that I noticed that a white nurse would have preferential treatment compared to me, a person of colour. White nurses would get their breaks, and whenever they needed help, somebody would always be there to support them. In comparison, when I had to ask for help, they would often say, 'You didn't sound so urgent'. In my first few months, I also experienced harassment in my accommodation, with European nurses telling me that I was stealing their jobs. When I tried to raise issues with the matron and tell them that there was a problem, they would say to me that I was the problem and that I was not performing well.

If there was a misunderstanding in the unit and it was between me and a white nurse, they would automatically assume that it was my fault and that the problem was with me. I was constantly being forced to apologise for things I had not done. When I did speak out and tell them what the problem was, I was often told that I was rude, a common racial microaggression used to undermine professional competence (Estacio & Saidy-Khan, 2014) and they would threaten to refer me to the matron all the time. I felt like I was a kid misbehaving, and people were using their power over me in order for me to submit to their will. In the beginning, I was trying to survive and thought that I had to prove my worth and impress them. I was worried about my status; I was afraid that if I did not do well, I could lose my job. If I lost it, I could lose my visa, and I would be forced to go back home with nothing to show. I was afraid I might be going home, even though I got my PIN; if they told me that I was not doing well, I might go home. That was my thinking at that time. I got advice from friends who suggested that if I did not think I was doing well in one area, I should apply somewhere else. So that's what I did.

I decided to transfer to the recovery ward to escape the bullying, and I thought that maybe I would finally be able to progress my career there. During my yearly appraisals, I would often ask for training. They would agree and tell me that they would try. However, the only occasion I was given a non-mandatory study day my manager only approved 75% of the cost, and it felt like they were not supportive of my training and development. After that incident, I stopped asking for study days and only did the mandatory training required. I saw that the white nurses working in the unit had many study days. They were able to get approval for courses. After a while, I realised it was not just me being new; it was something to do with my colour or my sexuality.

But the bullying continued, and it greatly affected my mental health. There were days when I felt like they were all ganging up against me and that I was left all alone to fend for myself. It was then that I decided to see the Matron and file my formal complaint. When Matron received my complaint, it was met with indifference; she then told me that,

> Your complaint starts with 'I feel …, I feel not appreciated …, I feel I was bullied.' Riel, let me give you some advice; I want you to stop feeling.

But I felt like my work was all about feeling, feeling for the needs of my patients and helping them. I thought it was not only my physical health that was important to the unit or to the people that are working with me. It's also my mental health. They wanted me to stop feeling and work and be productive. That's the only thing they wanted from me – to be productive. It dehumanised me. I was being treated just as a worker, just as something to get the job done, and not as someone who is part of the team and provides great service (Walani, 2015).

The experience that impacted me the most was when I finally informed my matron that I wanted to resign because I could not handle the bullying anymore. I think one of the things that impacted me the most was my matron and my manager actually assuming I was transgender. They started gaslighting me that I was only being 'overly emotional' because of the hormones I was taking to transition. This would be offensive enough if I were transitioning, but I was not transitioning at all. This was the final straw; it seemed like they were making up excuses for the way I was treated and the way I was bullied as a justification for their actions. First, they started questioning my ability and my qualifications to work as a nurse. And then it went beyond that; they were questioning my sexuality, which should not be an issue. It was the reason that I thought I would be safer working in the UK, but it was not the case.

Filipinos were not prioritised and protected in COVID

At the beginning of the COVID-19 pandemic, I experienced COVID-19 symptoms, but they would not give me access to a swab test. I was forced to self-isolate; however, despite my symptoms, my line manager would call me every day to find out when I would be back to work. When I returned to work, I was not given appropriate personal protective equipment (PPE), and I was not prioritised. So, all the doctors, the anaesthetists, and others who did not pass the fit test were given alternatives, like a respiratory mask. Even some nurses got it. But I was not prioritised. This escalated my anxiety. I would have patients with actual symptoms, fever, and coughing, and they would tell me, 'I think it's just a cold', but they had not swabbed them. It felt like they did not include us Filipinos in the protections or protocol.

In October 2020, I found out that I had been exposed to a COVID-positive patient. No one informed me. I only found out when I was reading my patient's notes. I requested a priority test, but I was refused. Other staff were freely given one, and on the weekend, I did my routine swab, and I tested positive for COVID-19.

Having COVID-19 in a foreign country was frightening for me. I lacked the support of my family, and I was riding through this disease alone. But do you want to know what was even worse? It was being constantly let down by the people in the institution that I work for; it was knowing that they would not be there for me when I needed them. Had I not done enough in my unit to receive the support and protection I was entitled to during these trying times of the pandemic? I was trying to give the best that I could to my work, and I thought that would be somewhat returned with protection or support from them. I felt let down by the people in the institution that I thought would be there and the government. I felt let down by the system.

Even the physical support from charities for nurses, giving us food or basic necessities, instead of giving it to everyone, we needed to wait for. They gave it to the white manager, who would decide who got it. They gave it to whoever they knew well, their friends. We only got whatever was left, if there was anything.

The most disturbing thing for me during the pandemic was the treatment of migrant workers like me (Gogoi et al., 2024). Filipinos or non-white citizens were not prioritised or taken care of. I had a friend who came to the UK around February 2020; I felt that she was also being taken advantage of because she was the one who was least able to say no because she just came in and started the job. Even without their PIN, they are deployed to COVID-19 wards; she worked five days a week in a COVID-19 ward without her PIN, taking care of COVID-19 patients without any recognition from the NMC yet. She cannot say no because it's no choice for her. If you say no, you might lose your job. You don't have any PINs yet. You do not have any actual status here. It was not fair. Also, in our community, it's not our culture to say no if we are needed, especially if it's nurses. You need to help; it's your responsibility as a nurse.

The NHS must recognise and respect international nurses

I feel that sacrificing both my physical and mental health to help patients without any proper protection or recognition finally pushed me to leave the NHS and the UK entirely for a job in America. At my exit interview, I told them that my experience in the NHS was the first time I was only appreciated by the patients, not by the management. I would constantly get thank you notes, letters sent to me personally, emails, maybe some sweets or things like that. One patient told me,

> Oh, I think you're born to do this; you have the perfect voice, the perfect attitude to be a recovering nurse. Like I felt safe waking up hearing your voice.

I think the most significant change that can happen in the NHS is to change the immigration system for international healthcare workers, ensure recognition of previous experience as a nurse, prior to coming to the UK (Nursing Narratives, 2022, point 11). When we went to the UK, we were experienced. Even though we have more than 3, 5, or 10 years of experience, you are still considered as a new, newly qualified. In the NHS, the senior always knows the best. There are never consultations with the ones who are working on the floor. I think that influences the culture, and the bullying and discrimination stem from this. So, it just cycles. The new staff that are coming in will be treated the same. I decided to speak out and take part in Nursing Narratives because I want other internationally educated nurses to know that they don't have to suffer in silence. I published my story in the media to encourage others to stand up for their rights and their dignity.

I will always wish the best for the NHS. Still, unless they change their ways and behaviours towards people of colour and of different backgrounds, I fear the UK will become a stepping stone for international medical professionals like me and not a place they want to work for in the long run (Royal College of Nursing, 2025). That would mean a costly and continuous struggle for the NHS to provide the healthcare services that every patient deserves.

Reflective questions

1 How can colleagues support individuals who are suffering persecution and harassment?
2 In what ways can the NHS support overseas nurses to transition to life and work in the UK?
3 How can intersectional solidarity support an anti-racist NHS?

References

Estacio, E.V. & Saidy-Khan, S. (2014) 'Experiences of racial microaggression among migrant nurses in the United Kingdom', *Global Qualitative Nursing Research*, *1*, 1–7. doi: 10.1177/2333393614532618. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5342848/ (accessed 25 June 2025).

Gogoi, M., Qureshi, I., Chaloner, J., Al-Oraibi, A., Reilly, H., Wobi, F., Agbonmwandolor, J.O., Ekezie, W., Hassan, O., Lal, Z., Kapilashrami, A., Nellums, L.B. & Pareek, M. (2024) 'Discrimination, disadvantage and disempowerment

during COVID-19: A qualitative intrasectional analysis of the lived experiences of an ethnically diverse healthcare workforce in the United Kingdom', *International Journal for Equity in Health*, *23*(1), Article 105. doi: 10.1186/s12939-024-02198-0. Available at: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-024-02198-0 (accessed 25 June 2025).

Nursing Narratives (2022) *Anti-racist manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (accessed 7 June 2025).

Royal College of Nursing (2025) *Unreciprocated care: Why internationally educated nursing staff are leaving the UK*. London: Royal College of Nursing. Available at: www.rcn.org.uk/Professional-Development/publications/rcn-unreciprocated-care-why-internationally-educated-nursing-staff-are-leaving-UK-pub-012-109 (accessed 25 June 2025).

Walani, Salimah R. (2015) 'Global migration of internationally educated nurses: Experiences of employment discrimination,' *International Journal of Africa Nursing Sciences*, *3*, 65–70.

Further reading

Alfonso, R. (2021) *I didn't quit the NHS because of the pandemic. It was the bullying*. [online] Available at: www.huffingtonpost.co.uk/entry/nhs-nurses-coronavirus_uk_60715cfdc5b6616dcd7881b6 (accessed 17 October 2024).

Hunter, W. (2023) *International nurses find UK staffing and workload 'worse than expected'*. [Online] Available at: www.nursinginpractice.com/latest-news/international-nurses-find-uk-staffing-and-workload-worse-than-expected/ (accessed 10 October 2024).

Kline, R. & Warmington, J.(2024) *Too hot to handle: Why concerns about racism are not heard or acted on*. [online] Available at: https://27aa994b-a128-4a85-b7e6-634fb830ed15.usrfiles.com/ugd/27aa99_4d4e620e6889408d926dad142839c0f3.pdf (accessed 17 October 2024).

Nursing and Midwifery Council (2023) *Spotlight on nursing and midwifery report 2023*. [online] Available at: www.nmc.org.uk/globalassets/sitedocuments/data-reports/insight-spotlight/2023/spotlight-on-nursing-and-midwifery-report-2023.pdf (accessed 15 October 2024).

Singer, N. & Robert, T. (2020) 'Black and Asian people are 2 to 3 times more likely to die of COVID-19, U.K. study finds', *Time*, 28 May. Available at: https://time.com/5832807/coronavirus-race-analysis-uk/ (accessed 25 June 2025).

Webber, A. (2023) *Nurses from overseas face discrimination and lack of support*. [online] Available at: www.personneltoday.com/hr/overseas-nurses-discrimination-nmc/ (accessed 10 October 2024).

Chapter 5

The struggle for fair treatment as an internationally educated nurse

Rona Cordero

Summary

This chapter reflects on the vulnerability and stress caused by immigration legislation for overseas nurses. Rona highlights how these vulnerabilities can easily be exploited to harass overseas workers. She reflects on the failure of managers to listen to staff representatives who raise uncomfortable concerns and the subsequent attempt to intimidate her. Her story also draws attention to a pattern of experience where Black and Brown staff are forced to leave their place of employment to achieve promotion. She also highlights how institutional hierarchies intersected with racism in the pandemic, leading to neglect and the over-exposure of Black and racialised employees to COVID-19. She reflects on the emotional toll that this took on her and her community and the importance of each and every nurse being valued.

Visa restrictions and work challenges in a foreign land

When I applied for a job in the UK as an internationally educated nurse trained in the Philippines and working in Singapore, I had imagined the UK to be a more modern and high-tech place, but to my surprise, it was not so technologically upgraded. I was assigned to work in a small hospital that was introducing new equipment and machines that we were already familiar with working in Singapore. However, I was determined to enjoy my new job despite the challenges of adapting to the English language alongside the slang thereof and the weather. I was missing my husband and my children, whom I was desperate to bring with me to the UK. Obtaining a visa for them was stressful as it was linked to my job. I needed to earn more and secure a house for us to live together. I had to complete my adaptation to nursing practice for three months to be able to secure a permanent contract with the hospital

DOI: 10.4324/9781041054276-6

I was working with. If anything went wrong in my practice, I could easily lose everything.

Being vulnerable due to my status made me nervous, and I had always to obey and follow whatever my managers told me to do. Even when I was sick, I had to work. I was afraid to cause any problems that could affect my visa status. My desperation to get my husband and children to the UK and help my family back home, especially after my dad's stroke, forced me to take loans and work even harder for my adaptation and a permanent contract at the hospital.[1]

Finally, I managed to get my husband and children into the UK. However, things started becoming difficult after my ward manager changed. I had requested to work at night as it was a convenient time for me, considering my husband worked during the day while I took care of our children. However, the manager kept insisting that it was unhealthy for me to work night shifts, but I had no choice because I could not afford the childcare. When I would not budge, she started giving me a hard time. She would nitpick on little things and complain about my work, creating a hostile work environment which was challenging as I was trying to do everything to perfection. The fear of making mistakes was overwhelming (Estacio & Saidy-Khan, 2014). I took a bold step and wrote a grievance against her.

Overcoming racism and career advancement

Working overseas as an internationally educated nurse and a mother had its ups and downs. Still, I overcame the language barriers, culture shock, and work challenges by ensuring my performance was good. I worked diligently, even when it seemed impossible to do so.

As an internationally educated nurse, I faced various struggles to establish my career in the UK. Despite my qualifications and years of experience, I found myself sidelined due to my language skills and ethnicity. From difficulty with promotion opportunities to being forced to leave my job due to a toxic work environment, my story highlights the difficulties that immigrants can face working as nurses in the UK (Ugiagbe et al., 2023; University Hospitals Birmingham NHS Foundation Trust, 2023).

As a result of my grievance against my ward manager, my employer asked me to move to a different ward since they said they could not move the manager. I was obviously hesitant. The staff on my current ward were a diverse group of individuals who supported each other through difficulties and hard work. So, I decided to stay and try to navigate the treatment from my manager.

However, I wanted to advance in my career. I was stuck in a Band 5 staff nurse post. I had worked in the orthopaedic unit for eight years, but I could not get a promotion. Not all international nurses get promotions. They said it was because of a communication problem, so I attended an English course at Manchester University and passed it, but it did not make a difference. I continued to work on the same band. I was applying for Band 6 roles, but I never

got a chance to progress. I tried to apply for courses to help me with my progression, but I was unsuccessful in achieving a place. In the end, after 15 years working in the trust, I had to resign from my job and made the difficult choice of working as an agency nurse to gain more diverse experience. After a year as an agency nurse, I applied for a Band 6 role in my previous hospital but in a different area. My interview went well, and during the interview, they asked me if I would accept a Band 5 post. I did not accept this as the post had been advertised as Band 6. I asked the interviewers what they needed from me, as I had all the experience they needed for the post. In the end, they offered me the Band 6 role but paid me at a lower rate, below my previous top Band 5 wage. I tried to question it but with no success. I took the position as I was tired of watching younger colleagues, who were my students and our previous healthcare assistants, become nurses and promoted ahead of me.

My story and experience raise a crucial question: Should you move to avoid racism? My story shows that there is no easy answer. Moving can be a difficult and anxiety-inducing task, but it can also lead to better career prospects and the chance to work with individuals who support your goals. My journey is an inspiring reminder that with perseverance and determination, one can overcome even the most challenging obstacles.

Speaking out for myself and others

As I continued in my post as a Band 6-unit sister, I noticed that the voice of the frontline staff in our unit was not being heard, so I decided to become a Staff governor as I believe frontline staff need to be represented. I raised issues about how our units are understaffed and about bullying and harassment being rampant. The director of nursing was not happy about me being outspoken. He disagreed with me raising issues in front of the council governors. He even had me in a one-to-one meeting trying to find out who I was. In the end, I felt that there was no point in my role as a staff governor if I could not express the issues that needed to be raised. I was there elected to raise concerns and ensure that the patients and the staff were cared for and listened to by management, but they did not want to listen. After this, management started investigating my private life and my social media. I felt they were trying to intimidate me. They asked about how much I earn through my channel and demanded that I remove some videos. It is challenging when to raise issues and concerns in the workplace, and it makes it even more challenging to speak up if you are from a minority ethnicity. I felt that it was time to look for another job.

Silenced in the system: The fight for fair treatment in the pandemic

It was March 2020 when my husband, a healthcare assistant working at the same hospital as me, came home with some alarming news. He had

unknowingly cared for a COVID-19-positive patient without the appropriate personal protective equipment (PPE), and now he had been exposed. Shortly after that, I began experiencing symptoms of my own and was urged by my husband to alert our managers.

To my surprise, the response was dismissive. They suggested my husband should have raised the issue, but back then, there was no protocol in place in terms of PPE. When I returned to work, I asked about PPE provisions but was given no additional protection – just a surgical mask, pinny, and gloves. Only two weeks later, I began experiencing more severe symptoms at work. My colleague was gravely concerned, so I immediately isolated myself at home.

Fearing for the worst, I decided to document my condition on an iPad during isolation – if I died, it would be something for my family to look back on. The situation was grim, with stories of other Filipinos and Africans dying alone in their bedrooms. This was my way of saying goodbye should the worst happen. My fears were not unfounded. In my weakened state, I reached out to the designated silver command, hoping to receive help. Instead, the female staff on the other end laughed at me, leaving me feeling hopeless. I requested a swab test, but it was constantly ignored.

Despite my cries for help, I was continuously ignored. Meanwhile, one of our ward managers posted on Facebook about being swabbed for COVID-19, while others, like me and my husband, were not being tested. Eventually, we had to pay for a private test to confirm that we both had COVID-19. I was left wondering why we were treated unfairly and if it was because of our race or position in the hospital (Kapilashram et al., 2021).

During the pandemic, frontline healthcare workers faced unprecedented challenges, including inadequate PPE and high infection rates. However, for international nurses like myself, the pandemic also amplified systemic racial inequities in healthcare at work (Race Equality Foundation, 2023). Many of my fellow Filipino and Black colleagues were consistently placed in high-risk areas without the option to choose, while white nurses were given more choice and flexibility. Managers claimed that it was a rotation, but it often turned into a long-term placement, resulting in a disproportionate burden on us international nurses. Even those with underlying health conditions were sent to high-risk areas, putting their lives in danger.

My husband, as a healthcare assistant suffering from diabetes and congenital heart disease, was at high risk, yet he was repeatedly sent to the COVID ward. As international healthcare workers and nurses, we often feel scared to speak out for fear of retaliation, but we must continue to raise our voices and fight for equity in our place of work.

The emotional toll of COVID-19 on internationally trained nurses

The COVID-19 pandemic was a difficult and trying time for all of us, and for healthcare workers like nurses, it was incredibly challenging. Many of my

colleagues, especially from overseas, lost their lives during the pandemic (UK Health Security Agency, 2023). While compensation was offered, there is truly no price that can be put on a life. What we need most is to be treated with respect and dignity as human beings and to be given the support and resources we need to do our jobs safely and effectively.

Personally, COVID-19 had a significant impact on my mental health. As a nurse, I was constantly worried about getting infected and spreading the virus to my family and loved ones. I felt like nobody was listening or taking my concerns seriously. This only added to my anxiety and left me feeling helpless and alone. However, I have also experienced the importance of support from colleagues and the power of perseverance. My vision for change is to have a fair and equal system for everyone, where everyone is treated with fairness, respect and dignity at work.

While it is important to be strong and stand up for us, it is equally important to seek help when we need it. I turned to emotional support and counselling to help me process my feelings and cope with the stress of the pandemic. It is okay to ask for help and to lean on others when we are struggling. I was fortunate to have access to support from an advisor, but it is important that every healthcare worker has access to support whenever they need it.

Looking forward, I hope the healthcare system will do more to prioritise the safety and well-being of nurses and other healthcare workers. We deserve to be treated as valued members of the healthcare team, with equal rights and equal opportunities for advancement. We are all human beings, and we all deserve to be treated with kindness, compassion, and respect.

Make your voice heard

I think the most important thing is to be treated equally and fairly, especially in the workplace: 'Build an NHS with equality at the core of health provision for all ethnicities'. It is essential to have someone to listen and to go to when you need help. For all the new Filipino nurses joining us here, I encourage you to be proactive when expressing your concerns and seeking support. It is important to make your voice heard, regardless of whether or not your English is perfect. Do not be afraid to show that you have the right to progress and be treated with respect and equality. Be tough and stay positive.

We need a workplace system in the NHS that treats everyone equally, including Filipino nurses who have contributed so much to the service (Nursing Narratives, 2022, point 3). I speak out for my children, who will live here in the UK. Even if I am gone, I want them to know that their mom fought for equality and fairness for all, no matter their race or background. Let us keep fighting for change and believing that one day, we will all be treated as equal, may it be in the workplace or the community.

Reflective questions

1 What steps can trusts take to create a more open and supportive environment where nurses can feel safe and empowered to raise issues of concern, such as racism and bullying?
2 How can all nurses support colleagues who speak out about racist bullying?
3 What is the responsibility of the government regarding legislation to prevent overseas nurses from being made vulnerable to bullying and exploitation?

Note

1 The attrition rate for internationally educated nurses and midwives has significantly increased with 37.5% leaving the NMC register between March 2018 to March 2023, in stark contrast only 7% of UK educated nurses left the register at the same time (NMC, 2023).

References

Estacio, V, and Saidy-Khan, S (2014) Experiences of Racial Microaggression Among Migrant Nurses in the United Kingdom. *Global Qualitative Nursing Research*, *3*:1–7.

Nursing Narratives (2022) *Anti-Racist Manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (Accessed: 7 June 2025).

Race Equality Foundation (2023) Not by Choice – the Unequal Impact of the COVID-19 Pandemic on Disempowered Ethnic Minority and Migrant Communities. Available at: https://raceequalityfoundation.org.uk/press-release/new-report-highlights-unequal-impact-of-covid-19-pandemic-on-disempowered-ethnic-minority-and-migrant-communities/ (Accessed: 14 May 2025).

Ugiagbe, M, Liu, Q, Markowski, M, and Allan, H (2023) A Critical Race Analysis of Structural and Institutional Racism: Rethinking Overseas Registered Nurses' Recruitment to and Working Conditions in the United Kingdom. *Nursing Inquiry*, *30*:1–10.

UK Health Security Agency (2023) COVID-19 Confirmed Deaths in England to 31 December 2022. Available at: www.gov.uk/government/publications/covid-19-reported-sars-cov-2-deaths-in-england/covid-19-confirmed-deaths-in-england-to-31-december-2022-report (Accessed: 14 May 2025).

University Hospitals Birmingham NHS Foundation Trust (2023) Culture Review Report and Response. Available at: www.uhb.nhs.uk/review/culture-review-report-and-response/ (Accessed: 14 May 2025)

Further reading

Campbell M, Tamburello H, Burnham J, and Argyrides A 2024 *Without a safety net*, Royal College of Nursing www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Publications/2024/August/011-752.pdf

Chisnall, G, and Vindrola-Padros, C (2021) A Rapid Literature Review on Inequalities and ETHNICITY in Healthcare Workers' Experiences of Delivering Care during the COVID-19 Pandemic. [online] Available at: https://www.researchgate.net/publication/349858275_A_rapid_literature_review_on_inequalities_and_ethnicity_in_healthcare_workers'_experiences_of_delivering_care_during_the_COVID-19_pandemic (Accessed: 5 December 2024).

Hussein, S (2022) Employment Inequalities Among British Minority Ethnic Workers in Health and Social Care at the Time of Covid-19: A Rapid Review of the Literature. *Social Policy and Society*, *21*:316–330.

Kapilashrami, A, Otis, M, Omodara, D, Nandi, A, Vats, A, and Adeniyi, O (2021). Ethnic Disparities in Health and Social Care Workers' Exposure, Protection, and Clinical Management of the COVID-19 Pandemic in the UK. *Critical Public Health*, *32*:68–81.

Nursing and Midwifery Council (n.d.) Trained Outside the UK. Available at: www.nmc.org.uk/registration/joining-the-register/register-nurse-midwife/trained-outside-uk/ (Accessed: 14 May 2025).

Nursing and Midwifery Council (2023) *Spotlight on Nursing and Midwifery Report 2023*. Available at: https://tinyurl.com/2xe7kah6 (Accessed: 2 June 2025).

Chapter 6

Survival struggle of a migrant nurse in the NHS

Olanike Babalola

Summary

Olanike's story highlights the difficulties that visa restrictions cause overseas nurses, especially when they have a family. Despite acquiring qualifications and the UK's need for overseas nurses, her story exposes exploitation, as well as emotional and financial suffering inflicted on overseas nurses, through precarity. This chapter narrates the further struggles created by the COVID-19 pandemic as she sought safe working conditions. She narrates the way racism and discrimination have stifled her career advancement despite her qualifications as well as how structural racism through visa costs and lack of recourse to public funds have left her family in poverty and made her feel undervalued. The chapter highlights the impact of racial capitalism. She calls for meaningful support for overseas nurses, more diversity in leadership, and fairer immigration policies to acknowledge the critical contributions that overseas nurses made during the COVID-19 crisis.

My first encounter in England

I was trained in Nigeria and came to the UK in 2008 to do the overseas nurses' programme. The programme was really fascinating. It was 20 and 16 years after I qualified as a registered general nurse and registered midwife, respectively, in Nigeria. When we finished the three weeks of classroom-protected studies, we were sent on placements. I was placed in a nursing home in the West Midlands. There was considerable discrimination from white healthcare support workers (HSW) in the nursing home. Even though I am a fully qualified nurse, the senior support staff made me do all the hard work while they took mini breaks for fresh air. Sometimes, while I was still doing personal care, the HSW allocated to me would go on their first break and say the team had completed

DOI: 10.4324/9781041054276-7

washing patients. While I was still doing personal care, they would be on their lunch break. If I said anything, they would answer back that I was employed to work. In the end, I had to let the manager know, and she addressed this at that time. On the other hand, I had a good experience with my mentor, who recognised my skills and the quality of my nursing education and commented, giving me feedback during the placement, that I was an excellent nurse.

Navigating the brutal trail of immigration

When I came for my overseas nurses' programme to register in the UK, I had intended to stay permanently from 2008. However, I had my nuclear family in Nigeria, with the youngest child being just four years old at the time, so I could not stay as long as I would have liked. I tried to find a way to bring my family with me immediately, but it turned out to be more difficult than I anticipated in the two years.

When I was returning to Nigeria after my post-graduate course in 2010, all my colleagues who had completed their top-up degrees with me and were on student visas transitioned to post-study work visas while in England. However, because I had a family and needed to return home, I decided to travel before applying for it. I planned to apply for my visa and then come back with a student visa extension to transition to the post-study work visa. I gathered all the required supporting documents from the university to apply for my visa back in my home country. Unfortunately, when I applied, my visa was denied, and I was only granted a two-week extension instead of the recommended two to four months at the time. By the time I received my visa, I had just one week left of my extension.

I went to the UK embassy in my country several times to explain that I was returning to complete the ongoing enrolled course in the UK and not a new study visa application. I had even prepared for the post-study work visa application, but my efforts were in vain, and my study period expired. This led me to apply for a post-study work visa in my home country, but that application was also denied. They did not accept the maintenance fee I already had in my UK account; instead, they required me to have funds in my Nigerian account for three months.

During this challenging time, my younger sister, who was my children's guardian in Nigeria while I was away, became ill and sadly passed away. I made the difficult decision to remain in Nigeria and eventually got a job at a diabetes specialist hospital. I worked there for about two years before moving to the Lagos State University Teaching Hospital. Meanwhile, I kept up to date with the renewal of my UK Nursing and Midwifery Council registration. Later, I learned in 2015 that nursing had become a shortage occupation in the UK, so I decided to apply directly to the NHS from Nigeria. I had my interview on Skype and was successfully employed by the NHS, where I currently work. That was how I returned to the UK in 2016, six years later.

My immigration status has had a significant impact on my life. I hold a work visa, and my residence card clearly states that I have restricted work conditions. This means that, after my contracted hours with my sponsor, I cannot work more than 20 hours a week in the same profession. The restrictions are so strict that even if I wanted to do extra work, I would need to monitor the hours I put in carefully. This limitation does not provide me with enough income to support my family. Additionally, I have a unique, challenging situation: the other adult income contributions to the household were cut short due to ill health shortly after I arrived in the UK, facing serious health challenges that required multiple hospital admissions before eventually receiving a transplant and living with dependent children and a sick person on the NHS limited income. Being on a work visa has been incredibly difficult, especially since we have no recourse to public funds.

Unaffordable visa costs and exclusion from public support crush overseas nurses

The costs associated with maintaining our visas are exorbitant. Initially, we had a three-year visa, and when it was time to extend it for another two years, the expenses became overwhelming. It has now been five years, but we cannot apply for indefinite leave to remain due to the high costs. The fee is £2,409 per person, which adds up quickly for a family of five persons. In addition, I have had to pay the immigration health surcharge to use the NHS. In 2019, when we were extending our visas, the immigration health surcharge IHS doubled from £200 per year per person to £400 per year per person. For the last two years of extension, it has amounted to £800 for each person. These expenses are substantial for a family of five. Dealing with the difficulties of visas has been very challenging for me as an international nurse. (Campbell et al., 2024)

As an overseas nurse coming to work for the NHS and care for people, it's painful not being able to access benefits from the NHS or the country. I put in a lot of extra time, including unpaid overtime, yet I cannot enjoy the benefits that should be available to all. I have faced challenges with private renting and providing enough food for my family. I could not approach the council to request a council flat, which would have been more affordable. Many times, I felt overwhelmed and cried because I struggled to feed the family. During COVID-19, things got incredibly difficult, especially when I was the only one working and had very little sustenance. When I took agency shifts and worked long hours, I would often be told I could not exceed 20 hours, so I ended up doing 18 hours mostly; if not, I didn't get paid for the extra hours. It was also challenging to access financial support or loans while on a visa. Eventually, I realised that my visa status was the primary reason for the difficulties I faced (Royal College of Nursing, 2025). It was tough for me and my family.

I have written to members of parliament (MPs) and tried to appeal for indefinite leave to remain. After paying our own quota for five years as overseas

nurses with visas, immigration fees, and IHS surcharges, I do not understand why we cannot be granted free indefinite leave to remain, especially considering our contribution during the COVID-19 pandemic. The issue of having no recourse to public funds is particularly troubling. Even when one is on a low income or if a partner is unable to work, not having access to public funds is incredibly difficult, especially when you do not have extended family in the UK. We work for the government and do everything necessary, yet we cannot access the support we deserve.

I feel that the government is not being realistic and does not truly value what we nurses do. We take on the responsibilities of everyone in the healthcare system. We cover the work of physicians, healthcare support staff, social workers, and more. There is an enormous amount of work that nurses handle, yet the government fails to recognise this and value us appropriately. A little appreciation goes a long way in protecting our mental health and overall wellbeing. When people step out to care for the community and the country, especially during the pandemic, nurses risked their lives without hesitation. Clapping is not enough. Merely applauding those who risk their lives to save others does not equate to proper recognition. We needed more meaningful rewards for our efforts.

Consider the nurses in our communities. Whether through their pay or other forms of recognition, nurses need to feel valued.[1] Additionally, for those international nurses who come to work here after being brought over thousands of miles, the government should offer worthwhile rewards rather than imposing strict rules and conditions. The work visa requirements for healthcare staff should be reconsidered, as these restrictions are overwhelming.

