The Racialized Somatic Norm in Nursing

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Foreword

Working conditions of BAME health-care professionals in Scotland, under Covid-19, a call for action

Current literature on race and inequality in carrier opportunities among health workers in the United Kingdom, is saturated with elite BAME professional's anti-racist strategies (i.e. equality through educational and occupational attainment, Ibid.). However, given the critical role played by BAME professionals in the health sector and documented inequalities in career opportunities that exist in the sector, the effect on health outcomes and limited opportunities for career advancement, there is very little done in terms of primary research to unpack institutional racism in nursing. It is with that in mind I team up with the Coalition with Racial Equality and Rights (CRER) to examine among other things institutional racism in nursing, using data collected through field surveys to inform BAME nurses' antiracist strategies with the goal to unpacking institutions' role in sustaining racism. The said objective was a reaction to a number of different anti-racist strategies, (i.e. multiculturalism, individual empowerment) that downplay the central roles of institutions in sustaining racism, and thus the importance of collective, bottom-up action as a viable strategy in the fight for racial equality.

Driven by the stated objectives, I used Nirmal Puwar's (2004) concept of 'space invaders' to describe BAME nurses' experiences in Scotland. Puwar's research focuses on elite BAME people (i.e. professors, judges etc.) and their experiences entering and evolving in traditionally white workplaces/institutions. She shows how BAME bodies, while not formally excluded from these workplaces, can never completely blend in and always inspire at best distrust, and at worse harassment from the institutions they work for, they are 'space invaders'. In this research, I show that the same concept can be applied in a non-elite environment; nursing. In fact, many of the rejections reactions elite BAME people face in the workplace are also faced by nurses.

BAME nurses in Scotland are a key part of healthcare institutions – the healthcare system could simply not function without them, particularly in light of the ongoing global pandemic of the Covid-19 (Royal College of Psychiatrist, 2020). While racial and ethnic data for Scotland

nurses is scarce, we know BAME nurses were often recruited from overseas to address staff shortages. [1] In the UK, some countries of origin of foreign-born nurses include former British colonies, including the Caribbean countries, and later India, China and the Philippines (Devine, 2018).[2] To this day, recruiting foreign, qualified nurses provides the easiest solution to address staff shortages; saving education costs, and compensating for the decrease in the number of people who choose to become nurses (bid.). BAME nurses are essential to the functioning of healthcare in Scotland and in the UK, and the ones I interviewed clearly took pride in providing such an essential service, a key work, to society.

Their working conditions fall short, though. They are overall less likely than white colleagues to access board memberships or promotions, and more than twice as likely to experience discrimination at work from a manager or a colleague.[3] BAME nurses are at the frontline in the struggle for decent working conditions because they are amongst those with the worst.

As I write this foreword in May 2020, the world is in the midst of the Covid-19 crisis, a pandemic affecting the lives of millions around the globe – BAME nurses' at the top of the list. BAME people and healthcare staff are disproportionately affected by the Covid in Europe North America[4]; nearly triple BAME nurses have died following contamination.[5] In an interview with Nursing Times, Carol Cooper, head of equality, diversity and human rights at Birmingham Community Healthcare NHS Trust, said that "BME staff feel that they are being put on Covid wards and exposed to patients with Covid over and above their colleagues." She also said that BME staff "feel that there is a bias – the same bias that existed before they are feeling is now influencing their being appointed and they are terrified, everybody is terrified". In response, the NHS and the Royal College of Nursing have both published recommendations to protect its BAME staff. Namely, they recommend employers carry-out risk assessments for

[1] Devine, T.D. (2018) '*New Scots: Scotland's Immigrant Communities since 1945*' Edinburgh University Press
[2] Ibid.
[3] NHS. (2020) *'NHS workforce race equality standard'*, 2019 data analysis report for NHS trust.
[4] Khunti, Kumar Singh, Pareek and Hanif (2020), '*Is ethnicity linked to incidence or outcome of Covid-19?'*
[5] ICNARC, (2020) '*Report on patients critically ill with Covid 19*', For more info, https://www.icnarc.org/About/Latest-News/2020/04/04/Report-On-2249-Patients-Critically-Ill-With-Covid-19 and Royal College of Psychiatrists '*Impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) staff in mental healthcare settings assessment and management of risk*', 2020 https://www.rcpsych.ac.uk/docs/default-source/about-us/covid-19/impact-of-covid19-on-bame-staff-in-mental-healthcare-settings_assessment-and-management-of-risk_13052020v2.pdf?sfvrsn=1068965_2

their staff, especially BAME[6] and have regular conversations with them to identify any physical or mental health issues that may make them more vulnerable to the Covid.[7] These recommendations however, are non-binding and there is no data so far on how widely and effectively they were adopted. While this dissertation was written prior to the Covid outbreak, its argument is still, very much relevant – it shows that the core values in nursing, work to systematically exclude BAME people. This means that strategies that aim at protecting BAME nurses from disproportionate vulnerability to the Covid should take into consideration systematic discriminations they face, to properly equip them to face the pandemic. Evidence indeed suggests BAME people's disproportionate vulnerability to the Covid is linked to discrimination BAME staff already faces. The Royal College of Psychiatrists published an impact assessment on the impact of the Covid that shows how established inequalities among BAME staff may render them more vulnerable to contamination. Namely, BAME people are more likely to report a personal experience of discrimination, experience formal disciplinary processes or bullying and harassment from colleagues and patients, they have fewer BAME leadership role models and reduced pay progression and promotion.

Traditionally, healthcare institutions have adopted a deficit-model, educational approach to promote racial equality. Racial awareness has mainly been promoted through trainings that focus on the benefits of a multicultural working environment. For example, both NHS Lothian and Greater Glasgow and Clyde published respectively the "Equality and Rights Improvement plan" and the "Equality, Diversity and Human Rights Policy" that promote valorization of diversity, through recognition "individual differences and contributions" of both patients and colleagues. Evidence however, shows racial inequalities persist.

In light of the current situation, this research challenges the current multicultural approach to antiracism in nursing and provides some valuable insights into the mechanisms behind the ever so present discriminations faced by BAME nurses. The qualitative analysis of in-depth interviews with 9 BAME and white nurses and a review of the existing literature on the topic show how BAME nurses are systematically excluded from nursing, both by patients, and more importantly by their institutions; despite their level of competence, they never seem to be able

[6] https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/risk-assessments-for-staff

[7] https://www.rcpsych.ac.uk/docs/default-source/about-us/covid-19/risk_assessment_tool_covid19.pdf

to “fit the scrub”. The interviews with both BAME and white nurses were essential in identifying care and professionalism as the two core traits for nurses, according to both groups. It showed how these values are traditionally associated to whiteness. BAME nurses entering a white space face extreme reactions, including rejection and terror, that manifest in bullying and super-surveillance – in 2019, BAME nurses were 20% more likely than their white colleagues to enter a formal disciplinary process.[8] By showing how BAME people are never fully allowed to embody nurses’ core traits, this research provides data to support antiracist strategies that departs from the current deficit-model, multicultural anti-racist strategies and center a different approach. For example, while writing my dissertation, I met with the leaders of the Leading Better Care, Leading Across Difference program, that center empowerment of racially marginalized nurses through trainings specially designed for them, delivered by BAME people show promising results in addressing racial inequalities in nursing (i.e. the program shows good results for career progression of its participants). This paper therefore calls for further research on anti-racist strategies in nursing that center BAME people, rather than multiculturalism. It is more urgent than ever we investigate and invest in strategies that take into consideration the systematic exclusion of BAME people from nursing, to effectively address the particular threat the Covid poses to BAME nurses.

[8] NHS, *‘NHS workforce race equality standard’*, 2019 data analysis report for NHS trust.

Abstract

In Global North nursing contexts, anti-racism is crucial in ensuring the organisation tackles adequately health inequalities between racialized minorities and white people, and does not contribute to perpetuate racism. Even though racism is recognised by these institutions as an ill to eliminate, it is often the case that whilst policies and trainings are adopted, underrepresentation of racialized minorities and inequalities in health persist. This dissertation aims to sociologically understand and theorise, through critical race theory and radical reflexivity, the disconnect between institutional measures against racism on the one hand and persistence of inequalities on the other. Based on field-work data consisting of semi-structured interviews with nine (RM and white) nurses, and drawing on the theoretical framework as set out by Nirmal Puwar on the racialized somatic norm, this study argues that institutional measures against racism are based on multicultural anti-racism that when institutionalized in nursing context, undermines the centrality of race in the previously mentioned inequalities. More precisely they intersect and feed individualist nursing values that hide the significance of race. This results in racism being reproduced through nursing. These findings can challenge more widely held scholarly and policy assumptions that multi-cultural anti-racism directly solve race inequalities.

Keywords: Somatic norm, institutional racism, multicultural anti-racism.

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Chapter 1: Introduction

Background, Motive and Argument

In the western institutional context, racism is still an important problem as showed by countless studies about lower employment rates for BAME people, less access to healthcare etc. (Berman & Parides, 2010). Therein, is it crucial from a radical reflexive (Deliovsky, 2017) perspective to attentively conceptualize these institutions, as part of a structure that sustains inequalities based on race. An analysis of the henceforth understudied institution of nursing provides a unique and novel example to substantiate this view.

Nursing's background with racialized minorities in the UK

Nursing in the UK is historically reliant on immigration. In 1940 the Colonial Nursing Service created an imperial market of nursing labour all over the UK (Nichols & Campbell, 2010: 32). Later, in the 90s, the UK initiated a new wave of recruitment of overseas nurses, in response to staff shortage which is still in force (Sheffiels et al., 1999; Smith et al., 2006). Even today, recruiting overseas nurses has remained the preferred strategy by governments in the global North to address staff shortages (Keshet et al. 2018). Together with globalization that lead for more and more nurses to emigrate to Scotland (Moyce et al., 2015), and general increase in RM immigration in Scotland[9], racial diversity has been part of the nursing landscape for at least eighty years (West & Nayar, 2016). However, despite this political agenda, nursing remains overwhelmingly white in that it is far more difficult for RM nurses to access and stay in the profession (West & Nayar, 2016). Various studies have also pointed to high levels of bullying towards RM nurses (Keshet et al., 2018).

Institutionalised nursing discourse and race

[9] Since the Asylum Seeking Act 1999, see 'Changing the Race and Equality Paradigm', CRER https://docs.wixstatic.com/ugd/7ec2e5_3326ce0c802a4bf8a5ec7f023a6cdae1.pdf

Nursing discourse (academic literature, education & policy) addresses these problems through a deficit model and cultural perspective (Keshet et al., 2018; Bonnet, 2000; Williams et al., 2014) that claims racism can be solved through educating people about the positive aspects of cultural diversity. Cultural diversity is being framed in nursing discourse as benefiting the workplace as well as patients, drawing from multiculturalist doctrine (Williams et al, 2014). For example, NHS Scotland adopted the Fair for All strategy in 2001 that provided NHS staff with cultural competency training, meaning "the ability to understand, respect and engage with people from a range of cultures" (Fair for All Strategy, 2001). In addition, Both NHS Lothian and Greater Glasgow and Clyde published respectively the "Equality and Rights Improvement plan" [10] and the "Equality, Diversity and Human Rights Policy"[11]. Valuing diversity, through recognition of "individual differences and contributions" of both patients and colleagues, is the guiding credo to guide further actions in eliminating harassment and bullying in nursing.

