Perspectives on discriminatory behaviours in health and care

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CONTENTS

1.	**Executive summary**	**3**
2.	**Background and research objectives**	**6**
3.	**Method and sample**	**7**
4.	**Perceptions of discriminatory behaviours in health and care**	**9**
	4.1. Spontaneous views on discriminatory behaviours in health and care	**9**
	4.2. Prompted views on discriminatory behaviours in health and care	**17**
5.	**Impact of discriminatory behaviours in health and care**	**22**
6.	**Views on sanctions for discriminatory behaviours in health and care**	**27**
7.	**Conclusions**	**34**
Appendix 1 – Discussion guide		**38**

1. EXECUTIVE SUMMARY

1.1 Background and research objectives

The Professional Standards Authority (PSA) oversee the work of ten statutory bodies that regulate health professionals in the UK and social workers in England, as well as the work of Accredited Registers[1]. The PSA commissioned this research to help inform a consistent and appropriate approach by the regulators and registers towards the various types of discrimination in health and care. The research needed to help the PSA understand better the views of the public and service users on the following key questions:

- What constitutes discriminatory behaviour in the context of health and care?
- What impact discriminatory behaviour may have on both public safety and confidence?

Through looking at these two areas, the research also drew out views from participants on how health and care professional regulators should respond to different types of discriminatory behaviour.

1.2 Method and sample

The research used a qualitative methodology which involved focus group discussions and paired depth interviews. In total, 50 members of the general public and health service users were interviewed through:

- 6 x focus group discussions;
- 10 x paired depth interviews.

The sample was structured to include both those with more limited and those with more frequent use of health and care services. Within this, participants from a range of groups were included, ensuring that the perspectives of patients with protected characteristics were captured. The research also involved the public and patients from all four UK countries.

1.3 Key findings

The notion that all patients should be provided the same standard of care and respect was at the heart of what the public and patients expected from health and care professionals. Within this, equality and diversity were understood as both providing a standard of service that was universal (the same for everyone), as well as ensuring inclusion so different needs

[1] The Accredited Registers programme is focused on public protection and was introduced in 2012 for health and care occupations that are not regulated by the law. The PSA accredits registers so patients can be confident when choosing health and care practitioners. For more information, see: https://www.professionalstandards.org.uk/what-we-do/accredited-registers

were recognised and met. Discriminatory behaviours were therefore defined as those where some patients were denied the same standard of care or respect or they were subject to practices that were not inclusive of their particular needs.

As part of the research, some participants shared experiences of health and care professionals' behaviours they felt were discriminatory and linked to their protected characteristics. Examples of such behaviours included:

- Verbal remarks which patients felt were disparaging;
- Making assumptions and being judgemental about patients;
- Not listening to patients;
- Not meeting additional needs of patients, for example, communication needs.

In a small number of cases, patients also reported what they perceived as more serious discriminatory behaviours, including aggressive behaviour in mental health hospitals, and harassment of Muslim women wearing a veil.

Further discussions prompted by using a range of scenarios involving potentially discriminatory behaviours revealed key factors the public and patients considered when assessing whether behaviours were discriminatory. These included:

- **Intent** – whether a behaviour was intentionally discriminatory or stemmed from a lack of knowledge and understanding;
- **Outcomes for patients and how vulnerable the patient was** – whether the impact was serious and negative for patients, which would be exacerbated if a patient was deemed vulnerable;
- **Frequency** – whether a particular behaviour was an isolated incident or part of a pattern of behaviour.

Most felt that discriminatory behaviours could potentially cause significant harm to patients, as well as undermine their confidence in health and care professionals and services more broadly. Such behaviours were perceived to potentially impact on:

- **Patients' mental health and wellbeing**, as direct experiences of discriminatory behaviours could make patients feel uncomfortable, anxious, confused, embarrassed, or distressed, depending on the severity and kind of behaviour in question;
- **Patients' physical health and wellbeing**, as many thought they would attempt to avoid professionals who behaved in this way, which could make accessing health services more difficult;
- **Patients' confidence in health and care professionals**, as discriminatory behaviours were perceived to undermine core values and professionalism expected in health and care;
- **Patients' safety when using health and care services**, as many felt that witnessing such behaviours would make them question whether these professionals may harbour other prejudices that could impact on their treatment too.

The public and patients in this sample were split over whether they thought they would complain about the discriminatory behaviour if they experienced or observed such behaviour in health and care. While some felt confident they would complain and saw this as their responsibility towards other patients, others worried that complaining might impact on their care so felt unsure whether they would do so. Some participants also felt that experiencing or witnessing discriminatory behaviours in health and care may make them less likely to complain about poor care more generally, as they did not trust those professionals behaving in such ways not to treat them unfavourably if they complained about poor care or other aspects of health services.

When considering the appropriate level of sanctions for different discriminatory behaviours, participants used the same factors they applied to judge the severity of discriminatory behaviours. Milder sanctions, for example a warning, were seen as appropriate where discriminatory behaviours were: not intentional; did not result in grave consequences for patients; and were not repeated. These circumstances were perceived as mitigating factors, which participants felt would make them perceive those behaviours as less serious. Other mitigating factors included: workload pressures and stress potentially impacting negatively on health and care professionals' behaviours; and organisational and financial constraints limiting how inclusive health and care professionals can be.

As more of the key factors were involved in particular scenarios, participants felt more serious sanctions were appropriate. Thus, suspension was seen as an appropriate sanction where there was a pattern of repeated discriminatory behaviour and/or grave consequences for patients. Similarly, being struck off was seen as appropriate where different aggravating factors were present, for example, a behaviour was intentional, frequent and with very negative consequences for patients.

