NHS
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Disrupting the Status Quo: Global Majority Physiotherapists experiences of the trajectory to Consultant Practice – A critical study

‘We are our ancestors wildest dreams’

Contents

Research Team

Adine Adonis – Imperial College Healthcare NHS Trust, University College London

John Hammond – St George's University of London

Jackie Walumbe – University College London Hospitals NHS Foundation Trust, University of Oxford

Andrea Wright – Integratherapy

Gita Ramdharry – University College London Hospitals NHS Foundation Trust, University College London

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Steering group:

Christine Callender
Adrian Capp
Paran Govendar
Roganie Govender
Babikir Osman
Kumar Soloman
Tanvi Vyas

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Background

The King's Fund highlights:

> "The NHS has one of the most ethnically diverse workforces in the public sector. However, year after year, ethnic minority staff report worse experiences in terms of their lives and careers, when compared with white staff and people from an ethnic minority background are under-represented in senior positions in the NHS."

A closer look at the WRES data reveals the inequity that racially minoritized staff experience (NHS WRES, 2022). Racially minoritized staff are 1.14 times less likely to access non-mandatory training and CPD compared to white colleagues; increasing numbers of racially minoritized staff (28.8% in 2021 vs 26% in 2016) still experience harassment, bullying or abuse from colleagues and 16.7% personally experience discrimination at work from a manager/team leader or other colleagues (WRES 2022). Fewer racially minoritized staff (69.2% in 2020 vs 73.2%, in 2016) believe that their employer provides equal career progression or promotion opportunities. The WRES data (2022) indicate that Band 5 is the highest AfC banding for the majority of racially minoritized staff (29.7%) within the UK but are only 10% of staff at grade 8C and above.

The higher AfC bands, at 8a and above, are associated with senior positions that include Consultant level practice. Consultant Physiotherapy and AHP roles are varied with autonomous clinical, leadership, strategic leadership, and clinical academic leaders. The latter usually requires collaboration with Higher Education Institutions that also present challenges to racially minoritized people with poor representation in the UK professoriate (Arday 2020) and low levels of lead applicants for awards from the main UK research councils (UKRI, 2020; NIHR 2021).

The killing of George Floyd at the hands of the police in 2020 brought shock globally and public awareness to the Black Lives Matter movement. These events highlighted the ongoing issue of structural racism that befalls not only those in the USA but shone a light across the world, including the UK. It has allowed those previously "silent" or unheard to raise their voices and demand to be heard and action to be taken. These issues are not isolated to one sector but have highlighted the structural inequalities that exist within the AHP professions. There are systemic issues of inequality and racism that continue to permeate health and social care workplaces and within the membership of professional bodies (Adebowale and Rao 2020).

There is a lack of representation in leadership roles in the clinical and academic workforce, in executive positions on councils of professional bodies, and exceptionally poor, undocumented employee experiences within the NHS and HEIs, brought into particular focus during the Covid-19 pandemic (Jesuthasan et al. 2021). Preliminary research on racially minoritized physiotherapy students (Hammond et al., 2019) identified the issues students experience in higher education.

There is a gap in research capturing the experiences of qualified racially minoritized Physiotherapists in the UK, even more apparent in its absence. Now more than ever, this needs the attention it deserves to direct real solutions to address these disparities. By understanding the lived experiences of Physiotherapists' working lives, only then can we truly address the issues relating to attainment of consultant practice positions. What we are doing is not enough and we need to find ways to disrupt the status quo.

1.1 How are we to address these issues within the UK?

This project's aim was to engage a participatory research inquiry centring non-white qualified Physiotherapists who are on a consultant practice trajectory (aspiring to a consultant role) or in a consultant role. The research team is made up of people from minority backgrounds, with four of the five racially minoritized and lived experience of working as a physiotherapist in the UK. We engaged with our research participants to identify, scrutinise, challenge and create a platform that gives voice to their experiences as professionals and enables them to collaboratively identify key moments, ideas and solutions of how to critically create tangible outputs that can bring about meaningful change. There is a definite opportunity to use this inquiry in a way that provides critical resources for further development and research within Physiotherapy and the wider AHP professions. It will function as a mechanism for enabling critical dialogue and actions to take place towards combatting discrimination within workplaces and identifying agents for change.

A participatory approach between researchers and participants was a crucial feature of how this project and research was conducted. The researchers did not adopt a dispassionate stance, where the participant's time, data, bodies, and energies are 'used' for research purposes only. Importantly, we positioned ourselves as co-enablers and supported the participants. This aspect of the project was vital, to not replicate the continued neglect of non-white bodies in conversations that attempt to bring about racial change and equity; but to include them in the identification of the issues as well as in the solutions, whilst not depleting their resources to do so at the same time.