In other countries, such as Canada, healthcare workers are valued differently. For instance, it only takes three years to obtain residency there, and after that, you can become a citizen. In the UK, it takes five years, and the costs associated with extending visas are exorbitant. For the two-year visa extension in 2019, I spent nearly £8,000 just on renewal. This heavy cost associated with visas pushes many overseas healthcare workers into poverty (Devereux, 2024). Only towards the end of the pandemic in 2022 did my family finally receive indefinite leave to remain (ILR) after paying 12 grand additional priority fees inclusive. This did not make my family's decision faster than the standard application, and that priority fee was never refunded when requested.

Racism in the workplace

I have experienced various forms of racism in the workplace, and they manifest in different ways. For instance, people's perceptions can be shaped by my accent or my appearance, leading them to believe that I lack knowledge or competence because of my skin colour. Gogoi et al. (2024) discuss the intersectional experiences of healthcare workers evidencing those with foreign accents or non-British training often face differential treatment compared to

their British-born counterparts. On more than one occasion as a charge nurse working alongside support staff, I have been undermined by support staff. For example, one day a patient in my care became unwell. The HSW, instead of addressing the situation with me as the charge nurse, ran to a senior white nurse to get advice. The senior nurse then entered my area of work after being summoned by a HSW. This support worker left my side to seek help from someone else, implying that they did not trust my abilities even though I had in fact already done all they came to suggest.

While they did not voice their doubts outright, their actions spoke volumes. It seemed as if they felt the need to bring in another nurse because they doubted my knowledge and skills. When I raised my concerns with my manager, I was asked if I was sure I was not imagining it. This response was incredibly frustrating. I know what their actions intended to convey—why would they bypass me when I am in charge of that team? It felt dismissive, especially when the manager suggested that I should not worry because the HSW had been with the patients longer and, therefore, felt more comfortable approaching a nurse who shared their background. Sue et al. (2007) identify and categorise microaggressions such as this where subtle yet dismissive actions undermine Black and Brown nurses professional authority.

It was disheartening to feel that no matter what I said or felt mattered, my concerns were brushed aside. I have come to accept that I won't easily win this battle. Many others in my situation might feel tempted to give up, but I choose to persevere. I believe that the work I do is ultimately for my own passion, benefit and professional growth.

Career advancement—'somebody did a little bit better than you'

To advance my career, I took every opportunity to further my education, often at my own expense. I actively sought out training courses, even if it meant using my annual leave or paying out of pocket to attend conferences or pursue a master's degree. I am committed to my professional development without relying on others for support, and I make the most of every free course available to me. With my nursing top-up degree in 2010, I had advanced management of diabetes qualification at level 6, and I applied for a diabetes specialist nurse role. Still, I was only able to be a diabetes link nurse. I asked the manager, as a diabetes link nurse in the unit, if I could to attend a three-day diabetes conference to develop my skills as I believe it will help me in my work. They dismissed my request. Their only advice was to use my annual leave and pay for it out of my pocket. I decided to invest in myself and went.

When a nurse is at Band 5 and wants to move to Band 6, they have to demonstrate an ability for the role. Nurses must prove that they qualify and meet all the specifications. I have been shortlisted for interviews several times, but the feedback usually states that 'somebody did a little bit better than you'.

Sometimes they say, if they had funding for two positions, you would have been selected as well. I have shared this experience with my African and Asian colleagues, and many of them express similar experiences, having heard the same unsatisfactory results at multiple interviews—unsuccessful, unsuccessful, and unsuccessful. It is frustrating to see someone who qualified only two or three years ago apply for the same Band 6 levels and get accepted over you. There you are, stuck at band five while they come in at Band 6, and you are then asked to help them with skills related to the Band 6 roles. The Royal College of Nursing (2022) highlights ethnic disparities in nurse career progression within the NHS.

It is disconcerting because if one has more experience, even up to 30 or 35 years, we still remain stuck at the top of Band 5 for 15–20 years. All the experiences I acquired outside the UK are never valued. Many of my Black colleagues are also not progressing because they are just not given the opportunity. It makes you wonder why everyone cannot be treated equally, notwithstanding where you acquire your qualifications, skills, and experiences.

Recently, I was moved to a Band 6 role because this is the job specification band for everyone where I am working now. It didn't just happen; I had to approach management and ask them why I was being paid at Band 5 since I performed the same tasks every day as all the Band 6s around me. Eventually, they acknowledged this, and I successfully moved to a Band 6 position. I believe that the barrier I faced was due to my race and my status as an overseas nurse. Stoye and Warner (2024) examine the career progression of nurses within the NHS, highlighting some of the disparities including ethnicity.

Struggling for a risk assessment in the pandemic

I first heard about COVID-19 in February 2020 while working in the NHS. Initially, since we were in a community-based setting, the response was that we did not need facemasks or personal protective equipment. This changed by the end of March when we had an active case on our unit. I was terrified, especially since I have a family member who has had a kidney transplant, and I feared bringing the virus home based on that vulnerability. Despite my fear, I continued working, wiping down surfaces, changing from work clothes, and washing my hands frequently. Eventually, we were allowed to use regulated facemasks.

Upon learning of the first COVID case in my unit, I felt the need to act to prevent bringing it home. I approached managers, but my concerns were dismissed. Everyone was scared, and my worry intensified due to my family's vulnerability, especially with reports highlighting severe outcomes for minority groups. When I started experiencing COVID-19 symptoms, I isolated myself. I sought home testing and redeployment to other areas, but the managers were unaccommodating—despite reassurances that I would not easily catch the virus, rising infections among healthcare workers, especially in minority

groups, left me terrified and vulnerable, particularly with my family member already shielding.

I was frustrated while trying to keep my family safe, especially knowing the disproportionate impact of COVID-19 on minority communities. When I initially spoke to my line manager, I expressed my fears about possibly bringing the virus home and requested to work from home. I recognised that this was challenging for a nurse, but I suggested being redeployed to an administrative role that would not involve direct patient contact. Unfortunately, my manager said there were no options available, but I encouraged them to look for opportunities within the larger organisation, highlighting my diverse skill set.

As a union member and representative, I felt compelled to share my experiences with the Union due to my management's refusal to help me, which left me scared and frustrated. The Union took up my case, but the process became increasingly stressful, especially as I dealt with COVID-19 symptoms and self-isolated for 14 days despite a negative swab test. My request for accommodation was not easily accepted, prompting me to reach out for union support. It was only after union intervention that I got a risk assessment, and they finally understood the risks for my family. After returning, I requested a redeployment, but management insisted I return to my unit. Eventually, the Union intervened and demanded I be reassigned due to health risks. During a meeting, management expressed concern that I might be dismissed, which bewildered me since I had done nothing wrong; I only wanted to protect my family. I made it clear that if I were fired, I wanted to know the reason behind it. Despite a challenging journey involving management, HR, and the Union, I was ultimately redeployed.

As a minority ethnic staff member, I faced difficulties that white staff did not. Many minorities were denied risk assessments, even those with severe health issues. I advocated for myself and encouraged others to complete self-risk assessments, as it was essential for managing health risks appropriately. Nevertheless, the risk assessment felt like a mere formality, like a 'tick-box' exercise (Qureshi et al., 2022) because ethnic minority health workers identified risks that were not taken seriously.

During or after COVID-19, I would not say that racism has worsened; it has always been present. Instead, the pandemic highlighted existing racial issues more visibly. It has become more apparent to people who were previously unaware, but the reality is that racism has deep roots and has been pervasive in workplaces for a long time. The pandemic did not worsen it; it simply exposed what has always been there.

More than a number

I would like to see significant changes, particularly regarding the treatment of people of colour in the health service. As a nurse, I want to do my best for my patients and ensure they are well cared for. While others may have given

up, I strive to continue making a difference. Yet, I often feel like I am just a number. If something were to happen to me or my family, it would not take long for someone else to be hired to replace me. Despite all of this, my passion for nursing remains strong, but I want to feel valued.

I want to see more Black nurses in higher positions within the NHS and the Department of Health. More individuals from minority ethnic groups should hold director-level and decision-making roles within the NHS. Additionally, I want to see improvements in the relationship between management and minority ethnic staff, especially in disciplinary matters. Many staff members face unfair treatment, which can lead to unwarranted dismissals. When a disciplinary panel is formed, there often seems to be a lack of diversity, which affects the outcomes for Black and Brown nurses. We need to move past judging people solely based on their skin colour or ethnicity.

I would like to see changes in the immigration system for overseas nurses. For an anti-racist health service, I believe the government must take seriously the following point raised in the anti-racist manifesto: Change the immigration system for international healthcare workers to end exploitative visa fees, the denial of recourse to public funds, and automatic indefinite leave to remain (Ramamurthy et al., 2022, point 14).

Reflective questions

1 How can we advocate and influence the government to transform the immigration system for overseas nurses in this country?
2 How can the NHS ensure transparency and fairness in career progression?

Note

1 The RCN State of the Profession Report (2024) which summarised the findings from an RCN members survey found that 22% of nurses think their pay level or band is appropriate falling from 44% in 2015.

References

Campbell M, Tamburello H, Burnham J, and Argyrides A 2024 *Without a safety net*, Royal College of Nursing www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Publications/2024/August/011-752.pdf

Devereux, E (2024) 'Overseas nurses 'pushed into poverty' by UK visa policies'. [online] available at: www.nursingtimes.net/workforce/overseas-nurses-pushed-into-poverty-by-uk-visa-policies-27-08-2024/ (accessed 12 December 2024).

Gogoi, M, Qureshi, I, Chaloner, J, Al-Oraibi, A, Reilly, H, Wobi, F, Agbonmwandolor, JO, Ekezie, W, Hassan, O, Lal, Z, Kapilashrami, A, Nellums, LB and Pareek, M

(2024) 'Discrimination, disadvantage and disempowerment during COVID-19: a qualitative intrasectional analysis of the lived experiences of an ethnically diverse healthcare workforce in the United Kingdom', *International Journal for Equity in Health*, *23*(1), p. 105. Available at: https://doi.org/10.1186/s12939-024-02198-0 (accessed 25 June 2025).

Qureshi, I, Gogoi, M, Wobi, F, Chaloner, J, Al-Oraibi, A, Hassan, O, Pan, D, Nellums, B and Pareek, M (2022) 'Healthcare workers from diverse Ethnicities and their perceptions of risk and experiences of risk management during the COVID-19 pandemic: qualitative insights from the United Kingdom-REACH study', *Frontiers in Medicine*, *9*, p. 1–9.. Available at: https://doi.org/10.3389/fmed.2022.930904.

Ramamurthy, A, Bhanbhro, S, Bruce, F, Gumber, A and Fero, K (2022) *Nursing narratives: Racism and the pandemic*. The draft report was submitted to the UKRI-Covid Rapid Response Call Project. [online] Available at: https://shura.shu.ac.uk/29860/1/NN%20Report_Final_EDIT.pdf (accessed 5 December 2024).

Royal College of Nursing (2022) *Employment survey report 2021: Workforce diversity and employment experiences*. London: Royal College of Nursing. Available at: www.rcn.org.uk/Professional-Development/PDFs/Employment-Survey-Report-2021-uk-pub-010-216 (accessed 25 June 2025).

Royal College of Nursing (2025) *Unreciprocated care: Why internationally educated nursing staff are leaving the UK*. Available at: www.rcn.org.uk/Professional-Development/publications/rcn-unreciprocated-care-why-internationally-educated-nursing-staff-are-leaving-uk-pub-012-109 (accessed 25 June 2025).

Stoye, G and Warner, M (2024) *Progression of nurses within the NHS*. London: Institute for Fiscal Studies. Available at: https://ifs.org.uk/publications/progression-nurses-within-nhs (accessed 25 June 2025).

Sue, DW, Capodilupo, CM, Torino, GC, Bucceri, JM, Holder, AMB, Nadal, KL and Esquilin, M (2007) 'Racial microaggressions in everyday life: implications for clinical practice', *American Psychologist*, *62*(4), 271–286. Available at: https://doi.org/10.1037/0003-066X.62.4.271 (Accessed: 25 June 2025).

Further reading

Royal College of Nursing (2024) *State of the profession report: RCN employment survey 2023*. Available at: www.rcn.org.uk/Professional-Development/publications/RCN-Employment-Survey-2023-uk-pub-011-484 (Accessed: 14 May 2025).

Chapter 7

Confronting racialised danger in the pandemic

Roseline Sanni-Ajose

Summary

Roseline Sanni-Ajose outlines her experiences as a student nurse and an agency nurse who is determined to be treated fairly. She narrates how racism impacted her and her position as an agency nurse on the frontline during COVID-19. She reflects on having to deal with the trauma of death on a daily basis, trying to balance her mental health and the needs of her family. She outlines how the decision to expose Black nurses to danger straightforwardly manifested itself during the pandemic and what she did to challenge that. She outlines the avenues she has taken outside of the NHS since the Nursing Narratives Project to support Black people's health through the media.

We are not second-class citizens

I love humanity. I love giving life back to people. When I see people that are sick, giving them help gives me great joy. That was the main reason why I decided to be a nurse in the first place. I did my training at King's College University Hospital in London. Getting into King's was very tough; student training is of a very high standard. As a young Black woman, I knew it was a brutal world; training in the heart of London, you see a lot of racism, and you can't sweep it aside. It's there. It's glaring in your eyes. In Nigeria, we use an adage, 'choose your fights'. If you are in the right, you pursue that fight and fight it properly, but if you know you're not going to win, don't go near that fight. I chose my fights during my training.

I was on a trainee placement in the Coronary Care Unit (CCU). Everyone that worked in the ward was white. Every morning, when we arrived on shift, we had to do an electrocardiogram (ECG) for all the patients because they had heart conditions. There was a particular nurse that was always on my case.

DOI: 10.4324/9781041054276-8

'When I ask you to calculate drugs for me, you don't know anything. You're so useless'. She never used to refer to me as being Black, but she would say 'people like you'. She kept using that particular phrase, 'people like you'; I just had to take it up with the university. I said, 'I don't understand the meaning of "people like you"'. I have a name tag. My name is Roseline; please make sure I am referred to as Roseline'. They dealt with the nurse, but they wanted me to repeat that particular placement, so I made a case about it. I got my supervisor involved, and they were clear that I was trained to a high standard, that the CCU ward had to facilitate a good learning environment, and that it was their job to transfer proper skills to the student nurses. In the end, they passed me, and I won the case.

As a Black nurse, you need to keep fighting to overcome the barriers. One day, I took a patient from my gynaecology ward to the theatre, and I went in with a white student nurse. When we arrived at the theatre, the sister turned away from me and started asking questions about the patient, to the white girl. The sister thought I was the student because I was Black. The student just turned around and looked at me. I said, 'You can answer, she is talking to you'. The sister decided to ignore me because I was Black. The sister looked surprised and said, 'I like your courage; many people don't stand up to me'. I asked her why she had assumed I was not the nurse and if it was because I was Black. The sister apologised and told me that there was a job as a theatre practitioner and asked me if I wanted to apply. I just gave her a big hug because that was my big dream, to be a theatre practitioner, so I took the job. Racism in the UK will remain as long as we are seen as second-class citizens. We are not second-class citizens. I like to challenge people's racist behaviour. NHS management does not like people who challenge them, but they need to be challenged because if we do not have the same attitude, it will continue in my children's generation and beyond, which I do not want.

Speaking up in danger zones

We were in panic mode during the pandemic; nobody knew what to do. We were not well equipped to deal with the crisis because it came suddenly, and it overtook the resources we had as NHS workers. Many people were coming into the hospital. It got to a point where we had to choose who we gave care to. If you have someone who is 50 years old, with lots of comorbidity, or somebody who is 20 years old with less comorbidity, then care was given to the younger person. That became an issue, and people asked us why we were not treating their parents well. It became difficult for the intensive theatre unit (ITU) consultants and for us nurses working with them, but we had to do it. We were outnumbered. We had to adapt the theatres so that they all became ITU spaces to look after COVID-19 patients. Personal protective equipment

(PPE) became a problem; they even asked me to reuse the PPE. We were all worried about it, so I took it up with management at a big meeting. Do you want me to reuse my mask? I have been touching patients with COVID, I have been touching my mask, and you want me to go on break, hang the mask and the PPE somewhere, come back and put it back on again? We all said no, we are not going to reuse our PPE; it became a national issue, and even the health minister had to make a public appeal on television to make PPE at home. It was very, very challenging.

There was a much more significant challenge for us, though, as Black nurses. The Accident and emergency unit (A&E) where I worked was divided into two sections: the red area and the green area. All the Black nurses were permanently allocated to the red area, which is where the most contagious patients were held; the green area was for patients in recovery. The government was saying that Black, Asian, and minority ethnic people were more likely to be impacted by COVID. Yet, we went in there every night, every day, and they allocated us to the red area. Masks were an issue; the matron told us we were not allowed to wear the FFP3 mask; we had to wear a normal mask, but only the FFP3 mask could protect us from catching COVID. One night, I had a big argument with the matron about this. I said, "if you bring a white patient in front of me, do I discriminate? No, I don't; I give everybody the treatment they need according to their illnesses. So why should you discriminate against us because we are Black nurses looking for our daily bread?" Many agency nurses decided to stay at home and not work during the pandemic because it was too dangerous. I said no if all of us choose to stay at home, these people will die. Some of us need to take that bold step to say COVID or no COVID; I am going to fight for these people. When you become a nurse or a doctor, you sign up to look after the people that are sick. So COVID or no COVID, I don't care. I see them as sick people; I see somebody that needs my help. So, I am not going to sit at home and let these people die. I told the matron all this and that she should not discriminate against us, and then she gave us access to the PPE.

Some Black nurses do not like to speak out. I'm not one of them. I want to talk. I want to point things out to say this is wrong; this is racist. If you do not speak louder, they are not going to hear you; they are going to be thinking, 'Oh, she is fine, it's all right, she can do it, they can do it'. No, we can't! We are scared! We are putting our lives on the line for this patient, your mom, your dad, and your relative. We go home to a dad, to a husband, to a child, to a relative. We are looking for after sick people with COVID, which is a deadly virus, and we're sticking our necks out for these patients. So many of us began to speak out about the discrimination between the red and green zones, and there was a meeting to discuss this. In the end, we had rotas, which were moved in shifts between the red and green zones. That's when they decided to deal with it when all of us chose to speak up.

The battle for life

In the pandemic, I would have daily panic attacks going to work. It's like a battle zone. You don't know what you are going to face day by day because most of the patients that come in with COVID-19 also have comorbidities – asthma, diabetes, obesity. If someone is obese, we have to turn them in the hospital bed every two hours. You can imagine the challenge of having to roll someone who is 110 kilos because when you are moving them, you are disconnecting everything like the intravenous drips. They are breathing and puffing particles at you, and you know that COVID-19 is airborne. Work was a challenge for me, but I always said I believed in God. I know God will go with me, and he will come back home with me. What really scared me was that I've got an eight-year-old boy at home. Each time I come back home, he runs towards me, wants to collect my bag, wants to kiss Mommy, wants to hug Mommy. So, I have to hide when I get back home because you don't want to say you can't hug Mommy. I come in through the back door, undress, and then run to the shower. Then the next thing he asks, 'Oh, Mommy, what parts of the body did you fix today? Who did you treat today? What did you do at work today?' You can't say that six people died today. You have to lie. Oh, everybody is okay. Meanwhile, you are not OK. You are thinking of somebody you could have saved, but the resources weren't there. Then you come home and lie to your child, but you are not okay. You are not OK.

There was a particular patient I looked after in the second wave called Peter. He came into the hospital to have a significant operation and developed COVID, which he survived, but he went home and passed it on to his wife, so she had to come in. I went to work one day, and they said Roseline, you are looking after this woman, but she is not good. She is not going to make it. You can imagine they are telling you that you are going to look after a life that is not going to make it. You feel broken yourself. Peter was there, and he said, 'Rosie, do you think my wife will make it?' What do I say? I can't lie. All I could say was that I was not sure. It depends on how your wife responds to the treatment we're giving her. She was on oxygen treatment because her oxygen saturation was low; we were trying to help her breathe, but when it gets to the stage where we are giving 100% oxygen and saturation is still 60%, then your lungs are gone. That's precisely what happened to that patient, and she died.

At one point, relatives were not allowed to visit the people dying. You have to be vital for these patients. We can't cry, although sometimes you can't help it. You cry not because they're dying; it's because they are dying and dying alone. You become their relative, you become their mom, their sister, you become their family. You read the Bible, you read the Quran, you become a hairdresser, and I've done lots of makeup in ITU. You try to make them feel

like normal human beings. Around lunchtime, we used to have to phone the next of kin to say we had to switch off the life support. They gradually go, and you can't leave them to go alone; you have to be there. They die in front of you. It's challenging. There was one patient who was a pastor, and every day, his wife sent us a psalm from the Bible for us to read before he went to sleep. He looked up at me and said, 'Nurse, please don't let me die'. When someone says that, it has a mental effect on you because you know they're not going to make it. If we're intubating and giving you 100% oxygen and your lung capacity is only at 50%, no miracle is going to happen. All we can say is you are going to be fine. Let's do what we have to do and see how things go. His family were ringing the iPad we used to communicate with next of kin, so we used to show the husband lying there intubated; it's not a very good sight to see as a family. Then the wife just started singing from the other end, singing gospel songs about Jesus and praising God to accept him into his hands. Oh, my goodness, the whole place just burst into tears; all of us started crying. The gentleman was dying, and then we saw on the iPad all his family join in, about 10 or 15 of them, praising God to accept him into his hands. They were all singing as he was going; it was very emotional. This whole period was very hard on me with much fear; you wake up every day to go to work, and your body's shaking because you're thinking: Oh my God, I'm going back there again. You don't know if you're going to contract COVID and bring it home. How many lives am I going to lose today? How many lies am I going to tell today? How many people am I going to call to tell them the news? How many families am I going to make cry today? In all of this, as a nurse and as a doctor, you have to remain strong. You don't let go because if you let go, we may all die. At the same time, some people are making it. There are people that we intubate for ten days or 14 days, and they come back to life. There was some hope, so we had to be strong.

Stories to improve the health of our communities

Coming on board with the Nursing Narratives project was an avenue to allow people to hear my voice because it was not heard before. I want people to know what goes on in our hospitals and our health centres so that they can become aware. Coming out to tell our story and narrating what really goes on behind closed curtains in the wards can only improve the health of communities. For me, one of the most important elements of the manifesto for change is point 3 (Nursing Narratives, 2022). I want to build a more compassionate NHS with respect and equity for Black and Brown workers because love and compassion are the driving forces for who I am. Since the project, I have been taking a master's degree in public health. COVID-19 was a real eye-opener for me. Knowing that this type of disease can wipe out so many people made me want to learn more about my community, World Health, and how we can improve

our own communities' health. I am also an actress and film producer, and my position as a health worker helps me showcase important narratives in my film company and raise awareness of people's health. I've been back and forth to Nigeria to do two significant movies. The latest one is about how to improve your health when you have kidney problems because there is not enough knowledge about the difference between being diagnosed with acute kidney disease and chronic kidney disease. People think kidney disease is a disease, but there are many different sides to the diagnosis. So, my health work and my acting are interwoven to help me help the community raise awareness of how to improve their health, whether that is in Nigeria or for Nigerians in the UK. My plan for the future is to continue to work to improve people's health and to continue to raise awareness of how you can really manage yourself if you have diabetes, or if you have kidney disease or hypertension. I am really dedicated to continuing to make more movies that raise awareness of people's health and well-being so that we can take control of our health and our lives.

Reflective questions

1 How can you bring love and compassion into the workplace?
2 How can you make links to your community to make the NHS accessible to their needs?
3 What can you do to amplify the stories and voices of healthcare workers that experience or challenge racism?

References

Raleigh, V (2023) *The Health of People from Ethnic Minority Groups in England*. [online] Available at: www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england (accessed 14 October 2025).(accessed 10 December 2024).

Further reading

Ajayi, O (2021) A perspective on health inequalities in BAME communities and how to improve access to primary care. *Future Healthcare Journal*, *8*: 36–39.

Brathwaite, B (2018) Black, Asian and Minority Ethnic female nurses: Colonialism, power and racism. *British Journal of Nursing*, *27*: 254–258.

Mbiba, B., Chireka, B., Kunonga, E., Gezi, K., Matsvai, P., & Manatse, Z. (2020). At the Deep End: COVID-19 Experiences of Zimbabwean Health and Care Workers in the United Kingdom. *Journal of Migration and Health*, *1–2*, 100024. https://doi.org/10.1016/j.jmh.2020.100024.

Newman, L, Jeve, Y, and Majumder, P (2021) Experiences and emotional strain of NHS frontline workers during the peak of the COVID-19 pandemic. *International Journal of Social Psychiatry*, *68*: 705–922.

NHS England (n.d.) Resources to help people to speak up. [online] Available at: www.england.nhs.uk/ourwork/freedom-to-speak-up/resources-to-help-you-develop-your-freedom-to-speak-up-arrangements/ (accessed 10 December 2024).Nursing Narratives (2022) *Anti-Racist Manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (accessed 7 June 2025).

Sanni-Ajose, R (2024) Perfectionist. A film by Roseline Sanni-Ajose. [online] Available at: www.youtube.com/watch?v=lYL0t8fj7fI.

Thomas, R (2022) NHS accused of racism as black nurses report being put in Covid areas. [online] Available at: www.independent.co.uk/news/health/nhs-racism-nurses-covid-b2028860.html (accessed 16 July 2024).

Chapter 8

A healthcare assistant speaks out

Janice Baptiste

Summary

This chapter highlights the lack of support for Black nursing students facing personal difficulties, leading to a failure to complete their studies. Janice's story provides insight into the intersection of race, gender, and class oppression. She narrates experiences of victimisation and reflects on the weaponisation of racialised stereotypes of Black women to prevent them speaking out. The exploitation of Black healthcare assistants during the COVID-19 pandemic is also laid bare by her experience, through disproportionate exposure in COVID 19 environments with an impossible workload. Her story highlights the moral injury that nurses suffered and the way the experience of racist overscrutiny led to fear of reprisals. Janice reflects on how speaking out has supported her, given her dignity, and helped her to feel valued.

Unsupported in training

I wanted to do a job where I could really help people. That is when I decided to study nursing. I was really excelling in my nursing at the university, above my expectations. But the last lap, when my dad died, I could not do it. I was depressed for a long time. The university did not care. I was in my final year, but they were not supportive at all. The mindset that I have now is that I would challenge the university for the way they treated me, but at the time, I did not have the energy. I lost my dad to cancer quite suddenly. That really affected me. I crumbled. I could not concentrate on my studies. My head was all over the place. I have always wondered how many Black people are passed and how many fail. How many are left unsupported? What is the proportion of those who failed? Because the second time I failed, I really think I had done much

DOI: 10.4324/9781041054276-9

better. In the end, I just thought, let me try being a healthcare assistant. So, I settled with that (Ramamurthy et al., 2023).

Speaking out against unequal treatment

I have worked at the same trust since 2009, mainly in the elderly wards. For the most part, I did not experience problems, although there was one Filipino manager who did not treat me well. She was always complaining about my work, and I felt her complaints were unjustified. She would always favour her own people; they would get more bank shifts than others, and nothing was equal to her. She singled me out because I would speak up about what I felt was wrong. She saw this as me harassing her. That is what she said to the staff, that I was bullying her, and she was going to leave. She started to cry and then encouraged the staff to draw up a petition against me. I could not believe that the majority of the staff signed; I could not believe that they could do that to me. I got on well with everyone. I thought they had my back, but they signed.

The situation made me ill with stress. I wondered how she could do this when she knew that she was in the wrong. I was ill and unhappy. I took time off. I felt really frustrated and had so many different emotions. I put my hands up to anything I have done wrong. I have always, always done that, but she would not. You cannot be wrong and strong. Moreover, that is what she wanted. I believe and trust in God. He is my number one support. I do not need validation from anyone. She could not control me. We went to mediation, and I raised all the issues I wanted. Whatever she had planned, it did not go anywhere. She did not get what she wanted.

I am a Black woman and am confident within myself. If I am not happy with certain things, I speak up. Because of this, some people look upon me as aggressive, a troublemaker, and a harasser. However, these are stereotypes of Black women to control us and put us down (Jones & Norwood, 2016). Black women are often treated like this. It was clear that the manager was harassing me. If I argued with a Caucasian or someone who looks like me, she would not bring us both in to talk about it. However, if I argued with someone from the Philippines, she would step in and say something. She listened to the other side more than she listened to my side. She had been doing that for a very, very long time. There were times I was singled out by email, asking where I had been. I was also discriminated against in relation to the allocation of bank shifts. Then, one December, there was a whole week when I was not given a single shift on the rota. I went to the office and brought a witness because I did not trust her. She said in front of my witness that I did not owe any hours. Then, after Christmas and New Year, she called me and told me that I owed 40 hours. Then the 40 hours went up to 60 hours. I was confused and upset. She could not give me a valid reason as to what had happened. I got in touch with Black Minority Ethnic (BME) JointCare and the equality and diversity (EDI) lead. They helped me draft a letter and gave her a deadline

for a reply. She replied with a letter of untruth and then decided to leave the ward. She did not return for months, but the EDI called me and told me not to worry, that I had done nothing wrong. She suggested that I keep on with my well-being course and get on with my life. I felt that they had finally seen that I was being singled out and discriminated against (Rhead et al., 2021).

Trauma and discrimination in the pandemic

When the pandemic started, we just had gloves, aprons and surgical masks. I remember seeing patients coming in very ill, with their families not able to visit. That was very hard for me. There was one gentleman who came in; he could have been my granddad. He was not cared for properly. He just came in the early hours of the day, and a few hours later, he passed away because the nurses were saying that they did not have oxygen for young people, so the elderly just got pushed aside. It made me so upset. Because he could have been my grandpa, he could have been my family. I did not see an elderly Caucasian person treated like he was. I felt, wow, what does the world think of us if we are treated this way? Are we animals to be treated in such a way? I was angry. I was hurt and frustrated. When you feel like this, you cannot think straight. There is too much going on in my head.

I caught COVID before the country locked down. I felt weak for a while because I was doing a lot of extra bank shifts. I wanted to have a really nice Christmas in 2019 with my family and the grandkids. I thought I was just overworked. However, it was COVID. During the lockdown, I was redeployed from the elderly wards. The only PPE we had was aprons, gloves and a surgical mask. We wrote to management, but we still did not have the proper protective clothing. Many people were scared and did not come to work because of it. They were afraid for themselves and their family. Many of us on that ward became sick one by one.

As a bank member of staff, I was sent to a respiratory ward, and most of the patients had COVID, but they did not tell me beforehand. It was not until I got to the handover. And then one of the healthcare assistants was leaving and said, 'Good luck, everyone'. That is when I was scared. On the respiratory ward, they had full PPE. I could hardly breathe, and I was not even allowed to go to the toilet or have a glass of water. At handover, the first nurse I was assigned to work with refused to work in the area. So, they assigned me to someone else. There were four patients. Everyone was very ill. I was left with too much to deal with. One patient had a continuous positive airway pressure (CPAP) mask and had to be watched all the time because he kept trying to remove his mask. Another lady was on hourly observations, and if she deteriorated, she had to go to the intensive therapy unit (ITU). Then, there was another young lady who kept trying to remove her nasogastric tube. I had to watch all of them. They were supposed to be one-to-one, but I could not be one-to-one with everybody. I did not see my nurse. He just came in to do

medication and went out. It is as though he was scared to stay in the room because everybody had COVID, and he did not want to catch COVID. So, I was in there. Basically, doing the paperwork, the two hourly checklists, making sure that the gentleman was not removing his CPAP, and the lady was not removing her tube and doing hourly urine checks. The nurse was in the office. Then the lady started to deteriorate, and I told the doctor and showed him the lady's stats, but he was not listening to me. He was acting like, she's just the care assistant, what does she know? However, when I came back, everybody was around this woman, she was rushed to ITU. I do not know what happened after that. So, then I had three patients, and it was still too much. The one with the CPAP died when I got up to attend to the one with the hourly urine, and that really, really got me. I could not eat, I could not sleep, I could not drink. I was traumatised. I thought to myself, what if I did not get up to get the gentleman that blanket? He would still be alive today. I was the care assistant, and he died in my care. But, I was in there on my own. I have not got eyes in the back of my head. They left me with three patients who should have had one-to-one care.