There was a strong educational element to what participants expected Fitness to Practise sanctions to involve, as they wanted health and care professionals to be given training in equality and inclusion to remedy any discriminatory behaviours. The public and patients in this sample wanted education to form part of a range of ways of addressing discriminatory behaviours. They hoped that education could help avoid more serious sanctions where possible, in the context of their acute awareness of health and care workforce shortages and pressures.

Participants did not think that the sanctions should vary across different health and care professions, as they expected all health and care professionals to uphold equality in their work. Discriminatory behaviour was therefore not seen as excusable by anyone in health and care, but age of health and care professionals, their seniority and health settings in

which discriminatory behaviours occurred were seen to potentially play a role as aggravating or mitigating factors.

2. BACKGROUND AND RESEARCH OBJECTIVES

The Professional Standards Authority (PSA) oversee the work of ten statutory bodies that regulate health professionals in the UK and social workers in England. The PSA review the regulators' performance, scrutinise their decisions about whether people on their registers are fit to practise and can appeal decisions that are insufficient to protect the public. It also carries out policy and research to promote best practice and improve regulation.

In overseeing the regulators and scrutinising their final fitness to practise decisions, the PSA have observed a variable approach to how regulators deal with discriminatory behaviours and at times uncertainty over which type of sanction to impose. In addition, the PSA has observed that cases ending up within the fitness to practise process are more likely to represent the more obvious incidents of racism, rather than subtler and insidious discriminatory behaviours that can potentially also be very damaging.

In the recent 2022 report *Safer care for all,*[2] the PSA therefore recommend that the regulators and accredited registers should review how their fitness to practise processes, including their indicative sanctions guidance, address allegations of racist and other discriminatory behaviour. The PSA recommend that guidance should be clear that racism and other forms of discrimination are a serious breach and may result in removal from the register.

To help inform a consistent and appropriate approach by the regulators and registers towards the various types of discrimination, the PSA commissioned this research to understand better the views of the public and service users on the following key questions:

- What constitutes discriminatory behaviour in the context of health and care?
- What impact discriminatory behaviour may have on both public safety and confidence?

Through looking at these two areas, the research also drew out views from participants on how health and care professional regulators should respond to different types of discriminatory behaviour, as well as how different types of discriminatory behaviour may be seen to undermine professionalism.

[2] Professional Standards Authority, September 2022, Safer care for all - Solutions from professional regulation and beyond. Available at: https://www.professionalstandards.org.uk/safer-care-for-all

3. METHOD AND SAMPLE

The research used a qualitative methodology which involved focus group discussions and paired depth interviews. In total, 50 members of the general public and health service users were interviewed through:

- 6 x focus group discussions (90 minutes long, 5 participants per group);
- 10 x paired depth interviews (1 hour long, 2 participants per group).

The rationale for using these methods was as follows:

- Group discussions can help capture wider social debate by creating a safe environment in which participants can share their views and consider other people's opinions. They were therefore useful for generating an understanding of what the public and patients agree and disagree constitutes discriminatory behaviour - and why. Focus group discussions also helped identify the range of impacts that these groups feel discriminatory behaviour has on public safety and confidence.
- Paired depth interviews were chosen as a more appropriate method for those patients more likely to have had poor experience of services and/ or to have additional communication needs to take part in the research.

Fieldwork was carried out mostly remotely using an online video-conferencing platform, with some paired depth interviews being conducted face-to-face. The group discussions and interviews were conducted between 15th and 28th of February 2023. The research team included Amy Smith, Danica Minic and Jill Barnett.

Sample structure

The sample was structured to include both those with more limited and those with more frequent use of health and care services. Within this, participants from a range of groups were included, ensuring that perspectives of patients with protected characteristics were captured. The research also involved the public and patients from all four UK countries. A more detailed sample structure is shown below:

Group discussion sample structure

6 online focus group discussions, 5 participants, 1.5 hours		
General public (less frequent use of health and care services)		Mixed gender All aged under 30 years old Mix of different ethnic groups Mix of religions

	Group 1 - ABC1[3] **Group 2 - C2DE**	
Patients[4] (higher service use across health, social care, professionals on accredited registers)	**Group 3 – older patients (65+ years old)**	Groups 3, 5 & 6 – mixed gender Groups 4, 5 & 6 – mixed ages Groups 3, 4 & 6 – mix of ethnic minority groups All groups – mix in terms of a socio-economic status All groups – mix of religions
	Group 4 – female patients	
	Group 5 - ethnic minority patients[5]	
	Group 6 – patients with disabilities	

Paired depth sample structure

10 paired depth interviews, 2 participants, 1 hour		
LGBTQ+ patients	Paired depths 1 & 2	Including those in civil partnerships
Patients with a learning disability/autism	Paired depths 3 & 4	Including those with dementia and autism and their family members/informal carers with experience of using services with the participant
Patients with dementia	Paired depths 5 & 6	
Patients with specific communication needs	Paired depths 7 & 8	Including those with hearing and visual impairments and participants who do not speak English
Patients using mental health services	Paired depths 9 & 10	Including those from ethnic minority groups

The group discussions and interviews were conducted across the UK, as follows:

[3] 'ABC1' and 'C2DE' refers to the socioeconomic group to which the research participants belong. These groups are based on the occupation of 'the chief income earner' within a household, which research participants self-identify at the point of recruitment. The groups are most often defined as follows:
A- Higher managerial, administrative or professional
B - Intermediate managerial, administrative or professional
C1- Supervisory, clerical and junior managerial, administrative or professional
C2 - Skilled manual workers
D - Semi-skilled and unskilled manual workers
E - Casual labourers, pensioners without private pensions and anyone unemployed and living on basic benefits.