We focused on the physiotherapy profession in an exploratory, proof of concept manner, to ensure that we identified the explicit steps/stages and guidance on what meaningful change looks like and how this methodology was refined and expanded to better understand experiences across other AHPs.

2 Purpose

To address racially minoritized Physiotherapists lived working experiences and to identify discriminatory practices that influenced their trajectory to their roles.

2.1 Research questions:

1. What are the lived working experiences of qualified physiotherapists from racially minoritized backgrounds who are aspiring to or have achieved consultant level practice?

2. How do current practices in the physiotherapy profession perpetuate privilege and how can racially minoritized colleagues, who are aspiring or have achieved consultant level practice, be supported to disrupt this?

3. How can physiotherapists who identify from a racially minoritized background who have been excluded from, or dropped out of a trajectory of consultant level practice, be better supported in practice and through policy?

3 Methods

3.1 Sampling

This study focused on qualified physiotherapists in the UK attending to their professional career progression up to and including consultant level practice. We identified participants from across the UK who are currently in consultant roles or aspiring to consultant level, through various social media communities developed more recently to collectively support those from racially minoritized backgrounds as well as formal professional networks.

3.2 Data collection methods:

The interviews were conducted via teleconferencing software, where face-to-face interviewing was not possible. We were aware the sensitive nature of this work, and built-in additional perspectives to our methods to ensure that we represented our participants the subject matter appropriately.

1. We conducted an initial individual interview with each participant allowing space for sensitive topics to be explored.
2. A follow up interview was offered for participants over 3-4 months allowing time for issues raised to be discussed in meaningful detail.
3. Space within and between interviews was structured to allow for pastoral care, for both participants and researchers (attending to and minimising impact of potential vicarious trauma).
4. Two facilitated group discussions were held at the point of data analysis to enable participants to attend one and to ensure we were interpreting experiences correctly.
5. A research advisory group was established who provided ongoing sense checking throughout the project.

Anonymised interviews were transcribed by a suitably contracted provider who met organisational information and data security requirements. Analysis was conducted by all members of the research team. We followed an iterative approach; scheduling follow-up interviews and the final externally facilitated workshops. Participants were invited to select pseudonyms to protect anonymity in all dissemination materials.

Data collection - Two stages:

Stage One

Individual interviews were conducted using a narrative approach drawing on past and present experiences with physiotherapists who were aspiring or had achieved consultant level practice. Questions and prompts were included about how participants were acting in their current practice, past practice, and what they felt what could be done to disrupt current practices (reflecting on how much they felt able to contribute to that). The following strategies were put in place to facilitate sensitive conversations:

1. The vicarious trauma that retelling of stories may highlight was acknowledged and pastoral care and support was a cornerstone of this project
2. Interviews were conducted with a member from the research team also from racially minoritized background

3. Opportunities were provided for iterative interactions following the interview e.g.: via email or telephone
4. Participants were invited to collect any reflections that they were willing to share as part of the research data such as: voice memos, short video clips, written narratives, or photographs.

The researchers met regularly during stage one to share field notes, reflexively share comments about the interviews, and provide support for participants and researchers as required.

Stage Two

Follow up interviews were arranged where participants could share data collected as per point 4 above. Once preliminary analysis of the transcripts was complete (see analysis below), two externally facilitated workshops were organised with the following aims:

1. To present preliminary findings of the analysis for shared consideration
2. Discussion of support and wellbeing of participants and researchers
3. Consideration of future actions and recommendations (see analysis below and link to critical discourse analysis- stage three or four)

The workshops were facilitated by an external consultant selected by the research team for the following reasons:

1. The team recognised the potential trauma for the participants and researchers and therefore an external facilitator would minimise the risk to individuals in the research team having to lead the workshop
2. The facilitator had extensive expertise in facilitation and work in the field of social justice
3. To provide an impartial role in the discussions to support the inclusion of the research team's views as part of the interpretive process

3.3 Study management

The work was overseen and advised by a steering committee, comprised of AHP colleagues from racially minoritized backgrounds working at consultant level (not physiotherapists), service users, service managers and colleagues working in Equality, Diversity, and Inclusion from other sectors. The time for service users was financially compensated, in line with NIHR INVOLVE principles (https://www.invo.org.uk/).

The steering group met three times during the project and advised on conduct, pastoral care, interpretation of results and, guidance as to impactful dissemination that would influence policy and practice.