Yet, whilst cultural diversity is institutionalized, racism in nursing is ever present, both from patients and from colleagues, with structural consequences (West & Nayar, 2016) and a recent study showed alarming rates of harassment and bullying in NHS Lothian[12] which is more likely to be targeted to Black and Minority Ethnic (BME) nurses (2016:10). Recently for example, BME nurses were found to be less likely than their white colleagues to progress in the hierarchy and overrepresented in the fitness to practice procedure (2016: 2). The Nursing and Midwifery Council shows debatable transparency in the process since the names of those who are undergoing it (and have not been judged yet) as well as details of reasons for hearings are available to all on their website.

The experiences collected in this research as well as critical race theory literature suggest the existence of a gap between nursing discourse and the reality of racism in nursing. However, most academic literature so far focused on cultural diversity's ability to tackle racism without looking at its actual effects on it (Barbee, 1993; Keshet et al., 2018). In order to address racism in nursing, it is crucial to better understand it and critically evaluate the assumption that education and promotion of cultural diversity lead to less racism. A better sociological understanding, through radical reflexivity and critical race theory prove helpful in unpacking

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[10]https://www.nhslothian.scot.nhs.uk/YourRights/EqualityDiversity/Documents/EqualitiesHumanRightsImprovementPlan2017-2018.pdf

[11] http://www.nhsggc.org.uk/media/235575/equality-policy-final-04082014.pdf

[12] Academy of Royal and Medical Colleges review, 2018
https://www.nhslothian.scot.nhs.uk/MediaCentre/PressReleases/2018/Pages/ReportWaitingTimesStaffPressures.aspx

the workings of racism in an institutional setting. This study therefore seeks to explore sociological mechanisms underlying the gap between cultural diversity discourse and racism in nursing. I explore this through a Work-Based Placement and field research I conducted with the Coalition for Racial Equality and Rights (CRER) and desk-based research. The organisation seeks to eliminate racism in Scotland through a rights based approach. With their help, the interviews collected and theoretical research, the study endeavours to reframe nursing as a racialized institution, through the concept laid out by Puwar (2002, 2004), the Racialized Somatic Norm. This is all the more pressing that the numbers of overseas nurses will in all likelihood increase in the coming years, to compensate staff shortage (West & Nayar, 2016). The knowledge gained through this research could help design effective strategies to creating enabling environment for a well diverse workforce in the healthcare sector.

Therefore, the research question is as follows: *Is the somatic norm reproduced within and through nursing in Scotland?*

Three research sub-questions will help answering the main research question:

1) What happens when RM bodies enter nursing in Scotland?
2) Are RM bodies more visible than white bodies in nursing? If so, what does this visibility entail?
3) To what extent and on what conditions RM bodies can enter from nursing?

1.1 Structure of the Study

This paper sets out to define and disentangle institutionalised key values in nursing and institutional racism. Chapter 2 will proceed to outline the methodology that was used for this research and describes interviewing approach, and ethical considerations. Chapter 3 introduces the academic literature on racism and nursing, highlighting gaps in the literature and justifying the relevance for the theoretical framework. Chapter 4 presents the findings from the interviews under the light of the theoretical framework and previous empirical research to highlight the existence and nature of the somatic norm (Puwar, 2004) in nursing. Chapter 5 finishes with concluding remarks and about how findings relate to wider debate on how the somatic norm fits under nursing discourse. The appendix section includes a table of participants, a project diary, in which I reflect on my academic and personal progress throughout the placement, and the Interview guide, Consent Form.

Chapter 2: Methodology

This study seeks to unveil the workings of the somatic norm that prevails in nursing and endeavours to make it visible. This chapter elaborates on the methods used to conduct the empirical and desk-based research which were used for the purpose of the study.

2.1 Sampling and interviewing Strategy

The sample of interviewees for this research is constituted by four racialized minority nurses, four white nurses and a white nurse by training, now councillor for Royal College of Nursing for a total of nine participants, ages 30 to 60 (see table in appendix 1). Interviews are semi-structured and lasted between 40 to 70. All interviewees had lived and worked in either Edinburgh or Glasgow for at least six months. Initially interviewees were being contacted through contacts in the RCN who promoted the research via email and social media (twitter). Later on and because of low response rates, participants were also recruited through direct interaction within hospitals and via social media. The LBCLAD program contributed to promoting the research via email. As a result, one white nurse was recruited over email though the RCN, two were recruited directly in the hospital, one over Facebook and one via the LBCLAD program. All four of BME nurses interviewed were recruited through the LBCLAD program.

The approach of semi-structured in depth interviews was chosen to gain trust of the participant when discussing about race which is a sensitive topic, both with RM and white participants. Interviews were led through a conversational tone, leaving space for participants to add any insight they deemed relevant while still allowing me to direct the conversation back to the topic in the case of excessive divergence. Questions were prepared in advance in order

to properly answer research questions including questions about work environment, experiences with racism and, basis for antiracism (universalism or particularism). Before the interviews, interview guides were sent out to all participants, presenting them with my research, their rights (anonymity, withdrawal…) (see Appendix 2). When this was not possible (two interviews took place on the same day than recruitment), the interview consent form reiterated these rights before the beginning of the interview. Participants were left the choice of the location where the interview took place. During the interview, the participant would first be presented with the consent form and their rights were orally reiterated before the beginning of the interview. Interviews were structured in such a way that participants would first be asked about their work and relationships and later about race. The first part of the interview included participants telling me about how long they lived in Edinburgh or Glasgow, what they liked about it, why they chose nursing etc. This helped me guarantee their insights were as complete and thorough as possible while allowing them to feel comfortable and safe. The interview only after moved on to discuss more sensitive topics such as race. Much of the findings are based on elaborations about specific experiences interviewees raised. After the first interviews, and the theme of culturally competent care emerged, some questions about universalism and particularism were added to which helped me get a more precise idea of how nurses situated their practice within these principles.
All interviews were sound recorded and transcribed by the researcher. Anonymity is ensured by pseudonyms, attributed to participants on the basis of their country of origin (Appendix 1).

2.2 Coding and Analysis

The coding process was central to the analysis step in highlighting correlations between the theoretical framework and findings from the interviews. An analysis software (Nvivo) was used to identify recurrent themes that came up during interviews and later match them to concepts developed in the theoretical framework and previous empirical research through its nodes functionality. Reflexivity was used throughout by ensuring flexibility of the coding process and changing themes when needed. This was particularly relevant for the last section, where the study considers the strategic use of universalism by RM nurses.

In addition to interviews, this research also contains references to previous studies led on nursing (can be found in the literature review) that can help give context to the findings.

2.3 Ethical considerations

This research is guided by a feminist standpoint epistemological perspective which means it aims to give a voice to oppressed groups, for instance RM nurses. To achieve such a goal, identifying the concealed standpoint the interview bestows is essential. Constant reference and dialogue with critical race theory are used for this purpose. This position also presupposes acknowledging the power imbalance between interviewee and researcher. Given the sensitive nature of the of the topic as well vulnerability of nurses and RM nurses in particular, pseudonyms were attributed to each participant and interviews were completely anonymized.

A dilemma I faced during the whole research process was the concern of being critical of the experiences participants shared, especially RM participants who are more vulnerable. The way I dealt with this insecurity was to base my research on critical scepticism and radical reflexivity (Deliovsky, 2017). The way I engaged in RR differed between RM and white participants so they will be examined separately.

RM is a group generally victimized in research which contributes to marginalize them (Solorzano, 1997). Radical reflexivity allowed me to find the right balance between acknowledging participants were subject to social constructs and being aware of their agency in the research process. Blee (1998), has showed how participants can use impression management during the research to serve their own interest in a way that limits the "presumed absoluteness of the researcher's power" (1998: 385). As such, radical reflexivity justifies the need to situate participant's accounts within broader social dynamics, because they do have power over the research process. To be thorough, the analysis must use the relevant social dynamics to highlight what the participant's use of their agency (through impression management for e.g.) reveals about the object of study. With RM participants, this entailed research about anti-racism in RM groups. Furthermore, for the sake of reflexivity, I also consider how my race (mixed black African and white French), may have affected responses I got from participants. With RM nurses, my race has certainly been helpful (as they themselves stated) in both recruiting them in getting them to open up to me about their experiences. In that sense my race played as a "racial passport" (Picca & Feagin 2007: 23) to RM nurses' experiences.

With white participants, my race and French accent may have limited my access to white nurses' insights. Previous research indeed indicates that white participants are likely to change their responses and behaviour when speaking to RM researcher (Deliovsky, 2017). To still produce quality research, and given the limits in time and scope of this study, I engaged in impression management, mostly with white participants to foster good research climate. It translated in not systematically sharing with them my opinions if I disagreed with something

they said, if I felt this wouldn't benefit the research. It also involved highlighting classed elements such as the institution I am part of to gain their trust. While impression management limits my openness as a researcher, it is justified in that participants do have power over the research process and do invest in impression management that needs to be considered in the research. To uncover these processes, I pay throughout attention to how nursing is situated, in terms of class and power. By doing so, this study aims to provide an accurate and detailed account of how the somatic norm operates in nursing.

Chapter 3: Literature review & Theoretical Framework

In this Chapter, the literature about nursing will be examined through literature about healthcare when relevant.

Academic literature about racism in nursing is divided in focus to address racism within healthcare institutions (Shaha, 1998). On one side is the dominant trend in academia, here qualified under 'multicultural' anti-racist research. On the other side, is research, largely influenced by critical race and post colonial theories, that explore norms within nursing and healthcare (Shaha, 1998).

This literature review will proceed with exploring multicultural anti-racist academic literature, its contributions and limits, namely, it is based on a flawed multicultural model. This will be highlighted by the second half of the section. It will later turn to empirical literature inspired by critical race theory to how multicultural research has shaped nursing and argue it is flawed in its anti-racist purpose. The last section will present the theoretical framework, the somatic norm (Puwar, 2004), that will be used later for the analysis and emphasize how the institutionalization of deficit model needs to be identified as the main factor for racism in nursing. Literature examined in this chapter concerns research led in Global North[13] countries, that present high similarities in institutions and therefore relevant to the Scottish context (Keshet et al., 2018).

[13] North America, Europe and parts of Asia that disproportionately control global resources.