[4] The language used to describe research participants throughout the report aligns with the classifications used for the sample.

[5] We recognise that it is seen as best practice to use language that is as specific as possible when talking about ethnicity and where possible avoid using generalised or blanket terms. The language used in the report to describe participants from ethnic minority backgrounds aligns with the classifications used for the sample and is in line with Government best practice on writing about ethnicity.

England (North, Midlands, South, urban and rural)	3 groups	4 paired depths
Wales (urban and rural)	1 group	2 paired depths
Scotland (urban and rural)	1 group	2 paired depths
Northern Ireland (urban and rural)	1 group	2 paired depths

Discussion approach

The topic guide was designed to first explore participants' spontaneous perceptions of discriminatory behaviours in health and care, before prompting them with a range of scenarios to capture more comprehensive and considered views. The discussions explored the following topics with participants:

- Participant experiences of discriminatory behaviours in health and care, if any;
- Their perceptions of behaviours they thought were discriminatory and why;
- Their views on:
  - a range of scenarios involving potentially discriminatory behaviours by health and care professionals;
  - the impact of experiencing or witnessing discriminatory behaviours in health and care on public safety and confidence in using health and care services;
  - the severity of such behaviours and how they should be addressed by regulators.

To help with the discussion, research stimulus materials were created which included the above-mentioned scenarios and information about the fitness to practise process. The scenarios were selected to:

- Include a range of different types of discriminatory behaviours (direct discrimination, indirect discrimination, harassment and victimisation)[6]
- Reflect a range of actual examples, as discussed in published fitness to practise cases and also wider literature of less obvious types of discrimination (e.g., micro-aggressions).

4. PERCEPTIONS OF DISCRIMINATORY BEHAVIOUR IN HEALTH AND CARE

4.1 Spontaneous views on discriminatory behaviours

There were two main principles which the public and patients in this sample expected health and care professionals to uphold in their work:

- To treat everyone in the same way, that is, to provide the same standard of care to all patients, irrespective of who they were;

[6] These were based on definitions provided by the Equality and Human Rights Commission. See: https://www.equalityhumanrights.com/en/advice-and-guidance/your-rights-under-equality-act-2010

- To meet individual needs, that is, to tailor their service to address different needs of different groups.

Equality and diversity were therefore understood as both providing a standard of service that is universal (the same for everyone), as well as ensuring inclusion so different needs are recognised and met. While the first view was consistent across different groups in the sample, participants aged 30 and under were more likely to also highlight inclusion as an aspect of equality and diversity in health and care.

> *They should be taught whenever they're training to be in a healthcare environment that everybody receives the same level of care no matter who they are or where they come from, they should be treated the same.* [General public, under 30, C2DE, Northern Ireland]

> *I feel that they should be giving a uniform service in terms of treating everybody with a similar standard, but also addressing individual needs. My needs might be different from another person's needs, so they need to be able to adapt to those.* [Ethnic minority patients, mixed gender and age, England South]

Discriminatory behaviours were therefore defined as breaches of the principles above, namely:

- Not treating everyone with the same standard of care, irrespective of who they were;
- Not recognising and meeting different needs of different groups of patients.

These behaviours were perceived to go against the core values of health and care professions to care for all patients.

> *Everyone should be treated the same, no discrimination, no matter what condition you're treated for, you should be treated fairly and with respect.* [Patients with disabilities, mixed gender and age, England North]

> *We've all got equal rights. So, they should treat us all the same. They shouldn't behave in discriminatory ways*. [Paired depth, patients with dementia, Wales]

> *Everyone's needs are a little bit different, so you'd have to promote inclusiveness to address everyone's needs depending on where you're based. That's important for people where English isn't their first language, and you need to be able to give the same service and be aware of the barriers.* [Ethnic minority patients, mixed gender and age, England South]

Participants also had higher expectations from health and care professionals to promote equality and diversity, than from other professions they interacted with. There were several reasons for expecting more from health and care professionals than from others:

- They were seen to be dealing with vulnerable people, who placed a high level of trust in them.
- Being caring and compassionate was seen to be at the core of health and care professions, thus setting a high bar for treating the public with respect and kindness.
- Interactions with health and care professionals were seen to be more personal, as they concerned individuals' health and wellbeing.

> *When it comes to healthcare, it's a little bit more personal to you. If someone's coming to fix your boiler, they're not really there to interact with you, they're there to interact with the boiler. I expect the person interacting with me on a personal level to have some kind of way of dealing with me that's appropriate. The person fixing my boiler probably doesn't care about me. There's a lot more care involved.* [General public, under 30, ABC1, England Midlands]

> *They have a high duty of care, in a trusted position, they're breaking a level of trust if they've made you feel unsafe.* [General public, under 30, C2DE, Northern Ireland]

> *It's your health and wellbeing that's in their hands. The tax man, you don't ever see him. The doctor is quite personal, you need to feel comfortable sharing your issues.* [Paired depth, LGBTQ+ patients, England North]

Some participants were also aware of equality and diversity training being provided across different sectors, so expected that health and care professionals should have received this training. This expectation was particularly shared by younger participants, who thought that health and care professionals should possess a high degree of 'cultural competence'[7] and awareness in their dealings with the public.