At that time, there were no white healthcare assistants. Everyone was complaining that all the Black people were assigned to the COVID-19 patients. I remember when I was redeployed, I prayed that I would not be sent there. But they did. However, the nurse in charge, she did not seem to give a damn basically. She was white. If I wanted something, she just stood outside. Can you pass me this? Can you pass me that? She would not come in. She would not come in for anything (Kapilashrami et al., 2022).

At the time, I did not complain about the allocation because I felt that because I spoke out, people already saw me as a troublemaker. It was not till afterwards, and the man died, that I said no. I said I would not do it again. I would rather be off sick or take annual leave; I do not want to go back to that ward. They did not send me back there. I had been left in an impossible situation, yet I remember being afraid that the hospital would blame me for what happened. I requested to speak to a senior nurse who looked like me, and I let them know that I had the documentation about what had happened. I did not want to get the nurse in trouble because I quite like him. However, I wanted them to know what happened and how I felt. I asked for a risk assessment, too, but it was not until much later that I was offered one and that is only because I queried it every day. I was assessed as medium risk (EHRC, 2022).

I could not handle the death. I imagined that it could be my son or my grandkids, and my family could not come and see them. It was the elderly patients who, on their last breath, could not see or be hugged by their family; that was one of the hardest things. I had to have counselling. I continued working in the elderly ward, and what I found was that Black staff were more frequently allocated to COVID patients. Now, everybody was talking about it, and they would come to me, but when I went with other people's complaints along with mine, people often did not stand up. They would remain quiet.

Black Lives Matter

After George Floyd was killed, that put me on the edge. I was not suicidal, but I was drinking to cope with the trauma. That is why, when they had a Black Lives Matter event, I joined the panel. I spoke about George Floyd. There were so many grown men and women crying. Moreover, there was a gentleman who said that he still has nightmares. So, it is not just me. It is many people. For me, all lives matter. Nevertheless, Black lives are more in danger.

We are all the same inside; our blood is the same colour. This is why I have joined groups to speak out. However, when you speak up, you have to really think about it because you can get singled out and seen as a troublemaker or as an aggressive person if you are not careful. You have to really think. Am I going to be able to cope with what comes after? Although I believe in justice, if someone had told me to be mindful of what comes after, I would have been better prepared. It has been a long, long, hard struggle for me.

Following the Black Lives Matter campaign, many things came to the surface. The way we were treated in the pandemic left a lasting impact. It was like we were nothing. Not caring enough about us to give us the proper PPE, knowing that we were more at risk. The government and the senior leaders did not care. No compassion, no understanding, no nothing. Management were just as cold as ice or colder than ice. After everything we coped with, it was insulting to get a 1% pay rise. If the politicians were in the hospital with COVID, who is taking care of them? Isn't it doctors, nurses and healthcare assistants? So, don't you think that we deserve better? We risk our lives and those of our families. Is it because the institution is racist that they don't care? Because the majority of us who care in that establishment are Black, if you look around, it is primarily people of colour that are in the hospitals (Wolflink, 2023)

Value and respect: See Me First

After George Floyd, I joined the BME network. I have the See Me First badge, which I have pledged to wear proudly. The aim is to encourage everyone not to judge people by the colour of their skin but to treat everyone with the same respect.

Through having a group like the BME network, I am included and supported and not judged. I am being understood and listened to. In the first BME newsletter, they spotlighted me. I was recognised as a valued member of the BME network. That was one of my big, proud moments, highlighting the pledge that I made towards togetherness and the network. To see that and to be recognised as a valued member of staff felt special. I think it is so valuable for everybody to come together and understand our experiences. It is for this reason that I believe Black History Month is so important, too. So often, Black people are seen as aggressive, and Black women are perceived as loud and rude. However, we are just not; we are just confident women who speak

up. We want to speak the truth about ourselves. Management need to listen to their staff and not be one-sided. We need a zero-tolerance policy and practice, and we need accountability for trusts that fail to address racism. Racism is a health and safety issue and should be referred to the Health Safety Executive. (Nursing Narratives, 2022, point 10). It is time for equality and equal opportunities for everyone.

Reflective questions

1 How does racism impact the experience and outcomes of work and training?
2 How does racism impact patient care?
3 How can Black healthcare assistants speak up safely?

References

Jones, T and Norwood, J (206) Aggressive encounters and white fragility: Deconstructing the trope of the angry black woman. *Iowa Law Review*, *102*: 2069.

Kapilashrami, A, Otis, M, Omodara, D, Nandi, A, Vats, A, Adeniyi, O, Speed, E, Potter, L, Eder, B., Pareek, M and Bhui, K (2022) Ethnic disparities in health and social care workers' exposure, protection, and clinical management of the COVID-19 pandemic in the UK. *Critical Public Health*, *32*: 68–81.

Ramamurthy, A, Bhanbhro, S, Bruce, F and Collier-Sewell, F (2023) Racialised experiences of Black and Brown nurses and midwives in UK health education: A qualitative study. *Nurse Education Today*, *126*: 105840.

Rhead, D, Chui, Z, Bakolis, I, Gazard, B, Harwood, H, MacCrimmon, S, Woodhead, C and Hatch, L (2021) Impact of workplace discrimination and harassment among National Health Service staff working in London Trusts: Results from the TIDES study. *BJPsych Open*, *7*: e10.

Wolflink, A (2023) Black Lives Matter and the politics of value. *Philosophy and Global Affairs*.

Further reading

Brathwaite, B (2018) Black, Asian and minority ethnic female nurses: Colonialism, power and racism. *British Journal of Nursing*, *27*: 254–258.

Equality and Human Rights Commission (2022) Experiences from health and social care: the treatment of lower-paid ethnic minority workers. [online] Available at: www.equalityhumanrights.com/sites/default/files/2022/inquiry-experiences-and-treatment-of-lower-paid-ethnic-minority-workers-in-health-social-care-report.pdf (accessed 12 December 2024).

Kauser, S., Yaqoob, S., Cook, A. *et al.* Learning from the experiences of Black, Asian and Minority Ethnic (BAME) university students who withdraw from their undergraduate degree. *SN Soc Sci* **1**, 121 (2021). https://doi.org/10.1007/s43545-021-00115-8

Chapter 9

Intersectionality and everyday racism

Dusu G. Dung

Summary

This reflection explores the multi-faceted experiences of racism of a Nigerian male healthcare assistant in the UK. Highlighting systemic inequities, the narrative reveals how individuals from Black and Brown backgrounds often face discrimination in healthcare settings. The author shares personal anecdotes of micro-aggressions and discriminatory practices, illustrating the intersectionality of race, migration status, and gender that exacerbates these challenges. Despite these adversities, the author emphasises resilience through academic and professional achievements, advocating for change and inclusivity within academia and the healthcare system. Ultimately, this reflection underscores the urgent need for systemic reform to combat racism and promote equity in the workplace, affirming that understanding one's positionality is crucial in the fight against racial injustice.

My positionality: A Nigerian perspective

This chapter will reflect upon my encounters with racism in the United Kingdom (UK), illustrating my journey of awareness and enlightenment regarding micro-aggressions and the impact of intersectionality on my experiences of exploitation. The concept of micro-aggressions were explored in seminal research by Sue et al. (2007). Intersectionality here refers to how multiple protective characteristics exponentially put me at a disadvantage. By articulating my positionality, I aim to provide insight into my motivations and the broader implications of these experiences. Closer to the end, I will recount some actions I have taken to understand racism and manoeuvre around my circumstances.

DOI: 10.4324/9781041054276-10

As a single male Nigerian, I spent 33 years in Nigeria before relocating to the UK five years ago—my first experience living outside my home country. My native language is Berom, and I am also fluent in English and Hausa. This transition has provided me with firsthand insights into the subject matter of this chapter. Prior to my move, I worked for over five years as a teacher in both secondary and higher education, volunteered in primary healthcare for two years, and completed a six-month industrial training at a research institute. In the UK, I have predominantly worked in health and social care as a healthcare assistant and support worker. My academic background includes a degree in medical biochemistry from the University of Jos in Nigeria and two master's degrees obtained in the UK. These experiences situate me in both emic and etic perspectives. While my migration status categorises me as an outsider, my professional roles have provided me with an insider's view of healthcare systems.

The awakening: Confronting naivety

I moved to the UK in the winter of 2019. During my five-year stay, I studied while working part-time as a healthcare assistant as well as a (mental health) support worker in nursing homes and a hospital. Initially, I attempted to ignore the fact that I was seen or treated differently, even though I understood that in the UK, racism is historically deeply seated, as in other countries (such as the USA and Australia), recalling colonialism and the slave trade era (Bhaskar et al., 2020; Cornelius, 2021). However, it was not long before I began to get suspicious. I noticed how work had been divided (who does this and who does that) and how my etic/outsider position as a Black migrant began telling on me (Bausch, Barmeyer, and Guttormsen, 2024).

Working within the health and social care settings, I have been assigned roles that other colleagues felt were demeaning. Roles like cleaning the incontinence of service users and the floors or even washing a corpse when a service user passes on. Often, the white support staff refuses, and the common appellation to force such labour is 'You are here; you have got to work for your money'. Several times, I asked myself how I ended up here. It felt as though my experience as a college lecturer back home and my postgraduate degree was useless and wasted. However, then, my condition is common to migrants and minoritised graduate students in the UK. Specific literature exploring the experiences of migrant nurses in England remains surprisingly limited despite decades of invaluable service. The integrative review by Lanada and Culligan (2024) highlights some of the often overlooked realities that validate my own experiences.

With my master's qualification, getting a specialist job is very difficult as I still find myself stuck with the same menial job and position after five years. A major shock for me was the knowledge that most of my colleagues and seniors do not attend higher education or formal education. This means that as a

migrant, I am subjected to Band 2 or 3 levels of work and pay grade regardless of my prior academic qualifications and work experience. My postgraduate qualification and previous work experience should have fetched me at least a level six job if I belong. This structural inequity denied me a few opportunities to secure specialist jobs. I am told these roles are mainly for citizens or those with settled status, regardless of my experience/abilities to execute the role (Equality and Human Rights Commission, 2022).

In my role as a healthcare assistant, I support adults and young people diagnosed with mental health issues. This group is constitutionally, legally, and sociologically classified as vulnerable. Being in the care environment has created vulnerabilities for me—vulnerabilities acknowledged in paperwork and during handovers yet often overlooked when workers are victimised. In my work experience, employers frequently adopt the notion (though rarely admitted) that migrant healthcare workers are merely expendable, which heightens employee anxiety, lowers job satisfaction, and leads to early resignations or terminations (Ramamurthy et al., 2022; Work Rights Centre, 2024). This dilemma underscores the importance of joining trade unions and why organisations must adopt the migrant care workers charter (MCWC) (UNISON, 2024), whose core mandate is to protect migrant workers on sponsorship visas from being exploited. In the face of neocolonialism, modern slavery and labour exploitation, the poor welfare of migrant workers within the health, and social care sector must be tackled.

In my experience, poor staff welfare and support, coupled with vindictive victimisation, tend to permeate healthcare environments, creating particularly harsh experiences for those who identify as ethnic or racial minorities. I have faced this firsthand. On several occasions, I was selectively attacked by white patients deemed mentally vulnerable. First, an elderly white client hit and kicked me while I assisted with personal care, despite two other white female colleagues observing. If I were a new face (which I was not), why was the Black man repeatedly targeted without provocation? Similarly, while supporting young people in a mental health institution, I was attacked on two separate occasions and spent hours in the Accident and Emergency (A&E).

My point is that I received little concern or compensation for my physical and mental health; instead, I got a call asking when I would return to work. As a novice in such situations, I did not know my rights to claim compensation. My employer never orientated me or other employees regarding this. It is crucial for employers and policymakers, especially in mental healthcare and hospice settings, to recognise employee vulnerabilities and their consequences, which disproportionately affect Black individuals and people of colour. Payne and Hannay (2021) hold that implicit biases or racialised employee treatments are a perfect reflection of systemic racism.

Looking back, I can see that my colleagues and managers firmly exploited my outsider position as a foreigner and a newcomer. Firstly, during the COVID-19 pandemic I contracted COVID-19 twice (Razai et al., 2024). As

a care assistant, I worked at the front line throughout the period and was given a higher workload than usual, as most of the white workers called in sick. My condition/situation was worse not just because I was an agency staff member but also because of my migration status, race and masculinity. These intersecting social identities played a pivotal role in putting me in a discriminated position. I knew my Blackness and masculinity were exploited. I felt treated like an inanimate object with a kind of resistance to the pandemic. The worst is that I do not qualify for any form of entitlement or public funds; hence, I must keep going to work during the pandemic, and there was little or no option to change my working conditions.

Everyday racism

I have experienced many microaggressions about my origin and what brought me to the UK. Essed's (1991) seminal work, 'Understanding Everyday Racism', though centred on the experiences of Black women, provides a crucial framework for understanding the subtle manifestations of racism. A female colleague once asked, 'What are you planning to do when you complete your studies?'. Before I could respond, she continued, 'Never mind, I know you are staying; at least that way, you get to pack our money back to Africa'. Similarly, I was not spared by patients either. I remember a patient who kept taunting me every time I was on the ward. He always asked, 'Why am I Black?' and 'Why am I looking different from them?' He would aggressively attack me each time I was allocated to his observation. There was one home I could not go to anymore as a resident kept calling me an animal and would pour liquid on me with no provocation. The last day I went to that home, a white colleague witnessed the incident and verbally inquired about the reason for such provocation. The client insisted that I was a bloody animal and needed to be treated as one. The colleague then replied, 'The days of slavery are over, and no one cares about that anymore'. Selective aggression often occurs in health and social care settings, but management often does little to nothing about it. The welfare of staff (predominantly ethnic minority staff, often at the lower chain of the institution) seems to matter less. It is all about chasing the money, and the clients are the reason why private institutions exist.

There were occasions where my competence and value were questioned at work. In 2022, I was working a shift when a newly employed member of staff started work. Usually, this involves staff pairing, and new staff are often paired with more experienced staff in the early stages of their employment. This newly appointed white staff member was in tears when she realised she was paired with me, a Black staff member. She demanded a switch to work with a white female staff member. When the Indian nurse in charge inquired why, she insisted she could not just stand to work with 'my type'. At this point, I realised my gender and race interlocked to raise questions about my competency as a healthcare worker (West, Dawson, and Kaur, 2015). I recall

vividly that the Indian nurse in charge of the shift called me to apologise and then swap the staff. Perhaps the Indian nurse, too, is constrained by the same minority dilemma.

Racial suspicion and moral integrity

Inequity is also in the way minority groups are often suspected and humiliated in and outside the workplace. The date 13 April 2021 is quite memorable in my mind. It was the second day that my former agency sent me to work an 11-hour shift in a care/nursing home. The home manager embarrassingly demanded that I open my bag for him to inspect. This occurred in the middle of the shift; he checked my bag and found nothing incriminating. The manager suspected I might have stolen some tissue papers and hidden them in my bag. I was so terrified and mentally depressed afterwards, and other workers were also confused as to why I was subjected to such an embarrassment. Healthcare jobs should allow staff supervision but should not permit staff to be subjected to targeted humiliation. According to my colleagues, there was never a report of missing supplies, and they had never seen any white colleague, either agency or a permanent staff member, being treated in such a manner. This manager only apologised once I stopped working with my agency in 2023. NHS Workforce Race Equality Standard (WRES) data consistently shows disparities in the experiences of staff from Black and minority ethnic backgrounds compared to white staff. The most recent report highlights a higher percentage of staff from BME communities experiencing bullying and harassment compared to white colleagues (NHS England, 2023).

The stereotype of Black men as a threat also impacted my experience in a supermarket. I was viciously chased and searched by a white cashier after I had completed a purchase and paid at the cash machine. The excuse was that I looked suspicious. Reflecting, I realised that being a Black man not only raises suspicion about my skills/competencies but also about my morality and righteousness. It is as if my identity is synonymous with offending or negativities. Perhaps this is why Black and Brown men easily end up behind bars without conviction or for minor offences compared to their white counterparts; overrepresented at almost every stage of the criminal justice system including stop and searches, being more likely to be imprisoned and they receive significantly longer prison sentences (Institute of Race Relations, 2024). Again, it also affirms the supremacy of whiteness. Whiteness is always right and can only be wrong for the right purpose, a purpose which is justifiable and forgivable (Hester and Gray, 2018; Johnson and Wilson, 2019).

Taking action: Towards meaningful change

Considering these experiences, I grappled with the question of how to improve my circumstances and those of others who are racially marginalised.

I recognised that applied knowledge could serve as a powerful tool for change. Resolving to excel in my academic pursuits, I achieved distinctions in my master's programs, with one of my research theses earning the public health postgraduate prize in 2021. My accomplishments have become a source of inspiration for others within marginalised communities, as I have frequently been approached for guidance by students and prospective scholars.

Determined to combat racism, I have begun research focused on the exploitation of Black workers in healthcare. I hope this will educate staff within the NHS. My doctoral study employs an intersectionality framework to investigate work allocation and the power dynamics influencing these decisions. Its goal is to determine whether there is a widespread disproportionate burden placed on ethnic minority workers, regardless of their qualifications and experience.

Additionally, the marginalisation of Black people does not happen only in the healthcare sector, but is widespread. Therefore, I signed up for the Accomplished Study Programme in Research Excellence (ASPIRE) (Awolowo et al., 2024). ASPIRE is an intensive mentorship initiative designed to empower students from marginalised communities and raise awareness about the impacts of racial inequality. Through this program, I have gained invaluable insights into the importance of inclusion and diversity, appreciating how equitable treatment can transform workplaces and communities. Similarly, the Staff Race Equity Network (SREN) in my university is where staff members from diverse groups gather to share the vision of one society. Being among people who shared a vision of an equitable society reinforced my belief that our differences should not only serve as strength but also charter a path where diversity is celebrated, and everyone is treated with dignity and respect. To this end, I resolve to be involved and engaged. Other assumptions about who I am will not deter me from maximising my potential and contributing my skills to humanity.

Conclusion

As a Nigerian male navigating a new societal landscape, my experiences highlight the intersectionality of race, gender, and migration status, illustrating how these identities can compound the challenges faced in new environments.

The documented incidents of exploitation and humiliation emphasise the critical importance of recognising and addressing the structural barriers that continue to marginalise ethnic minorities. By advocating for equitable treatment and utilising research to illuminate the experiences of those in lower job bands, I aim to contribute to a broader dialogue on racial justice. The call for institutional reform is clear: organisations must prioritise the well-being of all staff, regardless of their background, and actively work to dismantle the systemic biases that persist within their structures.

Ultimately, this narrative serves as both a personal testimony and a clarion call for collective action against racism. It reminds us that while the fight against

discrimination is fraught with challenges, it is also an opportunity for growth, solidarity, and transformation. By fostering awareness and understanding, we can strive toward a future where diversity is celebrated, and every individual is afforded the dignity and respect they deserve.

Reflective questions

1 In what ways can an understanding of intersectionality improve our strategies for combating racism within healthcare institutions?
2 What systemic changes are necessary to ensure that the qualifications and experiences of migrant healthcare workers are recognised and valued, particularly in the context of intersectionality and racism?
3 How can healthcare institutions establish effective reporting mechanisms to address incidents of racial discrimination and hold staff and management accountable, considering the principles of intersectionality?

References

Awolowo, I.F., Owolade, F., Abidoye, A., Dosumu, O., and Ajao, O. (2024) 'Towards widening participation in post-graduate research: The ASPIRE programme', *People, Place and Policy*, *18*(1), 48–58.

Bausch, M., Barmeyer, C., and Guttormsen, S. (2024) 'An outsider's insights from the inside: implications of emic concepts on qualitative international management research', *Qualitative Research in Organizations and Management: An International Journal*, *19*(4), 256–281.

Bhaskar, S., Rastogi, A., Menon, K.V., Kunheri, B., Balakrishnan, S. and Howick, J. (2020) 'Call for action to address equity and justice divide during COVID-19', *Frontiers in Psychiatry*, *11*, 559905.

Cornelius, N. (2021) 'From slavery and colonialism to Black Lives Matter: New mood music or more fundamental change?' *Equality, Diversity and Inclusion: An International Journal*, *40*, 8–20.

Essed, P. (1991) *Understanding everyday racism: An interdisciplinary theory*. Newbury Park, CA: Sage Publications.

Equality and Human Rights Commission (2021) Experiences from Health and Social Care: the treatment of lower-paid ethnic minority workers. [online] Available at: www.equalityhumanrights.com/sites/default/files/2022/inquiry-experiences-and-treatment-of-lower-paid-ethnic-minority-workers-in-health-social-care-report.pdf (accessed 29 November 2024).

Hester, N. and Gray, K. (2018) 'For Black men, being tall increases threat stereotyping and police stops', *Proceedings of the National Academy of Sciences*, *115*, 2711–2715.

Institute of Race Relations (2024) *Criminal justice system statistics*. Available at: https://irr.org.uk/research/statistics/criminal-justice/ (accessed 29 May 2025).

Johnson, D.J and Wilson, J.P. (2019) 'Racial bias in perceptions of size and strength: The impact of stereotypes and group differences', *Psychological Science*, *30*, 553–562.

Lanada, J.A. and Culligan, K. (2024) 'The experiences of internationally educated nurses who joined the nursing workforce in England', *British Journal of Nursing*, *33*(2), 78–85.

NHS England. (2023) *Workforce race equality standard 2023 data analysis report for NHS trusts*. Available at: www.england.nhs.uk/long-read/workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/ (accessed 29 May 2025).

Payne, B. K., and Hannay, J. W. (2021). Implicit bias reflects systemic racism. *Trends in Cognitive Sciences*, *25*(11), 927–936.

Ramamurthy, A., Bhanbhro, S., Bruce, F., Gumber, A. and Fero, K. (2022) *Nursing narratives: Racism and the pandemic*. The draft report was submitted to the UKRI-Covid Rapid Response Call Project. [online] Available at: https://shura.shu.ac.uk/29860/1/NN%20Report_Final_EDIT.pdf (accessed 5 December 2024).

Razai, M S., Chaudhry, F., Doibani, S., Hussein, J., Bhuyan, S. S., Jenkins, D. R. and Majeed, A. (2024) 'The impact of COVID-19 on migrant healthcare workers: A systematic review', *BMC Public Health*, *24*(1), 1021. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC10978526/ (accessed 28 May 2025).

Sue, D.W., Capodilupo, C.M., Torino, G.C., Bucceri, J.M., Holder, A.M.B., Nadal, K.L. and Esquilin, M. (2007) 'Racial microaggressions in everyday life: Implications for clinical practice', *American Psychologist*, *62*(4), 271–286. Available at: https://doi.org/10.1037/0003-066X.62.4.271 (accessed 27 May 2025).

UNISON. (2024) *Migrant care worker charter*. [Online]. Available at: UNISON www.unison.org.uk/content/uploads/2024/10/Yorkshire-and-Humberside-Migrant-Care-Workers-Charter.pdf (accessed 27 May 2025).

West, M., Dawson, J. and Kaur, M. (2015) 'Making a difference', *Diversity and Inclusion in the NHS*. [online] Available at: https://assets.kingsfund.org.uk/f/256914/x/eeb3fa7cd3/workforce_race_inequalities_inclusion_nhs_providers_2020.pdf (accessed 5 December 2024).

Work Rights Centre (2024) The forgotten third: Migrant care worker's views on improving conditions in England's adult social care sector. [online] Available at: https://www.workrightscentre.org/publications/2024/the-forgotten-third-migrant-workers-views-on-improving-conditions-in-englands-adult-social-care-sector/ (accessed 28 November 2024).

Chapter 10

Overcoming racism in midwifery

Benash Nazmeen

Summary

This chapter explores the journey of a midwife from student to senior leader, highlighting the covert and complex racism faced by midwives from minoritised backgrounds. She highlights the lack of respect and silencing that she has experienced as well as the Eurocentric nature of the curriculum that fails to address the health of Black and Brown women. This chapter discusses the founding of the Association of South Asian Midwives (ASAM) as a supportive platform for South Asian midwives to confront discrimination and tackle difficult topics with the communities they represent and advocate for. Additionally, it reflects on why she decided to leave practice and engage in teaching and research to address racism within midwifery.

Midwifery training – the first challenge

It is not easy to look back at my training and reflect on the boundaries or challenges I faced. I grew up in a very strict, conservative Muslim household. My family really wanted me to keep hold of that heritage. However, one of the cultural issues that affected me was that we do not talk about pregnancy, birth, or such taboo subjects with young unmarried girls. My lack of knowledge made it hard for me to pass the university interviews. I got into a university that had a more inclusive interview process—it was a group-based learning session, which was a non-midwifery-related scenario. Moreover, that is apparently where I excelled. The scenario was along the lines of 'you are preparing for a six-month expedition to the Arctic; how would you prepare?' I was thinking outside of the box. For example, others were thinking practically (eating, training), and I was more concerned about psychological preparation, distance from loved ones, inability to communicate at home, and preparing mentally

DOI: 10.4324/9781041054276-11

for possibly not hearing important news. I was thrilled, surprised, and proud of myself for getting in. I told my mom, and that is when she told me my grandma was the village midwife in Kashmir. So, it is in my blood.

Racism starts early, even before you become a healthcare professional. It begins with the fact that my name is Benash, pronounced Bee-nish; it has Persian origin, meaning one with foresight and intelligence. My family spent a long time deciding what to name me. It was my grandmother who named me in the end; it means something, but then you go to school, and you have to edit yourself. The minute you go there, you are Ben-ash, or you are Ben or Ash or whatever is more convenient to the others, an anglicised version of your name, so you can assimilate and fit in (James, 2020). That is the first lesson you learn: You have to edit yourself and continue to do that.

At university I was in a cohort of midwives who were mostly white British. They seemed to excel and thrive, while I seemed to struggle. Often, I did not feel welcome or as though I belonged, and I used to get feedback from my mentors, which was challenging. As a student, I had to edit everything I said according to who I was talking to. When I realised others were excelling and I was finding it more challenging, I worked harder. A small voice at the back of my head constantly informed me I was not good enough; this was subconsciously picked up from my environment, and it left me slightly paranoid. Unconsciously, I learnt I did not 'fit' and I was not 'right'. In fact, the systems were not right.

As professionals, we go to universities and expect them to teach us; we pay them to 'teach' us, but we were talking about cyanosis in white Eurocentric skin tones. Cyanosis does not present as blue lips on Black or Asian skin. If someone is Black or Brown, it is tough to tell. For instance, the Apgar score measures how pink a baby is. With Black and Brown babies, they rarely look pink. If Black skin does not go red, there may be an appearance of it being darker or discoloured. If someone's skin tone is discoloured, what other signs have come up before that point? What else has been missed? We are usually taught through the Eurocentric lens in most classrooms. It has provided us with a baseline for 'normal'. Then, when we are taught about different races or differences, it carries an underlying negative context. That has been normalised. We normalise the Eurocentric viewpoint and differentiate those as others who do not 'fit in'. Gishen and Lokugamage (2019) argue that diversifying and decolonising medical curricula can help to challenge Eurocentric norms.

This is where we start to learn about how to care and how we decide, unconsciously, to treat people. I have been working to understand our internalised biases, realising that unconscious bias affects outcomes in Black and Brown communities. We all have a responsibility to know what we are doing to the people we care for, consciously and unconsciously. We have to check our biases before we go into that room and care for the individual in front of us because women from marginalised communities already face enough barriers to access care.

I was determined to get my degree. I had to make my mom proud. I had to make my grandma proud because now I was following in her footsteps. I worked hard to make a difference for those I cared for. It made me happy every time I went into a room and spoke the language of a woman and family in my care. I often observed that women would unconsciously relax; their shoulders would drop, and relief would be on their faces. So, in small ways, I was making a big difference.

Challenged on the floor

Being a Brown midwife, I found that I was more likely to be allocated more complicated service users to care for, and I was expected to have a heavier and larger workload. I was expected to work extra. For a decade, I primarily worked nights and weekends. You are more likely to be 'spotted' for your talents if you are visible during weekdays when senior staff are around to witness your skills (Terry and Spendlove, 2025).

If it was one of those rare 'quiet' days (I still cringe to use that word, as if the word itself is a jinx) when there was only one birthing person in the Ward, I could guarantee that I would be the one having to work and care for that individual. At the same time, everyone else sat around the desk, having a cup of tea and a chat. I noticed that, being a Brown person, I was less likely to get my breaks on time, and I was forgotten when rounds for tea were made. I have often had to ask for a cuppa or a break. I was less likely to progress or feel supported to do so (West, Kaur, and Dawson, 2015). I was less likely to be supported in Continuing Professional Development (CPD), even given study days or study leave to attend a course. A senior NHS manager once said, at a conference I paid for myself and attended in my own time, that she always had an eye for spotting the 'tall poppies'. I was never considered a tall poppy, and they never looked like me. I remember one occasion when I sat in a manager's office, she didn't even deem it confidential enough to ask her PA to leave the office. I was crying, because as someone who likes to grow and feel challenged, I was asking her for help for my career development.

The experiences above are just some of the small day-to-day examples of how the system treats midwives from my background. The reality can also be harsher. I witnessed student midwives facing microaggressions with questions like, 'Are you just wearing a hijab so you can hide your headphones for this exam underneath your scarf?' Other actions were undermining. For example, when you are supporting someone in birth and facilitating a birth, you are the lead midwife. Then, during the time of birth, you generally call a second midwife to ensure support if it is needed for the new baby. One person cares for the mother, and the other cares for the baby, but if the second person comes in and takes over, it affects the confidence of the lead midwife; it also changes the way people in your care view you and your competence. Cortis and Law (2005) identify several cases in which it has been noticed that minority ethnic

matters are often presented to students in a tokenistic manner. There is a tendency to view Black and minority ethnic issues as the main concern of Black and minority ethnic staff. This is still the pattern. Additionally, being a Brown midwife means you are more likely to be criticised or held accountable for small things. In contrast, your white colleagues are not held responsible or criticised for those same things (Birthrights, 2022). Several Black midwives mentioned that the system often places blame on Black bodies, suggesting that it is somehow the fault of Black people for their bodies not functioning 'correctly'.

Challenging racism on the floor – speaking up

When I was a senior midwife on a shift, I was having my lunch quietly in the office corner. The lead midwife on that night shift walked in and was talking about something, and she stopped because she saw me, and whatever she was going to say, she edited. So, she went from probably saying something like Asian to 'all these' ... and then she named a specific country ... and said,

> All these so-and-so women, why did they not care for themselves properly? Why do they remove the hair from certain areas but do not remove it from areas like their legs and arms? What is this?.