3.1 Multicultural anti-racist research: individualist research

Multicultural anti-racism characterises research that has been conceived in a "post-war western world" (Lentin, 2005: 380) to address racism and therefore carries anti-racist potential (Berman & Parides, 2017). Multicultural anti-racism in healthcare is understood as originating from, inter alia, an analysis provided by Leininger (1991) describing shift from culturally homogenous to multicultural societies, and thus, justifying the investigation of the care of culturally different client and their preferences. It is assumed this shift inherently leads to conflict between the different ethnic groups because of culturally defined preferences that differ. Two strands of empirical research have subsequently developed. The first evidences inequalities in the health of RM (Barbee, 1993). Krieger (2014) for example, showed RM were more likely to suffer hypertension, low birth weight, premature labour and other issues. The second points to inequalities in access to jobs in healthcare and highlights the fact healthcare organisation in the Global North are essentially white (West & Nayar, 2016; Keshet et al. 2018). Racism in the nursing in the Global North is identified as a recurrent problem (Keshet et al 2018, Priest et Al 2015, Mapedzahama et al. 2012, Tuttas 2015, Williams et al. 2009, Deacon 2011). In fact, RM nurses are more likely to face racist harassment from colleagues than patients (Betts and Hamilton 2006: 72).

Multicultural anti-racism thus, has produced mainly two strategies to address these problems: the needs for first, healthcare professionals to improve their cultural literacy, and second, to adopt patient-centred care. Cultural literacy and person-centred care emphasize the need, in order to provide "compassionate and dignified care" (Manley, 2008:12) between professionals and professionals and patients, for better listening of the patient's need, as they define them and respect their needs may be framed by cultural preferences. These strategies are seen as improving care for RM and improve representativeness of RM within healthcare institutions (Shaha 1998: 145; Essed, 1991; Wievorka, 1995). For example, Murphy and Clark (1993), who qualitatively researched experiences of nurses caring for ethnic minority clients in the UK, highlighted factors that could prove problematic for good care of BME patients. Difficulties in areas such as communication, relatives and visits, feelings of frustration and stress, and lack of knowledge about cultural issues, all contributed to hinder good healthcare of culturally different clients. Maintaining an ethnocentric attitude with clients could therefore result in difficulties in the healthcare provider to patient relationship. They recommend adapting to needs of these patients though educating healthcare professionals to different cultural norms, for the sake of the patient' satisfaction. Culturally adapted care has been adopted by many scholars as a way to remedy to health inequalities between races (Shaha, 1998: 145; Essed,

1991; Wievorka, 1995). Language is portrayed as essential, in both aims of increasing diversity in the workplace and improving the care for RM patients (Johnstone & Kanitsaki, 2008; Jennings et al., 2018). For example, in investigating the nursing setting in Australia, Jennings et al. (2018: 114) have advocated for cultural safety to tackle unequal relationships between indigenous patient and healthcare professional. Their findings reflect how speech can fundamentally alter power dynamics between patients and carers. Professionals, through their speech must thus be willing to minimise their power and high words, and relate to their patient more equally (2018: 114). Although this research does recognise a structural power imbalance, it is only between the patient and the professional. At the core of the reasoning is the need to respect patient's culturally motivated choices.

In contrast, more and more studies, have sought to unpack this anti-racism. This strand of the literature is concerned with showing the limits of the previous approach and mainly inspired by institutional racism studies and critical race theory (Anderson, 2006; Anderson et al 2009; Barbee, 1993; Taylor et al., 2008). Scholars established a strong empirical basis justifying the need to move beyond multicultural explanations and frame health inequities as the result of broader social trends (Barbee, 1993; Blanchet Garneau et al., 2018: 4). For example, Blanchet Garneau et al., (2018) showed dietary practices have until now been framed as cultural choices that have an impact on health. This results in ignoring more immediate factors such as affordability of food, which are highly impacted by class.

Furthermore, in researching tensions and coping strategies from health professionals in ethnically mixed teams, Smedley et al. (2003) and Keshet et al. (2018) found a correlation between multicultural anti-racism a "marked silence pertaining to racial and ethnic discrimination experienced by professionals belonging to minority groups" (2018: 952), a silence that may turn into denial. Racist incidents indeed remain widely underreported in the UK (Hagey et al., 2001). In understanding this silence, research showed the omnipresence of colour-blindness in nursing discourse and institutions (Culley, 2006; Barbee, 1993). Colour blindness was defined by Frankenberg as a perceived ability not to notice colour, key feature in the "power relations of racism" (1993: 30). Puwar later characterized colour blindness as a myth and the "centrifugal force in imposing whiteness as the norm" (2004: 117).

Colour blindness in nursing exists through a "highly decontextualized individualist discourse" (Culley, 2006: 145), that multicultural anti-racism does not address. Nurses, in nursing discourse, are constructed as colour-blind and class blind, treating ill people from micro level causes indifferently (Barbee 1993). This individualist discourse has proven

essential in the ways nurses deal with health inequalities, including those influenced by racism: "Nursing discourse ignores macro-level dynamics, that embed nursing in unequal relations of power that inherently shape the nurse-patient and nurse-nurse relationship" (Harrison, 1994: 93). Nurses are assumed to transcend racial and class biases" (1994: 93). In investigating nursing practice, Barbee (1993), found there was an important emphasis on empathy and labor (or professionalism) of nurses in nursing discourse which was internalized by nurses. Leininger & Watson (1990) argue caring is essential to nursing practice. Nursing education is identified to be central in this emphasis (Barbee, 1993). Back then and still today, the major focus of the practice is individualistic (Andrews & Roy, 1991; Keshet; Jennings et al., 2018). Multi-cultural anti-racism, through patient-centred care does nothing to tackle this individualism. Morgan, as early as 1984, proved this focus led to racism. While investigating influence of individualism in nursing student's racism, found Euro-American nursing students perceived black patients more positively than black people but not as well as Euro-American patients (1984). They point that the difference in perception of black patients and people can be explained by the power imbalance when a black person is a patient. Caring is here fundamental to nursing practice. Later, similar research by Eliason and Rahiem (2000) found nursing students were more uncomfortable in treating RM patients, while reporting they felt as comfortable in dealing with RM and White patients. In this context, naming racism is particularly challenging as nursing culture fosters a climate denial of racism (Ngum Chi, 008). In investigating effects of racism on nurses, Cottigham et al. (2018) found RM nurses needed to engage in emotional labour in addition to their nursing work. This emotional labour works to preserve the racialized power in predominantly white organizations, at the expense of RM staff's well-being and performances (Wingfield & Alston, 2014: 280).

It is likely, then, that values present in nursing in the Global North, namely empathy and professionalism, need to be reframed as colour blind values. To better understand how they work to exclude RM, the next section will explore their institutionalization.

3.2 Theoretical framework: The Racialized Somatic Norm nursing

To better understand workings and consequences of the colour blind discourse in caring, this study uses the concept of somatic norm set out by Puwar (2004). It provides an institutional understanding of the nature of racism that is relevant because of the institutionalised nature of the multicultural anti-racism. Puwar's framework helps reframe the micro manifestations of

racism as part multicultural anti-racism (Solomos, 1999: 3). Institutional racism can be defined as:

> "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people" (MacPherson of Cluny 1999: 45).

Institutional racism perpetuated through the somatic norm (Puwar, 2002, 2004). The somatic norm is defined as the corporeal imagination of power as naturalised in the body of white, male, upper/middle-class bodies in the case of senior civil servants (Puwar, 2002, 2004). For the sake of this study, only race and to some extent class are explored. The core of the somatic norm is disembodiment. Which means the individual human is a universal entity that includes everyone, regardless of their race (Mills, 1997). Mills problematized this idea; for him, the disembodied human is an illusion "because a particular body – the white male body – is the presupposed somatic norm" for this mind-body decoupling (1997: 53). According to him, this is an essential condition for a capitalist society, fed by the formalized colonial project of racialization of personhood. Exclusion of black people is latent, way more difficult to name, camouflaged by the very recognition of humanity in all humans (Mills, 1997: 75). This recognition, Mills (1997: 76) argues, is the result of privilege.

It is now possible to establish a parallel between multicultural anti-racism and racist outcomes. Nurses are presumed to be capable of abstracting race to only see humans. In that sense, empathy, work and caring are here argued to constitute the somatic norm in nursing. Anti-racist multiculturalism may also be characterised as whiteness. It orientates bodies in specific directions, "affecting how they take up space and what they can do" (Ahmed, 2007: 149). Non whites are not formally excluded from white spaces. However, when they enter, they are seen as outsider, or 'space invaders' (Puwar, 2001: 657). In a way, the entrance of these bodies in these officially race neutral spaces racializes them. When dissonant bodies enter a white space, tensions arise. This is because RM nurses are not expected to be capable of exercising care, empathy and work like white nurses and face strong reactions when they enter nursing space (Puwar, 2001: 657). The somatic norm's power lies in the fact it does not formally exclude RM from spaces of society; it only does so indirectly, which does not completely preclude them from integrating spheres of society that are not shaped for them. For instance, while researching anti-racist strategies of African-American elite Lamont & Fleming

(2005) found that universalist values such as education and competence were highly valued strategies for equalization. Namely, they are used to discredit stereotypes about African Americans (2005: 29). However, these strategies actually reflect standards of American individualism and result in the exclusion of many poor and working-class African Americans.

Having set out the theoretical groundwork for the concept of the somatic norm, I will present the central hypothesis of this paper. It can be summed up as such: the somatic norm in nursing, through principles of empathy, work and care, results in the exclusion of black nurses. Now that this Chapter has provided a theoretical basis for this hypothesis, the study will now carry on with exploring some of the key findings from the interviews to test the hypothesis.

Chapter 4: Empathy and professionalism: The Racialized Somatic Norm in Nursing

This chapter explores how the somatic norm, through the principles previously addressed of empathy, professionalism, contribute to the exclusion of RM nurses. This relates to the research question: is the somatic norm reproduced within and through nursing in Scotland?

Analysis will follow Puwar's (2004) somatic norm framework and findings are discussed in the light of the main concepts she lays out. First section 3.1 will discuss processes of disorientation and amplification RM nurses face when they enter the nursing space. This will show that by entering nursing, RM people trespass a border, making them intruders. Section 3.2 will then analyse how this status makes RM nurses highly visible and requires significant work on their behalf to remain in their position, in that sense, the assumption is they are illegitimate occupants. Lastly, the analysis will probe further in section 3.3 by showing how RM nurses are not completely outsiders to the somatic norm. They indeed possess a capital that allowed them to enter in the first place, and can use this capital to subvert the norm from within.

4.1 Disorientation and Amplification: Racialized Minority Nurses as Intruders

This section seeks to answer the first sub-research question: *What happens when RM bodies enter nursing in Scotland?*

It explores the concepts of disorientation and amplification through experience of RM and white nurses. They help in highlighting how empathy, professionalism and care, (at the basis of nurses' practice), act as barriers, making fitting in highly challenging for RM nurses. In particular, they highlight events and reactions when RM bodies enter nursing, which indicate they are intruders.