> *You're dealing with people from different cultures, so I'd assume they'd have some training to deal with people from different cultures.* [General public, under 30, ABC1, Midlands]

When asked about any experiences or awareness of discriminatory behaviours in health and care, the following types of discriminatory behaviours were cited:

[7] Cultural competence is usually defined as the ability to communicate and interact effectively with people from different cultures and regardless of other differences. See: Vijay Nayar (Health Education England), *Developing Cultural Competence*, available at: https://heeoe.hee.nhs.uk/sites/default/files/cult_comp_psu.pdf

- **Verbal discriminatory remarks**: a few participants cited examples of health and care professionals making remarks which they felt were disparaging and based on patients' protected characteristics, such as their sexual orientation or disability. For example, a participant reported that a health and care professional made a homophobic remark about their partner who was poorly. Another participant recalled a situation where their brother who had Autism was distressed by healthcare staff remarks who asked him if he was stupid because he let his family members speak on his behalf.

  I have a younger brother, he's on the spectrum, he has Aspergers, his social skills aren't like other people's. A few years ago, in his late teens, I had to take him for a few tests and I had to speak for him because his social cues weren't the best, and the nurse in charge was very rude. She said my brother was very stupid, and was asking him, "Oh is your big sister having to do all the talking for you, is there something wrong with you?" He looked at me and I just knew how he felt, he needed to get out of there. It was supposed to be a routine visit for blood tests and it made it very stressful and unpleasant for him. When I broke my leg recently and had to go to hospital, he said, "I hope it's not the same people that were rude to me. I don't want them to be rude to you." So, he remembered that from years ago. He doesn't want to go there again. We might have to seek alternative places to go now because of how they made him feel. I was very angry. I still use that practice because I don't have a choice, and I haven't seen those particular people again, but if I did, I wouldn't want to be seen by them. [General public, under 30, C2DE, Northern Ireland]

- **Making assumptions and being judgemental about patients**: another type of discriminatory behaviour some participants cited involved situations where they felt health and care professionals made assumptions or were judgemental about them. For example:

  - A participant from an ethnic minority background shared their friend's experience who felt healthcare professionals assumed their illness was due to drug intake, which he felt was because he was black and lived in an area of London with higher-than-average drug use.

    I have a friend who suffers from certain mental health conditions, and due to their age, it was strongly considered that they had a drug problem, which wasn't the case. Because of the area of London they were in, common for drug use, he was stereotyped as being a black person who had those issues because of drugs. They ended up getting treated away from the area because they weren't getting the treatment they should be receiving. [Ethnic minority patients, mixed gender and age, England South]

- Another participant, who was housebound due to their disability, felt that a nurse judged them for being obese, rather than considering that their obesity was linked to their disability.

  Because I'm morbidly obese, I have community nurses come to check my skin for pressure sores or open wounds. Every now and again you'd see a different nurse, and I have seen a couple of nurses who weren't friendly, you could sort of see, not so much what they said, but how they acted. They're looking at a fat guy rather than a disabled person who is obese because of a medical condition. [Patients with disabilities, mixed gender and age, England North]

- A couple of participants thought that sometimes their illnesses or injuries were not taken seriously by healthcare professionals because of their younger age. They cited examples where it took a long time to identify and treat their problems, which they felt was partly due to assumptions that they would be unlikely to be seriously ill / injured and would recover quickly due to their age.

- A participant shared an experience of their transgender cousin, who reported that some healthcare professionals used the wrong pronoun to address them, despite knowing they had started their gender transition. This behaviour made the patient feel they were being judged for their choice.

  She said sometimes it's ignorance [about transgender people], that some health professionals don't understand. She explains and then most of the time they're okay, but there have been occasions when medical people have continued to disregard her name and use the wrong pronoun for her. She does see that as discrimination. Because they have judged her choice [to change her gender]. [Paired depth, patients with learning disabilities/autism, Scotland]

As participants discussed these and similar examples, some explained that such behaviours often did not involve explicit and obvious discrimination. Rather, participants felt they were being judged or that assumptions were being made from the overall demeanour of healthcare staff, for example, how friendly they were, how much time or interest they showed in helping them or how much they listened to them. They felt this made it harder for them to be able to point to evidence of discriminatory behaviour.

- **Feeling they were not being listened to or taken seriously**: this was a frequent complaint across the sample, as many raised the issue of some health and care professionals not listening and taking into consideration patients' views. While this was a general complaint that wasn't always linked to discrimination, a few participants felt

they were not listened to because of their age or gender or race. For example, some stressed that older people were not taken seriously and were patronised by health and care professionals.

> *My experiences have been of ageism, doctors seeing me as interfering in their sphere of influence. I've seen them treat elderly people as though their views don't count. I've experienced disregard because of my age, and because I'm trying to help my mum. I'm often made to feel like I'm being difficult. I feel the older you are the less seriously they take you. It's difficult to say why I think that. I don't think of it as discriminatory at the time, I just think they're not listening to me.* [Paired depth, patients with dementia, Scotland]

In another example, a young female participant from an ethnic minority background recalled a situation where she asked for more pain relief following a minor medical procedure, which she felt the nurses ignored. The participant believed her pleas for more pain relief were ignored because of her race. She also said her friends had similar experiences with healthcare professionals where they felt ignored and believed this was because they were black.