3.4 Ethics

Ethical approval was received from the Kingston University Research Ethics Committee (Ref No: 2784-BAME) on 14 July 2021.

3.5 Analysis

Interview transcripts, field notes and some participant generated data (such as emails), were analysed using a critical discourse analysis process. From a critical perspective, the primary focus of discourse analysis is on the discursive aspects of power relations and inequalities (Fairclough, 2010, p.4). Using this approach, examining the power relationships in racially

minoritized physiotherapists' constructions of ways-of-being in their profession was essential. Therefore, a critical lens was helpful to challenge inequalities and propose new possibilities. Fairclough (2010, p.226) proposes that there are four stages of critical discourse analysis (CDA):

1. Focus upon the social wrong
2. Identify obstacles to addressing the social wrong
3. Consider whether the social order 'needs' the social wrong
4. Identify possible ways past the obstacles

From a critical perspective the point of identifying the social wrongs becomes political. As Van Dijk (2001) suggests, the focus is to identify discourses which normalise the social order, in particular those that maintain inequalities and legitimate dominance. A part of critical discourse analysis is to challenge those discourses and offer new possibilities and clearly describe the impacts these can have (Fairclough, 2010). Applying this approach, discourses of racial discrimination were considered the social wrongs.

The analysis was conducted in two stages. These stages reflected the stages of data collection. Stage one analysis was completed during and after stage one data collection. Stage two analysis was considered as part of the data collection stage two (facilitated workshops).

Stage One

The research team commenced with analysis of two transcripts collaboratively. Each member independently read and analysed using Critical Discourse Analysis stages 1, 2 and 3 and met to confirm and clarify understandings in an iterative way. As previously mentioned, social wrongs represent any experiences reported in the transcripts of discrimination based on race/ethnicity. We included any social wrong that the participants confirmed by overt behaviours or outcomes, as well as those that the participants perceived without necessarily confirming this.

It was important at this stage to ensure all potential social wrongs were also acknowledged. The obstacles to addressing the social wrong were either explicit in the transcript (e.g., the participant articulated the obstacle that they perceived), or they were others that through the process of analysis the research team considered as possibilities. At this stage we also considered whether the social order (recruitment and progression to more senior roles) needed the social wrong (marginalisation and oppression of racialised minority physiotherapists).

The group split in pairs (GR/AW and JW/AA) to analyse another two transcripts each and JH joined both pairs. The remaining transcripts were then divided between the team and analysed independently. We then met as a team to share the analysis and further refine and finalise the social wrongs. Preliminary findings were shared through a brief presentation as part of the facilitated workshops.

Stage Two

During the facilitated group discussions, participants contributed to Critical Discourse Analysis stage 4, possible ways past the obstacles to address the social wrongs. In an iterative process the research team developed and refined the recommendations further through online and face to face meetings.

4 Results

4.1 Participant characteristics

There was a mix of ethnicities with 58% of participants from overseas. Seventy percent of the cohort identified as female and there was a wide age range, from 23 to 62 years. With the focus on consultant practice, most participants (41%) were at Band 8a to 8c, 18% at Band 7, 12% at Band 6 with 29% in private practice (table 1).

Self-described ethnicity	**Gender Identity**	**Age Range**	**AfC Grading**	**Physiotherapy Pre-registration training**
British-Asian African-British Black-British Indian-British Mixed-Black African Indian British-Indian White-other	Female: n=12 Male: n=5	23-62 years	Band 8a-c=7 Band 7=3 Band 6=2 Private sector=5	Overseas: n=10 British: n=7

Table 1: Participant demographics. *[Given the small sample and the sensitive nature of this project, data was not disaggregated to maintain anonymity and confidentiality of participants. Similarly, illustrative quotes were taken from across the full data set]*

4.2 Main findings

The findings will be presented in two parts. First the social wrongs identified through the analysis of the transcripts will be presented. The latter part will present the findings in relation to Identifying the possible ways past the obstacles to addressing the social wrongs. Figure one presents a summary of the domains of oppression and racism and how they are maintained in the organisations where our participants work or worked.

4.2.1 Social Wrongs (discrimination) and obstacles

The following section presents the social wrongs that were revealed through the participant narratives. These were considered from a micro to macro level. With micro level social wrongs that relate to individual and relational aspects in the workplace. Meso level represent those factors that are organisational and institutional and finally macro level factors that are wider sociocultural issues (figure 1). For each broad social wrong, specific instances from the data are highlighted in bold and illustrated using quotes from participants.