4.1.1 Disorientation: 'I want another nurse'

Disorientation manifests particularly through one theme that came up consistently throughout interviews, the refusal by some patients to be treated by BME nurses. Disorientation presents an aspect of surprise and direct confrontation (Puwar, 2004: 50). Through the example of senior civil servants, Puwar (2004: 42) finds that the disorientation manifests through the presence of a particular body representing a dissonance. In nursing, the menacing presence disrupts a white institutional space based on empathy, professionalism and care. It manifests itself in the constant questioning of the intruder's presence. The study will explore its manifestations by looking at accounts of RM and white nurses.

RM nurses:

Most RM nurses interviewed could recall being rejected by patients who asked for a different carer themselves or by their families. Asypha, a RM nurse, 13 years of experience for example, when asked if she had ever been treated differently by patients because of her race recalled that "a lot of patients" had refused to be cared by her. Often the reason invoked was the patient could not understand what the participant was saying. An indication that this is strongly related to race is that Paula, a white nurse with a strong Eastern-European who had worked in Scotland for 13 years, has never got rejected by patients.

White nurses:

When asked if they witnessed a racist incident, white nurses could also recall instances where some of their colleagues were refused by patients. Sheila, a white nurse with 20+ years of experience, shared the following experience:

> In my previous job, there were three Indian nurses that worked with us and they were excellent nurses. But some of the patients didn't like them to do their personal care and some are really quite nasty. Patients were like "we don't understand what she is saying" but their English was perfectly fine, it was just that they weren't in tune to it, because of accents. I remember one particular example when a patient was really quite nasty and told the nurses "I don't want you looking after me, you can't understand me". But their English was perfectly fine. It was just that they weren't in tune to it.

These examples first show some patients do not expect RM nurses to be able to perform care, because they lack the essential qualities of professionalism and empathy as participant 3's story shows. Then, these examples also illustrate how race can indirectly be targeted through different criteria. Bourdieu (1984: 102) has argued that in fact, "a number of criteria serve as a mask for hidden criteria, for example, requiring a given diploma". Language and accent often came up as reasons for refusing to be cared for by a specific nurse. Accent can serve as a mask because it is only indirectly racialized. Requesting a different nurse because of misunderstanding due to their accent can be portrayed as a purely practical request, and therefore mask the racial bias.

These two examples show how RM nurses' presence is automatically questioned as soon as they enter the space of nursing.

4.1.2 Amplification and terror: professionalism and empathy as white prerogatives

Beyond the initial disorientation they face, RM nurses are also confronted to what Puwar describes as amplification of numbers. When black bodies enter white spaces, their presence is automatically more visible, they are seen as taking up more space which represents a threat. Even if only one body enters nursing, their presence will be amplified and exaggerated, provoking terror (Puwar, 2004: 49). What is important to note is that the terror comes from the fact the occupier is known, rather than unknown. The occupier's identity is indeed already categorized and heavily conceptually laden. In exploring categories black and white bodies belong to, Butler (1993: 18) shows how the norm is characterised by vulnerability of white people. These categories justify the different treatment of RM bodies, based in appearance reasonable criteria, that work to hide the real criteria, terror. Experiences of RM and white nurses corroborate this hypothesis.

4.2.2.1 RM nurses:

Two themes in RM nurses' accounts indicate they faced terror upon their entrance: being ignored and bullying and harassment. All RM nurses interviewed reported feeling little support by their colleagues and sometimes being bullied or harassed. Among the insights shared during interviews, no experience demonstrates this more accurately than Abie's, a RM nurse who has worked with 2 year of experience in Scotland. She expressed receiving no help upon their arrival, neither from teammates nor their mentor which given the fact she was new, should have provided support. She describes their experience as such:

> My mentor tried to avoid me as much as she could on my first week. Anytime I'm with her she'd be trying to leave me.

During a meeting that took place after a few days working in their new ward, Abie was told by her manager she were too enthusiastic. Their situation kept deteriorating afterwards. After correcting a carer for a minor mistake, she got consistently assigned to this particular carer who was apparently a bully turned out to privilege helping other nurses over the one they were assigned.

> They said, forget about this thing, we've been doing this job for 30 years. I thought it was the end of it, I didn't know they carried this thing in her mind. They have this clique and they went and told them. I noticed they always put me with this carer because she was a bully. But as a professional you should be trained to work with anybody. In the morning she would be with me. At the end she would go on the other side to help them (the other nurses). […] But these carers they control the ward, they have been there for 30 years sometimes and they have so much power.

As a result of this lack of support, Abie made a minor drug error for which their manager called them for a meeting.

> The nurse manager called me in her office with other people. Normally, this is not a big deal, you do reflection, but that was not it. She said that because of the mistakes I made, I'm going to go down and get another uniform, get a carer's uniform because "you're under probation".

Different issues emerged from this example. First, the reaction the carer had when Abie corrected them shows a level of defensiveness about what they consider their territory. Their territory appears to be connected to their work and professionalism. By saying "this is the way

thing are here", they defend the identity of the space and their authority over it, leaving no room for an outsider. Their reaction shows the importance of tradition which can be seen in the nursing context as an agent of whiteness. Not only did Abie enter this predominantly white space, but she openly questioned tradition and competence which then, legitimates retaliation. Abie's behaviour was interpreted by white nurses through the lens of terror, which justified the attitude to be punished, in the form of bullying, and being constantly assigned to this carer. Here, the reaction to mistakes or questioning is a clear indicator of paranoia, triggered by the entrance of the RM nurse in a white nursing space. The fact, finally, that Abie was then asked to wear a carer's uniform, a position that is hierarchically lower than a nurse, shows a violent attempt to reject them from the nursing space, and punishment for daring to behave as if they belonged.

Professionalism in nursing can be seen as contributing to it being a problematic territory for RM nurses to enter. Their entrance deeply questions white nurses' claim territory which constitutes the terror white colleagues felt when Abie entered the nursing space.

4.2.2.2 White Nurses:

White nurses, in their accounts, were defensive about being called a racist, directly or implicitly. Defensive behaviour is indicative of paranoia. Paranoia because the threat perceived by white nurses is disproportionate compared to its reality, which for instance lies in visibility of race (Puwar, 2004: 40). More precisely, white nurses showed paranoia when their professionalism got questioned by direct or indirect racist accusations. Paranoia works to justify whoever feels it, in the case of white nurses it works to reject its object: the visibility of race. After going over white nurses' experiences, this section will highlight four themes which emerge from them: professionalism and its manifestation through person centred care; vulnerability of the profession and empathy. This will help to understand how these themes contribute to the sentiment of terror white nurses feel.

Racism was at the very least a touchy topic for white nurses, and there was not much space for discussion. For example, when Sara, a white nurse with 34 years of experience, and I were discussing the responsibilities her job entailed, she interrupted the course of the interview to express the following feeling:

> In nurse training, we are taught to be non judgemental, to treat everyone the same. It (the patient) could be a murderer, it's part of the core principles of nursing and midwifery. We are

> taught not to discuss religious, sex or politics. I've always just treated all my patients the same. In the late 90s, the law changed in respect of when anyone who is an ethnic minority accused you of being racial against them. It was then to the healthcare professional to prove they were not being racial. The person accusing them doesn't have to prove anything. We get complaints from everyone, but I suppose racial complaints are a bit harder to deal with. How do you prove you're a good person? Before, it was not really a complaint, you'd speak to the person and try to explain. Today the complaint goes straight to the practice manager.
>
> (Researcher): So the burden of proof was reversed, how did you feel about that?
>
> For me as a nurse, I love nursing, I love all my patients. For me it's quite insulting. We have to be careful that it's fair. Care professionals are under a lot of pressure and adding this aspect on top can be quite stressful […]. What is difficult for me is when the husband interprets and doesn't want an outside interpreter. My loyalty is to the patient. But I'm used to that. Sometimes, some doctors have insisted the husband left if they felt the wife isn't getting service she needs.

Another white nurse, Fiona, who has 17 yeas of experience, when I asked them if they had ever witnessed a racist incident at work showed similar feelings to Sara's. She first described a racist instance with her colleagues where one of them made a comment about a type of ice cream called "Black man" during one of their breaks. They told them "you're in your uniform, you're meant to be professional".

Fiona carried on with sharing what they perceived as a similar experience in the indignation they felt:

> Another time though it was actually done to me (being called a racist). "A black gentleman accused me of not treating him because he was black". But it was really annoying to me that he would say I wasn't treating him because he was black.

From these accounts, four themes emerge.

Professionalism

Both these extracts show ambiguity in what white nurses consider to be racism. First, they showed irritation at them personally being called a racist or when implied during causal conversation. Second, when the neutrality of the profession is being questioned. They justified this frustration by arguing their professionalism was a barrier to racial considerations. This

leads to the idea racism does not seem to have its place in nursing per se, and is more a matter of individuals rather than the institution (Culley, 2006). Racism here is clearly understood as an evil that needs to be fought and nurses view professionalism as a means to fight it, which echoes culturalist discourse in nursing (Shaha 1998). When it was implied that Fiona and Sara were being racist, it was a direct attack to their professionalism, that seems very tightly related to their human qualities as displayed by Sara's assertion "how do you prove you're a good person?" and their feeling of annoyance to doubting they were not racist. It also shows the degree to which they were prepared to defend themselves and their professionalism and how nursing values are highly internalised by nurses (Barbee, 1993). Supremacy of professionalism therefore justifies the proportion of nurses reaction when it is questioned and feeds the amplification of the threat the visibility of race poses, which indirectly leads to discriminate because of race.

Person Centred Care

Participant's professionalism takes the form described earlier in the literature review of person centred treatment, compatible with considering cultural differences, but ultimately comes down to respecting people's choices and preferences because culture here is framed as the issue of the individual rather than society (Vandenberg & Kalischunk, 2014). At the bottom line, nurses are here to cater to an individual, which results in individualising their issues and downplaying the structural importance of race (Blanchet-Garneau et al., 2018). This person-specific treatment is shown by the emphasis on person-centred care mentioned by Fiona as treating people how they want to be treated rather than how you'd like to be treated. It is also shown by Sara's claim that their "loyalty is to the patient". White nurses showed deep belief that this type of treatment was the solution to make sure everybody had access to fair treatment. This belief in the fairness is what leads to terror when paradoxically, assertions of racism enter the nursing space. Or when culture seems to contradict professionalism, as illustrated by Sara's difficulties in a situation where "the husband" was the only medium between the nurse and the patient. Then, it is justified to go against culture for the patient's best interest. Person centred care can therefore be seen as powering reactions of amplification as it justifies the invisibility of race and conversely the amplification reaction when it is made visible.