It was quite a stereotypical view, a very derogatory conversation, and she was speaking to a junior midwife for whom she should have been setting a positive example. I found it challenging to hear her remarks due to her leadership position. I wanted to challenge them but educate them in a way that allowed them to listen and not turn on me. I spoke about it and said that in some cultures or some religions, you are expected to remove hair from private areas because it is considered unclean for women to have hair there. That is their priority over anything else. However, if you want to have hair, do you really care? Aren't all midwives feminist? A pregnant person and a woman should have a choice to decide whether they want to have hair or not.

When I was a junior midwife, I used not to feel quite welcome, and I thought that was just me because I was a little bit awkward. As I progressed in my career, I observed that if you were white British in this ward, you were more likely to be central in conversations at the beginning. So, when the handover was just about to happen, you were having a conversation as more people came in, and you got welcomed into the group. That only happens if you are white British. If you are Asian or Black, you are less likely to have that same welcome or even be addressed if you walk into the room. I watched and observed, and as shifts went on, I noted that not only were you less likely to be welcomed in or even addressed, but you were also more likely to be sat on the outskirts of the room by yourself. At that point, I was a senior midwife, and I made sure I was in the middle of that group. I made sure I said hello to everybody who

worked. Before I left that institution, I attempted to raise these issues of inclusion with someone whom I thought I could trust. I was told they had not ever seen it, so it could not possibly be true (Sue et al., 2007). The dismissal of my thoughts on an individual level led me to think about how important it was for racialised midwives to come together.

As a labour ward charge midwife, I once had a junior Black midwife tell me she liked it when I was co-coordinating as she felt seen, she got her breaks, she felt her work allocation was fair, and she knew I would listen to her. This was when I realised that my historical experiences were not 'just me' but were still happening. This is when I reflected on all I have said with a different lens. This was when I decided that things needed to change. This was when I realised we needed our own organisation.

Setting up ASAM

Since 2016, I have attended the midwifery conference every year, and I have noticed how few Brown faces there were. In 2019, I went to the conference again and saw two Brown speakers in the programme. I wanted to listen to both the speakers but had to choose as they were both scheduled at the same time. I met them both during the break, and we decided to get together to chat about our experiences and journeys. We were three midwives. One of us was a newly qualified midwife. I had been in the field for a decade, and the third had been around for two to three decades. Still, our experiences were the same. What was happening to us and the stories we were hearing from our colleagues resonated so much that we felt we had to do something to make ourselves heard. We spent all afternoon planning. We wrote down our manifesto, outlining what we wanted to do and our vision. Then, in 2020, we launched The Association of South Asian Midwives (ASAM) to give ourselves a voice. The COVID-19 pandemic and all the structural discriminations that led to disproportionate deaths in our communities were the catalysts that made us come out, reach out and speak out to support, develop and gather our communities (Wan et al., 2022). Black Lives Matter (BLM) also confirmed the need for the ASAM. BLM propelled us forward in our work.

Through ASAM, we wanted to do three main things:

- Support the South Asian midwives in the workforce.
- Raise awareness among healthcare professionals about the needs and barriers faced by South Asian communities.
- Support South Asian communities.

The midwifery workforce is predominantly white British. About 2.5% of the UK population is South Asian, which is the largest ethnic minority in the UK. We make up less than 2% of the midwifery workforce (Nursing and Midwifery Council, 2024), which is way below the national average and below the NHS

average. This makes it a very lonely place to be, especially when you are facing discrimination. One of the first actions that we took was to produce a report to document the racist experiences that were reported to us: We heard about comments being made such as 'Being told I cannot take my curry breath to look after a labouring woman'. Alternatively, being told to look after my 'own kind' (Anwar et al., 2021, pp. 11–12).

We recognised that we needed a space to support the development of midwives; there was a lack of coaching and mentorship for them. We also recognised that we needed to encourage more South Asians to become midwives so that we could make the workforce more representative. We also recognised the importance of pastoral care and support for student midwives through their training because we know that they are more likely to drop out. We supported research to make sure that language is inclusive and appropriate in surveys, as well as having sessions around learning what a regular diet is for someone who is South Asian to make gestational diabetes friendly, etc.

We also started discussing the things that we recognise are problems within our communities, the conversations that are stigmatised but need to be had to overcome health inequalities: talking about adapting to maternity and sexually transmitted diseases in pregnancy; talking about pregnancy, grief and loss; talking about perinatal mental health; supporting our communities to complain when things have gone wrong because our communities are less likely to complain because they have been taught not to complain. That is the intergenerational trauma that's passed down from our parents. It is the lessons we have learned and lessons we need to unlearn.

The need for systemic change

I am currently working in academia and exploring how to make systemic change through research and policy. Research has historically had a hard science and positivist lens. This explores averages and generalisable results, and these behaviours exclude the experiences that impact marginal communities, which have often historically been abused in the name of science, progress, and research. James Marion Simms, the father of modern gynaecology, practised his techniques and tools on enslaved Black people without anaesthesia, even when anaesthesia was readily available (Campbell, 2021). The Tuskegee Syphilis trial and the story of Henrietta Lacks highlight how medical progress and research have been conducted to the detriment of Black and Brown bodies (McVean, 2019; Nature, 2020)

Such behaviours and biases have trickled down the medical field through teaching without context. So, we see medical students in America believe that Black people have thicker skin and a higher pain threshold. The bias of Asian women is the 'Mrs Bibi (or Begum) Syndrome' (Khan, 2018), contemporarily known as the 'Asian Princess' (Townsend, 2024). The biases are different. Still, the outcome is the same: when asking for pain relief, Black

and Brown women are not getting it in a timely manner (Birthrights, 2022). This is why research and education need to change. Education should give context, and research must have representation of marginalised groups at all levels (Moncrieffe et al., 2020). Participatory action research ensures that research is inclusive from the beginning while also evolving the research skills of people from these communities. This approach allows us to rebuild trust and engagement and ensure we have representation from participants to primary investigators.

To create true, lasting change, we must actively dismantle the inequalities that have been ingrained in our systems for generations. Every one of us—students, educators, policymakers, researchers, and healthcare providers—needs to prioritise this transformation. Health inequalities persist because too few are committed to this cause, and that must change. To challenge these disparities, we need diverse representation across all levels, ensuring research and policy reflect the realities of all communities.

The lack of diversity in midwifery, with its predominantly white British workforce, means that crucial conversations often miss the perspectives of those they aim to serve. We must advocate for inclusive research, representative advisory boards, and a workforce that genuinely mirrors our communities. When we hold these discussions openly and learn from one another, we foster growth and understanding across all levels of healthcare.

Discrimination impacts people differently depending on their identity—whether race, religion, gender, disability, or neurodivergence. As a Muslim, I face Islamophobia and constant vigilance in public spaces, from airports to daily interactions. This 'weathering' adds cumulative stress, affecting mental and physical health and shortening lifespans for many. Each layer of identity compounds this load, particularly for those with additional challenges, like disability or neurodivergence.

Our capacity for change

My vision is an inclusive NHS—a space where everyone, regardless of race, religion, disability, or LGBTQ+ identity, feels respected and empowered. In this space, whether student midwife or chief executive, each person can bring their whole self, raise concerns, and support one another's growth.

Achieving this vision requires decisive action; the NHS should enforce zero tolerance for racism and protect Black and Brown staff from harm (Ramamurthy et al., 2022, point 1). Staff are already exposed to significant weathering and increased pressures without these safeguards. At a time when staff attrition and retention are low, we cannot survive the loss of the few representative staff we have.

Universities and training bodies must ensure equal access to opportunities, enabling all students to succeed. Students are the future; their education

should challenge them to review a variety of perspectives, and it must stop othering marginalised communities. This is the foundation of professionals, and we need to humanise and normalise teaching with a golden thread of anti-racism.

Our institutions and policies must evolve and create lasting change. Regulatory bodies, policymakers, and educational structures must confront their roots and actively decolonise, building a healthcare system that truly represents and serves all communities. This includes research which has historically had gender and race biases impacting women's and reproductive health research. PPI and representation are vital in ensuring we are not causing harm and ensuring results relevant to all the demographics we care for (Nursing Narratives, 2022, point 5).

We have the capacity for change, but everyone's commitment is needed to realise it.

Reflective questions

1 How should people in leadership positions or positions of power be held accountable for tolerating or reinforcing racist behaviours?
2 What should healthcare organisations do to challenge structural racism? Can healthcare organisations ensure inclusivity?

References

Anwar, N, Nazmeen, B, Jones, M, and Okhamesan, P (2021) *What we need to thrive: Experiences ethnically marginalised midwifery professionals in the workplace*. [online] Available at: https://asamidwives.co.uk/past-projects/project-two-llrgk-pgp7c (accessed 15 November 2024).

Birthrights (2022) *Systemic racism, not broken bodies: an inquiry into racial injustice and human rights in UK maternity care*. [online] Available at: www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf (accessed 1 October 2024).

Campbell, C. (2021). Medical violence, obstetric racism, and the limits of informed consent for Black women. *Michigan Journal of Race and Law, 26*(47). https://doi.org/10.36643/mjrl.26.sp.medical.

Cortis, J, and Law, G (2005) Anti-racist innovation and nurse education. *Nurse Education Today, 25*, 204–213.

Gishen, F, and Lokugamage, A (2019) Diversifying the medical curriculum. *BMJ*, *364*, pp: 300. doi: 10.1136/bmj.l300. Available at: https://discovery.ucl.ac.uk/10068811/1/bmj.l300.full.pdf (accessed 25 June 2025).

James, C (2020) Westernizing names, the practice of cultural erasure. *Black Vanguard Magazine*, 4 April. Available at: https://blckvanguard.wordpress.com/2020/04/04/westernizing-names-the-practice-of-cultural-erasure/ (accessed 25 June 2025).

Khan, H (2018) Mrs Bibi Syndrome', the medical stereotype undermining elderly Asian women. [online] Available at: https://mediadiversified.org/2018/09/14/mrs-bibi-syndrome-the-medical-stereotype-undermining-elderly-asian-women/ (accessed 27 November 2024).

McVean, A (2019) *40 years of human experimentation in America: The Tuskegee Study*. [online] Available at: www.mcgill.ca/oss/article/history/40-years-human-experimentation-america-tuskegee-study (accessed 1 October 2024).

Moncrieffe, M. (2020) *Decolonising the curriculum: Teaching and learning about race equality. Issue 3 – July 2020*. Falmer: University of Brighton. Available at: https://cris.brighton.ac.uk/ws/portalfiles/portal/14207553/Decolonising_the_Curriculum_Issue_3_Teaching_and_Learning_about_Race_Equality_July_2020.pdf (accessed 25 June 2025).

Nature (2020) Henrietta Lacks: Science must right a historical wrong. [online] Available at: www.nature.com/articles/d41586-020-02494-z (accessed 2 October 2024).

Nursing and Midwifery Council (2024) *Equality and diversity reports*. [online] Available at: www.nmc.org.uk/about-us/reports-and-accounts/equality-and-diversity-reports/ (accessed 15 November 2024).

Ramamurthy, A., Bhanbhro, S., Bruce, F., Gumber, A. and Fero, K. (2022) *Nursing narratives: Racism and the pandemic*. The draft report was submitted to the UKRI-Covid Rapid Response Call Project. [online] Available at: https://shura.shu.ac.uk/29860/1/NN%20Report_Final_EDIT.pdf (accessed 5 December 2024).

Sue, DW, Capodilupo, CM, Torino, GC, Bucceri, JM, Holder, AMB, Nadal, KL, and Esquilin, M (2007) Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*(4), 271–286. doi: 10.1037/0003-066X.62.4.271.

Terry, R, and Spendlove, Z (2025) Early career midwives' experiences of development opportunities and their relation to retention and job satisfaction: An interpretative phenomenological analysis study. *BMC Pregnancy and Childbirth*, *25*(1), Article 156. Available at: https://doi.org/10.1186/s12884-025-07227-6 (accessed 25 June 2025).

Townsend, E (2024) Midwives call women in labour 'Asian princesses' amid 'hostile' environment fears. [online] Available at: www.hsj.co.uk/patient-safety/midwives-call-women-in-labour-asian-princesses-amid-hostile-environment-fears/7037380.article (accessed 15 November 2024).

Wan, I, Apea, J, Dhairyawan, R, Puthucheary, A, Pearse, M, Orkin, M, and Prowle, R (2022) Ethnic disparities in hospitalisation and hospital outcomes during the second wave of COVID-19 infection in east London. *Scientific Reports*, *12,* p. 3721.

West, M, Kaur, M, and Dawson, J (2015) *Making the difference: Diversity and inclusion in the NHS*. London: The King's Fund. Available at: www.kingsfund.org.uk/insight-and-analysis/reports/making-difference-diversity-inclusion-nhs (accessed 25 June 2025).

Chapter 11

Challenging racism across borders

Fatima Ezzahra Ghaouch

Summary

Fatima compares the different ways in which racism manifests in Italy and the UK, particularly highlighting islamophobia. She highlights how racism has made her feel and the impact on her mental health. She reflects on discriminatory work allocation and stereotyping. Her resilience and ability to challenge workplace racism is a constant theme, including during the COVID-19 pandemic. She discusses how the killing of George Floyd and the ensuing Black Lives Matter campaign eventually opened a space for dialogue. Despite achieving progression, Fatima reflects on the difficulty of changing the system, reflecting on her experience of working in India as well as on why she has decided to now become an educator.

The journey begins

I am originally from Morocco, and I was raised in Italy. My dream was to become a doctor; I wanted to do something in healthcare. I remember my sister asked if I had heard about midwifery. I talked to my mum, and she gave birth to me and my sister with a traditional midwife. My mum was an immigrant in Italy; she did not speak the language, and she was entirely new to society. I was really aware of what it means to be an immigrant woman in a completely new society, a society that was full of injustice and racism. I decided that midwifery was my path. I needed to do it for the immigrant and vulnerable women, to be alongside them.

I trained to be a midwife; it was three very difficult years. It was really tough to be a Muslim student wearing the *hijab* in an Italian university. Every day, I had to fight for my right to be who I am. I was never accepted as a Muslim woman (Bayraklı & Hafez, 2023); I was forced many times to remove my

DOI: 10.4324/9781041054276-12

hijab. I tried to be strong; I tried to fight, but it got to the point where I was going to leave the university because of racism (Calia & Flauto, 2024). Then I thought to myself about the other future Muslim students who might follow me if I stuck with it; the fight was not just about myself—I had to be strong for all of them. Someone had to take on the battle to show the university that I was equal to the other students and that I should be judged on my skills as a midwife, not on what I was wearing. It was a real struggle, but I managed with patience to graduate.

When I started the training placement in the hospital, I was never accepted by the other midwives. They could not tolerate the idea of having a second-generation immigrant trying to achieve what they were striving for, to be educated like them. Their problem was not just the fact that I was an immigrant, but on top of that, I was a Muslim, and on top of that, I was wearing a headscarf! My headscarf was never accepted; in fact, they used so many excuses against it: that it was not hygienic, and the patients would be uncomfortable. I kept being called to one side and asked to remove it; that is what I call micro aggression. It got to the point where I challenged them and asked if wearing the hijab was against the law in Italy; when they said there was no such a law, I told them that I had a right to wear it. I was insulted so many times that I have been called a terrorist in front of patients.

Islamophobia

It was 2012 when I qualified as a midwife in Italy. When I was a student, many doctors told me that I would be a massive resource for the hospitals because I had a great cultural understanding and had bridged the language barrier faced by many immigrant women. I would really need to be a midwife. That filled me with hope for the future as I was only the second Muslim midwife to have qualified in the whole country. I thought I would find a job easily but was confronted with the reality of society. I completely lost hope; I could not find a job, and it was for the same reason—my religion and my skin colour. In Italy, the CV must be presented with a photograph, and this is a disadvantage point. Due to your picture, personal bias and discrimination take over, and your CV is not looked at, regardless of your experiences, your skills, or your knowledge (Collini, 2022). Eventually, I managed to get an interview, and when I arrived, they thought I was a patient. When I said no, I was here for the interview, and they could not believe me. They said, 'No, you are lying'. The manager came, and she clearly did not expect to have a Muslim girl in front of her. The way she reacted and the way she looked at me made me realise that I was not getting the job.

I was getting nowhere, so I thought I needed to leave. I cannot do this anymore. I had been working hard in Italian society to try to change things, but it started to feel like a failure. I could not change anything, so I decided to leave my home and my family, and for a new chance, I decided to come to the UK.

I did not have any insight into UK society or what midwifery was like here, and I found nothing. I just needed to leave, and I had always thought that the UK was the land of freedom, where everyone is treated equally. I landed here in 2014 and had to sort out my professional registration with the Nursing and Midwifery Council, and in 2016, I started my job as a midwife. This was a massive achievement after the disappointment of the Italians. I initially struggled with the language as my English was basic; most of the time, I could not understand what people were saying. Also, during my first year, I was feeling some discrimination from some of my colleagues, but I tried to ignore it because I did not have the mental capacity to think of a second failure (Hochschild, 1983), just like in Italy. I forced myself not to see racism everywhere, to work hard patiently and to learn and acquire experience as a midwife. After gaining more confidence in my job and with the team, I started to open up with other Black and Brown midwives and understand their own experiences with discrimination and racism in the workplace.

I wondered many times where I needed to go to be free from any prejudice, but I realised that racism is everywhere and there is no place where you can be accepted fully. Ultimately, you must digest this bitter feeling, be strong, and fight this constant battle.

Out of the frying pan

Racism and discrimination in the UK are not necessarily blatant; I came from an experience in Italy where racism is in your face. It is voiced openly, and you can be abused verbally in public places with no right to self-defence (Bayraklı & Hafez, 2023).

Despite the fact that in England, discrimination is present in masked forms, having experienced blatant racism, I could read the red flags. You can feel it in the air. I can see it in a look; I can feel the tone of the voice. I can really feel it deep in my skin (Sue et al., 2007). In the workplace, it is about the treatment you receive during your shift. Most of the time, you are the one who needs to work harder than others. Initially, when I was still new, I naively thought that they cared about supporting my learning. After some time noticing the way patients were allocated, I realised that was not the case. In fact, most likely, you will be assigned to look after Black and Brown patients or someone with a particular disease or condition such as HIV. There are many indirect racialised actions which I faced, but unfortunately, they are the hardest thing to tackle because they are not seen and are difficult to prove. Even if you try, you will be challenged and gaslighted.

Facing racism is a powerless feeling. You are made to feel small with the need to escape while you are dying inside (Williams & Mohammed, 2009). Afterwards, though, there is a burning fire in the feeling of anger.

As mentioned previously, when I started to practice as a midwife, my focus was to find my space and allow people to know me. It was after some time that

silence was not my forte anymore, so I decided to raise my voice. I believed that if I wanted to see a change, I needed to start with my colleagues and have open and honest conversations about my own experience. Luckily, I had some fantastic peers who listened and provided support. In their own capacity, they started to make some changes, being aware of forms of discrimination and trying to challenge it. I also tried to have the same conversation with Black and Brown midwifery students. Sadly, I noticed some hesitancy in them to talk openly about racism, a sort of taboo; it was difficult for them to share their thoughts or experiences for fear of consequences (Essed, 1991; Runnymede Trust, 2020). That is why I felt a need to be the voice of the voiceless for my colleagues and service users.

The pandemic exacerbated racism

The pandemic exacerbated racism. I was conscious that, as happened on previous occasions, any COVID-19-positive patient was going to be allocated to me or a Black/Brown midwife. In these difficult and uncertain situations, the priority is the patient. The women were isolated from their birthing partners or any of their family support. Those who had language barriers faced even more challenges due to the lack of communication and feeling lost. Surrounded by fear and struggle, as a midwife, you feel helpless. After a few months, towards summertime, the news started to expose the fact that many of the healthcare workers who had died from COVID were from the BME groups (Chaudhry et al., 2020). It was then that I truly started to be concerned and scared; we were working in unsafe environments without anyone really caring.

The government during the pandemic was a total joke. It is a shame that numerous deaths were needed to realise the existence of inequality in the system. After discovering that a Black or Brown person is more susceptible to COVID-19, a work risk assessment became a requirement (Elwell-Sutton et al., 2020). Indeed, I was asked to avoid contact with COVID-19 patients because I was at risk. Everyone did not receive this decision well; in fact, I was challenged by some of the shift coordinators at work when I rightly refused to look after the COVID patients.

Black Lives Matter

The murder of George Floyd was another shocking and hurtful event in the already strenuous COVID-19 time. It was like reopening a bleeding emotional wound. I remember the strange silence and atmosphere at work, probably not because his death was a result of racist violence but mainly for the fact that many people and institutions were finally admitting there that racism was an issue (Dray, 2021). It was precisely around this time that breaking the silence

was a need, and some colleagues approached me asking what to read or watch to educate themselves and their kids or to share my story. Others asked what they could do to raise their children to be more aware of racism. I remember one colleague told me that what I had said was eye-opening; she was paying more attention to how people sometimes behave with their prejudices and biases. This was a refreshing sensation, a small positive step.

Many things need to be changed within a broken system. In my new higher role, my focus is to support Black, Asian and any women from ethnic minority groups to provide them with safer care in their childbirth journey. I want to improve on the adverse outcomes that these women suffer because we now know that a Black woman has a three times higher risk of dying in childbirth compared to a white woman, and for Asian women, the risk is two times higher (Birthrights, 2022). These reports are always a defeat. Vulnerable women need to be our priority in the need for more equity. This is why midwives need more education and support to be equipped with cultural awareness and safety. Everyone should be able to look after a diverse range of women. This is the important first step towards change.

I have this feeling of righteous anger, anger because I still do not understand how someone can be racist. The fact that many people do not even realise that bias can emotionally affect someone else and can even destroy other lives is unacceptable. We all have rights, including the right to be respected as human beings.

Nursing Narratives

Being on the Nursing Narratives project helped reinforce my self-belief in what I have done in my life. I am proud of every single step I have taken; I am proud of what I have achieved. I am proud that I have been strong, not just for myself but for the patients, for my colleagues, and for any single person who is facing injustice. I want to see a massive change in society, but some of my colleagues said to me,

> Fatima, you're not appreciating that change starts with baby steps, and you are actually doing that because you have changed our lives. You change the way we see things.

That is what I am proud of. My strength is my faith, which is where I can find hope. I try to look for positive light in the darkness. I always try to encourage and empower other young Muslim women to never allow racism or discrimination in society to make them feel inferior. Midwifery is a calling for me, and it is a passion that keeps me going. I am aware that my life has always been a fight for my rights and that this is always going to be the case, so I needed to keep going with patience and courage.

How do we create meaningful change?

My decision to participate in the Nursing Narrative initiative was a personal one, independent of any professional or contractual obligations. It was just following the launch of the final project that I shared my involvement with my workplace and CEO, who received it positively, viewing it as an opportunity further to advance the ongoing journey of change within the organisation (Nursing Narratives, 2022). During the filming process, I was promoted to higher positions within my role. However, this career progression ultimately proved to be short-lived, as the new responsibilities were set up to fail. I was the only non-white midwife on the senior team and the youngest. This experience served as a significant eye-opener, revealing the underlying realities of the NHS and the status of maternity care.

In this elevated position, I aimed to use my platform to address the systemic racial and discriminatory issues within the organisation, as well as to serve as a voice for colleagues who were grappling with understaffing and increasing workloads. Unfortunately, my efforts to raise awareness were met with resistance, and I found myself voicing concerns in isolation. From the outset, I received little support despite the clear acknowledgement of my relative lack of experience in such a demanding role. Over time, the situation worsened, with my involvement in decision-making processes diminishing, and I was excluded from important meetings. Ultimately, I found myself working relentlessly to cover three roles simultaneously, enduring unsafe working hours and reaching a breaking point. The toll on my mental health and personal life became evident. Despite promises to address these issues and uphold a 'zero tolerance to racism' policy, meaningful change was not forthcoming.

Faced with a toxic work environment, I decided to take a break from the NHS and resigned from my substantive role. I sought a new challenge and took on a six-month assignment in India as an International Midwifery Educator. The primary aim of this role was to prepare midwifery educators and practitioners in alignment with International Confederation of Midwives (ICM) standards, supporting the implementation of a government-led program to elevate midwifery services to global standards across India. I worked in both private facilities to enhance midwifery-led care and in public hospitals, where I reached out to disadvantaged and vulnerable women. This experience was transformative, offering me the opportunity to meet a diverse range of people from around the world and learn from inspiring role models. It reignited my passion for midwifery and helped me reconnect with my professional purpose.

During my time in India, I witnessed the struggles faced by society and the pervasive cruelty and abuse directed towards women. These experiences left me feeling small and helpless in the face of such widespread suffering. However, despite the challenges, my commitment to advocacy and empowerment grew

stronger. I departed from India with a renewed sense of hope despite the tears shed in the face of these hardships.

Upon my return, I decided to embark on a new path in academia and have since taken on the role of a midwifery lecturer. If addressing systemic issues within an entrenched, broken system proved difficult, I reasoned, perhaps it was time to begin at the root—by educating students.

Reflective questions

1 How can you make conversations in the workplace around racism and discrimination happen?
2 If a Black or Brown midwife starts speaking out how should white allies listen, learn and contribute?
3 When you are training, how can you take the opportunity to bring up issues that you think are missing from the curriculum with your lecturers?

References

Bayraklı, E., & Hafez, F. (eds.) (2023) *European islamophobia report 2022: Italy*, Istanbul: SETA / Leopold Weiss Institute. Available at: https://islamophobiareport.com/islamophobiareport-2022.pdf (accessed 24 June 2025).

Birthrights (2022) *Systemic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care*. [online] Available at: www.birthrights.org.uk/wp-content/uploads/2022/05/Birthrights-inquiry-systemic-racism_exec-summary_May-22-web.pdf (accessed 1 October 2024).

Calia, R.M., & Flauto, R. (2024) 'I don't dress like you': Islamophobia between the (in)visible violence against muslim women in Italy, and resilience strategies. In: A. Easat-Daas & I. Zempi (Eds.), *The Palgrave handbook of gendered Islamophobia* (pp. 329–351). Palgrave Macmillan.

Chaudhry, B., Raza, S., Raja, Z., & Ahmad, U. (2020) COVID-19 and BAME health care staff: Wrong place at the wrong time. *Journal of Global Health*, *10*, 1–4.

Collini, M. (2022) Italy: The promised land? Journeys of migrants, refugees and asylum seekers towards labour market integration. In: I. Isaakyan, A. Triandafyllidou & S. Baglioni (Eds.), *Immigrant and asylum seekers labour market integration upon arrival: Now here land* (pp. 129–160). Springer.

Dray, S. (2021) Black Lives Matter: New race inequalities commission and a london statue review. [online] Available at: https://lordslibrary.parliament.uk/black-lives-matter-new-race-inequalities-commission-and-a-london-statue-review/ (accessed 12 December 2024).

Elwell-Sutton, T., Deeny, S., & Stafford, M. (2020) *Emerging findings on the impact of COVID-19 on black and minority ethnic people*. [online] Available at: (www.health.org.uk/reports-and-analysis/analysis/emerging-findings-on-the-impact-of-covid-19-on-black-and-minority (accessed 14 October 2025).

Essed, P. (1991) *Understanding everyday racism: An interdisciplinary theory*. Newbury Park, CA: SAGE.

Hochschild, A.R. (1983) *The managed heart: Commercialization of human feeling*. Berkeley: University of California Press.

Nursing Narratives (2022) *Anti-Racist Manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (accessed 7 June 2025).

Runnymede Trust (2020) *Over-exposed and under-protected: The devastating impact of COVID-19 on Black and Minority Ethnic communities in the UK*. www.runnymedetrust.org/publications/over-exposed-and-under-protected.

Sue, D.W., Capodilupo, C.M., Torino, G.C., Bucceri, J.M., Holder, A.M.B., Nadal, K.L., & Esquilin, M. (2007) Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271.

Williams, D.R., & Mohammed, S.A. (2009) Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine, 32*(1), 20–47. https://doi.org/10.1007/s10865-008-9185-0

Chapter 12

The standard of whiteness

Fatimah Mohamied

Summary

In this chapter, the author shares their firsthand experiences with systemic racism, workplace injustice, and healthcare inequality during midwifery training. This chapter is set against a backdrop of global suffering and injustice, highlighting the significant barriers faced by Black and Brown healthcare workers. The author discusses the impact of a toxic work environment shaped by racism, colonial legacy and patriarchy. The narrative emphasises the importance of standing up for one's principles and beliefs, even in the face of institutional resistance, and calls for policies that promote true equity and respect in the healthcare sector. The chapter serves as an emotional reflection on the realities faced by Black and Brown midwives, underscoring the urgent need for anti-racist policies and practices in nursing and midwifery.

Becoming a midwife

I am writing this chapter amidst a storm of grief and within a climate of genocide. My own experiences of workplace racism and former fears of a virus feel insignificant, but all injustice is dehumanising. I, therefore, attempt to write with respect to those currently being bombed in Gaza, in the knowledge that it is the incremental efforts I can make that can affect communal and collective change.

I became a midwife because I knew I wanted to contribute to my community and empower women to empower themselves. My training was fraught with injustices; even now, I find it challenging to write about that time because of the acute vulnerability I felt. Rather than learn and exhibit that I was competent, I felt it imperative to be liked to get competencies signed off. Bearing the brunt of mismanagement, trauma and stress while witnessing and acting

DOI: 10.4324/9781041054276-13

as a bystander to racist attitudes towards vulnerable women meant that I was not prepared to practice as a good midwife but one that could withstand the toxicity of the National Health Service (NHS) Trust I was training at.

My midwifery training was emotionally, physically, and mentally exhausting. I earnestly wanted to learn but was obstructed by what felt like a tide of oppression. As you can imagine, reader, it was a struggle, as though I had to swim three times harder. The NHS Trust that I was training at was underfunded, then under proficient mismanagement, and impeding the success of marginalised students, Black and Brown. Despite a lack of support, racial attitudes, and flawed mentorship, I was determined to become a midwife.

White privilege: a perception or an encompassing reality

As a student, I faced racism of a systemic kind. I still remember a day when we had a meeting about the training at my hospital, which was attended by my peers, many of whom were people of colour themselves. I had mentioned that there was much white privilege at the NHS Trust, and the dean of midwifery responded with: 'white privilege is a perception' Stunned, I said nothing; my fellow students did not join me in challenging this, probably because many felt vulnerable and unable to speak out in relation to the enormous power gap between us as the dean. White privilege is not a perception; it is not something that bends with the will of an angry pair of eyes; it is the fabric of society that has been weaved for centuries at the cost of the lives, bodies and dignity of Black and Brown peoples all over the world, across all the European empires. White privilege is not a perception; it is what we are living in, and it is the main benefit of white supremacy. McIntosh (1988) mainstreamed the concept of white privilege in her essay at the time framing it as systemic. She spoke of an unearned advantage that white individuals unknowingly carry and famously described it as 'an invisible knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools, and blank checks'. In the context of midwifery this metaphor aptly captures the inequities present in education, recruitment and workplace culture with those unseen advantages accounting for the differing experiences of Black and Brown midwives over their careers.

The white privilege and systemic racism were apparent in how students were listened to and allocated roles. I challenged this by saying most white students are in the birth centre, where everything is excellent and low risk, and they get wonderful births and really relaxed environments. One Black student midwife had nine weeks of night shifts and was in a high-risk environment, often with mentors who were not supportive. This is a disparity. My challenge was met with disregard.