How domains of oppression/racism are maintained within organisations

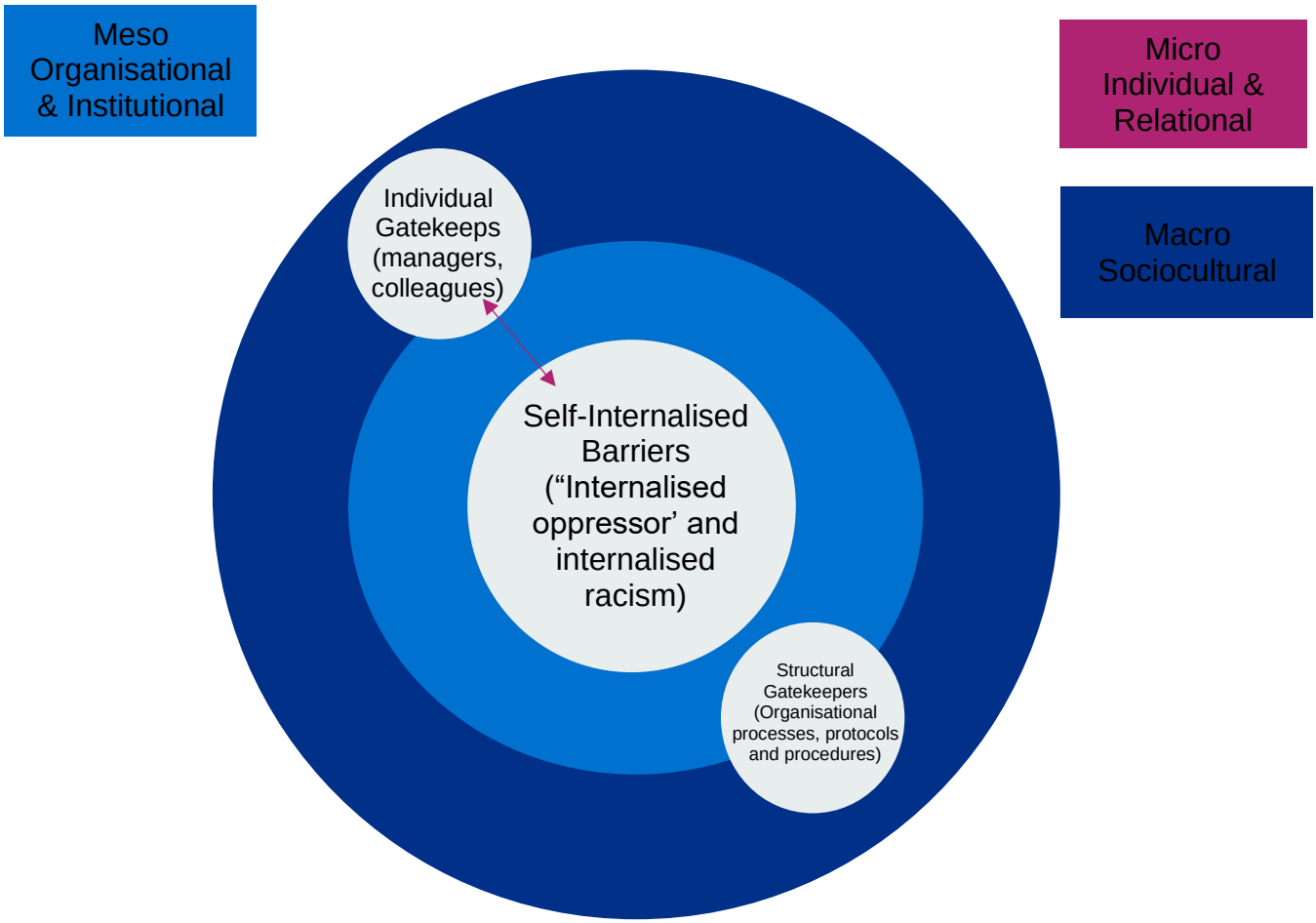

Figure 1: Domains of oppression and racism are maintained within healthcare organisations

1. Undervaluing skills, knowledge and experience: individual experiences

The participants talked about a number of experiences where they felt they would not put themselves forward for progression opportunities as they did not feel they would be valued or recognised. Therefore, physiotherapists from racialised minorities describe self-limiting practices because of the system they find themselves in. For example:

> “If there had been an open application, or an open opportunity, I'm not confident that would have happened” [P15]

In addition, participants described situations where this has significant implications such as **accepting low grade jobs** rather than what is appropriate for their level of experience. They also describe situations where they would either **carry out unseen labour** or take on more responsibilities, such as **working beyond existing grade level or in other specialities** in attempts to be recognised.