Working conditions

Sara's reaction also shows a level of self-victimization or rather victimization of the profession. This fragility can also be seen as a reaction to the material condition of nurses which reflects

real and justified insecurity. Hierarchy in the hospital is highly visible, if only for uniforms staff has to wear. Doctors are looked up to in society and have authority within the hospital, whereas nurses are often overlooked (Bertossi & Prud'Homme, 2011). Furthermore, nurses in the UK are indeed highly understaffed as mentioned in the introduction. Nursing seems to be subject to lack of means as pointed out by several participants and high pressure, leading to unfair working conditions. In this context, there is resentment towards upper management related to a general sentiment in nursing of feeling misunderstood by higher management as evidenced by phrases such as "let them come and do the job" or "managers don't understand" talking about senior management, which came back relatively often throughout the interviews. Central to these quotes is that nurses have an understanding of their work that hierarchy does not recognise. This perception of being misunderstood and devalued by higher management makes questioning nurses' professionalism even more delicate. As professionalism seems to be a central element in dealing with pressure, questioning professionalism also amounts to taking away from nurses one of the main source of support they have.

Empathy

Looking briefly at nurses' accounts of their professionalism helps understand their reactions when it is being questioned. Throughout interviews, white nurses gave out the impression they highly valued their work for altruistic reasons. For example, Sheila highlighted:

> You know you're looking after people, treating them with dignity and respect as I'd like to be treated, it's a feel good factor.

Fiona and Sara also placed an emphasis on their dedication to their patients and the education they had received that helped them administer fair treatment to patients. Here education is portrayed as a legitimising factor to nurses' behaviours, and nurses' anti-racism. As Sara puts it:

> In nurse training, they teach to be non judgemental, to treat everyone the same and not to discriminate against anybody.

Empathy appears to be central in white nurses' sense of self-worth. Together with professionalism, these values highly internalized by white nurses. It also appears to be central in coping with difficult working conditions. It is then easy to understand their unwillingness to

question it, especially if it comes from outside the nursing circle. This paranoia is also qualified as white vulnerability (Butler, 1993: 16). Together with working conditions, related to class, it appears white vulnerability can be tenfold. Paranoia in nursing is therefore intrinsically tied to the empathy, care and professionalism, as well as working conditions.

4.1.3 Organizational terror

Finally, the results of the interviews also showed some aspects of organisational terror, which is the fear that black bodies will alter the look of the institution, mainly through regrouping (Puwar, 2004: 52). By regrouping on the base of their race, minorities would become more visible and therefore an integral part of the institution. At least, this would mean for the institutions acknowledging the presence of race in an institution that pretends it does not exist, leading to the actual loss of power of whiteness. At worst, the fear is that they will take the central place in the organisation. This perception came to light with the accounts of white nurses, who addressed the absence of an institutionalized RM community.

Participants have indeed highlighted there existed support groups for disabled people, for smokers, even for runners, but not race. Michael expressed the following concern which was also addressed by Sheila:

> I'm part of the Royal College of Nurses RCN and we have an annual congress where we raise these issues. Every time you get something proposed with a racial element to it, you get lots of objections […]. White people either don't see race as an issue or can't imagine anything that can be done that would not place them at disadvantage. Under Equality Act 2010, if somebody has a disability, they can go on an interview guarantee scheme.

This is telling there is a support in the RCN for disabled people but not RM. It shows a majority of the members (which comprise more than two thirds of nurses in Scotland) are opposed to create a dedicated space for RM within the union, where they only represent around 3% of the staff, highlighting the disproportion of the threat they cause.

To conclude and answer the sub-question mentioned above, through mechanisms or disorientation and amplification, this section has established RM's entrance in nursing provoke strong reactions of rejection, that are justified by principles of empathy and professionalism. Now this is established, this study moves on to explore how these initial reactions contribute to shape the rest of RM's experience in nursing.

4.2 Racialized minority bodies in nursing: Big Brother effect

Thus far, this chapter has identified and discussed ways in which the somatic norm in nursing created disorientation and terror upon RM people's entrance in nursing. An attentive look on the somatic norm reveals RM people become highly visible when entering a white space (Puwar, 2004: 60), which means they are on a constant mission to prove their worth, resulting in emotional labour (Cottigham, 2018). This section will attempt to answer the second sub-research question: *Are RM bodies more visible than white bodies in nursing? If so, what does this visibility entail?*

It does so by looking at how visibility manifests for RM nurses, namely, through the burden of doubt and super-surveillance.

4.2.1 Burden of doubt on RM nurses

> "Existing as anomalies in places where they are not the normative figure of authority, their capabilities are viewed suspiciously […] although they endure all the tribulations and trials involved in becoming a professional, they are still not automatically assumed to have the required competencies" (Puwar 2004: 61).

The Burden: more work

Data collected overwhelmingly confirms accounts of constant vigilance and caution. Darla, a RM Chief Nurse with more than ten years of experience, and Abie for example, recorded everything did at work in a journal, to have on record that they acted professionally. As an outlet as well as a safety precaution. Darla reported always double-checking her work, and since she becoming manager, consistently went out of their way to do extra work. The extra work as well as the journal show a lack of trust in the institution recognising RM nurses' competence. This extra work actually constitutes additional labour (Cottingham et al. 2018), thus the "burden" of proof. The burden of constantly having to prove themselves is highly related to the little trust RM nurses have for their healthcare organisations. To prove their professionalism, RM nurses therefore have to work harder than white nurses.

Lack of institutional and interpersonal support

RM nurses generally feel they were not supported by their organisation and express little trust in them. When directly interrogated about whether they trusted their institution's fairness, RM nurses all replied they did not. Asypha expressed the feeling "there are things the

NHS could do, but they don't. For example, racist harassment cases are mainly dealt with according to majority all RM participants by moving the plaintiff to a different ward. Interpersonal matters in this context and are left power reproduce racism in a nursing context. In reference to interpersonal relations, Darla alluded to the "culture of the NHS" where there is no penalty for racist behaviour, "they just move people". Supporting the importance of interpersonal relations, Michael, the RCN rep, also expressed that most of the conflicts that came to them were of interpersonal nature. Michael as well as RM participants point to the fact bullying seems to take the form of rigidity of flexibility in bending the rules. As an example of the difference in treatment, that nonetheless remained within the rules of the NHS comes from following experience shared by Asypha:

> I went down to get change for my bus, then to take my meal from my daughter. I got reported. They (other nurses) always take smoking breaks but smoking breaks don't get reported. Some of them don't do anything, they just report people.

This last experience reveals subtle ways in which interpersonal conflict prevail over the organisation rules and are very difficult to prove. RM nurses interviewed indeed all expressed the difficulty in proving that they are being treated unfairly by their white colleagues. This was also expressed by Michael in the following terms:

> I think people are getting smarter about how to camouflage racism behind policy (cases often concern drug errors). The policy says you're not supposed to make a drug error it is a clear breach of policy. Often, the arguments look something like "these two did the same and I'm the only one sitting in front of the disciplinary panel", you can't use this as a defence in front of the disciplinary. And nine times out of ten, cases get dismissed.

Inadequate material and human resources were considered by RM and white nurses, as some of the reasons for inefficient handling of the issues raised as cause for low institutional support and for not removing racist staff. Abie also mentioned that although she had been removed from their previous ward, rumours and gossip followed her to their new ward and she eventually decided to quit. Darla highlighted that she got no support when applying to higher up positions and in fact was dissuaded by their colleagues because it had "never been this way". There are indeed very small numbers of RM people in managing positions (West & Nayar, 2016). Abie reported that because her numerous applications for managing positions were all

rejected, she filled in a grievance complaint but expressed that it was a very long process and never succeeded. Because of the lack of support, both organizational and interpersonal, RM nurses therefore have to work more, to stay in the organisation and have the same rights than white nurses.

In contrast, white participants showed faith in the overall fairness of healthcare institutions in Scotland, they all highlighted that structures were in place in order to deal with racism in Scottish healthcare. Sara expressed this faith as such:

> Most GPs and nurses are quite good. We establish a good relationship with patients. In our training we're taught we get angry patients or relatives. But it's because they're worried, if you've got a bit of compassion, you try not to make it personal. Scotland is one of the fairest societies; in general, it's a fair society, when people come in from different places. There's a lot of support going on.

Michael also expressed that RM people should have trust in the remedies available to them because the legislation is in place. What is interesting here is that the same participant had awareness that RM people were overrepresented in the fitness to practice procedure. Despite this, they showed some faith in the structures in place as safeguards against racism.

This presumption of fairness in regards to racism fundamentally reflects the privilege of white nurses. Indeed, this faith that "things will end well" is a privilege that RM nurses cannot afford, being constantly confronted to counterexamples and can be summed up in Mill's words, "the fish do not see the water, and the white do not see race" (1997: 76). In that sense, the burden is solely carried by RM nurses.

4.2.2 Super-surveillance

The final theme that will be mentioned in this section is super-surveillance. When outsiders enter white spaces, they are subject to intense scrutiny because of their high visibility (Keith 1993, Sibley 1998). Their professionalism is not assumed, therefore the burden of doubt previously examined exists in close dependence with super-surveillance. Accounts of RM nurses unanimously confirm this. Asypha's example is particularly striking. She was reported five times in her first week. She expressed her impression on her treatment:

> If you reported me 5 time in a week, that means you're not doing your job, you must be watching on me. I said you should have asked me what happened.

This is the case previously mentioned where the participant got referred for taking a break to run short errands. High visibility also makes a mistake fatal to BME nurses' perceived competence and justifies the initial doubt towards it in the first place. Because they initially are out of their natural space, a mistake becomes a justification for the initial feeling of intrusion their entrance triggered and for their exclusion which appear clearly in the representation of BME nurses in the fitness to practice procedure. This super-surveillance requires minorities to be perfect, which involves self-surveillance (Fanon, 1986: 117).

To conclude, it is undeniable RM nurses are highly visible as not trusted to fit to nursing. This manifests in more work for them as they cannot trust their institution will recognise their professionalism an in that sense, carry a racist burden. Now this is established, it is possible to move on and examine how RM nurses survive in a hostile environment and what this tell us about their 'outsider' nature.

4.3 RM nurses in the scrub, outsiders/insiders

After discussing how RM faced violent reactions to their entrance in nursing space, this section will address the last sub-question: *To what extent and on what conditions RM bodies can enter nursing?*

This section demonstrates the importance to understand that despite RM's exclusions, they had to embody some aspects of the somatic norm in order to be admitted in the first place (Puwar, 2004: 119). It is all the more important that in the UK, as seen in Chapter 3, individualisation of RM downplays complex intersection between race and class structures (Bonnet, 2000). The concept of performativity (Butler 1996: 111) will be used to highlight how and to what level RM nurses are insiders in Scottish nursing.