I complained to the university three times, once about a mentor whom I was incompatible with and from whom I learnt nothing. They just said you must be more confident and communicate better, as though being told was

the secret to being so. All students of colour experienced a lack of support. Some lecturers said inappropriate things about African countries and countries of low income on the topic of birth there. They needed to develop more knowledge and understanding of others, unlike them. When the white midwives complained, the university was there to support them. They did not always resolve the complaints, but at least they were listened to. I lost my trust in the university.

Standing up for your beliefs

Proper respect lies in making space for diverse beliefs and individual dignity, but in healthcare, I have found professionalism is often measured by appearances and framed in a capitalist, masculine way. Imagine being told by a lecturer to remove my undershirt from beneath my uniform (to cover my upper arms that were exposed while being bare below the elbow) during a meeting to 'comply with the policy'. This was not even in clinical practice. There was a disregard for my spiritual needs and my willingness to compromise my modesty code for the sake of infection control (Muslim women in hijab cover all their arms in public). When I refused, I faced threats. The lecturer failed my essay following this. Instead of accepting the injustice, I fought back to prove its value and eventually had that same essay published in the British Journal of Midwifery (Mohamied, 2019). To defend the university, the policy was changed, but not with any input from myself or any of the students it would affect, a repetition of history.

This experience taught me that policies in healthcare need to challenge racism and include the people it is meant to target. Students, despite their vulnerability, need to make their voices heard to challenge unfair practices and remember that their value goes beyond grades; instead, it is the impact they make on the community they serve. Speaking up, especially in the face of adversity, is necessary to adhere to your principles and ferment positive change.

Reflections on workplace challenges and racial bias

I graduated and then escaped. At the new NHS Trust, I was excited to see smiles on young faces in a newly renovated department, a sure sign that the unit had money, which I naively interpreted as an opportunity. I was eagerly anticipating being in a supportive environment where I could grow into the type of midwife I wanted to be. Due to being aware of decreased fertility with age and the unreliability of having ovaries at the mercy of their polycystic nature, I knew I wanted children sooner rather than later. I was fortunate enough to begin work as a midwife who was already pregnant. What I was not prepared for was being overwhelmed physically by my new workload and the knowledge that I had been poorly prepared to do it. I learnt the vast majority

of how to do my job, on the job, as though the previous three years were just a vague, pointless nightmare.

I spent most of the four months prior to maternity leave in the postnatal ward and had a few shifts in the labour ward, at my request, so I could be better prepared for when I came back from maternity leave. I had limited experience, except the harrowing vision of a literally breathless, floppy newborn. A couple of nightmares later, I asked to leave the labour ward, and a few shifts after that, I took early maternity leave because my uterus was rebelling against my workload by being annoyingly painful at regular intervals.

My labour was a traumatic one. The atmosphere was so rushed that the obstetrician did not check if I was completely pain-free, having assumed that my epidural, which had not been topped up in three hours, was top-notch; it was not. My main concern was the kiwi (vacuum assisted delivery). I was scared; who would not be after seeing so many grown adults use all their force to pull out babies from vaginas? I communicated this prior to the first pull when the coordinator squeezed my hand and encouraged me to be brave. That small act of kindness during one of the most vulnerable times of my life meant so much to me and remained indelibly imprinted on my soul.

My anxiety was very high the day I returned to work because I was to be placed in the labour ward, the place where I had sustained most trauma both as a student and as a birthing person and a place I had not solidly worked in for almost two years. However, my upbringing was strenuous in asserting that I do not complain or reject duty, especially when delegated by white people, for fear that my entire religious community (over a billion people) would be labelled as lazy and demanding. After one supernumerary shift where I was expected to spend it mask fitting for an FFP3, I was then expected to get on with the job as another wheel in a metaphorical conveyor belt, devoid of all the emotional complexities of birth or healing. I was made to do theatre work after having no preparation for theatres and supporting women when I could still feel the tainting fear of having an obstetrician assess my perineum.

On my first shift after the supernumerary one, I cared for a woman who had had a rushed Kiwi delivery and postpartum haemorrhage. The experience left me with clenched jaws as I would wash dishes at my kitchen sink; it was all I could think of; it stopped me from sleeping. I was plagued by this mash of guilt that I had let happen to her and fear as though it were happening to me. I spoke to my practice development midwives, where I discovered that I had sustained a traumatic birth, and it was impacting my care. The next shift, a woman I had looked after during the day had had a baby during the night but was born in poor condition. The notes were dissected, and as I had not written much of anything due to my inexperience, it made others wary of me because when you are Brown, you are not allowed to make mistakes or have mitigating circumstances.

There was one case I will never forget. A woman I cared for was pushing her baby. I requested a second midwife in anticipation of the birth, and I remember my heart sinking that it was another young white midwife, as that demographic of midwives had not been very welcoming, warm or receptive to me since I had arrived. The woman had a beautiful birth despite my perceiving the second midwife taking over command of the room, but with the baby came a steady stream of blood that meandered its way consistently, almost dropping off the sheets on the bed. I stood transfixed, knowing I should probably pull the call bell but feeling a strange compulsion to follow the white midwife's lead for fear of upsetting the power she had effortlessly taken while knowing that I was not well. I waited for instructions that did not come, and the coordinator left in the middle to attend the handover as the shift had ended, but the bleeding had not. The same coordinator who held my hand as I declared my fright had left.

The second midwife talked to me afterwards and said she felt there were parts of my practice that needed support, and she was going to write an email to the practice development midwives (PDM). I was in tears and expressing feelings of shame and guilt. At no time did she ask if I was okay? Her actions were racist because she assumed I lacked intelligence, not health. A few days later, when I picked up the phone with a different midwife who I believed would discuss my trauma, I was told instead that I would be placed under 'supervisory support'; when I asked in confused shock what that meant, the reply explained that I would be, in essence, like a third-year student midwife. We did not discuss my trauma. There were a lot of tears and meetings after that. The need to put me on supervision was communicated with a detached, careless concern.

Something in my soul was telling me something was very wrong. I began speaking to some friends and colleagues from the Association of South Asian Midwives (ASAM) about what happened. They enabled me to view the injustices I felt but could not see. It was not fair to have placed me in a labour ward after a traumatic birth that I had had in the very same ward. It was not fair to expect me to perform with no mistakes as a newly qualified midwife, having come back from a year of maternity leave and without labour ward experience for almost two years after being trained at a different hospital. It was not fair to expect me to serve labour ward care with no respect for treating my underlying trauma. It was not fair to label me as a potential threat to women and babies just because I sometimes dared to challenge how things were done (one of the reasons given for my life-threatening tendencies was my aversion to being 'hands-on' to guarding the perineum). It was not fair to expect me to communicate confidently and commandingly when I was the only person of colour in the room, sometimes the only non-blonde for the whole shift, where I had very few colleagues who would talk to me or greet me with a good morning and even fewer who would speak on friendly terms. The Care

Quality Commission (CQC) report 'Listening to maternity staff from ethnic minority groups' (2022) explores how racism, exclusion and the lack of support experienced by many impact on our confidence and career progression, leaving many feeling unsafe to speak up about our concerns.

After just eight weeks, during which I worked 16 shifts, I was deemed dangerous and placed under supervision; no one had read any documentation I had written for any of the women under my care after my second shift, and no one had asked me what I felt of my practice, no one had asked me how I was trying to adjust after coming back from maternity leave. No one asked me if I was okay. In this maternity unit, where women give birth, where I gave birth, there was no shred of compassion to be found.

When I voiced my concerns about racial bias, I was met with diplomatic responses and no explicit acknowledgement of the discrimination I was experiencing. Of course, I filed a grievance; the main outcome I wished for was justice so that no other midwife would experience what I had. The Head of Midwifery then investigated, and they told me it was reported that I had been involved in neonatal death, a concrete falsehood. Instead of acknowledging my vulnerabilities, mistreatment, and mismanagement of my return from maternity leave, no plans or even promises were made to change the unit so that others would be protected.

I finally accepted that the unit would never be a place for my prosperity because justice was not fostered, and my humiliation was not recognised. I could no longer work among people who had no respect for me or my integrity, and I contacted the director of midwifery to request a transfer to a different unit. The director was the only one who tactfully accepted that much learning was needed at the unit to bring about cultural safety.

It was only after I had transferred units that I came to understand the severity of discrimination I had experienced. I was now able to compare the two ward cultures—the acts of kindness I received, the compassion I was graced with even after I made a mistake, and the simple humanity of being spoken to in the staff room or the changing rooms. Many months later, I finally had access to the e-mails that were written about me during that dark time, something the writers were either unaware they could access or did not anticipate pushback. Two e-mails are unforgettable, one from a fellow midwife of colour who had worked with me for one shift, saying in fierce language how she would not trust me to care for any woman she knew or did not know, and the other from the same co-ordinator who held my hand as I had my baby pulled out of me, saying she had repeatedly communicated her concerns to me (she did not) and that she had seen 'little to no improvement' in my care. I now cannot reflect on my birth in any other colour but the colour of betrayal.

Upon reflecting on my experience returning to work, it is crucial to offer strong support for new midwives and returning staff by providing clear guidance, structured support, and continuous feedback, especially after extended absences. It is also essential for NHS organisations to acknowledge and

address racial biases in the workplace explicitly and to evaluate support systems to ensure they do not unfairly disadvantage Black and Brown midwives. Moreover, transparent communication is essential, and any concerns about competency should be openly addressed, involving the midwife in question rather than allowing anonymous or behind-the-back reporting, as transparency fosters trust and a more supportive work environment. Above all, all staff need to receive training on systemic racism and cultural competence to create a more inclusive environment where midwives of all backgrounds feel safe and supported. The CQC report (2022) calls for structural change, inclusive leadership, and meaningful anti-racist strategies. The history of colonialism, and hence the current perpetration of coloniality, needs to be part of the education package.

It is women that I have cared for that have often reminded me of why I became a midwife. One woman told me, 'Fatimah, you have been amazing. If you were not here, I would have had a C-section. I am so glad you changed careers'. Her words validated that this is more than just a job for me; it is deeply meaningful work. Knowing that I could support her in one of the most vulnerable and pivotal moments of her life and that I helped create a positive experience for her and her family fills me with pride. Birth is such a crucial time, and when you make that experience suitable, you contribute to the well-being of the family and, by extension, societal stability.

Personal reflections on the fight for justice and racial equality

What gives me the strength to continue fighting for justice is staying aligned with my core values. If I do not stand for justice, I compromise those values, which in turn leads to a disconnection from my soul. That disconnection causes the spirit to decline, leading to self-betrayal. I fight for justice because it allows me to live with integrity. At the end of my life, I want to know that I stood for what I believed in and that I fought for a world aligned with my values—not just for myself but for others. My purpose is to leave the world better than when I entered it.

Returning to work during the pandemic was a scary time, and the lynching of George Floyd struck a profound chord. As someone who is asthmatic, I know firsthand the panic and desperation that arises when you are unable to breathe. Watching George Floyd being suffocated reminded me of the fundamental nature of breathing, which is an intrinsic part of life from the moment we are born. The denial of breath was a metaphor for the more significant issue of denying the humanity of Black lives. Floyd's death exposed the undeniable truth: Black lives were being devalued. His death heightened the awareness of the injustices suffered by Black people, not just in America but globally. It forced a reckoning with the systemic racism that affects our families and communities.

The 2019 Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBBRACE) Report highlighted that Black women are five times more likely to die from childbirth complications than white women, and Asian women are twice as likely (Knight et al., 2019). The latest report (Felker et al., 2024) has shown a slight decrease in these rates, but it is still far too high. Despite the NHS's reputation, these figures expose a deeply ingrained racism in our healthcare system that has persisted for decades. Even though the 2019 MBBRACE report came before George Floyd's death, it was not until his murder that the issue gained the necessary attention from the media and the public. It saddens me that it took such an atrocity to awaken people to the injustice that has long been documented. However, this shows that evidence alone is not enough; it takes a shared sense of humanity to drive real change. I am proud of the efforts being made currently in the NHS, such as cultural safety lead midwives being implemented and enrolled in London South Bank University's ELEVATE programme,[1] but my trust has been broken many times. Nevertheless, I remain committed to trying because the fight for equality and justice must continue.

Speaking out against injustice for women, especially in childbirth, is imperative for me. However, speaking up for women in the UK holds no weight if we cannot speak up for women everywhere. The past year has proven just how hard it has been to do so. Women and families in Gaza have gone through unimaginable trials, displacement, bombardment and dehumanisation by a wholly unfit reporting of their situation by the media. When speaking to colleagues about Palestine, I have been met with awkward fear of the conversation or just being ignored. My online activism (Mohamied, 2024) nearly led to me being featured in a national tabloid newspaper as an inciter of hatred and violence. My now former workplace attempted to silence my political activism by 'requesting' that I no longer post politically. Once I challenged this by stating my right to support Palestinian resistance to illegal occupation, they dropped the matter. There have been numerous instances where health and social care professionals have faced significant challenges and repercussions for speaking out about Gaza (Coghlan, Kelly, and Alser, 2024; Koutsounia, 2024). However, the issue recurred as more provocateurs external to the NHS Trust e-mailed to call for my dismissal, including UK Lawyers for Israel. My workplace did not appropriately support me, and the e-mails were not interpreted as harassment. I discovered I had been anonymously referred to the Nursing and Midwifery Council (NMC) for a fitness for practice for posting supposedly antisemitic social media posts 11 months prior. However, the same e-mail informed me that the NMC found no antisemitism or concern in any of my posts. I am still a midwife.

Another anonymous referral was made to the NMC followed by a referral from my former employer for whom I had ceased to work for a year prior. The third NMC referral preceded a Prevent referral, the government's counter terrorism program, also made by the Trust. This followed a second letter the

Trust received from UKLFI. The relentless harassment I was subjected to was not only at the hand of the Trust, but also of the NMC for enabling repeated referrals and protecting the referrers via anonymity from being held accountable for using the NMC as a vindictive tool in their quest to racistly punish me for speaking up for Palestinians and criticising Zionism (Ng, 2025).

It is not my pain that is the main character in this story, but the pain of those being killed, maimed and starved. The past year has taught me that we cannot advocate for justice in complete safety; there will always be a risk because it is in the interest of the powerful within a capitalist, white supremacist world to maintain injustice and oppression. It is, therefore, the duty of those with privilege and power to protect us from that injustice while we speak up against it.

Colonial legacy and its impact on the NHS

Colonialism and coloniality remain deeply embedded in the NHS and many of our institutions today (Sowemimo, 2023). The British Empire, once spanning a quarter of the world's land mass, dissolved only about 70 years ago, yet its legacy endures. Institutions often deny the presence of colonialism, yet the systemic inequalities, particularly in healthcare, expose its lingering effects (NMC, 2023). Black and Brown healthcare workers are disproportionately vulnerable due to their socioeconomic circumstances, and this vulnerability is often overlooked rather than addressed, perpetuating colonial attitudes and power imbalances.

The NHS, originally modelled on the British military (Klein, 2013; Webster, 2002), naturally reflects hierarchical structures. Britain's deeply ingrained class system permeates the NHS, where there is a clear class divide. Within this structure, racial divisions are also evident. In London, for example, many doctors and staff are Black and Brown, while most domestic, cleaning, and catering staff are overwhelmingly from ethnic minority backgrounds. These workers, often in lower-paid roles, face additional vulnerabilities not experienced by midwives, nurses or doctors.

Our institutions must recognise how white-centric their systems are. For example, medical students should learn to identify symptoms in all skin tones, not just white skin. Inclusivity should not just mean adding diversity but dismantling whiteness as the default standard. This is why the fourth point in the Anti-Racist Manifesto for change is so important: Remove whiteness as the benchmark in training and organisational culture. This is the only way we can build an NHS with equality at the core of health provision for all ethnicities (Ramamurthy et al., 2022, point 4 & 5).

It is also essential to have systems in place to support staff of colour (NMC, 2020). They should have a platform or panel that represents them, ensuring they do not face their struggles alone when speaking out. There needs to be spaces for open, honest conversations about race and spiritual

well-being—about living by your values, appreciating time, beauty, and the emotional aspects of work, whether in midwifery or any other profession.

We must have hope for the NHS and the future, as it is damaging to hold a bleak outlook.

I want those in power to understand their mortality and the legacy they will leave behind. Many have failed the younger generation and Black and Brown communities, and this will not be forgotten. Those in power must acknowledge the shared humanity they have with ordinary people—those with less privilege, money, and freedom. There needs to be an honest reckoning with what it means to hold power. Power should not be used for personal gain, fame, or recognition but to genuinely improve the lives of others. After all, power is temporary, and one day it will end.

Reflective questions

1 What steps can individuals take to challenge and dismantle white privilege and racism in healthcare settings, especially when faced with institutional resistance?
2 How can trusts improve transparency in their response to complaints and staff grievances, to ensure that all midwives feel heard and supported when raising concerns about safety and discrimination?
3 How can institutions like the NHS address the lingering effects of colonialism, and protect the civil rights of racialised staff?

Note

1 Cultural safety leads are specialist roles focused on embedding cultural safety principles into maternity services. They aim to ensure care is equitable, respectful, and inclusive of diverse cultural needs. The focus on diversity in practice is mirrored in education with universities like the University of Salford implementing annual cultural safety training and inclusive curriculum reviews (Royal College of Midwives, 2022).

References

Care Quality Commission (CQC) (2022) *Listening to maternity staff from ethnic minority groups*. [online] Available at: www.cqc.org.uk/about-us/transparency/external-reports-research/listening-to-maternity-staff-from-ethnic-minority-groups [Accessed 2 June 2025].

Coghlan, R., Kelly, B. and Alser, M. (2024) Help us save lives that are being lost: Health workers have a moral and professional obligation to call for medical neutrality in Gaza. *ABC Religion & Ethics*, 4 October. Available at: www.abc.net.au/religion/health-workers-moral-obligation-medical-neutrality-gaza/104433376 [Accessed 2 June 2025].

Felker, A., Patel, R., Kotnis, R., Kenyon, S. and Knight, M. (Eds.) on behalf of MBRRACE-UK (2024) *Saving lives, improving mothers' care compiled report – lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2020-22*. [online] Available at: www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports [Accessed 18 October 2024].

Knight, M., Bunch, K., Tuffnell, D., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S, and Kurinczuk J. J, (Eds.) on behalf of MBRRACE-UK (2019) *Saving lives, improving mothers' care – lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2017-19*. [online] Available at: www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf [Accessed 06 June 2025].

Klein, R. (2013) *The new politics of the NHS: From creation to reinvention*. 7th ed. London: Radcliffe Publishing.

Koutsounia, A. (2024) Social workers don't feel able to speak about Israel-Gaza war at work, poll finds. *Community Care*, 29 May. Available at: www.communitycare.co.uk/2024/05/29/social-workers-dont-feel-able-to-speak-about-israel-gaza-war-at-work-poll-finds/ [Accessed 2 June 2025].

McIntosh, P (1988) *White privilege: Unpacking the invisible knapsack. Independent School*, *49*(4), 31–36. Available at: www.racialequitytools.org/resourcefiles/mcintosh.pdf [Accessed 2 June 2025].

Mohamied, F. (2019). Postpartum psychosis and management: a case study. *British Journal of Midwifery*, *27*(2), 77–84.

Mohamied, F. (2024) A midwife's duty of care to pregnant women in Gaza. *New Arab*. www.newarab.com/opinion/midwifes-duty-care-pregnant-women-gaza

Ng, E. (2025) Midwife brings claim against trust after 'Prevent referral over Palestine posts'. *The Independent*, 20 August 2025.

Ramamurthy, A., Bhanbhro, S., Bruce, F., Gumber, A. and Fero, K. (2022) *Nursing narratives: Racism and the pandemic*. The draft report was submitted to the UKRI-Covid Rapid Response Call Project. [online] Available at: https://shura.shu.ac.uk/29860/1/NN%20Report_Final_EDIT.pdf (accessed 5 December 2024).

Royal College of Midwives (RCM) (2022) *Decolonising the curriculum: A cultural safety approach in midwifery education*. [online] Available at: www.rcm.org.uk/decolonising-the-curriculum/ [Accessed 2 June 2025].

Sowemimo, A. (2023) *Divided: Racism, medicine and why we need to decolonise healthcare*. London: Profile Books.

Webster, C. (2002) *The national health service: A political history*. 2nd ed. Oxford: Oxford University Press.

Further reading

Nursing and Midwifery Council (NMC) (2020) *Ambitious for change: Research into NMC processes and people's protected characteristics*. [pdf] Available at: www.nmc.org.uk/globalassets/sitedocuments/edi-docs/nmc_edi_research_full.pdf [Accessed 2 June 2025].

Nursing and Midwifery Council (NMC) (2023) *Spotlight on nursing and midwifery report 2023*. [pdf] Available at: www.nmc.org.uk/globalassets/sitedocuments/data-reports/insight-spotlight/2023/spotlight-on-nursing-and-midwifery-report-2023.pdf [Accessed 2 June 2025].

Chapter 13

Lift as you climb

Rosetta Binu

Summary

This chapter narrates the experiences of a nurse, educated in Kerala, South India, who completed her adaptation as an overseas nurse in England. Rosetta highlights racist bullying and culture of intolerance that led to unfair disciplinaries in the work place. She also narrates the lack of support she experienced for professional development, highlighting how her white colleagues were treated differently. This chapter highlights the emotional toll of racism. It also narrates a nurse's pride in her contribution in the pandemic and compares the stress of the pandemic to the stress of racism. This chapter ends by highlighting the difference between a supportive and an unsupportive workplace. Rosetta highlights her experience of being enabled through training and development opportunities which has allowed her to become an Objective Structured Clinical Examination (OSCE) trainer and nurse lecturer, holding the principle of lifting others as she climbs.

How it all began

I graduated as a nurse from a very reputable institution in India, Trivandrum Medical College in South India, Kerala. I was always passionate about education and learning and, like many overseas nurses, thought coming to the UK would allow me to progress in my career. In reality, my previous experience and clinical expertise were not valued. Instead, I was treated like a newly qualified nurse and placed at the lowest spine point of the Band 5 NHS 'Agenda for Change' (NHS England, 2024a) pay rate for registered nurses (Alegado, 2024).

In order to work as a nurse in the UK, I was required to complete a period of supervised practice known as 'adaptation'. The whole adaptation process, including getting all my documents signed off to receiving my nursing

DOI: 10.4324/9781041054276-14

professional identification number (PIN), took three months. Gerrish and Griffith (2004) described adaptation as a much longer process than I experienced and something that should not be seen solely as the achievement of professional nursing registration. The findings of that seminal research concluded that the successful integration of overseas nurses required investment, equality of opportunity for career progression and organisations that value cultural diversity. Twenty years on from this research, it is disheartening that institutional racism continues to be a barrier to the full implementation of this foresight.

My experience caring for people in a care home was very different from how we were trained in India. Although I enjoyed the caring aspect of working in a nursing home and looking after the elderly, there were no opportunities for professional development or furthering my learning and education. I felt like I needed to specialise to be able to progress, so I eventually applied for and began working in an intensive care unit (ICU) in a well-respected hospital in Yorkshire.

Working in the NHS: experience of bias and disciplinary panel procedures

I worked as an ICU nurse for 10 years, and during my time in this environment, I experienced lots of barriers. However, I was passionate about learning and development; I was not encouraged to apply for roles that would allow me to progress. Other nurses were given the opportunities, but not me or other colleagues from overseas, leaving us feeling frustrated and unfulfilled in our roles (Adhikari & Melia, 2015). We were not treated fairly in the ICU, and when international nurses made a small mistake like not signing the charts, for example, it was always taken further, and disciplinary actions were imposed. I felt very overwhelmed by the discrimination and injustice (Allan & Westwood, 2016). I think this was exacerbated because I had no support from extended family; there was no one I could talk to when I had a problem.

In India, we have a custom of wearing marriage chains, a symbol of our wedding vows, like the wedding rings in England. A senior nurse asked me to remove my wedding chain, and after this incident, I felt like she was always waiting for me to fail. On another occasion, I was wearing two earrings in my upper ear; she asked me to take them off due to the infection control policy, and she also pulled me up on a silly documentation error. The nurse documented the issues and filed a complaint against me. My whole life was on hold for a month during the process. I did not know what I had done, and although patient care was not affected, I was told I could not work without supervision. I felt so defeated and was questioning how I had come from being in a position of teaching nursing students back home to this. Where did I fail? What had I done wrong? I was ridiculed by other members of staff, too; people kept

asking me why I was under supervision, commenting on the fact that I had been working there for a long time.

The details of the complaint were not explained until the day of the disciplinary panel. I went along with my representative a month after the initial complaint had been filed. I knew immediately who had filed the complaint when they explained the issues. I think if it were another English or white colleague, it would not have gone the disciplinary route; I felt white colleagues were treated very differently to the overseas nurses. According to the most recent NHS Workforce Race Equality Standard (WRES) data (NHS England, 2024a), in 46% of NHS trusts, staff from Black and ethnic minority backgrounds were over 1.25 times more likely than white staff to enter the formal disciplinary process.

The outcome of the disciplinary panel allowed me to continue working in the ICU because I did not do any harm. It still severely knocked my confidence. They said they would refer me to occupational health and counselling, but I did not want to go that route. I was a strong person; I had lost my brother, and nothing could break my heart more than that. I would not take time off sick; I was determined that I would continue in the same place following the disciplinary. Colleagues could see I was being victimised and suggested I leave. I carried on because I wanted to prove I could work, lift my head and walk over the people who had done that to me.

When I did decide to leave, I applied for at least ten other roles before securing a 6-month secondment covering maternity leave in research. I had sought feedback from other nurses about why I kept getting rejected. I could speak good English and communicate well, so what was I lacking? They would not say anything and instead suggested that maybe I was not answering the questions sufficiently. I was receiving interview calls from all over the country, but not in the hospital where I had spent the last 10 years of my career. I could not progress, and I could not understand why. I had completed courses and tried to do everything to progress up the ladder. I had all the necessary experience, but the people who came after me were the ones who were given the Band 7 positions. I had been a nurse for over 14–15 years when I was applying for Band 7 roles that newly qualified English nurses would be progressing to easily within two or three years.

Nursing through COVID-19

I was working in the outpatient department when COVID-19 hit, and all our services stopped. I decided to volunteer to work in the ICU, and it was an enriching experience for me. I had to work with the person who had filed the complaint against me; it did not affect my professionalism, and she thanked me for going back to help. I knew she lost her mother, and I spoke to her about it. I can forgive her, but I will never forget those moments. It was a horrible experience for me, even worse than the pandemic.

In the early days of the pandemic, I remember I would kiss my children before going to work and wondering if that was my last kiss. It was scary because we could see the disproportionate impact on ethnic minority background people; many of our doctors and nurses were not recovering as fast as the others were, and my husband lost his colleague. The survey "Over Exposed and Under-Protected – The Devastating Impact of COVID-19 on Black and Minority Ethnic Communities in Great Britain" by Runnymede Trust and ICM (Haque et al., 2020) highlighted those disparities.

The Black Lives Matter protests and subsequent discussions about health and social disparities were taking place, but I do not think it really made any difference in my life. I do not think it was even discussed working in the previous trust. I spoke to the Chief Nurse, and she was prepared to listen to me, but it still made no discernible difference to my life. I still have not gotten any of the jobs I applied for. Being from an ethnic minority background, I did not discuss Black Lives Matter with any of my colleagues because I was anxious about what they might say.

Barriers to progression

In the UK, I have not had inspiring nursing role models that looked like me. Research shows the NHS treats staff from a Black and minority ethnic background less favourably than their white counterparts in recruitment, promotion, discipline and career progression (Kline, 2015). I paid for coaching to develop my interview skills when I felt like I was getting nowhere and there was no support within the NHS. I knocked on many doors asking for help and feedback following interviews, but I would not get feedback, or if I did, the feedback would be, 'You did well, but someone else did better than you'. There was no advice on how I could improve. I used to go for informal visits and make myself familiar before I went for interviews, but that still did not work.

Coming to work in an entirely different NHS trust after experiencing such a difficult time working in the NHS made me reflect on what could be changed to tackle discrimination. I think it is important that NHS Trusts look after their international nurses. They do so much more to support international nurses where I am now. They are compassionate about the recruitment of overseas doctors and nurses, and they do a lot to make the recruits feel welcome. I think this model should be rolled out throughout the UK because there is a shortage of staff, and they must treat the people who come from abroad to meet the needs of the population fairly. These workers have left their families; it is not that they do not have a job in their country, they came here for their reasons and should be seen as an asset, not a burden (Lanada & Culligan, 2024).

When I came to work for my new NHS Trust, I was advised to apply for courses to develop my skills. I was encouraged to complete the mental health first aid course. They noticed my passion for teaching, and within four months,

they put me on the Nursing Midwifery Council (NMC) Objective Structured Clinical Examination (OSCE) Train the Trainer course. I never had these opportunities in the past. I wanted to learn and apply for funding, and my manager always told me that if I did not have the money to support myself, I should not do it, and she would not support me. In the past, I funded my self-development, whereas other English colleagues who had been there for less than a year got the opportunity to have funded places on courses I was refused.

My journey from clinical to academia

I have always wanted to get into teaching, and I initially applied for a fixed-term contract. I enjoy supporting (lifting) others at the same time as I progress (climb) and develop my nursing career in the new direction of academia. Being an international nurse, I believe that my previous experience is truly valued and celebrated in my new role. I am the OSCE trainer for international nurses. I provide pastoral support for them, and I am responsible for teaching them and preparing them for the OSCE. We have them for three weeks, and we train them for the OSCE, which the NMC conducts; once they complete the OSCE, they get their PIN and can start working as a nurse.

My role is rewarding, and the feedback I got from the first cohort was so overwhelming that I nearly cried. From stepping out of the coach on their first day, they were so grateful that they could communicate with someone in their language. They could not believe they were all from India, the same place as I am, South India, Kerala. They had been struggling to understand what their team leader was saying, but I explained it to them in a more straightforward way and told them how to protect themselves.

I want to be a voice for all the people who are experiencing the same level of discrimination and racism I faced and provide encouragement to those who want to develop and progress in their careers. I want to be a nurse, lending a helping hand. Being an overseas nurse should not bar them from progressing up the ladder. I want to see all my junior recruits from India progress and do well in their career. Whether they want to stay as Band 5 nurses or continue developing and progressing further, they should be given the same opportunities (Nursing Narratives, 2022 point 7).

This is why NHS trusts must create a fair and transparent recruitment process, including all internal opportunities and why the government and regulators need to recognise the experience and training of overseas nurses and midwives and not automatically treat them as unqualified, as the Manifesto for Change highlights. When envisioning the future that I would like to see for the NHS, I believe it should treat the people working in the service equally and fairly, wherever they are employed in the country. My one demand would be to treat people fairly and give educational opportunities to all.

Reflective questions

1 How can organisations such as the NHS, universities, and the NMC ensure that international nurses are welcomed and integrated successfully into their new roles in the UK?
2 How can the NHS increase fairness and transparency in the recruitment process?

References

Adhikari, R, and Melia, M (2015) The (mis)management of migrant nurses in the UK: A sociological study. *Journal of Nursing Management*, *23*: 359–367.

Alegado, P (2024) A wealth of overseas experience to us. *British Journal of Nursing*, *33*: 400 – 401.

Allan, H, and Westwood, S (2016) Non-European nurses' perceived barriers to UK nurse registration. *Nursing Standard*, *30*: 45–51.