"I would say, getting a job is hard. Landing the first job in itself, was the hardest I would say. I have a Master's, I have a research background, I have published my articles in gait and posture and gait analysis, 2D, 3D gait analysis, you have done manual therapy, you have done Master's. But you won't get the first band 5 job". [P2]

"So, as a band 6 I played the role as both band 7, band 6, but I was only on the salary of band 6, beginning salary. That's when I started facing a lot of discrimination and started to face a lot of lack of support, because of what I am. I could see my colleagues, some of them would go on holidays and come back as band 6 and the people who came on rotation to care of the elderly, they quickly went into band 7"[P6]

"When we sat in the meetings, everyone said, 'But your job description is this and this.' I said, 'Yes, but I'm also doing this role because so and so, she's off sick, you know, so I have to do her role.' So, I was, like, doing 2 roles. A band 6 role and a band 7 role. But the picture is, nobody actually recognised that. On top of that, they were giving me more responsibilities, so giving me more responsibilities with no staff."[P5]

Often participants described situations in which they admitted defeat and accepted that this is 'just the way it is' and in effect were complicit in a **'deficit' narrative,** where individuals accepted it was them that needed to work harder. For instance:

"One of the very senior people once told me, 'You are from India, yes?'. 'Yes.' "You have to work double, harder than others, to get anywhere, to do anything.' I said it's not a problem to me, I'm hard-working, I'm ready to do whatever work needs to be put in. …. but the whole point was you were expected to work doubly hard, 4 times harder, to reach where it is" [P2]

"Definitely not. You have to work harder, I must say, to prove yourself. That is undoubted, you have to, you can't slip up, you can't. Keeping on your guard, keeping on making sure that you are doing a good job and almost having to be better than good, above average, all the time. Even one little step out of line could be, 'Yes, you just proved a point didn't you, we thought that. That fear is always there, and that fear, I don't think is created internally." [P15]

Racially minoritised physiotherapists **internalised racism** and negotiated their way through the system by adopting normative ways of being that are sanctioned, leading them to **becoming complicit** in maintaining the system of oppression, but also surviving.

"If I had my time back again, what advice I would give myself and how I could have been different. I was fairly quiet, and I said yes to everything and complied with everything and never ever would have spoken out because I thought, I could never say back anything." [P15]

"What do you mean, you can speak English? You've heard me speak English. What do you think?' There was lots of other stuff. 'You speak very fast. You're very emotional.' The assumption being, 'You're foreign, you're going to be emotional.' 'Yes, maybe I'll be unemotional then and I'll try and conform." [P15]

These are social wrongs enacted at a micro (individual) level within a wider system. Other organisational and Institutional factors directly contributing to social wrongs that affect career progression for racially minoritised physiotherapists will now be presented.

2. Skills, knowledge and experience not being recognised as equivalent or valid: the role of gatekeepers

Participants identified that there were particular gatekeepers who had oversight of a hidden culture that resulted **in inequitable access to opportunities** that supported career progression. Particularly pertinent, was their function in providing (or specifically limiting) access to resources provided by organisations.

This inequitable access led to the participants describing how managers b**locked career progression** because they did not recognise the skills or knowledge of racially minoritised physiotherapists. This meant that they perceived managers as judging physiotherapists from racialised minority backgrounds as insufficiently qualified and therefore not suitable for career progression.

> "There was a focus coach training that was 3 day (course) for you to become a coach and it just came through and I said my manager..... he sent the email for all band 7 and I said, 'Oh my god, this is wonderful.' And I said, 'Can I go?' He said, 'No, I don't think so, because you are already going to do this, and, you know, I had to give chance for the other people.' But it's always like this, when I've got something really big coming to grow and I can't go." [P7]

In turn, participants reported being expected to **absorb low status work delegated by managers**. This perceptual bias reflects the wider socio-cultural norms that ascribe 'lesser than' properties to racially minoritised physiotherapists, leading to **undervaluing** their **experience and qualifications.**

> "So, again, things were getting increasingly difficult to progress up the ladder. To make it more challenging for me, I felt as though they were giving me more menial tasks each time, and not downgrading me, because they couldn't physically do that, but they stripped away all my Band 7 managerial responsibilities. I didn't supervise students for about six years. Those were some of the things that I couldn't quite understand why I wasn't being allowed to develop those abilities."[P6]

Though reluctant to name it as such, participants described **instances of cronyism** where gatekeepers with a managerial function would identify more junior individuals (often from white backgrounds), who they then favoured by offering covert and overt support and preferential access to opportunities for career progression.