The concept of performativity helps in understanding how the norm can bend, but only within certain limits. The concept of performativity will show the reason the scrub is white is because it was and is performed mainly by white people, instituting the necessary repetition in time of the characteristics that constitute the identity (1996: 111). In assessing to what extent RM nurses fit in the nursing scrub, this section will first look at how professionalism and empathy are used by RM and white nurses to justify their belonging. It will then continue with addressing the "gang mentality" that prevails in nursing.

4.3.1 Professionalism & Empathy

RM Nurses

When analysing RM nurses' coping mechanisms similar themes came up than for white participants. Participants placed great value on professionalism and universality of care. Firstly, about professionalism, the theme of education also came back often throughout the interviews. In that, recognition of their compliance to these values seemed to be a vital coping mechanism for RM nurses facing racism. Darla for example affirmed being better at their job than most of her colleagues. Asypha similarly said they were hard working. Affirmation from colleagues, patients and other outside sources also are particularly valued. Abie for example, showed me an extract of newspaper she had appeared in after graduating. When she was bullied, she manifested that feeling indignation from colleagues to her unfair treatment was helpful and acted as a validation the experience she were living was unfair.

Secondly, on empathy, her as well as Asypha and Abie showed attachment in caring for people, Abie for example exemplified this by emphasizing she valued understanding everyone's potential as a reason to enter in nursing.

These themes all points to the fact these nurses all had social capital (Bourdieu, 1984), mainly through education, which is seen as key in transmitting the dominant values in society. They were able to access these positions because they had college education and adhere to some extent, to core values of nursing. In that sense the somatic norm is therefore not absolute and leaves room for "outsiders" – who are not really outsiders because of their social capital – to perform nursing. This shows how categories are not fixed, rather, they are performed, because there is no such thing as a natural nurse (Puwar 2004: 80). This performance however, is limited because nursing remains predominantly white in numbers, and thus, through repetition of this norm has become white. This also shows how the somatic norm works to hide privilege. By allowing some outsiders in, the somatic norm becomes more difficult to grasp while still perpetrating racism.

White nurses

White nurses' perceptions further demonstrate that RM can perform nursing to a limited extent. When speaking about RM colleagues, which was often when they were asked if they had ever witnessed a racist incident, white nurses often emphasized qualities of their colleagues to discredit the racist abuse against them. They used adjectives such as "lovely" or "they were excellent nurses" to describe their colleagues. These qualities are however already racialized as we have seen previously. Professionalism and being a lovely in general are equated to whiteness. The simple fact they would delegitimize the racist incident by pointing out that the

nurse was competent or a lovely shows how much the RM people's quality resides in their ability to master codes associated to whiteness. This reaction ignores the fact that behind competence, it was race that was questioned. Professionalism's ability to alter racism is very limited and overrated, just as women entering politics and fitting the suit does not make them insiders, racialized minorities wearing the scrub does not make their race disappear.

In fact, speaking of racialized bodies with white nurses, carried some level of awkwardness which relates well with Puwar's observation that somatic speech finds it difficult to speak of BME bodies without eroticizing, fetishizing or ridiculing them (2004: 88). Indeed, when speaking about racialized bodies, white nurses often used caution and respectful language such as the term "gentlemen". Sheila for example showed some aspects of exoticization in speaking about a group of black Muslims they met on the bus, after being asked about whether they believed it was natural for people of the same kind to help each other. She notes:

> The ladies were beautiful, outfits and costumes and they were all stunning. I though they all seemed to get on together, they seemed very friendly

Acceptance here seems based on either competence, friendliness and beauty that appear as innocent and antiracist all derive from eroticising narratives that fail to consider racialized minorities equally because inherently marked by whiteness.

4.3.2 "Gang mentality"

Furthermore, accounts of RM nurses and previous research (Deacon, 2011), showed that besides professionalism, the importance of hierarchical and affinity based environment in nursing potentially amounting to what Darla qualified "gang mentality". In order to fit in with their team, nurses need to integrate codes inherent to such an environment. In the worst cases, this gang mentality results in harassment and bullying. Within such a system, members achieve respect through partaking in interpersonal relationships and/or gossip. Cliques and gossip were mentioned by all RM participants a Paula (who is from eastern-European descent). Whiteness and in particular Scottish whiteness seems to be a solid advantage if not a prerequisite for membership to the clique. Within such a system, members achieve respect through partaking in breaks (smoking breaks as Asypha highlighted) or in extreme cases bullying. Shawn (2002) who has investigated this gang mentality in the workplace shows that those who do not partake are quickly undermined when speaking out and ritual authority is central in sustaining

whiteness. James, a mixed-race nurse with 10 years of experience indicated speaking out against their bullying only intensified their mistreatment experience. Waddington (2005) has noted that gossip is a form of control because BME people are more likely to be targeted by gossip. In that sense belonging for RM may entail extreme negation of their race. Again these themes highlight the nursing context, which is that nurses are under high amounts of pressure and under staffed (West & Nayar, 2016). Interviews showed some defiance towards hierarchy, and although this needs to be further explored, bad working conditions, under-acknowledgement, as well as gendered dynamics could easily be correlated to the prevalence of gossip and harassment in nursing.

Hence, we showed here that RM's level of education and values (empathy and professionalism) allowed them to perform nursing, both structurally, in terms of education and later be accepted by colleagues. Their performance is limited for two reasons. First, in order to belong, they need to initially possess social capital, which is far from being the case of all RM people. Because nursing discourse does not recognise race as a structural mechanism, this discourse contributes to the marginalization of uneducated RM by not recognising structural obstacles to their education (Lamont & Fleming, 2005), which in return comfort the institution – for instance nursing – in the idea it is open to all (Puwar, 2004: 119).

4.3.3 Subversive potential of the somatic norm

This sub-section will briefly explore how racialized minorities can use the somatic norm strategically to subvert it. Fanon (1986) has indeed highlighted through the example of poet Aimé Césaire who used his mastery of French/white language to push forward a black agenda with concepts like 'Négritude'. Using the codes of power and whiteness, Césaire was able to make himself heard by white people and reclaim power to RM. There is however, a limitation in that Césaire was part of an elite group in terms of class as a result of having attended university. A similar remark can be made of RM nurses. I met with the leaders of the Leading Better Care, Leading Across Difference program. The program aims to provide a platform for nurses to find support, advise about their rights and leadership skills. While the program is designed for everyone, a special emphasis is put on understanding cross-cultural issues, embracing difference to enhance patient care and developing mentorship. The program leaders, who are RM people, are clearly aware of the racism problem in Scottish healthcare. However, their program is sold as a leadership program to improve cross-cultural issues with the end goal of enhancing patient care. In light of the analysis that was conducted throughout

the chapter, it is clear that these are values that are inherently white who's potential to help uplift RM people is limited . However, the potential of this type of program to deal with racism without naming it seems quite promising as the number of RM nurses on band six and seven (the highest in the hierarchy) went from two to thirteen after having followed the program. The program leaders were able to get funding as well as a platform with the Royal College of Nursing and recruit racialized minority and white participants. Most importantly, the program provided RM nurses with a platform, which has probably played a great deal in helping them, based on their testimonies. It is clear that the program actually addressed racism. However, helping RM nurses accessing more senior positions was presented as the end goal.
Although this is outside the scope of the research, the program shows a double nature that is interesting and deserve more attention for further studies.

4.3 Conclusion

This Chapter has outlined how the somatic norm works to exclude RM bodies in a Scottish nursing institutional context. The data indicates empathy, professionalism and person-centred care – essentially colour blindness – comprise a large part of white and to some extent RM nurses' practice and personal beliefs. It shows they are prime values in normalizing patient's and white nurses' responses to RM entering the profession, powering disorientation and amplification. Not only do these values make it difficult for RM to enter the profession, they also continuously challenge their belonging, resulting on considerable burden on them to constantly prove themselves, translating in emotional and physical labour. Finally, the Chapter reveals the complex nature of the somatic norm, which intersects with class. By doing so, it shows RM nurses are not complete outsiders to the somatic norm, as they possess the necessary social capital to enter the profession, but not enough to truly belong. The last considerations are dedicated to explore how RM nurses use their social capital to transcend the somatic norm, and paves the way for further research. The following chapter attempts to relate the findings of the study back to the broader discussion of how the somatic norm fits under nursing discourse.

4.4 Limitations to the Analysis

The first limit addressed here resides in the recruitment method. Recruiting nurses revealed challenging, especially RM nurses who in addition to being underrepresented in nursing, often occupy positions that make them work night shifts. In that regard, the representativity and diversity of the sample is limited. Furthermore, participation is based on a voluntary basis.

Participants, except for the two white nurses who were recruited directly in the hospital, had to make the effort to send me an email to say they were interested. Given the sensitive nature of the topic, this method probably already operated a filtering of participants. White participants who contacted me were probably initially open to talking about racism which based on the findings, is unlikely to be the case of majority of white nurses. RM participants who were interested were part of the LBCLAC program, which beyond the awareness of racism issues, indicates a will to tackle them and little isolation, which is also unlikely to be the case of majority of RM nurses.

A second limitation to the study can be found in that it leaves the gendered aspect of the somatic norm unexplored. In order to fully understand how the somatic norm filters down to less elite spheres of society, such as nursing, further research is important.

Chapter 5: Conclusion & Answering the Research Questions

The overall aim of this study was to demonstrate the existence of the somatic norm within nursing and by this, show it works to the exclusion of RM bodies. The specific sub-research questions were:

1) What happens when RM bodies enter nursing in Scotland?
2) Are RM bodies more visible than white bodies in nursing? If so, what does this visibility entail?
3) To what extent and on what conditions RM bodies can enter from nursing?

This chapter will proceed to demonstrate how the study has answered the different research objectives.

The literature identified empathy, and professionalism as central values to nursing in the global north. It suggested these values were internalised by nurses to form the somatic norm in nursing, resulting in the exclusion of RM nurses. Section 3.1 discussed how the empirical research provided evidence that showed RM bodies are not expected to fit these values. Upon entrance, RM nurses face two reactions by patients and colleagues: disorientation and amplification. Thus, their entrance causes rejection and terror as they are not expected in this space, and therefore, not trusted. This contradicts the common idea in nursing discourse that whoever possesses the nursing values can automatically belong to the institution of nursing, regardless of their race. It shows these values are seen as attributes of whiteness.

Secondly, Section 3.2 showed because RM nurses are not expected to belong, they are kept on close watch, and any mistake they make is interpreted as a proof they do not belong. RM nurses therefore are constantly on alert, and have to engage in physical and emotional labour their white colleagues ignore. This threatens their presence in nursing because in order to achieve the same recognition, they have to engage in considerably more labour.