> *When I was in the hospital, I had a very minor surgery, 20 minutes. Afterwards I was still in pain because I had stitches, and I told the nurse and asked for something for my pain, and she just said it was perfectly normal. So, I left it but the pain was still there, so I went to find a nurse, and the nurse looked directly at me and walked away. I had to find another nurse to give me painkillers. It was frustrating because the nurse looked right at me and didn't bother asking me if I was okay and what I needed. […] I would say it's to do with my race, it wasn't the first time a doctor or nurse has thought I was exaggerating my symptoms. It happens all the time. My friends have stories of going to the GP and they feel they're exaggerating their symptoms.* [Ethnic minority patients, mixed gender and age, England South]

- **Not meeting individual needs:** some recalled instances where healthcare professionals were not inclusive, as they did not consider different patients' needs in terms of communication or otherwise. For example, a participant whose son had Autism reported that a doctor put pressure on her son to speak for himself, rather than have his mother speak on his behalf (with his consent). A couple of participants raised experiences of hospital food, which did not meet medical dietary requirements or lacked cultural diversity. Others commented on increasing reliance on digital channels of communication in health and care services, which excluded elderly patients.

> *I have the same issue because my father is a technophobe, and when he has to order prescriptions and make appointments, I have to do it for him. Most prescriptions*

have to be ordered online now, so it's not including him. [Patients with disabilities, mixed gender and age, England North]

I remember someone talking about how they were an inpatient at a mental health facility and the food they were given was traditional English food most of the time. When they asked for Caribbean food, they ended up getting Caribbean food but it was the same meal every day. [General public, under 30, ABC1, England Midlands]

A smaller number of participants also reported other kinds of discriminatory behaviours, which they felt were more extreme forms of discrimination:

- **Aggressive behaviour and violence**: a male participant with mental health problems was sectioned several times and reported they experienced aggressive and violent behaviour from health and care professionals. They perceived these behaviours as discrimination against people with mental health conditions.

- **Being treated differently to others**: a female participant reported an incident where she felt she was discriminated against and treated differently because of wearing a veil. In this instance, the participant said hospital staff told her she could not take her children with her when visiting her mother in hospital, whereas they allowed other visitors to enter with their children.

Across different examples, participants varied in the extent to which they defined discrimination as linked to their protected characteristics or not. Younger participants, some of whom also had training on these issues, as well as those with lived experience of discrimination (for example, belonging to minorities or with disabilities) were more likely to identify discriminatory behaviours as linked to their race, age, sexual orientation, gender, or disability. They therefore invoked examples where patients were treated with less care or respect because of their protected characteristics, or their particular needs were not being met as some health and care services were not inclusive.

For other participants, there was more uncertainty when trying to define discriminatory behaviours and separate them from a range of other behaviours in health and care they would see as inappropriate:

- Some felt that any instances where patients were not given the same standard of treatment as everyone else involved discrimination, whether this was on the grounds of their protected characteristics or not. For example, a patient with ME complained of not being listened to by GPs, which they felt was discrimination linked to their condition rather than a particular protected characteristic.

Terrible things, like not believing you, snide comments, there's nothing wrong with you. Assumptions about me as a person, what I should and shouldn't be doing, I don't need certain support because who do I think I am. That's from GPs mostly. All the other people I've been in touch with have only ever been lovely, empathetic, kind and reassuring, treating me as a real individual with no pre-judgement or discrimination. [Patients with disabilities, mixed gender and age, England North]

- Some patients highlighted behaviours which they saw as inappropriate but were not always sure if they involved discrimination. For example, a female participant reported a GP attempted to persuade her not to use contraceptives on religious grounds, which the participant felt was very inappropriate and left her avoiding that GP.

- Those participants who reported their GP practices caused difficulties to their relatives who could not communicate through digital channels thought this was poor practice and unfair. However, they did not always spontaneously think of this as discrimination (even though it could be seen as age discrimination, for example) because they thought that using digital technology has become the norm everywhere.

  I wouldn't have said discrimination. Non-inclusive. It's not including the people who are most vulnerable. It's a general assumption that you can jump online and do everything, and they forget not everybody has the capability to do it. [Patients with disabilities, mixed gender and age, England North]

  I don't know if it's discrimination as such, it's assuming. But it's not necessarily a bad assumption, it's just the way of the world at the moment. Everyone just assumes people have access to technology, or they could use a library. Everyone just assumes that's the way it is now. [Paired depth, patients with specific communication needs, Wales]

- A very common experience many shared were instances where they felt some health and care professionals did not listen to them. As mentioned before, some patients felt this was linked to who they were – their age or gender or race, for example – but for others, it was a general experience of poor care, which they cited in the context of discussing discriminatory behaviours in health and care. A patient who was undergoing surgery in a private hospital recounted,

  I couldn't breathe, so I buzzed the nurse who came in and told me I had wind, and she took my buzzer off me. I was really struggling for breath, and luckily my father came in, and it turned out I had a blood clot on my lung. If he hadn't come in, I could have been dead. [Female patients, mixed age, Wales]

At Christmas, I was treated very badly by the out of hours GP service. […] He wasn't listening, he was not respectful, he was judgemental because he was bringing up my past. When I can't breathe, it's not because of my diabetes or my depression, he was judging me based on the notes he had in front of him, and he wouldn't even see me in person. [Paired depth, patients using mental health services, Northern Ireland]

These and similar accounts from patients showed that for some patients there may be a blurred line between what they would see as discriminatory and other types of inappropriate behaviours and poor care.

4.2 Prompted views on discriminatory behaviours in health and care

When prompted with a range of examples of potential discriminatory behaviours,[8] participants considered some as obviously discriminatory, whereas there were more mixed views on other examples or participants felt they needed more consideration.

Those behaviours that involved explicit negative remarks by health and care professionals which were linked to patients' or colleagues' protected characteristics were perceived as obvious discrimination. In addition, health and care professionals deciding not to treat someone on the grounds of protected characteristics was also seen as clear discrimination. These kinds of behaviours were illustrated by the examples below, which were shared with participants:

> A health or social care professional does not want to treat a child whose parents are gay.