Gerrish, K, and Griffith, V (2004) Integration of overseas Registered Nurses: Evaluation of an adaptation programme. *Journal of Advanced Nursing*, *45*: 579–587.

Haque, Z, Becares, L, and Treloar, N (2020) Over-exposed and under-protected. [online] Available at: www.runnymedetrust.org/publications/over-exposed-and-under-protected (accessed 29 October 2024).

Kline, R (2015) Beyond the snowy white peaks of the NHS. Better health briefing. Race equality foundation. [online] Available at: https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/Health-Briefing-39-_Final.pdf (accessed 31 October 2024).

Lanada, A, and Culligan, K (2024) The experiences of internationally educated nurses who joined the nursing workforce in England. *Practice Nursing*, *35*: 92–98.

NHS England (2024a) NHS Workforce Race Equality Standard (WRES) 2023 data analysis report for NHS trusts. [online] Available at: https://mft.nhs.uk/app/uploads/2024/10/Workforce-Race-Equality-Standard_WRES_Report-2023-24_Final.pdf (accessed 29 October 2024).

NHS England (2024b) Agenda for change – Pay rates. [online] Available at: www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates (accessed 27 November 2024).

Nursing Narratives (2022) *Anti-Racist Manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (accessed 7 June 2025).

Further reading

Allan, H, Cowie, H, and Smith, P (2009) Overseas nurses experiences of discrimination: A case of racist bullying? *Journal of Nursing Management*. *17*: 898–906.

De Kock, H, Latham, A, Leslie, J, Grindle, M, Munoz, A, Ellis, L, Polson, R, and O'Malley, M (2021) A rapid review of the impact of COVID-19 on the mental health of healthcare workers: Implications for supporting psychological well-being. *BMC Public Health*, *21*: 1–18.

Chapter 14

Standing up to racism empowered my mental health and well-being

Gemma Newbold

Summary

This chapter describes the impact of a sustained period of both individual and institutional racism throughout Gemma's career in nursing. Her narrative highlights the persistence of crude racist stereotypes. She recounts the exhausting toll repeated microaggressions took on her mental health and wellbeing and the ways in which institutions fail to address racism, often protecting the perpetrators and blaming the victim. She argues for the importance of addressing racism in order to respect the nursing code of practice. She describes how speaking out has allowed her to take control of her narrative and support her mental health and well-being in the process.

Experiencing racism as a student nurse and early career

I was ecstatic when I received my conditional offer to study nursing at the University of Manchester; I felt so lucky because, on paper, it ticked all the boxes and had been my preferred choice. I encountered some amazing clinical areas and was exposed to some excellent learning opportunities, but unfortunately, from the very start of my career, I also experienced racism. As a student nurse, I first started noticing it during my clinical placements; all the Black and Brown student nurses were told to be grateful for the opportunity we had been given. I also experienced countless microaggressions. Torino et al. (2018, p. 5) explain that:

> Microaggressions may be expressed in the form of implicit bias where the individual is unaware of the biased communication, or via explicit bias where the person is well aware that they are engaging in discriminatory actions.

DOI: 10.4324/9781041054276-15

I was often left questioning myself: Were they being racist? I was asked unnecessary questions, like if I had certain kinds of food for breakfast. Asking if I had ever seen snow. Of course I had, having grown up in the Peak District, but I just tried to laugh it off and carry on.

One of the first experiences of racism in the National Health Service (NHS) was devastating but also embarrassing. When I started my first job, I was asked a lot of questions about my family, including if I had brothers. When I told them I had a brother, they actually asked me what size his genitalia were because he was a Black man. I felt ashamed, and I did not know who to talk to about it. I did not know whether to go home and say somebody had said this to me. Am I overreacting? I did seek help and went to speak to a senior nurse, but they just dismissed it and said I was probably being oversensitive because I was the only person of an ethnic minority within the team at the time. The dehumanisation of Black bodies (Farley, 1997) and fetishisation of Black masculinity and white curiosity (Asare, 2021) were not acknowledged by this authority figure. Instead, I was gaslighted, and my feelings were ignored.

I have experienced sustained bullying and racism within the workplace, predominantly from colleagues. At one point, I was subjected to racist comments almost every day. I remember saying something along the lines of 'I am exhausted today, or I seem to have more patience than you', and receiving comments like 'It beats being a slave'. When I asked if there was an opportunity for me to go back to university to complete my district nursing degree, the sister who was in charge turned around, laughed in my face and said something along the lines of

> People like you do not get to wear a dark blue uniform. It is not for you; you should feel privileged and happy that you have been given a job because there were lots of other people who probably deserved it over you.

On another occasion, we were planning a laser quest team-building experience, and a member of staff turned around and said, 'I do not want to go with you … because I will not be able to see you in the dark so that you will win'. I was so shocked, and their response was, 'But I know you, so it is fine'. I remember crying all the way home in the car. Another member of staff reported the incident to my manager, who was amazing, agreed it was not appropriate, and supported me in putting a grievance in. I was discouraged from following this up by another person of colour who worked in HR. She said, 'Would you really want to go through that? Do you want to put the rest of your team through that? They could have some bitterness towards you?' This type of internalised racism or the reframed construct of 'appropriated racial oppression' (Versey, 2019) describes how individuals from dominant and non-dominant groups embrace racist negative attitudes, stereotypes, and

ideologies for marginalised racial groups within our society, allowing them to maintain normative white ideals, privilege, and systems of inequality.

I went through with the grievance, but I wish I had not because I was interrogated and removed from my role whilst the perpetrator was allowed to carry on in her role. I was made to sit in an office for two months, but I was unable to discuss it with anybody else on my team apart from those who had been present. They kept saying, 'What has happened to Gemma? Why is she not allowed to work in the schools? Why is she not allowed to do things?' I felt like the perpetrator, and it just got worse and went on for over a year. The lady was retiring, so they waited till she left. I then received a letter from my NHS Trust on New Year's Eve saying we do believe it was racist, but we will learn from this, and that was it.

As nurses, we should always act in accordance with the Nursing and Midwifery Council (NMC) Code (2018) and uphold the reputation of our profession at all times.

> ... all nursing staff act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment…treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
>
> (Nursing and Midwifery Council (NMC, 2018, p. 21)

The incidents I have experienced throughout my career make me question the validity of the code. The NMC Independent Culture Review (2024) reflects my observations when it concludes that there is a fundamental disconnect between what the NMC embraces and what is practised, along with normalisation and tolerance of race inequalities.

Mental health

Whenever I tried to stand up for myself, I was told I was being aggressive, and because of not wanting to be labelled with the trope of 'the angry Black woman', I found myself not wanting to talk about anything and was instead often mute. I just did my job and tried to change myself so I could fit in. I would not have dreamt of having curly hair; I would not have anything that might offend them more. I tried to assimilate to navigate the trauma (Quach, 2021). I thought I was managing, but my mental health was declining, and ultimately, there were psychological consequences following the persistent microaggressions and racism. I ended up having to take antidepressants, and after two years of holding it all in, I had to go off sick because it all got too much, and I had a breakdown.

These experiences changed me as a person, took all my confidence away, and made me question whether I could be a nurse. I got to the stage where

I did not want to be Black anymore (Fanon, 1986). I think it was one of the worst stages of my life. A lot has changed since then, and I am proud of who I am now. Counselling helped me to get through a really challenging time, and I still feel pretty angry that I was made to go through that. Despite caring being a fundamental aspect of nursing, which involves empathy and responding with compassion, my own experiences contradict these fundamentals in the way my peers treated me.

I am glad I got the help because it also made me realise that I did not want to quit the career that I fought so hard for. When I returned to my role, I became more actively involved in the Trust's BAME support network. Staff were able to come together and share their experience, which was cathartic and helpful to know we were not alone. Everything changed when they suddenly decided to involve executives so they could learn from our experience. I was encouraged to take part in the reverse mentoring scheme. This is where a junior employee is partnered with a more experienced colleague, but to be honest, I did not find the experience helpful. I was tired of teaching people how to be human and how to make sure we are all treated the same.

Pandemic

Initially, one of my biggest worries at the start of the pandemic was redeployment; I have always been the only nurse of colour where I have worked, and because of experience, I was absolutely petrified of how colleagues in a new team would treat me. I was also aware there was a higher risk of Black and Brown people catching COVID-19 and dying, so it was a scary time. I requested not to be sent back to where I had previously experienced racism. I also asked not to be placed on a COVID-19 ward due to the outcome of my risk assessment showing increased risks. The two options I resisted were the places they wanted to send me.

There were significant issues with personal protective equipment (PPE) in our NHS trust at the start of the first wave; we were not getting enough. Everyone was scared, and we did not know what to do. We were getting regular updates from the prime minister and senior healthcare professionals like the Chief Nurse Ruth May, but there were never any nurses of colour in those briefings. We were not important enough to be delivering anything like that. The most I saw was a British Filipino nurse who gave the first COVID-19 vaccine on TV. That was the first positive story involving someone from an ethnic minority that I saw on my screen during the pandemic.

The racism we experience every day in the NHS, not feeling like a valued member of staff, was in stark contrast to the communities coming together, clapping and thanking the NHS. I think following the pandemic, I have noticed more media images of Black nurses, which never used to happen, but sometimes you feel like you are being used.

Nursing Narratives, a call for change

One of the colleagues I met as part of the NHS Black and ethnic minority backgrounds staff network encouraged me to complete a survey that allowed me to talk about my experiences with the Nursing Narratives Project. I am so grateful that I managed to connect with her and find somewhere to channel my frustrations with the way the system has treated me. I have learnt so much about myself, and I also feel more confident speaking up and challenging racism. It used to be anything for an easy life, but now I feel more empowered to speak up about injustices and ensure I express how actions have made me feel. There needs to be clear and real consequences for racist actions in every organisation (Nursing Narratives, 2022, point 6).

I was shunned at work for speaking out in the Nursing Narratives film *Exposed*. It feels frustrating that little (if anything) has changed in the NHS, especially for myself and my career, but also for so many others. I attended a number of screenings for *Exposed*. I spoke on the panel as a representative, connecting with the audiences, often made up of other nurses of colour with similar experiences or allies who want to work to make a difference. The value of doing this creates safe spaces where we see and hear people who look like us and we are reminded that we are allowed to feel, to express our emotions and perhaps most importantly are validated. It also raises awareness and educates allies on the extra complexities people of colour face daily in the workplace.

Since speaking out, I have become involved in the SHURI Network (https://shurinetwork.com/). The network is the first NHS and care network for women from minority ethnic groups in digital health. It is named after Shuri, the Black Panther character who is responsible for her country's technological success, and it champions safety, innovation and diversity. I have received coaching from the network, which made me feel that I had stepped into my power and that it is OK to be authentically me. I learnt that I hold my value and self-worth and that my well-being and mental health are so much more important than the oppressive systems and methods within the NHS; I no longer have to stay in environments that only tolerate me or use my ethnicity to promote their diversity. I now only want to work where I am celebrated and able to be my true, authentic self. '*Build a more compassionate NHS with respect and equity for Black and Brown workers'* is a call in the manifesto for change that is the most important for me (Nursing Narratives, 2022). I would like to demand equality so that every nurse who works in the NHS feels their worth and knows how important what they do is.

Reflective questions

1 What could employers like the NHS do to safeguard and support the mental health and well-being of nurses who have reported instances of racial abuse and discrimination?
2 What self-care strategies could nurses use to support their mental health?

References

Asare, J.G. (2021, February 7). What Is Fetishization And How Does It Contribute To Racism? *Forbes.* Link to article: https://www.forbes.com/sites/janicegassam/2021/02/07/what-is-fetishization-and-how-does-it-contribute-to-racism/?sh=4eb7e11e6e39

Fanon, F. (1986) Chapter Five 'The Fact of Blackness' in Black Skins, White Masks, Pluto Press. [Online] Available at: https://monoskop.org/images/a/a5/Fanon_Frantz_Black_Skin_White_Masks_1986.pdf (accessed 29 November 2024).

Farley, A.P. (1997) The Black Body as Fetish Object. Oregon Law Review, 76(3), 457–535, 1997, Available at SSRN: https://ssrn.com/abstract=1518415

Nursing and Midwifery Council (2018) The Code. [Online] Available at: www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf (accessed 29 November 2024).

Nursing Narratives (2022) *Anti-Racist Manifesto.* Available at: https://nursingnarratives.org/anti-racist-manifesto/ (accessed 7 June 2025)

Quach, D. (2021) The Fawn Response to Racism Part 1: A Reflection on POC Strategies to Mitigate Violent Oppression. [Online] Available at: www.psychologytoday.com/gb/blog/healing-oppression/202104/the-fawn-response-racism (accessed 29 November 2024).

Torino, C., Rivera, P., Capodilupo, M., Nadal, L. and Sue, W. (eds.) (2018) *Microaggression Theory: Influence and Implications.* [Online] Available at: http://ebookcentral.proquest.com/lib/brookes/detail.action?docID=5526226 (accessed 29 November 2024).

Versey, S. H. et al. (2019) "Appropriated racial oppression: Implications for mental health in Whites and Blacks," *Social Science & Medicine*, 230, 295–302. Available at: https://doi.org/10.1016/j.socscimed.2019.03.014.

Further reading

Art Institute of Chicage, (2025) Library Guide: Enduring Legacies of Fetishizing and Consuming the Black Body, https://libraryguides.saic.edu/facing-race-pleasure/body

Nursing and Midwifery Council (2024) The Nursing and Midwifery Council Independent Culture Review. [Online] Available at: www.nmc.org.uk/globalassets/sitedocuments/independent-reviews/2024/nmc-independent-culture-review-july-2024.pdf (accessed 29 November 2024).

Shellae, H. V., Courtney, C. C., Clara, L. W. and Nakita, J. (2019) Appropriated Racial Oppression: Implications for Mental Health in Whites and Blacks. *Social Science and Medicine*, *230*: 295–302.

Chapter 15

Challenging racism in mental health

Rachel Ambrose

Summary

This chapter is an exploration of the author's personal journey encompassing experiences of addressing racism as a child, a student and as a registered mental health nurse in mental health and public health settings, as well as more recently, within academia. It examines the interplay between political engagement and activism alongside their role as a nurse and how active participation in these processes enhanced their comprehension and confidence to address racism observed within the nursing profession and the institution of the NHS—an institution and its founding principles to which they are profoundly committed.

Early life and everyday racism

The intersectionality of my identity as a young female of dual heritage, white British and Black Caribbean, who grew up in a working-class family from a small West Yorkshire town on the outskirts of Leeds, created many barriers to accessing education. I was the first member of my family and friendship circle to attend university. It wasn't something I had anticipated when I left high school and started studying beauty therapy at my local college. Like a lot of people, mental health has touched the lives of many people in my own family and that is part of the reason why I chose to pursue a career as a mental health nurse. Suicide, self-harm, substance misuse, dementia, psychosis, depression, autism, and attention deficit hyperactivity disorder (ADHD) have all affected people I know and love. I have seen their strengths and challenges firsthand, providing me with greater insight and empathy for the people that I went on to work with. Another reason I became a mental health nurse was that growing up, I always seemed to connect with people, even those whom others actively avoided. I have vivid memories of sitting with the homeless lady in

DOI: 10.4324/9781041054276-16

Leeds market with a wild nest of backcombed hair on her head, often found talking to herself and shouting at strangers, but she would sit calmly beside me telling me her stories, and I loved to listen. I started my diploma of higher education in mental health nursing studies in January 2002 at Huddersfield University. I consider myself very lucky that when I completed my nursing training, I didn't have to pay university fees. I received a full bursary, which allowed me to consider higher education as a realistic option.

I do not recall race and ethnicity being explored through my nurse training; looking back, I think due to early experiences of dealing with racism, I downplayed issues that did arise. There was one occasion on placement with an experienced Community Psychiatric Nurse (CPN) and a family that made me feel uncomfortable. They had taken an instant dislike to me and did not like me working with their adult daughter alone. They made a point of staying in the same room for our visits; on one occasion, they were talking about their time in Australia and how much they disliked the place but said I would be OK as they do not like Brits, but they are okay with everyone/anything else. I remember my mentor apologising to me after that particularly challenging visit. However, nothing was done or said to the family and at the time, I did not escalate the issues.

Growing up, I was the only Brown kid in my family and one of a handful of non-white kids at school; people used horribly offensive and racist language, and for a long time, I did not know how to deal with it. There were many times I felt uncomfortable about a comment or a look. Still, like many people of colour, unless the comment is 'outright racist', it is often difficult to pinpoint and explicitly call it racism. It does not make the experience any less hurtful or impactful. It impacted my self-esteem, and when I look back, I wish I could have said more or that someone had spoken out on my behalf. Teachers were deaf to the name-calling. Even the n-word went unchallenged and without consequences.

As a nurse, it can be challenging, especially when you are the only person of colour to challenge racism. There are times I have challenged it and then heard silence from my colleagues around me. It has impacted my trust in those nursing colleagues and, ultimately, the profession. I remember one occasion I sat with a colleague that I had considered a friend; she was talking about her husband, who was a police officer, describing their journey home from the shops when they saw a dark-skinned lady wearing a headscarf driving around the roundabout. The nurse was laughing as she said her husband had said, 'That will be another (drugs) mule'. I called out her husband's behaviour and why it was not funny, highlighting that those kinds of attitudes impact how people feel about the police and why there are disproportionate numbers of stops and searches in certain communities. None of the other colleagues around said anything. I remember feeling so uncomfortable. One of the nurses that was with me was much more senior. She should have been someone to whom

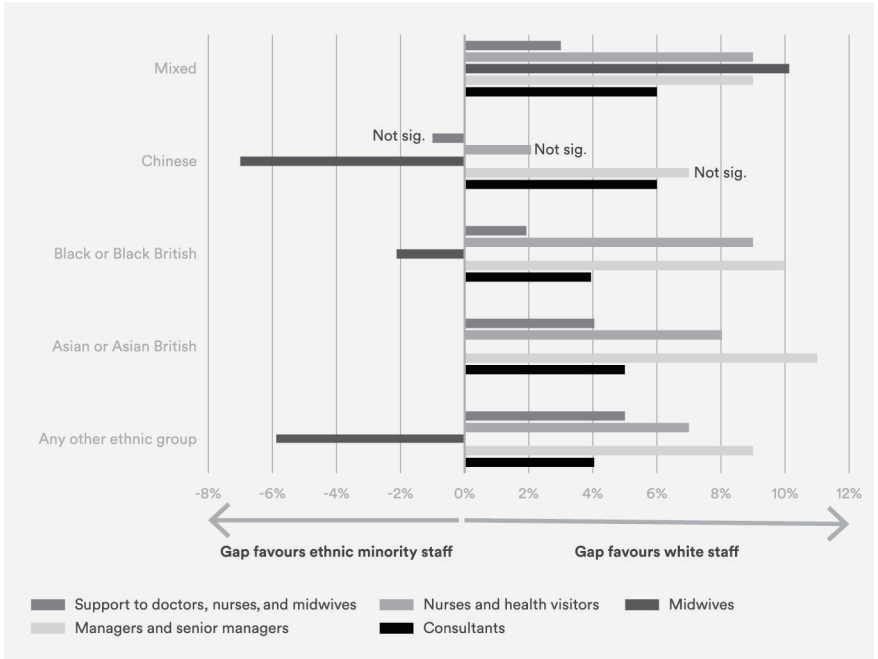

Figure 15.1 Ethnicity pay gap (median basic pay per FTE) for five NHS staff groups by ethnic identity. Adopted from Appleby, Schlepper, and Keeble (2021).

I would report an issue like this, but the conversation just continued and moved on to something else.

I have also experienced institutional racism; I took the opportunity to train as a Specialist Community Public Health Nurse in a School of Nursing at an NHS Trust. I was told at the interview that I would have to leave my Band 6 positions for a Band 5 post while studying. I later discovered that a white colleague and friend who was also accepted onto the course had not had to take a wage cut despite having considerably less experience than myself. I have come to learn that my experience is widespread. Appleby, Schlepper, and Keeble (2021) discovered a 9% ethnicity pay gap in favour of white staff compared to mixed heritage nurses.

I was really embarrassed when I discovered the pay difference between my colleague and me, mainly because I had more experience prior to taking the role. The trust had decided that I was not worth as much. Why did I feel shame when it is the perpetrator of the oppression that should be feeling shame (Webster, 2021)? I ended up leaving my career in public health and going back into mental health because of that and other issues of discrimination at that

time. In some ways, you think you should fight; you should try and change it from within, but it is exhausting. You cannot always put that on the shoulders of the nurses experiencing racism; sometimes enough is enough. We need to collectively call out the places that are treating Black and ethnically diverse nurses as inferior. I had hoped that the Equality Act (2010) and the expectations around diversity data monitoring would call both attention and action to racial discrimination. Discussions and frameworks were developed around that era to address health inequalities and understand the experiences of Black and ethnically diverse staff, including lack of career opportunities and progression. I was part of those discussions in the Midlands, which made me feel like a valued member of staff. However, 14 years later, there has been little change. According to the National Health Service (2023) Workforce Race Equality Standard (WRES) data research, Black and ethnically diverse nurses continue to be overrepresented in lower bands of the agenda for change.

NHS and tackling racism

The available literature has repeatedly highlighted the negative experiences of 'Black and racialised communities' accessing the NHS; we need to be clear that all these issues stem from racism. Statistics and literature continue to show us that service users from Black Caribbean and African backgrounds experience greater rates of detention under the Mental Health Act 1983 for those diagnosed with schizophrenia (NHS, 2023). Ethnic inequalities in patients accessing specialist obsessive-compulsive disorder (OCD) treatment are much lower than anticipated in the Black population (de la Cruz et al., 2015). Some illnesses, such as personality disorders, are also less likely to be diagnosed in Black African and African Caribbean patients than in white patients (The Synergi Collaborative Centre, 2018). Nationally, children and young people from racialised communities are underrepresented within child and adolescent mental health services (CAMHS) (Chui et al., 2021; Leeds City Council and NHS, 2019). As a CAMHS nurse, I witnessed firsthand fewer Black and ethnically diverse families being referred and accepted into CAMHS, unlike adult services, where Black and Brown service users are overrepresented. In children's services, our children are almost invisible. Why haven't the disproportionate number of Black adults detained under the Mental Health Act been supported earlier in life? What happened to early intervention for Black families? These children are instead overrepresented within the criminal justice and care systems, many excluded from schools and labelled with special educational needs.

Throughout my career, I have seen the failure to address ethnicity and race within mental health, from the lack of diversity of children and families referred to services and the diversity of the workforce. We ask so many questions of children and their families going through the assessment process. Still, there are no questions that explore race and identity, making it more challenging to

address crises in ethnic identity. It is an unmet need. How do we offer a space to talk about racism? That is something that definitely needs to change, and indeed, it did following the discussions that were finally allowed space in the NHS after the murder of George Floyd and the Black Lives Matter (BLM) movement. At the time, another colleague and I were involved in providing a safe space for the young people in our care to explore their racial identities and racism; I felt empowered and able to support the young people who were requesting this support that was not routinely available. This is something that needs to be embedded in all wards/trusts. It will require the training and involvement of a more diverse workforce with lived experience and more understanding of issues affecting communities so that services are able to provide a more holistic approach. Gurpinar-Morgan, Murray, and Beck (2014) suggested that young people preferred working with practitioners who are from similar ethnic backgrounds because of their lived experience; however, we have to be careful that this important work is not just held on the shoulders of the Black and ethnically diverse workforce and is understood and appreciated throughout the whole of the NHS.

As a mental health nurse, I wanted to get involved to change things. It was demoralising working in one trust that had no active Black and ethnic minority network. Not having opportunities to network with other professionals passionate about challenging racism and tackling racial inequalities is frustrating. In the West Midlands, I previously felt empowered by the regional ethnic minority network. It was a space for Black and Brown staff and allies to share experiences, build relationships and share information and opportunities to enrich the workforce and, ultimately, patient care. The opportunity to network with other Black and Brown staff should exist everywhere, but I have heard from nurses around the UK that this is not happening, and people feel like they are alone.

Nursing and activism

I became involved in nurse activism following a challenging time for my family when we continued to come up against hurdles in accessing support for our eldest son, who is autistic. Having children has compelled me to speak up and challenge racism because I wanted a better future for them. As a nurse, I had experience supporting children and their families with neurodiversity, yet when, as a family, we needed help, I saw racism first-hand. All the stereotypes of Black people as ignorant and innately aggressive came to the fore. Assumptions were made about the reason why my child was 'misbehaving'. Instead of being offered the support we needed, my child was punished. He was excluded from school at the age of 6, whilst his white peers with similar behaviours did not have the same consequences and instead were able to remain at the school.

As a qualified mental health nurse with experience working within CAMHS, mainstream education and special schools, I was not listened to when my child was in crisis. My own professional experience was ignored, and this highlighted the depth of racism within the system. You always have to fight harder the darker your skin. During my son's tribunal I told them how uncomfortable it felt being the only Black and Brown person in the room. All the professionals were white, and I did not think they could understand why I felt the way my son had been treated in their system was linked to racism; I tried to make them understand the impact of exclusion on his young life but came up against a brick wall. Many of the issues depicted in Lyttanya Shannon's BBC documentary, *Subnormal: A British Scandal*, are still at play today in the UK's modern education and health systems. Families like mine have experienced a system that works against them and not for them.

Like many nurses, I am proud of my profession and of the NHS, where I have worked for the majority of my career as a nurse. The NHS was created in 1948 to provide everyone with access to healthcare based on their needs and not on their ability to pay. After my experience in accessing support for my son, I decided to get involved in politics. I was fed up with treatment of children like my son being put to the back of the queue when they needed support for their mental health needs. Those who could afford it jumped the queue and accessed the same doctors with a private assessment, with the majority left waiting years to have an initial assessment, let alone receive any meaningful interventions. During this time, I met a young nursing activist who inspired me to find out more about my union and the Royal College of Nursing (RCN). I re-engaged with some of the Black and ethnic minority background health workers network opportunities that I had previously been involved with much earlier in my career. During the pandemic, I also got involved with the organisation Nurses United. It was plain to see that Black nurses were dying disproportionately, so we decided to set up a Nurses of Colour (NOC) Network with an online Zoom meeting titled 'Black Nurses Matter'. We had hundreds of nurses joining that first call. More recently, NOC has encouraged and supported grassroots groups in Edinburgh where local nurses felt excluded, experiencing over-scrutiny and lack of promotion. They came together to help each other and hosted community meals, held workshops and canvassed in local hospitals about the need for change and challenging racism. The authentic face-to-face organisation within our own workspaces and communities focusing on issues that directly impact those nurses is powerful. Nurses joining together to support each other stops you from feeling alone. NOC created an anti-racism reporting tool to enable people to report on their experience of racism. When people complete the NHS Trust surveys, their experience is reduced to statistical analysis. We wanted to enable people to get their stories heard and attach a human face and experience to those numbers.

Through NOC, I completed media training and appeared in media interviews on shows like Jeremy Vine, Trisha, ITV and Al Jazeera to discuss issues

related to health and nursing. I do not particularly enjoy speaking to the media. Still, having a presence as a nurse of colour in the media, especially one with a northern accent from an ordinary working-class background, is extremely important. Despite the pandemic disproportionately affecting and taking the lives of more Black and ethnic minority nurses, the faces and voices representing the nursing profession are often white. Developing and encouraging more healthcare professionals from diverse backgrounds in the media is essential if we are to hear diverse opinions and experiences.

I heard about Nursing Narratives through my involvement with NOC. I again thought it would be a good opportunity to develop connections with other nurses and create something special that could get people to take racism in the NHS seriously. It was challenging speaking about issues and experiences that I had locked away; often, the only way to cope with the trauma of racism is by burying it deep inside. Meeting and listening to other nurses who experienced their own difficulties was really empowering; we sat together and answered questions following screenings of the documentary and created our own community – a community that continues to grow and share opportunities and resources, encouraging each other to progress within our careers and aspirations.

I recently left frontline nursing practice for a new challenge in my career. During the pandemic, through the Nursing Narratives project, Nurses of Colour (NOC) and Nurses United (NU), I learned new skills and gained confidence in speaking out. It gave me the confidence to apply for an academic role, and I hope to continue my journey of challenging racism in the university and nursing practice. As someone new to organising, returning to work as a nurse after maternity leave, along with raising a family and maintaining the commitment and energy required to set up and sustain NOC, has been challenging. Being a national organisation without much funding, we relied on volunteer support from ordinary people like me to nourish and maintain the organisation, to develop organising skills and develop ideas. NOC and NU as a national organisation have folded, but many of us keep in touch through WhatsApp networks and continue to encourage and support each other.

I like to think of nursing as a team event. In my interview, I spoke about where I was working on the ward and the solidarity I experienced every day at the end of a difficult shift. When we had supported a young person through a challenging time, it was done through teamwork. Nursing is not carried out by yourself; you do it as a team, and you need to work with your colleagues, patients, and families in order to create a positive outcome. My experience of grassroots activism through NU and NOC has been invaluable, and again, that thread of solidarity continues; the most impressive changes we created during our journey have been when we have come together, having our own agency and speaking out for the betterment of our profession and each other, sharing ideas and empowering each other. Getting involved in nursing activism and

local politics has proved to be good for my own mental health and personal development; I feel better about myself having an opportunity to connect with other like-minded people, and it has also encouraged me to feel like I can make a difference to the world around me. I have more recently been involved in a Parents for Palestine grassroots movement along with my professional union, University and College Union (UCU).

Future

In the past, I was often the person sitting at the back observing and reflecting but not able to find my voice, ask questions or speak up in a group. This has changed as a result of organising. I am passionate about tackling racism and trying to ensure the nurses coming up after me do not have to experience the same challenges I went through. At university, I address racism and identity in my lectures and my work with students on our Global Majority Network. The network has created a space where students can raise issues to ensure they are not swept under the carpet. We have raised concerns about the scrutiny of Black students that has impacted their passing placements, including the lack of procedures that exist when problems arise. We try to create an open culture where people feel safe talking about the barriers they have faced, with lecturers, practice partners, and students working together to find solutions. *Exposed* has been screened and discussed with university lecturers to enable them to acknowledge that if we want to make a difference for the next generation of nurses and our patients, we need to implement the Manifesto for Change. It is essential that there is accountability and penalties for Trusts that do not comply with a zero tolerance to racism policy (Nursing Narratives, 2022, point 10). This is such an important aspect of the manifesto because, as I have detailed in this chapter, the data collection and research on racism have been happening for decades. Still, the impact continues to lead to serious psychological harm. We cannot just continue to collate data and hope that behaviour changes occur (Nursing Narratives, 2022, point 12). It is time for organisations to be accountable for the impact of this public health emergency on the workforce for the sake of the health and well-being of the workforce and the UK population.

Reflective questions

1 How can universities ensure the psychological safety of student nurses during clinical placements where incidents of racism have previously been reported?
2 Why is it important for nurses to be politically aware?
3 In what ways could nurses be involved in politics and policy development?

References

Appleby, J, Schlepper, L, and Keeble, E (2021). The ethnicity pay gap in the English NHS. Nuffield Trust. [Online] Available at: www.nuffieldtrust.org.uk/sites/default/files/2021-04/nuffield-trust-ethnicity-pay-gap-web3.pdf (accessed 12 December 2024).

Chui, Z, Gazard, B, MacCrimmon, S, Harwood, H, Downs, J, Bakolis, I, Polling, C, Rhead, R, and Hatch, L (2021) Inequalities in referral pathways for young people accessing secondary mental health services in southeast London. *European Child Adolescence Psychiatry*, *30*: 1113–1128.