Finally, Section 3.3 highlighted the intersectional nature of the somatic norm, that works to hide its racist nature. Indeed, the somatic norm is not absolute in that it allows for RM bodies to access nursing. But to do so, they need to adopt codes of whiteness that are transmitted through social capital. The somatic norm therefore marginalises some RM bodies less than others based on their class, without however, allowing RM bodies to truly 'fit in the nursing scrub'.

This study therefore provides further evidence to debunk the assumption nursing at its core through values of empathy, professionalism and person-centred care guarantee anti-racism. To

the contrary, they are seen as attributes of whiteness and embody the racialized somatic norm in nursing. It has nuanced this by showing these values are often fed by vulnerability of nursing position, introducing a class element to the somatic norm. This carries the necessity of a paradigm shift for education as well as policies healthcare organisations need to adopt in order to effectively address racism.

Moving Forward

A first step would be acknowledging the existence of race, through encouraging support groups in the institution for e.g. The Leading Better Care Leading Across Difference program has also showed promise and its ability to de-marginalize RM nurses deserves more attention. Finally, the research has highlighted some class elements that need to be addressed. Indeed, the fight against racism cannot be dissociated from class struggle and the fact nurses are overworked and under recognised appears central in the internalization of problematic values.

Project Diary

PART I

The start of my work based placement has been a very pleasant experience. After two weeks with CRER, I feel like my team is ready to offer me the support I need in order to produce quality research. The environment I am working in is quite similar to the one I am accustomed to in university. I am mainly working independently on my research and therefore getting accustomed to my new environment is relatively easy.

My first two weeks with Coalition for Racial Equality and Rights (CRER) have been filled with introductions to the CRER team and desk based research for my dissertation, to define more precisely the limits of my topic. I was explained my role as a placement researcher there. My work there is very autonomous. I will be collaborating mainly with Lesley Warren and Carol Young, respectively the Policy and Senior Policy officers. After discussing with my manager, we decided that I would come in the office between once and twice a week and work from Edinburgh for the rest of the week. I came in the office two days in the week of the 7th of May which was my fist week. My main task at CRER is the "Everyday Racism in Glasgow" research project, of which I am very much in control of. I will also be invited to join in on occasional tasks including blog posts and attending events.

The first two weeks at CRER were dedicated to defining the scope of the project and finding out who to interview. During the two days I came in, I wrote a short project brief for my colleagues who are helping me reaching out to participants to the research. My supervisor and I had come to the conclusion, that because of the time and scope of my research, a relevant group of people to interview would be hospital staff. After discussing it with Carol and Lesley, we decided to definitely stick with hospital personnel, and that they would help me recruit participant through contacts they have. We decided to take this approach, get organization consent that would help us reach out to hospital personnel rather than going straight to them, as hospitals are often busy and staff difficult to access. Because the research is on a sensitive topic, having the organizational consent would probably give credibility to the research and trust to the potential participants, rather than reaching out to them individually.

Hospital staff seemed like a sensitive choice of participants. Indeed, it was shown in a government census that most BME people living in Scotland worked in the 3rd sector industry. Hospitals present the advantage of being a third sector institution where workers both interact with a wide range of colleagues and patients. Hospital staff therefore have rich experiences full of interaction of diverse nature (work or healthcare service) and with a wide variety of people. In terms of reaching out to people, it also seemed like it would be easier to reach out to a hospital that will than advertise the research to their staff, rather than recruiting people

individually. I transmitted the brief to my colleague who is to help me reach out to people from the NHS who can help me find participants.
On a the theoretical side, I started researching what would be the framework of my research and for my literature review. I researched authors such as Balibal, Wallerstein or Lentin who describe the construct of Race as inherent to nation states. My idea is to describe everyday racism in Scotland through the framework of capital accumulation. From initial research, Scotland doesn't perceive itself as a racist country, in particular in comparison with the rest of the UK and especially England. This may be due to Scotland's history, of being oppressed by England and resent towards that history. Today, this still manifests in a general perception of England dominating Scotland and Scotland being exploited by England. This rivary with England seems to have fed much of Scottish identity, including the belief that racism is not an issue in Scotland. Scottish people perceive themselves as more left than the rest of the UK and more tolerant. Westminster is very much framed in the media as the oppressor and reason for Scottish problems. In this context, where Scottish people perceive themselves as being abused by Westminster, and have a general impression of being lower in the hierarchy of belonging than English. This adding to the fact immigration is quite recent in Scotland, compared to England.

At the end of the second week, I attended an event organised by the Royal College of Nursing and a program within the NHS called Leading Better care, leading across difference. The event was a conference about experiences of BME nurses in Scottish NHS. It was an interesting opportunity for me as some BME nurses attended the event. Although my research focuses on Glasgow, they may have contacts who would be willing to participate. The event was overall helpful. The LBCLAC program aims at providing support for BME nurses, as evidence shows they struggle to progress in their jobs. Support takes the form of 5 day training, mentorship and reflective collective sessions, to develop leadership. The event was helpful and instructive. The meeting included different testimonies of BME nurses who went through the program. Furthermore, many of them had also experienced racism. After the meeting, I was able to promote my research with the Royal College of Nurses, who agreed to promote the research via email and on social media.

PART II

In the second quarter of my placement, I further researched literature for my literature review, continued the recruitment process and went on a trip to Bucharest with my organization. I feel like I have made good advancements on the theoretical side. I am however concerned about the rate at which I am recruiting participants and am feeling the pressing need to attract more people to the research.

On the theoretical research side, after meeting with my supervisor at the end of the third week, I reoriented the direction my literature review was taking. I had previously researched macro explanations for racism with authors like Lentin, Aquino and Mann. I had intended to explain racism in Scotland by looking at capitalist nations states and the necessary creation of an Other in order to create a justification for state belonging. However, after meeting with my supervisor, we came to the conclusion that this would be too much work for the time and scope of a dissertation. I therefore started researching individual experiences of racism, somatic norms in healthcare, especially in Scottish nursing. I am drawing from authors like Sarah Ahmed, Nirmal Puwar to look at nurses' (working and living in Edinburgh and Glasgow) take on race equality. My goal is to draw from these individual experiences of racism and in order to explore the somatic norms in healthcare – a priori a neutral institution, or framed as one – and the impact. For this, I draw on similar studies by Nirmal Puwar and Michele Lamont who looked at the somatic norm in senior civil service and anti-racist narrative that was being used. Evidence suggests that senior civil servants are still expected to be white and that black senior civil servants have to face racial barriers in order to access it. It examines the tactics they use in order to face such barriers and narratives they adopt to justify their success. I intend to follow a similar approach in my research and explore Scottish healthcare institutions somatic norms. Healthcare professionals are represented as neutral, objective professionals, who's function transcend the bodily. They are generally represented as "good" and helpers. Nurses adding to that are overwhelmingly female. In relationship to the Scottish context, I want to use space invaders as an analytical framework in order to explore the relationship between nurses from various racial backgrounds.

At the end of my first three weeks, I went for a four-day trip to Bucharest with my organization. We attended a conference organized by a collaborating organization in Romania with various anti-racism organizations. During my time there I did little research directly related to my dissertation but that provided me with the context and different approaches anti-racist organizations are working with. The conference lasted one full day, was an introduction mainly to anti-racist training in the workplace. The rest of the time was dedicated mainly to team activities and discovering Bucharest. The conference gave an interesting insight although

contrasted of anti-racist initiatives. So far, I feel like it has made me develop skills in thinking critically with regards to what issues and debates anti-racist organizations face and the methods they use to address them. It was also a great opportunity to bond with colleagues.
After coming back from the trip, I continued to contact various professors of nursing at the university of Glasgow, Student Unions representatives in order to extend my pool of study and also recruit nursing students who have experience working in hospitals. Carol has circulated the research to other members of the NHS since the first attempt was unsuccessful.

Part III

In the past two weeks, I have stumbled upon some difficulties in the recruiting process which have taken up a lot of my time and have to say I am concerned with finding participants to the research. As a result, I decided to centre my research around nurses and nursing students.
They indeed seemed to be the group that was the most responsive and interested in the research. The recruitment process therefore was part of my daily tasks during these last two weeks. On my third week, I processed feedback from my supervisor and colleagues about my research and interview questions. In my fourth week, I had my first interview with a male nurse and decided to change the recruitment process. So far, I believe to have elaborated an interview guide that contribute to a safe environment for participants to open up about experiences of abuse and made some valuable connections with the Royal College of Nursing and the Leading Better Care, Leading Across difference program.
The Royal College or Nursing as well as some professors and PhD have circulated my research to hospital staff and students via email and social media (twitter) but with little response rates from participants. So far, only one person has reached out to me to take part (I need around 8). I decided to reach out to participants directly via social media. I send around 100 messages to people over social media (twitter and Facebook), posted the research on my social media pages and on Facebook groups of nurses in Edinburgh, Glasgow, and nursing students from different universities.

Along with my supervisor, I also elaborated an interview guide and interview questions. We agreed on a set of 20 questions regrouped in three categories. Given the sensitive nature of the topic, we She also helped me elaborate an interview consent form that would take into account participant' vulnerability. Indeed, I will be interviewing both BME (Black and Minority Ethnic) and white nurses. First, their employee status puts them in a in a vulnerable position

toward their employer as well as their colleagues. Second, I will be interviewing BME nurses, who are a vulnerable group because of their race. It is therefore important to make sure they understand their anonymity will be preserved and their integrity

In the 6th week, I conducted my first interview with a make nurse now working with the RCN. The interview was interesting and provided me with an insight of the professional setting of healthcare institutions. The interview has made me optimist about the data I could gather. The interview provided me with in depth context and after the interview, and I know feel like I have a better understanding of the functioning of hospitals and wards. I have afterwards slightly adapted the line of questioning in order to better fit nurses' experiences.
On a personal level, it has made me more confident in my radical feminist approach to the interviews. Indeed, discussing with the participant made me realize the importance of respecting their experiences while remaining critical and being open about it.

At the end of the 6th week, with the advice of my supervisor, I decided to change recruitment techniques and go directly to healthcare institutions and try to recruit people there with flyers and posters and by talking directly to the staff. This technique revealed to be the most successful. Upon my first visit to a hospital, I made two appointments for the same afternoon.

Part IV

In the last part of my placement, my data collection has really taken off. In these two weeks, I have mainly conducted the interviews and transcribed them. I conducted eight semi-structured, between 45mins and 75mins interviews and have continued reading more specific literature relating to racism in healthcare, anti-racism in the workplace. I have accessed insights I believe are very valuable for my research. I have further developed more questions. I also feel a lot more confident with reaching out to participants, and conducting interviews. The recruitment process has really taken off and I managed to find equal numbers of white and BME people take part in the research. I now feel positive about the data and experiences I have gathered and confident they will allow me to produce quality race research.