> “Everyone is going for interview, they get shortlisted… it will be based on the interviews, but a lot of time, if it's the same trust, probably it will go to the favourite person of the manager” [P12]
>
> “Because, I had applied for permanent posts there but clearly their interview processes are always looking for something else. And, I was always getting that thing of, 'You did really well with the questions, the nervousness came through, but somebody else just answered the questions that little bit better.” [P3]
>
> “I'm now a very strong believer that when we go out for recruitment it should be external, I've seen that and I know that I was part of that process, but actually I've seen how because somebody has shouted the loudest that they've ended up getting roles without a really proper process behind it. So I think one thing we do have to do is we've got to stop the internal type of promotions, just because you're able to have that voice and you can go there, it needs to be competitive.” [P10]

Ultimately, this perceptual misdirection led to stories from the participants of those in power **codifying inequities into official policies and procedures** (e.g. in interview practices and protocols) thus perpetuating the limitations racially minoritised physiotherapists face when aspiring to consultant roles. The impact of which was inscribed in participant bodies and at worst manifesting in physical symptoms of ill health. For example:

> “I'm happy to start getting the interview experience, but that was not a good idea, because that interview experience was just soul destroying. It then scarred me, because as I tried to apply in other places, when you look at the job descriptions it made little sense to me to apply for another Band 7 role... Every time I applied, I got an interview, so I knew that my qualifications were on par, and my experience, but I physically couldn't attend the interviews. I would be so visceral in my response, I would be ill, I would throw up, I would have panic attacks” [P6]
>
> “It was just such a toxic thing that my personal health, my mental health, my work environment, all them just kept colliding and smashing into bits, and I was made to pick up the pieces myself. There were times where I just couldn't do it. So, that's my journey.” [P4]

In the examples presented here, we are referring to specific gatekeepers within an organisational setting with direct power to support or obstruct racially minoritised physiotherapists career progression. Other gatekeepers include, peers, educators, professional networks, patients and, social media. These gatekeepers often work around the edges of organisational boundaries but exist in a symbiotic relationship with the wider system to maintain and amplify hegemonic power. We now present these socio-cultural factors at macro level enabling social wrongs that affect career progression for racially minoritised physiotherapists.

3. The absence of recognisable, visible, and viable pathways to career progression and into consultant practice

The analysis of the participant narratives also demonstrated the perception that there were no pathways to career progression. These may be present but were either not visible or not viable to the participants.

> "So, you find your other colleagues who are in a similar situation to you, they're getting all these permanent roles and I'm like, 'How are you getting them? I didn't even see them advertised. Where are they advertising them?' You just feel like you're always one step behind. It's almost like there's this underground world. I don't know. If you're not in the right network, or if you're not in the right group, then you're always one step behind and you only hear about things when they've happened." [P14]

> "And this is the interesting thing, so never in my career, when I talked to XXX originally, she asked me if I was interested in this research and I said, 'I don't know what you're talking about because I've got nothing to do with a consultant role. It's never crossed my mind,' and basically had the conversation and said, 'Isn't that part of the problem then?' And I was like, 'Yes, I suppose you're right actually.' It's never ever been part, and I mean this literally, it's never been a conversation or even a mention in any of my supervision or any of my appraisals within any of my management within therapies." [P16]

> "Subtler ones are when you go for, an example is, advanced clinical practice. You wouldn't get a job, or you wouldn't get shortlisted. These things are not very, very open. Initially, things are becoming very, very, difficult and it takes years to persevere.....I wanted to be a consultant physio or a consultant AHP. Rightly, or wrongly, I think I have seen people where their face fits. Now, whether you like it or not, if you are talking about any other nursing profession, any other medics, any other AHPs, and you see things. You just wonder, how on earth? These people have not even done their Master's. That is just astonishing for me to see that there are people who have jumped from Band 6 to a consultant position. And then we say there are, I'm like, you start questioning. I am sitting here with a double Master's and in the system, it's like, what is it? I've told you the things that I am doing, I really want to know the questions answer, how to become a consultant, I really want to know. I'm still exploring that option for me now. I have been to the interviews. Believe it or not." [P11]

This also had implications for systems that might support career progression through continued professional development opportunities. Individuals **were either not aware of access to funding or restricted access to institutionally provided funding** thus rendering funding invisible particularly when in comparison to their white peers.