Equality Act (2010) London: HMSO. [Online] Available at: www.legislation.gov.uk/ukpga/2010/15/contents (accessed 12 December 2024).

Gurpinar-Morgan, A, Murray, C, and Beck, A (2014) Ethnicity and the therapeutic relationship: views of young people accessing cognitive behavioural therapy. *Mental Health, Religion & Culture*, *17*: 714–725.

National Health Service and Leeds City Council Report (2019) *Social, emotional and mental health needs assessment: Children and young people from Black, Asian and Ethnic Minority Communities in Leeds.* [Online] Available at: https://observatory.leeds.gov.uk/wp-content/uploads/2020/06/Leeds-BAME-children-young-people-HNA.pdf (accessed 12 December 2024).

National Health Service England (2023) *NHS workforce race equality standard (WRES)*. Data analysis report for NHS trusts. [Online] Available at: www.england.nhs.uk/long-read/workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/ (accessed 12 December 2024).

Nursing Narratives (2022) *Anti-racist manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (accessed 7 June 2025)

The Synergi Collaborative Centre (2018) The impact of racism on mental health. [Online] Available at: www.synergicollaborativecentre.co.uk (accessed 12 December 2024).

Webster, K (2021) Making sense of shame in response to racism. *Canadian Journal of Philosophy*, *51*: 535–550.

White, N (2024) Pupil exclusions soar as Black Caribbean and Traveller students kicked out of school at higher rates. [Online] Available at: www.independent.co.uk/news/education/education-news/school-exclusions-black-caribbean-traveller-students-b2606996.html (accessed 13 December 2024).

Further reading

Fernández de la Cruz, L, Llorens, M, Jassi, M, Krebs, G, Vidal-Ribas, P, Radua, J, Hatch, L, Bhugra, D, Heyman, I, Clark, B, and Mataix-Cols, D (2015) Ethnic inequalities in the use of secondary and tertiary mental health services among patients with obsessive-compulsive disorder. *The British Journal of Psychiatry*, *207*: 530–535.

Kiran, G, Harry, Q, and Danny, S (2017) Making the difference: Breaking the link between school exclusion and social exclusion. [Online] Available at: www.ippr.org/articles/making-the-difference (accessed 13 December 2024).

National Health Service (2023) *Detentions under the Mental Health Act*. [Online] Available at: www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest/#by-ethnicity-16-ethnic-groups (accessed 12 December 2024).

Sewell, H (2008) Working with ethnicity, race and culture in mental health: A handbook for practitioners. Jessica Kingsley Publishers. Available online at: www.google.co.uk/books/edition/Working_with_Ethnicity_Race_and_Culture/z2dByTgffQMC?hl=en&gl=GB (accessed 16 December 2024).

Chapter 16

Against the grain

A nurse's fight for an inclusive NHS

Michelle Cox

Summary

This chapter explores the experiences of a senior nurse who, from the outset of her career, actively challenged racism and worked to implement policies aimed at fostering genuine inclusion within the NHS, especially within the area of public health. It highlights the patterns of racism she encountered: exclusion, gaslighting, exploitation, disrespect, and discrimination in promotion. By sharing her journey, including her decision to take legal action via an employment tribunal, this chapter underscores the failure of Human Resource managers to recognise and understand racism. She also attends to the importance of compassion, both for oneself and for others, in the pursuit of equitable healthcare.

Challenging racism in training

My mother was a nurse long before I was born, and my father's sisters, who came from the Caribbean, had also pursued nursing careers. My mother, who was white, rarely spoke much about her experiences, as she passed away when I was 18, but I still remember seeing her certificates and medals. My Caribbean aunts, however, were more forthcoming about their treatment. Their qualifications from Barbados were not recognised in England, forcing them into state-enrolled nurse training. This limited their opportunities and made it harder for them to find fulfilling work. They often faced overt exclusion: for instance, while all the white staff might be invited to a wedding, the Black nurses were deliberately left out. I was well aware of these injustices, yet I remained undeterred in my ambition to become a nurse, despite my father's reservations. He viewed nursing as a demanding, low-paid profession with poor working conditions, especially as he had observed it during the 1950s and 1960s. However, a family friend—Dame Ruth Nita Barrow, a renowned

DOI: 10.4324/9781041054276-17

nurse from Barbados (Hezekiah, 2001)—helped change his perspective and lent her support to my career choice.

It took me ten years after leaving school to enter nursing, starting first as a healthcare assistant. I qualified as a nurse in Liverpool in 1998, where I was the only Black student in a cohort of 120. My experience there was broadly positive. There was an appreciation of my needs as a single parent, particularly regarding shift patterns during ward placements. Although early shifts, nights, and weekends were challenging, my network of family and friends, coupled with supportive ward managers, helped make things manageable. The introduction of community-based nursing also provided a more flexible work-life balance. It allowed me to observe patients in their home environments, focusing on preventative care and public health—an aspect of nursing I found deeply rewarding.

Recalling instances of racism from the early stages of my career, one particular incident stands out. A nursing tutor gave a lecture on sickle cell disease and thalassaemia, repeatedly referring to Black people from Sub-Saharan Africa as 'negroids'. I felt acutely uncomfortable, and I could see other students were uneasy, too. After careful consideration, I wrote a letter of complaint. I was concerned that 119 newly qualified nurses might go into the workplace using this deeply offensive term. Following an investigation, I received an apology, and the tutor was instructed to amend her materials. She returned to the lecture theatre, asking everyone to remove the offensive term and replace it with more appropriate language, such as 'Black and ethnic minority' or 'Black and racial minority'.

While addressing my concerns, the end of the university letter, noted that, while changes had been made, they did not consider the tutor's behaviour to be racist. They rationalised this by citing her past missionary work in Africa. Thus, it was an apology without fully acknowledging the harm caused. I did not pursue the matter further; I had achieved my primary aim of removing the term from the curriculum, ensuring patients would not be labelled as 'negroids'. I was also aware that I needed to focus on my studies and graduation without unnecessary distractions.

Creating an inclusive public health approach

Finding employment after qualification was relatively straightforward. Community nurses, trained in holistic and preventative care, were in high demand. In Liverpool in the late 1990s, there were high levels of deprivation, low vaccination and screening rates, and elevated morbidity and mortality. My role as a community nurse was to empower patients, helping them manage chronic conditions and navigate healthcare systems. Working closely with GP practices, we tackled the socio-economic and environmental factors influencing health.

Early in my career, I found myself advocating for Black communities and other minority groups. Around 2000, Liverpool became a dispersal centre for asylum seekers, many arriving with complex health and social needs. The city's infrastructure was not prepared for this influx. Given my awareness of these issues, the Health Authority approached me to coordinate services, and I became the Health Administrator for asylum seekers (BBC, 2001). Collaborating with education services, GPs, and other agencies, I helped develop a responsive, inclusive model that met the needs of these new and vulnerable populations. We lobbied for practical measures such as broadening the range of supermarkets accepting asylum-seeker vouchers to include those selling culturally appropriate foods (Oxfam GB, 2000), and we improved interpreting services, which at the time could not always address the multitude of languages and dialects we encountered.

I developed a locally enhanced service to incentivise GPs to accommodate the extra time and resources needed to serve these communities effectively. While there were pockets of good practice, there were also unacceptable gaps. My role often involved challenging systems and processes that were not fit for purpose, highlighting how requirements like three forms of ID and a utility bill made no sense for newly arrived migrants who wanted to register with a GP practice. These barriers prevented timely health screening and treatment. My efforts led to the creation of a Social Exclusion Manager post, which I secured after proposing that the focus should be on inclusion rather than exclusion (Cedeño, 2023).

This new role was possibly the most rewarding job I ever had. We built a team that represented the communities we served, including staff who spoke Arabic, Chinese, Urdu, Bulgarian, Somali, French, and various other languages. We also engaged with Irish Traveller communities, deaf communities, and long-established British Black communities whose health needs had been historically overlooked. We had HIV nursing services, a homelessness outreach programme, and a Community Development Worker service connecting mental health services with marginalised groups. We won awards and made a tangible impact. The legacy of the model I implemented remains visible decades later (NHS England, 2023).

Liverpool, known as 'A World in One City' when it was the European Capital of Culture in 2008, takes pride in its diversity and global connections. Yet, as a Black community, we remain marginalised. The tragic case of David, 'Rocky' Bennett, a Black British man who died in 1998 after being restrained by hospital staff in a mental health facility (Blofeld et al., 2003), personally affected me. The inquest into his death concluded that excessive restraint and racial stereotyping played a part, illustrating how systemic racism within healthcare can compromise patient safety and dignity.

These events reinforced my resolve. Working with commissioners, we established the Community Development Worker service to bridge the gap

between mental health services and Black communities, to inform policies around restraint, and to address inequalities. This was award-winning work, making a real difference in the city and beyond. Eventually, I became Head of Equality and Diversity for Liverpool Primary Care Trust and later contributed to regional and national equality and diversity programmes. When NHS England was formed in 2013, I secured a senior nursing position focusing on patient experience and the quality agenda.

Discrimination in promotion

Encouraged to apply for a patient experience and equality role, I moved into a position that was not a promotion but increased my scope of responsibility over a wider geographical area. It was presented as a chance to enhance my CV and widen my networks, but it offered no financial reward. I couldn't help but notice that white colleagues moving into equivalent roles often received pay increments. Such inconsistencies would later become crucial evidence in my discrimination case.

After a year, a promotion opportunity arose. I was already doing the job, understood the demands, and was prepared for the challenge. Yet, before the post was advertised, an inexperienced individual was slotted in. All the pledges and programmes around identifying Black nurses for promotion and supporting talent management seemed hollow. Despite being the only Black nurse in the directorate, I felt invisible, my confidence eroding. Soon, another white colleague received a 'quiet' promotion under the guise of doing a 'piece of work' elsewhere. The pattern of difference was painfully clear.

Whistleblowing

After prolonged deliberation and consulting close allies, I made the difficult decision to raise concerns about a number of issues, particularly about practices that I believed were unfair, discriminatory and ones that breached legal obligations. As a nurse, I take my professional code seriously, and I felt I was in a compromising position. At the time, I did not label my actions as whistleblowing, but I followed the official 'Raising Concerns (Whistleblowing)' policy (Nursing and Midwifery Council, 2023).

My complaints were ignored, and the more I spoke up, the more I was portrayed as the problem. I pursued mediation, grievance, and appeal processes, all to no avail. No one upheld my concerns or acknowledged the issues I highlighted. Instead, I experienced detrimental treatment that left me feeling gaslit and isolated.

Racist exclusion

When I needed to return to work after planned surgery, I found barriers at every turn. Despite feeling well enough, I was prevented from attending a

team awayday during my absence. The concept of 'keeping in touch' days, something I had routinely offered to others, was denied to me. On my return, the exclusionary tactics continued. I was consistently left out of crucial meetings, given unworkable schedules, and eventually cut out of email communication chains. Unable to perform my duties effectively, I felt vulnerable, constantly second-guessing my every move and anticipating potential performance management.

Rumours began to circulate about my mental health and competence. A mentor admonished me to face reality: as a Black woman trying to integrate into a predominantly white network, I would always remain an outsider. I had moved, in their eyes, from 'pet' to 'threat' (Thomas, 2024; Thomas et al., 2013).

After a series of escalating incidents, I filed a formal grievance alleging bullying, harassment, and racial discrimination as a consequence of whistleblowing.

Escalating racism during the pandemic

The COVID-19 pandemic exposed profound inequities. I lost friends, and close friends lost family members, and I was supporting nurses across the North region who reached out to describe their own experiences of discrimination. I was proud to be the North region lead to the Chief Nursing Officer of England on matters affecting Black and ethnic minority nurses and midwives. Yet, even as I worked at a senior level to address systemic issues, I was simultaneously experiencing direct discrimination—being undermined, overlooked, and targeted with psychological games in my workplace.

Black Lives Matter

The Black Lives Matter movement reinvigorated discussions on race equality (Brathwaite, 2020). Many NHS organisations issued statements pledging renewed efforts to tackle workplace racism and support fair promotions. I hoped this climate would encourage a more impartial review of my grievance, which was still unresolved. Yet, after six months of waiting, my complaint was deemed unfounded, reduced to my mere 'perception'. Although some vague changes were promised, nothing materialised.

I appealed, asked for an external investigation, and provided further evidence, but my requests were refused. The stance taken was that... while I had been treated 'less than', it was not considered racism. A hollow apology was offered, but no meaningful action followed.

Fighting an employment tribunal

The internal grievance and appeals process lasted a year. Aware of the 90-day time limit to file a claim with the employment tribunal, I proceeded with legal action (HM Courts & Tribunals Service and Employment Tribunal, 2023).

Although some instances were out of time, others—such as ongoing exclusion from emails, events, and training—were recent and continuous. I felt I had little to lose. My career prospects seemed shattered; I had named senior individuals and called out racist policies. In their eyes, I was now a troublemaker and a whistleblower.

Over four years of legal proceedings, I learned about gaslighting (Christensen and Evans-Murray, 2021) and how subtle manipulations can psychologically harm individuals. I realised I had grown accustomed to mistreatment, rarely challenging it until it became intolerable. This journey taught me that I had to fight for myself in the same way I had always fought for patients and staff.

I encountered senior leaders and HR professionals who were supposedly experts in equality and diversity training, yet they seemed unable or unwilling to recognise racism when it confronted them directly. I remain perplexed: can they truly not see racism, or do they choose not to, protecting each other and the institution?

I was born into a family that experienced racism first-hand, so I know how it manifests. It was deeply offensive for senior NHS leaders to deny my experiences. People become so fixated on denying accusations of racism that they lose sight of the initial concerns. Usually, employees reach the point of citing racism only after exhausting all other explanations (Sue et al., 2007).

Legacy of Cox v NHS England

My case—Cox v NHS England (Cox v NHS England, 2023)—ultimately became a landmark in recognising race discrimination and whistleblowing detriment (Kline, 2023). Since then, hundreds of people have contacted me, feeling empowered to question their treatment. Many minority staff do not lightly invoke racism; by the time they do, every other avenue has failed them.

Reflecting on the Anti-Racist Manifesto for Change from the Nursing Narratives project, one demand resonates powerfully: 'Stop putting Black and Brown staff in danger of death and psychological harm' (Nursing Narratives, 2022, point 2). While the focus was COVID-related, the principle applies to all forms of discrimination and harassment. We must build a more compassionate NHS with equity at its core. Employers, regulators, and unions must take racism seriously. If they fail to understand and recognise it, how can they ever hope to address it effectively?

Racism, whether subconscious bias or direct discrimination, inflicts real harm. It should be no one's 'low priority'. Organisations must commit to transparency, acknowledge systemic problems, and stop defending the indefensible.

Reflective questions

1 In what ways can organisations ensure that employees who raise valid concerns are not subject to retaliation?
2 What role should transparency and accountability play in grievance investigations?
3 How can organisations create environments where issues of race, fairness, and whistleblowing are handled responsibly?

References

Brathwaite, B. (2020) 'Black lives matter and the disparities and risk of COVID-19 in BAME nurses', *British Journal of Healthcare Assistants*, *14*(7). https://doi.org/10.12968/bjha.2020.14.7.318 (accessed 25 May 2025).

Cedeño, D. (2023) Social exclusion and inclusion: A social work perspective. *Families in Society: The Journal of Contemporary Social Services*, *104*(3), 332–343. Available at: https://journals.sagepub.com/doi/abs/10.1177/10443894221147576 (accessed 25 May 2025).

Christensen, M. and Evans-Murray, A. (2021) Gaslighting in nursing academia: A new or established covert form of bullying?. *Nursing Forum*, *56*(3), 475–477. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/nuf.12588?saml_referrer= (accessed 25 May 2025).

Hezekiah, J. (2001) *Breaking the glass ceiling: The stories of three Caribbean nurses*. Kingston: University of the West Indies Press.

HM Courts & Tribunals Service and Employment Tribunal (2023) Ms A Cox v NHS Commissioning Board (Operating as NHS England/NHS Improvement): 2415350/2020 and 2401365/2021. [online] Available at: www.gov.uk/employment-tribunal-decisions/ms-a-cox-v-nhs-commissioning-board-operating-as-nhs-england-slash-nhs-improvement-2415350-slash-2020-and-2401365-slash-2021 (accessed 13 December 2024).

Blofeld J, Sallah D, Sashidharan S., Stone R., Struthers J. (2003)) *Independent inquiry into the death of David Bennett*. Norfolk, Suffolk and Cambridgeshire Strategic Health Authority.

Kline, R (2023) Michelle Cox. The honourable nurse failed by sustained racism. [online] Available at https://www.rogerkline.co.uk/post/michelle-cox-the-honourable-nurse-failed-by-sustained-racism (accessed 21 October 2025).

NHS England (2023) *A national framework for NHS – action on inclusion health*. Available at: www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/ (accessed 25 May 2025).

Nursing and Midwifery Council (2023) *Raising concerns: Guidance for nurses, midwives and nursing associates*. Available at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.nmc.org.uk/globalassets/blocks/media-block/raising-concerns-v2.pdf (accessed 25 May 2025).

Nursing Narratives (2022) *Anti-racist manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (accessed 7 June 2025).

Oxfam GB (2000) *Token Gestures – The effects of the voucher scheme on asylum seekers and organisations in the UK*. Oxford: Oxfam GB. Available at: https://oxfamilibrary.openrepository.com/bitstream/10546/112369/1/token-gesutres-voucher-scheme-asylum-seekers-UK-011200-en.pdf (accessed 25 May 2025).

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, N. (2007) Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*(4), 271–286.

Thomas, K & Johnson-Bailey, J & Phelps, R & Tran, N & Johnson, L. (2013). Women of Color at Midcareer: Going from Pet to Threat. 10.5040/9798216002536.ch-014. In L Comas Diaz and B Green *Psychological Health of Women of Color*. [Online]. Emerald Group Publishing Limited, pp. 265–283. Available at: https://doi.org/10.5040/9798216002536.ch-014 (accessed 25 May 2025).

Thomas, K. (2024) The persistence of pet to threat. [online] Available at: www.forbes.com/sites/keciathomas/2024/01/13/the-persistence-of-pet-to-threat/ (accessed 13 December 2024).

Further reading

British Broadcasting Corporation (BBC) (2001) Liverpool's bleak sanctuary. [online] Available at: http://news.bbc.co.uk/1/hi/uk/1485313.stm (accessed 13 December 2024).

Cox v NHS Commissioning Board (operating as NHS England/NHS Improvement) (2023) *Ms A Cox v NHS Commissioning Board (operating as NHS England/NHS Improvement)*. Available at: https://assets.publishing.service.gov.uk/media/63f393008fa8f5612d615da4/Ms_A_Cox_v_NHS_Commissioning_Board_-_2415350_2020___Other.pdf (accessed 25 May 2025).

Newitt, S and Warmington, J (2024) Moving from not racist to anti-racist. [online] Available at: www.kingsfund.org.uk/insight-and-analysis/blogs/moving-from-not-racist-to-anti-racist (accessed 13 December 2024).

National Health Service Confederation (2022) Shattered Hopes Black and Minority Ethnic Leaders' Experiences of Breaking the Glass Ceiling in the NHS. Reflections on the Lived Experience of Senior Black and Minority Ethnic Leaders in the NHS. [Online] Available at: www.nhsconfed.org/publications/shattered-hopes-NHS-BME-leaders-glass-ceiling (Accessed: 10 December 2024).

Royal College of Nursing, (2023) *Imagine a world without racism*. [online] Available at: https://www.rcn.org.uk/magazines/Action/2023/Oct/Michelle-Cox-Imagine-a-world-without-race-discrimination (accessed 13 December 2024).

Chapter 17

Challenging national healthcare institutions through frontline activism

Neomi Bennett

Summary

This chapter recounts Neomi's experiences of racism as a healthcare assistant and as a practising nurse. She highlights the way in which multiple state institutions from hospital trusts to the police, Disclosure and Barring Service and the NMC are all used unfairly at times to victimise Black nurses. Her story uncovers tales of racism, resilience and resistance. Neomi highlights her experiences as an agency nurse in the Pandemic and how she was inspired by the Black Lives Matter movement to set up Equality for Black Nurses (E4BN). She explains why she took part in Nursing Narratives and the importance of speaking out. She recounts examples of the work that E4BN have carried out to defend nurses unjustly referred to the Nursing and Midwifery Council (NMC), highlighting the importance of demanding accountability from governing bodies regarding racism.

I had to fight to clear my name

Nobody really prepared me for dealing with racism as a nurse or how to handle it. My first experience of racism happened when I was a healthcare assistant (HCA). I was working in accident and emergency (A&E) and was allocated to carry out an electrocardiogram (ECG). I went in, introduced myself to the patient and his family, gained consent and started to put the ECG probes on the man's chest. The son interjected, declaring, 'We do not want you to look after our dad'. Then the daughter added, 'We want a white nurse'. They started shouting at me, telling me to get out of the cubicle. I was shaken up. I left the cubicle. The father told his children off, saying, 'Leave the Nurse alone and let her do her job'. However, the son and daughter brushed his request aside, and they continued to abuse me verbally. I was shaken up

DOI: 10.4324/9781041054276-18

and immediately reported it to the matron. The matron just called a white nurse to take over, essentially acceding to the patient's relatives request. I was so upset because I had done nothing wrong—I was simply the wrong colour (Church and Devereux, 2024).

The next day, I had a phone call from my employer saying the patient's relatives had put in a complaint. They said that I had held the daughter up against the wall and damaged her thumb. I was confused because we had had no physical contact. I was told that I would need to go through the disciplinary process, but I thought that justice would prevail. The management invited me in for a hearing. Despite my explanation of innocence, they steamed ahead and sacked me for gross misconduct, accepting the patient's relative's testimony. Subsequently, I made an application to an employment tribunal and won my case. The judge, in his decision, said I had been ambushed. However, it did not end there; the family subsequently reported me to the police for assault. I was arrested and released with no case to answer. The disciplinary and police process was very long, and I was traumatised (Archibong & Dar, 2010; NHS England, 2023). However, the harassment continued. I applied to university, but when they carried out a DBS check (Disclosure and Barring Service), the false allegations against me at work showed up on my DBS certificate. Due to these false accusations against me, the university withdrew my unconditional offer. I had to fight to clear my name to regain my university place.

From that day onwards, I have been wary of working in predominantly white spaces. When I got my first nursing job, as soon as I picked up some cues that the people I was working with did not like me, I left. I felt that it was too dangerous to stay because all it takes for harassment to begin is one racist colleague or senior person who does not like you (Anderson, 2022). In my first nursing job, I did not receive good support and felt vulnerable. Consequently, I decided to work as a full-time agency nurse. This meant that if I sensed any discrimination, I could request my agency to place me in another workplace. A shared experience I found working as a Black nurse in white spaces was exclusion, but I would never say anything. Teamwork is very important in nursing, and when you confront racism, they say that you are a lousy team player. So, many nurses say nothing and suffer in silence. I found comfort in spending time with the patients, making them cups of tea and being of service to them to improve their hospital experience.

Throughout the COVID-19 pandemic, I worked as an agency nurse in multiple hospitals. I could not help but notice that Black and Brown nurses were consistently assigned to high-risk areas on the frontline. This pattern was not limited to just one hospital. I observed it in various locations across London and Surrey. I spoke with other Black nurses. We discovered significantly fewer Black and Brown nurses in less hazardous areas. It appeared that the allocation of Black and Brown nurses was biased towards the places with more patients and a higher viral rate of COVID-19.

I was not provided with adequate protection when assigned to work in COVID wards. Despite requesting a properly filtered mask, I was denied one because it was believed it would frighten patients. I was assigned to care for a patient with COVID-19 on a hospital ward but was only given a surgical mask. I was not given adequate head protection. The standard cap designed for European textured hair did not cover afro hairstyles or braids. I had to improvise using yellow clinical or supermarket carrier bags to cover my hair. In one hospital, I noticed that the matron was selecting who she gave PPE to. At first, I thought it was because I was an agency nurse, but then I realised that the white staff were getting more equipment. Despite knowing the increased risk of Black and Brown people developing COVID-19, no one seemed to care. This lack of concern for our safety put me at risk and made me feel undervalued. It made me wonder if nursing was for me because I was having to risk my life.

The impact of witnessing a disproportionate number of Black colleagues die from COVID-19 was devastating. I believe that if the same issue disproportionately affected white nurses, management would have acted with greater care and addressed the issue urgently, putting pathways in place and conducting proper, reliable risk assessments. It felt as though Black lives within healthcare were not valued in the UK. These experiences of racism during the pandemic led me to establish Equality for Black Nurses (E4BN).

Challenging injustice collectively

The Black Lives Matter movement inspired me to speak out against the racial injustices I have faced since birth in this country. It provided me with a platform to have conversations with my white colleagues that were previously unimaginable. I created E4BN during the pandemic. I wanted to support nurses who experienced discrimination and become a voice for them. The organisation began as a WhatsApp group, where nurses shared their stories of fear and worry, often unable to sleep at night due to stress and anxiety. Our group grew to incorporate Zoom sessions, in which we met every Tuesday to discuss our experiences and concerns, creating a safe space and a peer-led network of Black nurses who support each other.

We opened up to each other. We discussed the patterns of racist behaviours we observed, such as gaslighting, micro-aggressions, and victimisation. We found that nurses who highlighted racism to their employers and raised it as an issue would often face retaliation. The most disturbing experiences I witnessed during the pandemic were the bullying and harassment Black and Brown nurses received and the lack of empathy shown towards them. We saw patterns of behaviour that indicated a lack of compassion and excessive scrutiny toward Black nurses when things went wrong. Black nurses were blamed and scapegoated for structural and systemic issues.

EB4N offers psychological support and representation at employment, tribunal and regulatory bodies. A legal team helps us to understand various legal processes. We have a diverse membership. For example, many of our members are Asian as well as Black. We have also created a culturally sensitive psychological counselling service for our traumatised nurses. Some members their employers have falsely accused have been left in dire financial straits. This is particularly true for migrant nurses, who are more vulnerable due to immigration laws. As a result, we provide food for those who cannot afford a loaf of bread.

Case study: Unfounded allegations

We had a nurse who came across in her workplace a scenario of two white untrained carers with a patient who was having a seizure. Our Black nurse immediately intervened, sat the patient up, rubbed her back, checked the pulse, and did everything she was supposed to do. And then, when the patient came to and regained consciousness, our Black nurse openly expressed her gratitude to God that the patient survived. She then left and documented everything. The next day, when our nurse arrived for her shift, she was surprised to be met by her deputy. She was suspended and subjected to disciplinary actions because the two carers had reported that she was punching the patient in the back and praying incessantly. When this lady came to E4BN, she was in a state of deep trauma. She could not verbalise her situation because she was so confused. After a lengthy E4BN triage and reviewing the documents, we identified the racial and religious discrimination entwined in the circumstances. We intervened, went to the hearing, and explained everything from the nurse's point of view. The nurse was finally listened to, and the managing director even apologised.

The problems that nurses have highlighted existed before the pandemic, but the pandemic exacerbated the wider issues of racism. From the experiences of our members, it is clear that systems of accountability need to be put in place to protect both staff and patients and to challenge discriminatory and racist actions.

Nursing Narratives

I got involved with the Nursing Narratives project because I am deeply committed to social justice and equality. Witnessing the persistent racial disparities and injustices that Black healthcare staff face compelled me to take action. Participating in the Nursing Narratives project is a way for me to contribute

to the ongoing struggle for a more just and equitable society. Working with Nursing Narratives was powerful because it enabled people to see our lived experiences.

There are words we learned that I did not even know existed when I was growing up, such as gaslighting, micro-aggressions and all the other elements that make up race discrimination. We can now string words together and present a coherent narrative to describe the impact of covert and overt racism on us individually and as a group. Nursing Narratives gave us a platform to amplify our voices and try to help others understand how racism works and highlight the discrimination that we have faced for over 400 years (Andrews, 2021). The film *Exposed* sends the message that we no longer tolerate discrimination and that it must be challenged and confronted. We do not want another generation going through this!

The film *Exposed* has given us a tool to encourage and enable discussion. The 'Anti-Racist Manifesto for Change' was an important part of the work, especially the emphasis on accountability and the need for regulators' work to be investigated and scrutinised because this is what we are doing.

Challenging the racism of regulatory bodies

Since the pandemic, E4BN has focused much of our attention on challenging unjust referrals to the Nursing and Midwifery Council (NMC) and unjust Disclosure and Barring Service (DBS). We have nurses who have been maliciously referred to the NMC with minimal evidence and others who have been referred to the DBS with unfounded allegations to stop them from working in healthcare. Racists working within organisations use structures and systems as tools to carry out the abuse of Black and Brown nurses.

In 2017, a study conducted by the University of Greenwich revealed that Black nurses were disproportionately referred for fitness for practice investigations (West, 2017). They also found that while employers and members of the public are the most frequent sources of referrals to the NMC, they refer to different groups of people:

> Employers refer BME nurses and midwives, and members of the public refer white nurses and midwives.
>
> (West, 2017)

Training in Africa is also a risk factor for referral to the NMC. Recent statistics show that Black nurses are still more likely to be referred. In 2021-22, Black nurses made up 10.52 per cent of the register, yet they made up 16.1 per cent of referrals. They are also more likely than white nurses to have an interim order placed upon them. However, 62 per cent of Black nurses who were referred for their fitness for practice have no further action taken against them,

suggesting that employers are referring their employees without substantive evidence. Greenwich University researchers found that:

> Cases involving nurses or midwives who are white, other, or of unknown ethnicity are most likely to be closed at screening, whereas those brought against Asian or Black nurses or midwives are most likely to be closed at investigation (West, 2017)

As Black nurses, it almost feels like we are facilitating the racial abuse of Black nurses through the subscriptions we are obliged to pay. E4BN have supported many nurses in challenging unjust referrals. These Black healthcare professionals must endure every stage of an investigation before they are shown to be false. It is a traumatic experience.

Case study: Racist stereotyping and bullying

Another case E4BN took up involved a 48-year-old nurse accused of theft from a service user. Her employers knew about the lack of reliable procedures and processing for petty cash and patients' money at the care home where she worked. Numerous staff had complained to management. Months later, our nurse purchased items for a resident with petty cash funds while she was with two white nurses. A discrepancy of £38.28p was identified, and management accused her of theft and suspended her immediately. This was a nurse with no previous complaints and who was well-liked by the residents she cared for.

Her employers harassed her repeatedly about the missing money. They added accusations of stealing food and referred her to the NMC and the DBS, who were on the verge of barring her when she came to E4BN. The immense stress caused her to become unwell, and she resigned from the role. The two white nurses were never suspended or accused. E4BN demonstrated that this was a vexatious referral. We identified from statements and copies of the shift rota that the accusations against her were on days when she was not even on duty. The two white nurses had created false statements. After the screening stages, the NMC and the DBS marked this as a No Further Action (NFA) case.

Even though 62% of referrals of Black nurses have no case to answer, there are no consequences for the hospitals or the employers regarding these false allegations. It seems clear that perpetrators of racism spread their hate for Black and Brown nurses by abusing internal and external processes and

making disproportionate referrals to the NMC. We need accountability for this discriminatory practice. Point 13 in the Anti-Racist Manifesto for Change asks regulatory bodies to 'Investigate and challenge referrals of Black and Brown nurses and midwives to regulatory bodies with no evidence and no case to answer'. Such investigations would help highlight where discriminatory practice is taking place and if there are patterns of behaviour that we can address. In our work at E4BN, we record patterns of behaviour that occur repeatedly. We have become aware of specific individuals and organisations that have frequently referred Black nurses to the NMC without evidence.