A first interesting finding is the prevalence of gossip and even harassment in hospitals. Out of the 10 interviews I have carried out, more than half the participants implied they had experienced in their careers working in teams where bullying took place. The participant who now worked as an agile worker expressed that this was the majority of the cases that came to

them and the Leading Better Care Leading Across difference have expressed that these were the majority of cases of racism they received.
It also seems like racism manifests differently whether it is between colleagues and patients and staff. The racism faced by hospital staff by patients is way more overt, and often the issue of accent and understanding. Racism between colleagues is way more difficult to prove, and takes the form of everyday racism, bullying, pretending not to understand, looking down on people and low tolerance for mistakes (lower than for white colleagues).
What was interesting is that most of the participants could remember witnessing a racist incident. However, none of the white ones, except the one working as an agile worker, seemed to fully understand the need for more antiracist training. Maybe due to low levels of BME workers in Scotland healthcare, the issue does not seem pressing to white participants.
The second is the importance of the chief nurse or team manager in setting the work environment. Again, all of the participants seemed to point out the fact that the manager was the key figure in determining whether bullying and gossip would be tolerated or not. This finding also speaks about healthcare institutions. It seemed like the safeguards to prevent any sort of bullying are quite low and that people are being reported to disciplinary action on the discretion of managers. They seem to have quite a lot of discretion in the matter and although some seem to use it in a reasonable way, others seem show favouritism and partiality when referring people.
The last finding is that Scottish NHS does not seem ready to effectively tackle racism within its ranks. While disability or even smoking is addressed and effort I being made to tackle these issues, racism remains widely underdressed. This may be due to the political nature of the topic and seems to reflect the wider Scottish context where racism is not perceived as an issue in Scotland.
At the end of the last week, I met with the LBCLAD team, which was particularly helpful and rich in findings. They confirmed the presence of bullying in NHS Lothian, between nurses as well as doctors with the term "culture of bullying". One of their main aims if to encourage work progression for BME people. Indeed, BME staff are way less likely to get selected for senior management positions than their white colleagues, with the same or sometimes superior level of education (Masters or PhD).

To conclude, I feel confident the data gathered throughout the placement will allow me to support my Masters dissertation. If seems like racism in Scottish healthcare services exists, in concealed and sometimes unconscious biases. It also seems like there is a gap between BME's

perception of racism and white people's perception of racism, and little will from the last, who manifested strong beliefs and values, to question these. I also feel confident that the findings will be useful data for CRER in their mission to fight racism in Scotland.

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Appendices

Appendix 1: Table of participants

No.	Date of interview	Pseudonym	Gender	Race & Ethnicity	Years of Experience in Edinburgh or Glasgow
1	18/06/2018	Michael	Male	White	25 (trade union representative for 10 years)
2	21/06/2018	Fiona	Female	White	17 (Chief nurse)
3	22/06/2018	Sheila	Female	White	20+
4	26/06/2018	Sara	Female	White	34
5	12/07/2018	Paula	Female	White – Eastern European	13
6	27/06/2018	Asypha	Female	Black Afrian	13

7	02/07/2018	James	Male	Mixed-Race	10
8	02/07/2018	Darla	Female	Black African	10+ (Nurse Manager)
9	13/07/2018	Abie	Female	Black African	2

Appendix 2: Interview Guide & Questions

THE UNIVERSITY *of* EDINBURGH
School of Social and Political Science

Title of study: "Everyday Racism in Edinburgh and Glasgow".
Research investigator:
Interview procedure

Interview type: Semi-structured

Length: 45 mins

Interview mode: In person or Skype

About this study

Thank you for taking part in the Everyday Racism in Edinburgh and Glasgow Research. My name is ***, I am a MSc student in Sociology and Global Change at the University of Edinburgh. I am conducing this research in partnership with CRER (Coalition for Racial Equality and Rights), an organization based in Glasgow committed to fighting racism in all its forms. We are committed to ethical research methods that respect our collaborator's integrity. This interview will be anonymized and its use will be confined to the purposes of the research. You can stop the interview whenever you want and anything you wish put off the record will be.

The purpose of this study is to explore the experiences nurses and attempt to answer the following questions: *Is the somatic norm reproduced within and through nursing in Scotland?*

Three research objectives will help answering the main research question:

4) Assess whether RM bodies' entrance in nursing trigger a reaction. If so, what reaction?

5) Assess whether RM nurses more visible than white nurses? If so, what does this visibility entail?
6) Evaluate to what extent and on what conditions RM bodies can enter from nursing?

These issues are of increasing importance; racist attacks against Black and Minority Ethnic hospital staff have risen since the 2016 United Kingdom European Union membership referendum. Furthermore, racism in nursing is growing, both from patients and from colleagues, with structural consequences (West & Nayar, 2016) and a recent study showed alarming rates of harassment and bullying in NHS Lothian which is more likely to be targeted to BME nurses (2016:10). Evidence suggests this type of incident is not addressed effectively by Scottish health institutions as diversity management

Interview Questions: Questions will be divided in the four sections

I – Living in Edinburgh or Glasgow (E/G)

1- Can you tell me a little about yourself, how long have you lived in E/G?
2- How do you like living in E/G?
3- What you enjoy about living here? Is there anywhere in E/G where you feel a particular attachment?
4- Is there anything you dislike about living here? If so, what?

II – Working for a care institution

5- How long have you worked for this institution?
6- Where have you worked before? 1st job in nursing?
7- Why did you choose this job?
8- Tell me about your responsibilities in your job. What would be a typical day at work for you?

III – Work Relationships and Communication and race

9- How is communication with your colleagues? Would you say you can easily go to all your colleagues if you need to?
10- And with patients?
11- In your work, have you ever perceived your ethnicity as an advantage? (White participants only)
12- Are applications from RM people encouraged? If so how and how do you perceive it?
13- Can you think of a time you have ever been treated differently in your work (by patients or colleagues) because of your race/ethnicity (for polish participant)? If so describe it in as much detail as possible. It can be something that appears minimal (RM participants only).
14- If so can you tell me how this makes you feel? How do you cope with it? Where did you learn to cope with it in that way? (RM participants only)

IV – Race in the workplace

Studies have shown that racist incidents against hospital personnel have risen in the UK since the Brexit.

15- Did you notice a difference in the treatment of BME people by patients before and after Brexit?
16- Have you ever witnesses a racist incident at work? If so please describe.
17- If so, did you think of intervening? Why/Why not.
18- If there is an incident, is there a procedure, an action, you can take to report it?
19- If so, do you have confidence in its efficiency?
20- Are there programs to support and help minority staff members? Like groups of BME personnel to have a safe space to share experiences, get support and advice about promotions etc.?
21- In general, are there diversity management initiatives, like diversity days etc.?
22- If so, did you find them effective in raising consciousness and contributing to a better working atmosphere?

V – Anti racism: Universalism or Particularism?

23- Do you believe people of all races and ethnicities are equal? Why?
24- Would you encourage anti-racism tactics such as color blindness (with some explanation about the concept)?
25- Do you believe it is natural to help people of the same kind over others?
26- To finish, would you like to you like to add something you felt wasn't mentioned?
27- If at some point the need presents itself, would you be willing to answer some follow up questions?

Appendix 3: Interview Consent Form & Questions

THE UNIVERSITY of EDINBURGH
School of Social and
Political Science

Interview Consent Form

Title of study: "Everyday Racism in Edinburgh and Glasgow".

Research investigator:

Research participant's name:

About this consent form

You have been invited to participate in a research project titled "Everyday Racism in Glasgow". This project will serve as *** research project for the requirements of obtaining a Master of Science in Sociology at the University of Edinburgh. Ethical procedures for academic research undertaken from UK institutions require that interviewees explicitly agree to being interviewed and how the information contained in their interview will be used. This consent form will explain the purpose of the research project and procedures used in the study. Please read this consent form carefully and ask any questions if you need additional clarification.

About this study

Thank you for taking part in the Everyday Racism in Edinburgh and Glasgow Research. My name is ***, I am a MSc student in Sociology and Global Change at the University of Edinburgh. I am conducing this research in partnership with CRER (Coalition for Racial Equality and Rights), an organization based in Glasgow committed to fighting racism in all its forms. We are committed to ethical research methods that respect our collaborator's integrity. This interview will be anonymized and its use will be confined to the purposes of the research.

You can stop the interview whenever you want and anything you wish put off the record will be.

The purpose of this study is to explore the experiences nurses and attempt to answer the following questions: *Is the somatic norm reproduced within and through nursing in Scotland?* Three research objectives will help answering the main research question:

7) Assess whether RM bodies' entrance in nursing trigger a reaction. If so, what reaction?
8) Assess whether RM nurses more visible than white nurses? If so, what does this visibility entail?
9) Evaluate to what extent and on what conditions RM bodies can enter from nursing?

These issues are of increasing importance; racist attacks against Black and Minority Ethnic hospital staff have risen since the 2016 United Kingdom European Union membership referendum. Furthermore, racism in nursing is growing, both from patients and from colleagues, with structural consequences (West & Nayar, 2016) and a recent study showed alarming rates of harassment and bullying in NHS Lothian which is more likely to be targeted to BME nurses (2016:10). Evidence suggests this type of incident is not addressed effectively by Scottish health institutions as diversity management insufficient to effectively tackle racism.

What you will be asked to do

Should you agree to participate in this study, you will be asked to do the following:

1. Participate in a recorded interview lasting approximately 45 minutes in length. The interview content will be outlined in an additional interview guideline document to be send prior to the interview.

2. Possibly respond to email or phone-based inquiries from the researcher in the event that further clarification is needed.

Your participation is voluntary

Taking part in the interview is completely voluntary. You may choose not to take part at all. You may refuse to answer any of the questions. If you start the interview, you can stop at any time without giving any reason and without there being any negative consequences.

Your answers will be confidential

The researcher will maintain confidentiality of study participants as far as possible. Your interview responses may be quoted directly in the dissertation. These quotes will be fully anonymised, and any identifiers will be removed (including your personal identity and organisation's name). You will be assigned a specific Socio-economic and ethnic group and number to protect your identity and ensure the anonymity of your responses. The investigator alone will have access to the information collected as part of the study. Once transcribed, the digital recordings will be deleted. Interview transcripts will be kept on the researcher's personal computer.

In signing this form, you certify that you agree to the following:

- The interview will be recorded, and a transcript will be produced for transcription
- You can request to be sent the transcript and correct any factual errors
- The transcript of the interview will be analysed by the research investigator
- Access to the interview transcript will be limited to the research investigator and academic supervisors

- Any summary interview content or direct quotations from the interview that are made available through academic publication or other academic outlets will be fully anonymised so that you cannot be identified, and care will be taken to ensure that other information in the interview that could identify yourself is not revealed
- The actual recording will be destroyed after transcription

This research has been reviewed and approved by the Edinburgh University Research Ethics Board.

I agree to take part in this interview.

Printed Name:

Participant Signature: **Date:**

Researcher Signature: **Date:**

Contact information: If you have any further questions or concerns about this study, please contact the researcher at any time: ...