Lack of racial diversity within the palliative medicine workforce: does it affect our patients?

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INTRODUCTION

Health in the UK has stopped improving and progress in reducing health inequalities has been negative.[1] The COVID-19 pandemic has further emphasised poorer outcomes in health for people from socioeconomically deprived and ethnic minority communities.[2] There is an urgent public health need to consider the effects of structural discrimination, both among our patients and our staff. Creation of a workforce that reflects the patient population will go some way towards tackling health inequities. A palliative medicine workforce that reflects the diverse population that it serves will understand their needs through lived experience and be better equipped to meet those needs.

INEQUALITIES WITHIN THE WORKFORCE

Within medicine inequalities along the career ladder exist from the bottom to the top. Schemes to widen participation into medical school have improved gender disparity and increased the number of ethnic minority students, but there has been little progress in recruiting those from socioeconomically deprived backgrounds.[3] Beyond medical school, the discrepancies in class and job opportunities continue. There is a direct association between trainees' socioeconomic characteristics, academic ability and career choices, with trainees from more deprived backgrounds pursuing less competitive specialties.[4] Palliative medicine has very few training posts and is comparably competitive to enter.[5]

Data looking at the palliative medicine workforce in the UK show a female predominance and have also been examined in terms of age and the proportion of people who work less than full time.[6] However, there are no published data on ethnicity of the workforce. This may not be considered to be an issue because we are all trained to provide culturally sensitive palliative care. But it is an issue, because without data we cannot examine our diversity deficit in detail.

ARE WE IGNORING STRUCTURAL RACISM?

In palliative medicine, we pride ourselves on providing individualised care with a focus on personal narrative. So why are we not talking about race more? Despite the increasing interest in disparities in healthcare, research pertaining to this and the term 'racism' are rarely found in the palliative care literature. While we do not have detailed data pertaining to the palliative medicine workforce, we know there is a lack of diversity in leadership positions within the NHS (National Health Service). Over the last 15 years, the chairs and non-executive directors on boards that run NHS organisations in England have become less diverse (ie, more white and more men).[7]

It is possible that the observed lack of racial diversity within our workforce contributes to the lack of access to palliative care for patients from ethnic minority backgrounds. While research on the poor representation of minority staff is minimal and much needed, it is known that there is a lack of applications from diverse professionals to work in the hospice setting, and this is a barrier to cultural competence.[8] Awareness of the term 'palliative care' is less likely among ethnic minority patients than those classified as white British, and awareness of the term is also low among the least affluent in society.[9] With lack of awareness, comes lack of access, and there is a growing body of literature that suggests that palliative care services are not accessed by those who are ethnic minorities for a number of reasons: lack of referrals, previous poor experiences when accessing care and a lack of information in the relevant format or language.[10]

The Commission on Race and Ethnic Disparities recently released a controversial government report in the UK which denied institutional racism.[11] This report obscures the fact that most people of ethnic minority backgrounds are disadvantaged from birth due to the interplay between race and class and invalidates the professional and personal experiences of many individuals.

WHAT CAN THE UK LEARN FROM THE USA?

The NHS aims to be a universally accessible healthcare system. In contrast, healthcare in the USA is largely governed by private systems. This means that access to and outcomes from healthcare are dependent on patients' insurance policies, and by extension, their socioeconomic status. While the two healthcare systems are not

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directly comparable, the majority of the evidence and lessons to be learnt about racial disparities in end-of-life care comes from the USA. In the American literature, structural racism appears to be more openly acknowledged and discussed than in the UK.

The UK has mainly examined poor access to palliative care, but we need more information on the outcomes when patients from ethnic minority backgrounds receive palliative care. Research from the USA shows that the inequities continue, and these are largely due to differences in communication. Many black patients do not have discussions around goals of care,[12] and when treatment preferences are discussed, physicians exhibit different patterns of non-verbal communication depending on the race of the patient.[13] Black patients are less likely to receive positive, rapport-building non-verbal cues than white patients despite being given similar verbal information.

The USA has also published data on the lack of racial diversity within the palliative medicine workforce, showing that <5% of their fellows identify as black.[14] Even though the UK has not published this data about their own workforce, it is likely that we would see similar figures when it comes to ethnicity.

RECOMMENDATIONS

Reversing the culture of structural discrimination may sadly never happen, but it is something we must aspire towards. As individuals, there are simple actions that we can take to foster a more inclusive environment within palliative medicine. We must reflect on our own unconscious biases and how they impact on our view of the world. Affinity bias is the tendency to gravitate towards people that we perceive similar to us, and unconsciously leads to discrimination in recruitment.[15] Insidious racism may have manifested

within the palliative medicine workforce due to affinity bias creating a largely white workforce, and resulting lack of representation from minority groups. Purely having awareness of affinity bias can be advantageous. We can use it to look for commonality among colleagues and patients, empathise with them and advocate for them. But we can also be curious about it, slow down when making quick judgements, and use it to seek out diversity and voices that are struggling to be heard.

Changes at organisational and systemic level will undoubtedly take time to implement. Data around racial inequality will provide the impetus to change policies. Collecting demographic data on the workforce and mapping it to communities will allow us to see where the need for palliative care is and provide the opportunity for culturally diverse training tailored to the local population.

We must be aware that the system we work in is not currently set up for diversity. Being able to define racism and acknowledge that it exists is an important step in looking for ways to create a more compassionate and inclusive culture. Within healthcare, there are many facets of racism: institutionally it creates structural problems such as differential access to palliative care; culturally it perpetuates negative stereotypes based on skin colour and interpersonally it results in undermining behaviours within teams or in the doctor–patient relationship.[16]

CONCLUSION

By addressing inequalities within our own workforce and understanding a range of perspectives, we can begin to tackle the health inequalities that exist in palliative medicine and in society. More research is needed and justified to understand the association between diversity among clinicians, and access to palliative care and diversity among patients. Diversity in the palliative care

workforce should be a societal goal in itself, even in the absence of documented patient benefit. Collectively, we have an obligation to create a diverse medical workforce that represents the diverse communities it serves.

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