> "There were those instances. There were instances with another head of physiotherapy, I'd go and ask for, whether it was staff or funding for courses for staff or whatever the case may be, I always got turned down. Then the Band 8 respiratory (whtie colleague) would go and ask exactly the same thing and always got what she asked for." [P8]

> "I've always funded myself, by the way, all my courses are funded myself. Most of the clinical courses I've done, I have somehow not managed to either get the funding, or I have not been on a priority to get the funding for it, or I've not been in substantive positions to get that." [P7]

There were also exclusionary practices that made the individual feel they were **not being part of team in the workplace with an absence of belonging**. These included aspects that were part of the wider organisational system including nor being included in workplace conversations or not **being invited to the social activities outside work**

> "I noticed that I was left out from a lot of the social gatherings, so whether it was going to the pub or whether it was going for a meal or something similar." [P8]
>
> "The other instance with the superintendent group was when the head of physiotherapy had made a game pie of some description and had brought it in and had given the rest of the superintendent group a piece and then she turned to myself and the other 8A, care for the elderly, who happened to be from India and she said, 'I didn't bring you guys because I didn't think you'd be used to that or know about it." [P8]
>
> "In some hospitals, old fashioned, some of them, they can make a certain type of naughty comments about the food, or the odour of the food, Asian means we like spices. And then, when you take that kind of stuff and you use the microwave, some of them might not feel comfortable. And then, you just want to be unconscious, you don't want to disturb others so you just start eating sandwiches or other things, where other people can't get uncomfortable. So, those kinds of minor things. And then again, it might just be cultural background differences or the way we eat. But then, you start becoming a little bit more perceptive of being a little bit extra cautious that you don't offend anyone." [P12]

These practices contributed to the racialised minority participants feeling excluded in the everyday conversations with a range of peers and colleagues, making them feel an outsider in default white physiotherapy community.

4.2.2 Racism as an enduring social wrong: emotional and physical

Amongst these discourses and the social wrongs, they produce, there is a distinction between overt and covert discrimination that participants struggled to name as discrimination. Many of the participants internalised discrimination and as such were complicit with institutional racism. The very systems that are ostensibly put in place by organisations to address these concerns appear to be failing to protect those who experience systemic harm. Participant quotes are presented here without an accompanying narrative as they illustrate the enduring social wrong via first person perspectives:

> "It was, yes, prolonged victimisation and bullying, and every corner you were made to believe that you imagined it, and that you were over exaggerating. Then when you realised that you weren't, you were then isolated." [P4]
>
> "So, it was the most toxic relationship, and I call it a relationship, because I spent 37.5 hours of my life there for over ten years. It didn't get easier. It just got worse. The more unwell I got, the harder it was. I was dehumanised as well. I was told things by my manager such as-, I remember slipping in the bathroom one morning, and getting ready for work. I slipped. I smashed the glass shower screen, completely smashed it, because of the way I slipped. I pushed it, it hit the door, that sort of thing. So, it hurt. My back hurt, and then because it's glass you have to clean it up straight away, because I have a small child. I couldn't leave it around. So, if you can imagine, you hurt yourself, but then you have to clean for an hour,

mop, sweep, whatever. When I phoned my manager to explain, 'I've had an accident. My back's really hurting. I can't come into work,' the response was, 'You're a physio. You shouldn't be off with back pain." [P6]

"And then Eid is relying on the sighting of the moon, and then there might be 1 plus/minus day. And I've seen some of my colleagues getting challenged, 'No, you have to give us a notice,' so they might have to take 2 days off rather than 1 day off, which according to the annual leave policy, if it's not there, it's not there. But then, those type of policies don't reflect that there are certain other ethnic backgrounds that they need to look into and that's not covered." [P12]

4.3 Identifying possible ways to disrupt the obstacles to addressing the social wrongs

It is important to state that in recommending strategies from the research, there is a risk (as with many interpretivist studies) that the focus of action is remedial and inadvertently emphasises a 'deficit' model. The focus of our critical research is to draw attention on the need to i) empower individuals and collective response and ii) providing ways to review and disrupt the meso and macro systemic issues we have highlighted. Hence, we are choosing not to use racialised minority as a descriptor (from this point on) but to deliberately use global majority, centring the alternative decolonised narrative. "The term 'global majority' was coined to reject the debilitating implications of being racialised as minorities. In addition, it was then, as it is today, a more accurate descriptor of those labelled as 'ethnic minorities' or 'diverse minority communities." (Campbell-Stephens, 2021 p4)

4.3.1 Empowering individuals and building a collective response

"Be brave, be bold, find your tribe, find your voice and use it" [Workshop participant]

These points highlight collective voices and particularly speak to physiotherapists from the global majority working in UK healthcare settings. While they have come about through a study in relation to progression within the profession and healthcare, they may be relevant to all those in the profession at any stage of their career. These specific recommendations were co-created with participants following the facilitated workshops. They focus on supporting internal capacities and capabilities from which to withstand or tolerate existing systems, whilst wider work continues to dismantle the systems of oppression.