> A paramedic makes discriminatory remark about patient to another colleague when transferring them from ambulance to A&E.

> A health or social care professional makes negative comments about a colleague wearing a headscarf, which is overheard by patients.

In responding to these hypothetical scenarios, participants were quick and confident to class all three as discrimination and a major breach of core professional values in health and care to treat all patients with the same care and respect.

The health service is for everyone. As soon as you start refusing someone treatment it's discrimination. [Older patients, mixed gender, Scotland]

[8] The examples shared with participants are included in the section below.

Very unprofessional. They are passing judgement on a patient. It might affect how they treat that patient. [Paired depth, patients with learning disabilities/autism, Scotland]

It's cultural discrimination against that person's culture and beliefs. [General public, under 30, C2DE, Northern Ireland]

Other scenarios shared with participants as stimulus for discussion provoked more discussion or mixed views. There were two main reasons why these examples provoked more discussion over whether they involved discrimination. Firstly, participants were split over whether those behaviours were intentionally malicious or arose from a lack of understanding and knowledge. Secondly, some of the scenarios prompted a debate over how to delineate discriminatory from other behaviours also perceived as highly inappropriate in health and care, for example, negligence or harassment.

The following scenarios provoked mixed views, with some arguing they involved discriminatory behaviours and others suggesting they could be due to a lack of awareness and understanding:

A health or social care professional asks patients to communicate with them by email, regardless of those who do not have access to the internet.

A health and social care professional assumes that a patient who speaks English as a second language will not be able to understand complex treatment options – and does not explain them fully.

A health or social care professional repeatedly uses the wrong pronoun when speaking about a transgender patient.

Participants who questioned whether the behaviours above were discriminatory thought they may not be intending to exclude or provide lesser service to anyone, but rather they may be due to a lack of understanding that can be remedied through education. A lack of a malicious intent or conscious disregard for patient needs was therefore what separated these behaviours from discrimination in their view. However, should these behaviours persist following education, they would then become to be seen as (intentionally) discriminatory.

I think it's stupidity, not discrimination. If they think all elderly people can use the internet, then the health care person is stupid, but not being discriminatory. [Older patients, mixed gender, Scotland]

I think we just accept it. My nephew who can't book an appointment in person just accepts it and gets his mum to book the appointment. So, it's not changing. We haven't complained, but we should. They told him to go to a public library. [Older patients, mixed gender, Scotland]

That could just be a slip of the tongue if you don't know if it's a he or a she, or you don't know what to say. Sometimes you say the wrong one by mistake. [Older patients, mixed gender, Scotland]

Other participants were less tolerant of such behaviours irrespective of whether they were intentional or were due to a lack of understanding. Participants in this group saw these behaviours as discriminatory because their outcome was exclusion or potential harm for patients, whether this was intentional or not. In addition, participants under 30 years of age were less likely to accept that a lack of awareness was a mitigating circumstance. They assumed that equality and diversity training was provided in health and care, so were less ready to excuse discriminatory behaviours due to a lack of knowledge.

They're not going out their way to discriminate against anyone, but I do think it's discriminating because I know if the GP asked my mum to do this online, she wouldn't be able to. It does discriminate against people who might not have access to the internet, but it's not directly meant to be that. [General public, under 30, C2DE, Northern Ireland]

It's discriminating because they are assuming, because they don't speak English as well, they won't understand the language there is no point explaining it. [Paired depth, patients with specific communication needs, Wales]

It's down to the healthcare practice to provide a translator to explain the complex procedures, so it is discrimination if they haven't done what they can for the patient to understand what's happening to them. [General public, under 30, C2DE, Northern Ireland]

The second type of scenarios that provoked more debate and consideration involved behaviours which some participants saw as discriminatory and others as other kinds of inappropriate behaviours:

A health or social care professional makes sexually explicit remarks to a female patient.

A health or social care professional refuses to treat a patient who has made a complaint about discrimination against disabled people by their service.

In the first case, participants who saw that behaviour as discriminatory assumed the scenario involved a male health and care professional making sexually explicit remarks to a female patient. In that context, they saw female patients as being targeted by this behaviour because of their sex, which is why they thought the behaviour was discriminatory. Other participants, however, perceived this behaviour as deeply unprofessional and harmful, but thought it could happen to a patient of any sex or classed this behaviour as harassment rather than discrimination.

> *It's a sexual remark to a female, who just by virtue of being female is vulnerable. It might make them fear for their safety, depending on what was said*. [Paired depth, patients with dementia, Scotland]

> *She's been picked out because she's a female patient, she wouldn't have been treated that way if she was male.* [General public, under 30, C2DE, Northern Ireland]

> *I see this as sexual harassment rather than discrimination. It's inappropriate behaviour towards a female, more than a discrimination against a person.* [Patients with disabilities, mixed gender and age, England North]

In the second scenario, whether participants perceived this as discriminatory depended on whether they linked it to protected characteristics or not. Some pointed out that the person was being refused treatment because they made a complaint, rather than based on their disability. For this reason, they were unsure if this involved discrimination. Others, however, felt that this behaviour amounted to 'double' or 'secondary' discrimination, as it made it more difficult for the person with a disability to achieve equal access to health and care. In other words, they were prevented from seeking to redress discrimination that happened in the first place, thus making discrimination worse.

