The realities of racism

RAMAMURTHY, Anandi <http://orcid.org/0000-0002-4830-9029>, BHANBHRO, Sadiq <http://orcid.org/0000-0003-0771-8130>, AMBROSE, Rachel and FERO, Ken

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Chapter 1

The Realities of Racism

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

Abstract

This chapter analyses the realities of racism faced by nurses, midwives, and healthcare workers in the NHS. Drawing on 47 interviews and written narratives, the research adopts a Critical Race Theory (CRT) framework, recognising racism as systemic, a socially constructed entity, not a biological reality. By recognising racism as pervasive and not just present through overt acts of race hatred but through more subtle and hidden operations of power, we highlight the pervasive nature of racism in healthcare (Delgado & Stefancic, 2017).

This chapter is organised into two sections. The first section explores the roots of racism. It considers the impact of colonialism on the racial stereotypes and cultures of Whiteness, as well as the institutionalisation of racism through the immigration laws. We highlight the impact of racial capitalism in the NHS. The second section explores three pervasive ways in which racism is practiced: exclusion and neglect; over-scrutiny and victimisation; and exploitation through unequal work allocation. Together, these policies and practices enable the exploitation and victimisation of Black and Brown workers with the administrative violence of the immigration laws

creating extreme vulnerability for overseas staff, leading to devastating consequences in the pandemic.

This chapter, as well as two further chapters by health workers produced for this book (see Appendix A.1), brings together our understanding of the realities of racism faced by nurses, midwives, and other healthcare workers in the NHS through individual audio and video narrative interviews (n = 45) and a survey (n = 308) conducted between 2019 and 2020. 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 racism. 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 White 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 racial division of labour is required and enforced, through differential treatment and rights.

This chapter draws on all the interviews that we conducted. 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.

This 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.

1.1 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, 1981; Said, 1979). At its most extreme, Africans and Asians were seen as less human, and therefore less deserving of the full range of rights that the European Enlightenment theory (developing at the same time as the transatlantic slave trade and colonial forms of capitalist accumulation) afforded an 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.

1.1.1 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 has also acknowledged 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).

1.1.2 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’. 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 (Ahmed, 2007). 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).

1.1.3 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, when the Race Relations Act outlawed racism in Britain, Sivanandan argues that the British state institutionalised racism at the same 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, 2021) 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

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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 OSCEs 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 (UK Council for International Student Affairs, 2025).

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 …’

1.2 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—that have structured the experience of Black and Brown healthcare workers. While all staff have experienced these 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 to extreme exploitation, victimisation, and vulnerability, which was more evident in the pandemic.

1.2.1 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).

1.2.1.1 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.

1.2.1.2 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). 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., 2022).

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.

1.2.1.3 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.

Instead of offering support for her personal circumstances, 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. 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-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.

1.2.1.4 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 and legitimacy away from racialised staff and towards their White peers.

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. 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).

1.2.1.5 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 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).

1.2.1.6 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 SRN 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.

1.2.1.7 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 BME 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.

1.2.2 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.

1.2.2.1 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 wormen in materinity (Knight et al., 2028), 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.

1.2.2.2 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.

1.2.2.3 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.

1.2.2.4 Bullying and Victimisation in COVID-19

COVID-19 exacerbated both over scrutiny 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 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.

1.2.3 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. 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.

1.2.3.1 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'. 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 healthcare 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 3, 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 (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.

1.2.3.2 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. Yet others in her workplace were paid for acting up, but she was not.

1.2.3.3 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 (Janice’s chapter). 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 3). 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.
>
> Sam

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 as well as challenging practices outside them.

The impact of racism on the physical, psychological, and emotional health of nurses 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 your 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, 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 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 colonised 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 by highlighting the profound impact it has on our society and demanding 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.

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.

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.

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/.

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

Hall, S. (2021). The Whites of Their Eyes: Racist Ideologies and the Media' (first published 1981). In Gilroy and Gilmore (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.

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 et al. (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., Fleming, T., Khetan, T., Meredith, A., Hastie, C. R. (2021). Translating Cultural Safety to the UK. *Journal of Medical Ethics*. https://doi.org/10.1136/medethics-2020-107017.

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/.

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., 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.

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

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.