The narratives here call for providing support for globalised majority individuals in the workplace. This can be by identifying and engaging with their cultural heritage, fostering ontological security, and disentangling from dominant deficit-based colonial narratives. Ontological security occurs when "an individual has confident expectations, even if probabilistic, about the means-ends relationships that govern her social life" (Mitzen, 2006 p345)

"Don't lose your identity. Your identity is your strength and uniqueness" [Workshop participant]

Collectively the participants were mobilised to use the acronym **PIE**: **P**erformance, **I**dentity, **E**xposure, as a means to encourage managers to rethink the manner in which they conduct appraisals with physiotherapists from the Global Majority, using this information in understanding and celebrating individual identities and guiding these physiotherapists towards opportunities that aid their career progression

As has been pointed out elsewhere, this dismantling work, ought not to fall to those on the shoulders of the oppressed.

4.3.2 Disrupting the meso and macro systemic issues

The points that follow speak directly to those with leadership responsibilities that have come about through having certain successes within the healthcare system and as such have both earned and unearned privileges (Nixon 2019). These privileges may include European heritage, identified as white, native English speaking, higher socioeconomic background and gender.

Managers and peers need to seek greater and meaningful acceptance of cultural diversity and cross-cultural engagement within professional and organisational arenas, making sure NOT to leave others behind should they progress. Opportunities for celebrating diversity should be actively sought and facilitated by senior leadership. Resistance to this from individuals, needs to be challenged positively but firmly, and needs to be from leaders. Modelling inclusive practice is one strategy for altering the actions of individuals, and we can look to frameworks such as behaviour change models used in health to inspire ways to address pervasive behaviours within departments and organisations (Michie et al. 2011). This is just one example of using models to develop strategy, but what is key is that the emphasis is NOT on changing the behaviour of the individual experiencing racism and marginalisation, but the individuals and gatekeepers who are maintaining the status quo through oppressive practices and conduct. The prevailing culture that supports existing practices requires fundamental change in the context of the crisis of injustice (Scott et al. 2003) presented here. Systemic and culture change within the NHS has been attempted and investigated to improve staff well-being, so organisations can pull from theory and practice in aligned areas to take a stepwise approach to transformation (Daniels et al. 2022).

Alongside this, there is a crucial need for all to critically review policies, procedures, and traditional ways of working to question whether some individuals are inadvertently being marginalised and disadvantaged. Further reflective questions might include who and how are individuals with managerial responsibility (gatekeepers) implementing or operating policies and procedures, and whether these consistently applied. Organisational leaders must implement systems of accountability, supported by HR and departmental data, with a lens on these gatekeeping individuals and practices. Exposing these practices and the extent that they occur is an important first step to then monitor change with the implementation of inclusive policies in recruitment, personal development, and appraisal. The current policies are not working, so brave and constructive disruption needs to occur to make the changes needed for justice and inclusion. The two stages of analysis in this study highlight how collaboration, co-creation and community, as strategies for inclusion, have significant merit. These have the potential to move beyond the normatively driven linear, technocratic approaches that appear to have gained greater social capital in organisations.

5 Conclusions

This report represents the first known investigation into globalised majority individual's experiences of physiotherapy career progression in the UK. The small pool of participants available in the workforce to recruit from highlights the urgent need to redress the inequalities. The critical nature of the project has already created momentum for change for the participants and research team. Collectively, informal, and ad hoc support mechanisms have emerged. Nevertheless, the findings of this project do have implications for system wide change in healthcare organisations and Health Education England.

Our recommendations in light of this work are:

1. For organisations to accept that inequities exist within a framework of colonial (white body supremacist) ideology that are maintained and perpetuated in a symbiotic relationship on the macro, meso and micro levels.

2. To challenge the ideological position of colonial (white body supremacy) that dictates (at the macro and meso levels) policies and procedures which create disadvantage and codify assumptions about those from the Global Majority. Understanding that what has been put in place to help people of the Global Majority may in fact be hindering their progression.

3. To recognise a) how power is utilised to influence decisions that impact the career pathways of people of the Global Majority and b) who the agents in power are to make those decisions.

4. For leaders to create a culture that critically challenges the operational and policy status quo to create opportunities that recognise and support the diverse needs of those people of the Global Majority.

5. To co-create clear, consistent transparent consultant career pathways that are financially resourced and demonstrate equity in how these pathways are understood and accessed.

6. That though structural change is slow, immediate actions can be made that can deliver tangible meaningful impacts.

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