> *It's supporting a person who has made direct discriminatory comments about a certain group of individuals so if they support that it is discrimination if they agree with the statement, even if they didn't make the comment themselves.* [General public, under 30, C2DE, Northern Ireland]

Participants' rationale for why certain behaviours involved or did not involve discrimination suggested there were three main factors they considered in this respect:

- **Intent:** Whether there was an intention to discriminate or not was the first factor participants considered when deciding if certain behaviours were discriminatory. A lack of knowledge or understanding was therefore accepted as a mitigating circumstance by some participants, who wanted this to be addressed through education. Others,

however, expected health and care professionals to have cultural awareness and competence in dealing with different groups of patients, so were less open to excuse any behaviours that resulted in exclusion or harm for patients.

If they're doing it intentionally then, yes, it's discrimination. If they know it's a trans woman but they keep calling them a 'him' then that's not right. It's discriminating because, gender is a tricky one, but if that person identifies as a woman, then they should be treated as a woman. [General public, under 30, C2DE, Northern Ireland]

I wouldn't say that [expecting patients to communicate online] is discriminatory because how are they to know if the patient has internet or not. [Older patients, mixed gender, Scotland]

- **Frequency:** Whether a discriminatory behaviour was a one-off incident or a pattern of repeated behaviour was another factor participants considered. In the case of isolated incidents, many stressed the importance of providing opportunities to health and care professionals to undertake training and correct any discriminatory behaviours. Repeated behaviours resulting in exclusion or distress for certain groups of patients were more likely to be seen as intentionally malicious and discriminatory. Some participants, however, questioned how patients would know if something was a one-off or repeated behaviour.

  Once is an accident, but if you keep doing it [addressing a transgender patient using a wrong pronoun], that person's identity is being compromised so it's not proper patient care. [Paired depth, patients with specific communication needs, Wales]

  If they're repeatedly showing the same discriminatory behaviour, then it shows they can't learn. [Ethnic minority patients, mixed gender and age, England South]

  It shouldn't happen anyway. You don't know if it's a one-off. You might see it once but how do we know if they're doing it all the time or not? [Paired depth, patients with dementia, Wales]

- **Outcome for the patient / how vulnerable patients were:** The worse the outcomes for the patients from particular discriminatory behaviours and the more vulnerable the patients were, the more likely participants were to see particular discriminatory behaviours as severe and serious breaches.

  If it was a situation where somebody needed immediate attention and they refused to give the service, then that would probably be a suspension or being struck off [for

the health and care professional who refused to provide treatment in those circumstances]. [Ethnic minority patients, mixed gender and age, England South]

A child should be given care regardless [of whether their parents are gay]. It's a moral element, a principle, everyone should be treated regardless but especially a child as they have no control over who their parents are. [General public, under 30, C2DE, Northern Ireland]

5. IMPACT OF DISCRIMINATORY BEHAVIOURS IN HEALTH AND CARE

The research suggested that experiencing or witnessing discriminatory behaviours by health and care professionals had the potential to undermine how confident and safe patients felt when using health and care services. There were two main reasons for this:

- Discriminatory behaviours in health and care were seen to go against the core values of health and care professions to be caring and compassionate;
- They were also perceived to undermine professionalism of health and care workers who were expected to treat all patients with the same standard of care.

For these reasons, most participants felt that observing such behaviours in health and care would make them question the values and professionalism of those health and care professionals.

You'd expect them to be trained in how to communicate with people, to be caring. They have values they have to meet, and caring is one of them. You'd expect them to be compassionate. [General public, under 30, ABC1, Midlands]

It is unacceptable. The healthcare motto is do no harm. [Paired depth, patients with dementia, Scotland]

It would affect my confidence because if they can't behave while patients are around, it would make me question how good they are at their job. [General public, under 30, C2DE, Northern Ireland]

At a minimum, most participants thought that such experiences would negatively affect how they felt about being treated by a health and care professional who behaved in a discriminatory way. Participants thought they may avoid being treated by that health and care professional, as they would question what other prejudices they may have and whether they may treat them in a similar way. In a few cases, where participants or people close to them had personal experiences of discriminatory or other inappropriate behaviours

by health and care professionals, their response was indeed to avoid those individuals and attempt to be seen by other professionals at that health and care service.

> *With the doctor who made my [autistic] son speak for himself, my son got up and left the room. We did ask to see a different doctor, and they shouldn't ask you the reason either, you should just be allowed to request a different doctor. And we did see another doctor who is great, she's our GP now.* [Paired depth, patients with learning disabilities/autism, Scotland]

> *My [transgender] niece changed doctors because of it too. She didn't complain, she just decided to change. Because some of the doctors at her GP before didn't see her as female, she was worried how they might be with her. She felt judged*. [Paired depth, patients with learning disabilities/autism, Scotland]

> *I went to see a GP once, who is also a pastor or a minister or something. I was asking for contraception and I had a bit of a stern talking to about contraception. I think I was about 17 or 18, able to legally get contraception and do so without judgement, and I felt that wasn't the case. That GP still practices, but I never go to see him.* [Female patients, mixed age, Wales]

Many also felt that once they started questioning individual practitioners' professionalism, they may also start feeling unsafe, as they would question whether that individual may be unprofessional in other ways and whether their prejudices may affect their work with other patients. This was particularly the case with discriminatory behaviours perceived as more severe, for example, in the case of professionals making sexually explicit remarks to patients, making disparaging remarks about patients, or refusing treatment to some patients based on their protected characteristics or because they complained about discrimination.