We have supported several nurses who have either yet to be provided induction or inadequate induction that has been offered in the early stages of joining an organisation. This makes them vulnerable, and in our experience at E4BN, this affects our overseas nurses more severely. Starting employment in a new country can be challenging for nurses, mainly due to immigration restrictions that can make them more susceptible to workplace bullying. Unfortunately, many of these nurses face disciplinary action for failing to follow procedures they were not properly trained to do. This is often due to a need for proper induction and early training. Additionally, international nurses may also face false accusations placed upon them by racist colleagues, knowing that they cannot defend themselves, which further complicates their already difficult situation.

The NMC does a crucial job ensuring the public is kept safe. However, they have not addressed their institutional racism. I have been referred to the NMC three times. In February 2021, people on social media reported me for being a racist. They said that I was displaying racist content on social media. Moreover, they sent the NMC screenshots of me using the term *house negro*, which is not a racist slur. I explained this to the NMC, but they would not accept it. They went on to contact my patients and my previous employers. I had to pay a legal team to defend me for over three months before they eventually dropped the case against me. My legal team had to educate the NMC regarding the meaning of the term and why it should not be conflated with the N-word, which has a different etymology and context. As Malcolm X has set out, there is a history to the terms *house negro* and *field negro*. These are also words that can only satisfactorily be used by the Black community to describe each other. The Black community has chosen to own that language, albeit with boundaries that others may not use casually. It is for the Black community to decide if and when to give up using these terms.

They went on to highlight that there are white individuals who do not like this because it is an area in which they are not in control. These are words in the English language over which they do not have ownership and power (Malcolm, 1963).

I am fortunate enough to be able to employ an excellent legal team to defend me, but many nurses cannot defend themselves and cannot afford legal

counsel. Even more shocking is when we compare our treatment to that of cases such as Melanie Haynes, a white nurse who used appalling racist language to describe her colleagues. She was given a measly six-month suspended sentence until there was an outcry, and the NMC had to look at the case again, at which point Haynes rightly got struck off the NMC register.

During one of my experiences representing a nurse at the NMC, I raised concerns about racial discrimination and false allegations to the panel members. What I did not know then was that the independent panel chair would refer me to the NMC. The chair accused me of being racist for bringing up the discrimination that Black healthcare professionals face daily and took offence at my use of the term 'white nurses'. Although the NMC dismissed the case at screening, it is nonetheless concerning that individuals with such views could serve as chairs on NMC panels and judge Black nurses who might be innocent.

In my opinion, the NMC needs to be restructured. It needs to rebuild its policies and governance from the top downwards. It needs to look at the disproportionate referrals of Black nurses and the difference and more favourable experiences in the process for white nurses (Nursing and Midwifery Council, 2024). Fairness and justice for nurses and patients should be a priority. There need to be consequences for nurses and management in hospitals and institutions who unfairly and unjustly discriminate when referring Black nurses to the NMC. Many of the nurses abusing their power in this way need to be referred to the NMC and investigated.

Conclusion

Nursing is a vocation. Nursing comes from your heart, and we do not do the job solely for the money. We do not do it for validation. We nurse because it is our calling. Our soul is calling us to help others. Moreover, that is what we want to do. We should not be forced out of a profession that some of us are born to do. Why should we be persecuted? Why should we be attacked? Why can't we be nurses? Why can't we get our patient load, do a good job, look after our patients and go home?

I do not understand why there is so much focus on Black nurses. It needs to stop. Society asks us to be docile and oppressed and do as we are told without asking questions or standing up for ourselves. However, as soon as we try to be assertive, allegations and micro-management come along. It is just terrible. When we speak out, we are judged as loud, aggressive, insubordinate, and a risk to patients. Racist colleagues profile, target and harass us and go on to make up lies, and what they say and write against Black nurses becomes a facilitated fact. Whether their racism is conscious or unconscious, it must stop and be challenged.

Accountability and consequences are imperative in such cases. There must be repercussions if someone wrongly accuses a Black nurse and hastily involves the NMC (Nursing Narratives, 2022, point 13). The individual making the

allegation and the institution supporting it should glean valuable lessons from their actions. A question arises. What leads managers and colleagues to hesitate to engage with Black nurses when addressing issues and seeking improvement? Why not opt for a more constructive approach, where staff acknowledge that things may not align with past teachings but commit to working together to impart a different, more effective method? Why does the immediate recourse often involve referring a Black nurse to the NMC, thus abusing the process and detrimentally impacting their lives?

The fight for justice is something we should all be doing. The responsibility for challenging racism lies with us all. To my white allies, I appreciate you, and you must keep speaking out (Reid, 2021). When you see the injustice and speak out, you are helping a Black nurse. Why should we go through this trauma and the suffering? There is no place for racial discrimination in health care, and racists in the service need to be challenged. Let us breathe.

Reflective questions

1 What is the responsibility of individual nurses to ensure the protection of colleagues from racist behaviours?
2 How can healthcare organisations ensure that they are not enabling or supporting inappropriate referrals?

References and further reading

Anderson, E (2022) *Black in white space: The enduring impact of color in everyday life*. Chicago: The University of Chicago Press. ISBN 978-0-226-65723-3.

Andrews, K (2021) *The new age of empire: How racism and colonialism still rule the world*. London: Penguin.

Archibong, U and Darr, A (2010) The involvement of black and minority ethnic staff in NHS disciplinary proceedings. A report of research carried out by the Centre for Inclusion and Diversity, University of Bradford, on behalf of NHS Employers and NHS Institute for Innovation and Improvement.

Archibong, U, Kline, R, Eshareturi, C and McIntosh, B (2019) Disproportionality in NHS disciplinary proceedings. *British Journal of Healthcare Management*, *25*:1-7.

Bennett, N (2021) Film Testimony. [Online] Available at: https://youtu.be/gtWVxg_FtH8 (accessed 13 December 2024).

Church, E and Devereux, E (2024) *Investigation: Massive increase in racial abuse against NHS staff*. Nursing Times, 10 June. Available at: www.https://www.nursingtimes.net/workforce/investigation-massive-increase-in-racial-abuse-against-nhs-staff-10-06-2024/ (accessed 23 June 2025).

Malcom X (1963) Malcolm describes the difference between the "house Negro" and the "field Negro." [Online] Available at: https://ccnmtl.columbia.edu/projects/mmt/mxp/speeches/mxa17.html (accessed 12 December 2024).

NHS England (2023) *Workforce Race Equality Standard (WRES): 2023 data analysis report for NHS trusts*. Available at: www.england.nhs.uk/long-read/workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/ (accessed 23 June 2025).

Nursing and Midwifery Council (2020) *Ambitious for change*. [Online] Available at: www.nmc.org.uk/globalassets/sitedocuments/edi-docs/nmc_edi_research_full.pdf (accessed 13 December 2024).

Nursing and Midwifery Council (2021) Racial discrimination, nursing and fitness to practice. [Online] Available at: https://nmcdefencebarristers.co.uk/2021/11/22/racial-discrimination-nursing-and-fitness-to-practise/ (accessed 13 December 2024).

Nursing and Midwifery Council (2024) Independent culture review: Reflection, accountability and action. Available at: www.nmc.org.uk/about-us/nmc-culture/shaping-our-culture/independent-reviews/ (accessed 23 June 2025).

Nursing Narratives (2022) *Anti-racist manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (accessed 7 June 2025).

Ola, Anika (2025) How a Black nurse was dragged through the system and still found no case to answer. *Equality 4 Black Nurses*. Available at: www.equality4blacknurses.com/post/how-a-black-nurse-was-dragged-through-the-system-and-still-found-no-case-to-answer.

Ola Anika (2025) *Race and Regulation spotlight: When regulation becomes racial weapon: the case of an E4BN nurse against the NMC*. Available at: www.equality4blacknurses.com/post/race-and-regulation-spotlight-when-regulation-becomes-racial-weapon-the-case-of-an-e4bn-nurse-agai.

Reid, N (2021) No more white saviours, thanks: how to be a true anti-racist ally. *The Guardian*, 19 September. Available at: www.theguardian.com/world/2021/sep/19/no-more-white-saviours-thanks-how-to-be-a-true-anti-racist-ally (accessed 24 June 2025).

Royal College of Midwives (2016) *Disciplinary proceedings and the workplace race standard*. London: RCM.

Scott, K (2020) *Equality for Black Nurses*. [Online] Available at: www.rcn.org.uk/magazines/Bulletin/2020/October/Equality-for-black-nurses-COVID-19 (accessed 13 December 24).

West, E, Nayar, S, Taskila, T and Al-Haboubi, M (2017) *The progress and outcomes of black and minority ethnic (BME) nurses through the Nursing and Midwifery Council's "Fitness to Practise" process: Final report*. [online] Available at: www.nmc.org.uk/globalassets/sitedocuments/other-publications/bme-nurses--midwives-ftp-research-report.pdf (accessed 13 December 2024).

Chapter 18

Black healthcare workers organising for justice

Esther Akinpelu

Summary

This chapter recounts the experience of a paediatric nurse who suffered and witnessed racism in her role as a frontline member of staff. She reflects on the continued presence of anti-Black racism that not only leads to her own differential treatment but also the treatment of Black and white children in healthcare. She reflects on the differential progression outcomes for herself and the white colleagues with whom she went to university. She draws attention to experiences of neglect and sidelining, that spiralled to impact detrimentally on her mental health. She reflects on the importance of support networks and comments on the impact of the pandemic and Black Lives Matter on her ongoing politicisation, leading her to join organised groups to resist racism and dedicate her life to lifting her people.

Language is just the tip of the iceberg

While training as a student nurse, I wasn't very aware of racism in nursing, but it became very apparent when I moved to London to work in a Hospital Trust. White middle-class parents sometimes recoiled at me, as they did not want me to touch their child; they would ask for another nurse. Thirty years ago, people would say, 'Don't put your Black hands on my child', but because people are acutely aware of having to modify the language so that they are not accused of racism, it now emerges more insidiously, they won't say it. Still, you can feel it in their body language, tone and attitude (Rankine, 2015). When I have highlighted their racism, they often backtrack and are shocked that I have had the audacity to accuse them of being racist. Time and time again, when I get told a white patient's family wants someone else, I will leave the room. I will send in a white nurse. They may not be as experienced as I am, but when that

DOI: 10.4324/9781041054276-19

family starts to challenge the nurse about the care, they want me back. These things go on, and you cannot explain that to management; they will never understand (West, Dawson, and Kaur, 2015).

Senior management tends to be 95% white; we know this from the Workforce Race Equality Standard (WRES) data (NHS England, 2024). The WRES has been developed as a tool to measure improvements in the workforce with respect to ethnic minority background staff, but when white managers deal with racist incidents, what they expect is a discussion about racist language. They shut you down because they only register overt racism, like the use of the N-word or the P-word, but that's just the tip of the iceberg. There's so much more.

I was at work one day, and we had a Black teenage boy with mental health problems come in. He was calm, and he was quiet. He was on his phone; he was with his support worker, and there were two police officers there. I was busy dealing with other patients, and I had my nursing colleagues deal with the situation. When I checked on them later, I was shocked. They took the mattress off the bed, emptied the room completely, and put the mattress on the floor. As if he was in a prison cell. This boy obviously got upset. The police officers did not see a boy; they saw a Black man whom they believed they needed to hold down aggressively. He was upset, he got angry, he fought back, but he was a boy. He was suffering, and we are to give him care; we owe him the benefit of the doubt. If this was a white teenager, I had to wonder, would they have done the same? Frankly, I don't think they would have, but because he was a Black boy, they held him down. I remember going into the room to give him some water; he looked at me sadly and said, 'Thank you, Miss'. I treated him with respect, and he did the same to me. I remember going home, and it deeply affected me. It was blatant racism. He was in our care. How is he ever going to trust a healthcare professional again?

Personal progression

I have been qualified as a nurse for eleven years. Opportunities for development have been constantly denied to me. In order to progress, you need to be able to show the Nursing and Midwifery Council (NMC) that you have completed Continuing Professional Development (CPD). It could be training in university or clinical training, and it's imperative for patients also to know what areas a nurse has trained in. When you work in a specialist area like children's emergency, you have to do some emergency courses like life support training, for example. The lack of support I have received from employers has often led to me moving on to a different hospital. At one hospital trust where I worked for over a year, I noticed that I needed to be allocated patient cases that would allow me to improve my learning and development. Instead, I was constantly getting potty emptying, feeding and nappy changing duties. In my previous job, I had been attending cardiac arrests, assisting the doctors and pushing

medications. I had been on the chest of patients giving Cardiopulmonary Resuscitation (CPR), trying to save their life. That takes a lot of skill and dedication. Then you look at other white colleagues, and they haven't been qualified if they are getting all the patients offering extra learning. I found that my white counterparts would get on courses more easily (West, Dawson and Kaur, 2015). I have had a white matron who was two years younger than me. Now, she may be a fantastic nurse, but she also benefits from a system that gets white people very quickly to the top. Whereas I was told there is no money for my training and development, I have got to stay in my position. Obviously, you have to ask, 'What's the difference between me and them? Is it the colour of my skin?' (Kline, 2014).

White people within my university class are in management positions and lead nurse roles. I am still in a Band 6 role. My manager said there was no funding for courses. They systemically just pulled me down to the point where I went into depression. I was feeling really low; I could not read or focus. The act of just getting into a shower was a difficult task. The act of just mustering the ability to say hello and work was difficult. Concentration at work was very hard. It took so much more energy. On my days off, I wouldn't get out of bed, I would switch my phone off, I wouldn't watch TV, I would stare into the abyss. The emotional toll of persistent workplace inequity can lead to burnout, anxiety, and depression (Public Health England, 2021).

It crept up on me, but I tried to bury it. At work, I could see myself becoming an unapproachable person, a bit angry and hot-headed. I was challenging people in ways that maybe I shouldn't have, and I was serious all the time. My friend called me and said, 'Esther, you need to get yourself to the GP'. She just referred me to the Samaritans. At this point, I was feeling suicidal. I'd witnessed a man jumping in front of the train before, and I thought maybe I should do that to end the pain. I could not cope. I wondered if it was safe for me to go to work. Part of my role is looking at drug calculations; I had to make clear documentation because it's a legal requirement. I couldn't work or function at that level, and that's when I knew I needed to be away from work. I needed to get better; I needed to be safe for my patients. I was off work for five months.

Fighting back

By the time my mental health improved, the pandemic had begun. It was apparent early on that Black people were dying disproportionately. I was hearing stories from colleagues of Black staff being pushed into the more dangerous work. I became part of an organisation called Nurses of Colour to provide a platform for Black and Brown nurses to speak out. Whilst the WRES data looks at numbers and statistics, it doesn't often reveal the trauma of racism that people experience within the walls of health and social care. We got together, and we managed to develop a racism reporting tool, which aimed to

provide a completely anonymous system for people to be able to report what they've seen or what they've experienced themselves. What we want to do is collate all this information, place it on a heat map, and show the government what is still happening. We tried to argue that you cannot turn around and say that racism doesn't exist just because a government report says so, as was done by the Commission on Race and Ethnic Disparities in 2021 (The UK Government, 2021).

The British are very good at gaslighting. They are very good at saying that racism does not exist, but unfortunately, day in and day out on the shift, you'll see it. Healthcare professionals need to acknowledge that they have racial bias; they need to admit that they benefit from it. What I have learnt is that no matter how good you are, the system will work against you. I dream that this is something that will eventually be broken down. We need people from all backgrounds working in senior leadership positions within health and social care to represent our diverse population. We need staff to speak the languages of our communities and understand cultures. That would make such a huge difference because then we can reach out to care and support all communities effectively. I hope in the future to live in a fair healthcare system where Black people are not put on the back burner.

Black Lives Matter

When the murder of George Floyd happened, it impacted me deeply. I couldn't watch the video because I would be looking at a man who would probably remind me of my brother, and if I saw something like that, I would fall apart. I talked about it, though, to everyone who wanted to listen and even to some people who did not want to listen. It felt like it was the time to speak openly. Black Lives Matter, as a philosophy, has always been important to me because we do matter (Sobo, Lambert and Heath, 2020). It's not to say that white lives don't matter, but history has told us that Black lives never mattered in the West. We are just not seen as human. We are not seen as valuable. Our lives are disposable, and we are seeing this happen even now in the Middle East within modern slavery (Statista Search Department, 2024). Historically, slavery has destroyed lives, and rich people have got richer, so when the statue of Edward Colston was pulled down in Bristol in 2020 (Olusoga, 2020), I felt joy in that. This guy had made his wealth through slavery; he branded the skin of human beings; Black people weren't seen as humans. I always think about what Malcolm X (1998) said:

> I read descriptions of atrocities, saw those illustrations of black slave women tied up and flogged with whips; of Black mothers watching their babies being dragged off, never to be seen by their mothers again; of dogs after slaves, and of the fugitive slave catchers, evil white men with whips and clubs and chains and guns.' (p.189)

During the height of Black Lives Matter in 2020, when people were rioting in the UK, the public complained about damage and demanded that rioters should be arrested and thrown in prison. I asked them how they think Black people got their freedom. Because it literally wasn't by a white man deciding that slavery was wrong. Malcolm (1998) again said,

> I read about the slave preacher Nat Turner, who put the fear of God into the white enslaver. Nat Turner wasn't going around preaching pie-in-the-sky and 'non-violent' freedom for the Black man.
>
> (p.189)

Whiteness is always given the benefit of the doubt, and Blackness is not. I keep fighting against these racist structures because there were Black people before me who really fought, especially the Windrush generation (Campbell, 2024). The struggle is generational. When you feel like you've lost hope, you will always find somebody of colour, a Black person, who will be willing to help you. Even throughout my training days as a student nurse, I had lecturers teach me who were Black women. They looked at my essay and challenged me to help improve it. Even after night shifts, they would come and meet me in the library to teach me how to improve my skills. When I look throughout my career to get where I am today, it's always been women of colour and Black women who have brought me where I am, Black women pushing me forward (Mirza, 2015).

Equality for Black nurses

Since I participated in the Nursing Narratives project, I have joined Equality for Black Nurses (E4BN). I found massive relief in leaving full-time contracted work attached to one hospital and having the freedom to work as a locum nurse across the country where needed. I am able to be myself 100% unapologetically in this life. It is no coincidence that a high number of Black staff who are not able to get the job they desire are also working as locums.

It turns out you can only fight so much alone to 'rise through the ranks,' so to speak. My job kept delaying what I trained for with more excuses. So, instead of accepting the crumbs they wanted me to have, you have to recognise when you are not valued and go where you are wanted. Some leaders are from Black and ethnic minority backgrounds, and they will unfortunately be the 'racial gatekeepers' and do nothing to help. My advice is to be aware that your allies will be the ones who see your value and support you.

I needed a sense of belonging in my work; undoing institutional racism fuels my desire to wake up every day and keep on being motivated. Working with E4BN, I have found them to be 'radical' in actions to help those impacted by racism. Many overseas healthcare workers are unaware of how racism works in the UK, and I am astonished at what they have endured. At E4BN, we now

have weekly Zoom meetings, and more and more people who are caught up in the recent scandal with the Nursing and Midwifery Council (NMC) are approaching us because we are openly challenging the NMC about their biases, their racism and their knee jerk reactions to the nurses that are reported to them. The latest scandal is the targeting of Nigerian nurses around Computer Based Testing (CBT). the company that did the CBT with healthcare workers in Nigeria got in touch with the NMC and said that there was an anomaly with the testing. Rather than investigating the testing itself, they just turned around to the health workers and made them repeat the test to prove that they were legally allowed to practice as a nurse. They accused every single one of them of cheating. This is a racist trope used against Africans that is pervasive throughout British society. If the NMC does not issue a pin to the nurse, they are not allowed to work in the UK as a nurse. A lot of them have lost their jobs. A lot of them are under threat of deportation. A lot of them have been downgraded after working for decades as nurses and healthcare assistants. They have come to this country spending thousands of pounds in the hope of a better life, and now that's taken away from them. There was a man who had been a certified mental health nurse for over 20 years with no drama, no issues, no problems at all attached to his career. Since the CBT scandal took place, he has not been allowed to work as a nurse. It's shocking and so unjust. The NMC has got this all wrong, so we at EB4N sought the best advice we could about employment law from senior lawyers. We are trying to help nurses support them through the NMC processes, and we act as the nurses' representatives to deal with the NMC.

I have been a paediatric emergency nurse, where I learned the skill of triaging. When I do a case triage case for E4BN, I get the information about what's happened, how it happened, who was in the room, and all the facts. A lot of the healthcare workers who are reported to the NMC are traumatised because, by the time they come to us, they might have been suspended. They may have been frog-marched off the unit. Some of them have been made to write several statements to absolve the employers from anything that may have gone wrong while the nurse or midwife was on duty and instead put this blame solely on the workers. We have also started picketing the NMC to raise attention to the public about their failures and their racism because a disproportionate number of Black, Asian and migrant nurses and midwives end up being reported (West, Dawson and Kaur, 2015). It's sometimes used as a weapon against them because of a personal vendetta or just sheer racial hatred. The pickets have been getting media attention, which has helped put pressure on the NMC. We also do this so that more people can understand it. They are not alone; like Malcolm X said, 'We are not outnumbered; we're out organised' (Malcolm X 1964), so we are organising.

I live every day by point 8 in the Nursing Narrative manifesto: 'End the exploitation of Black and Brown workers—delegate work equitably' (Nursing

Narratives 2022, point 8). Work with E4BN does what it can to undo this little by little, building up power in numbers to support those who need it. In turn, they will reach out and help others. My life now is dedicated to ending the exploitation of my people.

What I want Black healthcare workers to do is ask themselves – 'How do they organise in the workplace?' For white allies, I would ask you to reach out and support those who are being racially targeted, but make sure it is on their terms. Finally, everyone needs to understand that it is our NHS, so let's fight for it.

Reflective questions

1 What role can you play in fighting racism in the workplace?
2 How should white allies support those who are being racially targeted?
3 How should Black workers organise independently?

References

Campbell, A (2024) Who was the Windrush generation, and what is Windrush Day? [online] Available at: www.bbc.co.uk/news/uk-43782241 (accessed 28 November 2024).

Kline, R (2014) *The "snowy white peaks" of the NHS: A survey of discrimination in governance and leadership and the potential impact on patient care in London and England*. London: NHS. Available at: www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf

Malcolm X (1998) *The autobiography of Malcolm X: As told to Alex Haley*. New York: Bantam Doubleday Dell Publishing Group.

Mirza, HS (2015) 'Respecting difference: Widening participation in post-race times', in Alexander, C. and Arday, J. (eds.) *Aiming higher: Race, inequality and diversity in the academy*. London: Runnymede Trust, pp. 27–30. Available at: https://assets-global.website-files.com/61488f992b58e687f1108c7c/617bcf1cd124685da56a014c_Aiming%20Higher.pdf

NHS England (2024) The Workforce Race Equality Standard WRES. [online] Available at: www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/ (accessed 28 November 2024).

Nursing Narratives (2022) *Anti-Racist Manifesto*. Available at: https://nursingnarratives.org/anti-racist-manifesto/ (Accessed: 7 June 2025)

Olusoga, D (2020) The toppling of Edward Colston's statue is not an attack on history. It is history. [online] Available at: www.theguardian.com/commentisfree/2020/jun/08/edward-colston-statue-history-slave-trader-bristol-protest (accessed 28 November 2024).

Public Health England (2021) *Beyond the data: Understanding the impact of COVID-19 on BAME groups*. London: Public Health England. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_d

ata/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf (accessed 22/06/25).

Rankine, C (2015) *Citizen: An American lyric*. [EPUB] London: Penguin.

Sobo, J, Lambert, H, and Heath, D (2020). More than a teachable moment: Black lives matter. *Anthropology & Medicine*, 27: 243–248.

Statista Search Department (2024) Number of people living in modern slavery per 1,000 inhabitants in Arab states as of 2021 by country. [online] Available at: www.statista.com/statistics/1399583/prevalence-modern-slavery-arab-states-country/ (accessed 28 November 2024).

The UK Government (2021) The report of the Commission on Race and Ethnic Disparities [online] Available at www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities/foreword-introduction-and-full-recommendations (accessed 28 November 2024).

West, M, Dawson J. and Kaur, M (2015) *Making the difference: Diversity and inclusion in the NHS*. London: The King's Fund. Available at: https://assets.kingsfund.org.uk/f/256914/x/6e2054c949/making_the_difference_december_2015.pdf

Further reading

Malcolm X (1964) *'The Ballot and the Bullet', Speech delivered at the Methodist Hall*. Cleveland Ohio, USA.

Chapter 19

An anti-racist health service

Our manifesto for change

Due to the history of racist practices towards Black and Brown health workers that have been further exposed by our experience of the pandemic we demand a health service that is actively anti-racist:

We call upon the NHS to:

1. Implement a Zero tolerance to racism policy and practice.
2. Stop putting Black and Brown staff in danger of death and psychological harm.
3. Build a more compassionate NHS with respect and equity for Black and Brown workers.
4. Remove whiteness as the benchmark in training and in organisational culture.
5. Build an NHS with equality at the core of health provision for all ethnicities.
6. Create clear and real consequences for racist actions including dismissal and legal action.
7. Create a fair and transparent recruitment process, including for internal vacancies.
8. End the exploitation of Black and Brown workers—delegate work equitably.

We call upon universities and practice learning partners to:

9. Be accountable for providing equitable access to learning opportunities that enable all student nurses and midwives to meet the NMC competencies for registration.

We call upon the government and regulators to:

10. Create accountability and penalties for trusts for failure to address racism through the Health and Safety Executive.

DOI: 10.4324/9781041054276-20

11. Recognise the experience and training of overseas nurses. Don't treat them automatically as unqualified.
12. Evaluate and reflect Black and Brown staff experiences of discrimination in CQC ratings.
13. Investigate and challenge referrals of Black and Brown nurses and midwives to regulatory bodies with no evidence and no case to answer.
14. Change the immigration system for international healthcare workers to end exploitative visa fees, the denial of recourse to public funds and give automatic indefinite leave to remain.
15. Reinstate third party discrimination into legislation.

We call on all Black and Brown staff to build a collective voice which will also be supported by all allies to build a just health service

Produced by the healthcare workers who participated in Nursing Narratives: Racism and the Pandemic https://nursingnarratives.com/

Endorsed by: Equality for Black Nurses; Nurses of Colour Network, Association of South Asian Midwives, Kanlungan Filipino Consortium, Caribbean African Health Network, Filipino Nurses Association, Nigeria Nurses Charitable Association UK, Malawian-UK Nurses Association, Uganda Nurses and Midwives Association UK, Caribbean Nurses and Midwives Association (UK), Society of African and Caribbean Midwives, Nurses Association of Jamaica, Zimbabwean Midwifery and Nurses Association,
Philipine Nurses Association, British Indian Nurses Association, Ghana Nurses Association,
Kenyan Nurses and Midwives Association UK, Cameroon Nurses, Association of South African Nurses in the United Kingdom, Gambia Healthcare Matters, Ivorian Association for Health Promotion UK, British Pakistani Nurses and Midwives Association, Migrant Media

Appendix 1

List of Participants in Nursing Narratives: Racism and the Pandemic

NO	*Name or Pseudonymn*	*Job Role*	*Band*	*Ethnicity Self-Defined*	*Gender*	*Migration*
	Participants with chapters					
1	Benash	Midwife	7	Pakistani	Female	UK
2	Dusu	Support Worker	3	Nigerian	Male	M
3	Estephanie	Regional/RCN Director	Senior	Black Caribbean	Female	UK
4	Esther	Trainee Nurse Practitioner	6	Black British	Female	UK
5	Fatima G	Midwifery Team Leader	7	Arab	Female	M
6	Fatimah M	Midwife	5	Egyptian Bengali	Female	UK
7	Gemma	Immunisation Nurse	5	Dual heritage Black Caribbean/ white	Female	UK
8	Janice	Health Care Assistant	2	Black British	Female	UK
9	Olanike	Specialist Nurse	6	Black African	Female	UK
10	Michelle	Nurse Manager	8b	Black British	Female	UK
11	Neomi	Registered Nurse	Agency	Black British	Female	UK
12	Rachel	Charge Nurse	6	Dual heritage Caribbean/ white British	Female	UK
13	Rona	Sister (Charge Nurse)	6	Filipino	Female	M
14	Riel	Staff Nurse	5	Filipino	Male	M
15	Roseline	Senior Theatre Practitioner	6	Black African	Female	M
16	Rosetta	International OSCE trainer	6	Indian	Female	M
17	Zoe	Former Student Nurse	N/A	Mixed Black Caribbean and Greek Cypriot	Female	UK

(*Continued*)

NO	Name or Pseudonymn	Job Role	Band	Ethnicity Self-Defined	Gender	Migration
	Additional participants					
18	Aaju	Lab Worker	3	Indian	Male	M
19	Aamina	Nursing Associate	4	Somalia, African	Female	M
20	Abby	Head of Nursing (need to just say senior manager)	8b	Indian	Female	M
21	Abel	Staff Nurse – ICU	5	Filipino	Male	M
22	Abhinav	Team Manager & Clinical lead Phisio	7	Indian	Male	M
23	Anita	Midwife	6	Black African	Female	M
24	Adelaide	Research Associate/ Nurse	7	Black Caribbean	Female	UK
25	Cynthia	Matron	8a	Black Caribbean	Female	UK
26	Dawn	Head of Health and Wellbeing	NA	Black Caribbean	Female	UK
27	Deedar	Staff Nurse	5	Pakistani	Male	M
28	Divya	Clinical Review Officer	7	Mauritiusian	Female	M
29	Felicia	Associate Director of Nursing	8d	Black British	Female	UK
30	Feroza	Staff Nurse	5	Pakistani	Female	M
31	Humera	Community Midwife	6	Pakistani	Female	UK
32	Iris	Staff Nurse	5	Filipino	Female	M
33	June	Research Nurse Manager	7	Black British	Female	UK
34	Layla	Mental Health Nurse	6	Mixed Asian/ white	Female	UK
35	Luna	Staff Nurse	5	Filipino	Female	M
36	Maria	Nurse and Equality Lead	6 & 8a	Black African	Female	UK
37	Mustafa	Staff Nurse	5	Pakistani	Male	M
38	Mushtaq	Staff Nurse	5	Pakistani	Male	M
39	Nafiza	Midwifery Lead	8a	British Bangladeshi	Female	UK
40	Precious	Nurse Educator	7	Black African	Female	M
41	Rani	Mental Health Activities Coordinator	2	Mauritian	Female	M

NO	*Name or Pseudonymn*	*Job Role*	*Band*	*Ethnicity Self-Defined*	*Gender*	*Migration*
42	Riaz	Specialist Physiotherapist	6	Indian	Male	M
43	Saima	Research Midwife	6	Pakistani	Female	UK
44	Sam	Staff Nurse	4-5	Filipino	Female	M
45	Susan	Kanlungan Filipino Organisation	n/a	Filipino	Female	M
46	Tina	Nurse Paediatrics	6	Black African	Female	UK
47	Usma	Adult Nurse and Paediatrics	6	Bangladeshi	Female	UK

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