> *I think it would be very upsetting, it would destroy my confidence. It would be ridiculous for a professional to refuse to treat a patient because they've complained. You might not have a choice but to keep using that service*. [Older patients, mixed gender, Scotland]

> [About HCP making sexually explicit remarks to a patient] *I wouldn't want to go there again. Because it's totally unprofessional and shocking. I wouldn't feel safe going to see the doctor alone*. [Paired depth, patients with specific communication needs, Wales]

> *It's supposed to be a safe place for everyone. You might think, what do they think about me? You don't feel safe anymore.* [General public, under 30, ABC1, Midlands]

Experiencing or witnessing discriminatory behaviours in health and care also had the potential to undermine patient confidence in using health and care services more broadly. For example, some thought that seeing such behaviours may make them question whether they were being tolerated at a particular organisation, for example, in the scenario where patients were allowed to overhear discriminatory remarks made by health and care professionals. Others explained they would want to know if steps were being taken by the employer to educate staff behaving in discriminatory ways and ensure such behaviours had no place in their service.

> *If they're doing something as obviously outrageously racist in public in an area where patients can hear them, what are they doing between them and their colleagues. It's the casualness of it, the fact that they felt so comfortable to be able to say that. The expectation is that he or she is saying that to people who are of the same mindset. For them in that position, you would have to question the training that people would have in that situation, how did they get to that point.* [Paired depth, LGBTQ+ patients, Northern Ireland]

> *It would definitely make you feel paranoid and wonder if any other professionals have these same views. What are they saying in private? Is it affecting the level of care they give? It would make you question everything.* [Ethnic minority patients, mixed gender and age, England South]

Participants believed that the negative impact of personally experiencing discriminatory behaviours would be significant, particularly in terms of mental health and wellbeing but also potentially compromising physical health and wellbeing. For example, a participant explained that doctors not addressing and seeing their transgender niece as female left them feeling more confused about their gender identity. A participant whose autistic brother was subjected to disparaging remarks for wanting his sister to speak on his behalf to health and care professionals, was left feeling anxious and avoiding using that health and care service. Through these and other examples, some participants highlighted the emotional damage caused by such behaviours and the potential for patients' physical health to deteriorate if they avoid using particular health and care services.

> *GPs are there for your physical health but also for your mental health, making these kinds of comments isn't taking care of someone's mental health as it will make them feel anxious.* [General public, under 30, C2DE, Northern Ireland]

> [About discriminatory remarks made by HCPs] *If they're doing it while the person is there and can hear, that's awful. They shouldn't be doing it all, no matter what. But it's worse if the patient hears. They might not want to go back to that place, even if they need to medically, it might put them off so it might make their condition worse*. [Paired depth, patients with learning disabilities/autism, Scotland]

A smaller number of participants thought that witnessing discriminatory behaviours would not impact on their confidence and feelings of safety when using health and care services. In those instances, participants mainly assumed that such behaviours were isolated to individuals, so not affecting the organisation and services as a whole. A few participants also thought that no matter how abhorrent someone's views were, they were unlikely to impact on the person's medical skills. They thought they would be appalled by such behaviours, but that they would still feel confident in seeing those health and care professionals if they needed their medical attention.

> *I don't think it would affect the treatment I would get*. [Paired depth, patients with dementia, Scotland]

> *I wouldn't think that their behaviour no matter how abhorrent would affect their qualified medical skills. It wouldn't affect my overall view of the hospital that employed them*. [Paired depth, patients with dementia, Wales]

The presumed impact on patient confidence and safety was also more limited where patients did not see themselves as belonging to groups that were discriminated against in particular scenarios. For example, some acknowledged they would not be aware whether practices were inclusive or not in terms of their communication channels with patients, if they were confident using the internet and had no additional communication needs. A few participants also thought that health and care professionals showing prejudices towards particular groups of people would not affect them, as they did not belong to those groups. They, therefore, did not think those prejudices would impact on their care, so felt confident to use those services for their medical needs.

> *No, not at all. I don't wear a headscarf, so it doesn't affect me*. [Paired depth, patients with dementia, Wales]

> *It wouldn't affect me feeling safe, because I'm not necessarily in the category being discriminated against, and I wouldn't expect to come up against this level of discriminatory behaviour personally. So, I wouldn't be the one suffering as a result.* [Paired depth, patients with dementia, Scotland]

Many participants also stressed that often they may not have a choice over which health and care services they used. Participants therefore thought they may be forced to carry on being treated by the same health and care professionals whose discriminatory behaviour they experienced or observed. Some acknowledged this would make them feel uncomfortable and may make them feel anxious about seeing those individuals and the care they would receive.

If you're faced with no choice, you'll have to use that same place. Maybe you can request a different doctor, but it's down to availability of services. It's quite restricted where we are. [General public, under 30, C2DE, Northern Ireland]

I just didn't go back to him [the GP who was judgmental about using contraception]. That in itself limited my options, because there were only three GPs at the surgery, so there were times I had to wait weeks for an appointment. [Female patients, mixed age, Wales]

There were mixed feelings about how likely patients would be to complain about discriminatory behaviours. Most thought there should be an opportunity to express their objections at the time when they observed or experienced a particular discriminatory behaviour. Some also thought they would formally complain to prevent discrimination happening to other patients and saw this as their responsibility to other patients who may be targeted in a similar way.

There needs to be a mechanism for people to feed back if they see something 'in the moment' before they wander off and forget about it. We've all seen things and not said anything. [Pair depth, LGBTQ+ patients, Northern Ireland]

I would stick with my doctors, but I would report it. If they're going to do that to one patient, how many others are they doing it to? [General public, under 30, C2DE, Northern Ireland]

I would make a complaint. Having it on record about a particular person, so if I make a complaint and they review it, and then somebody else makes a complaint about the same person, they can build up a file against that person. They can review, so it's happened before several times, this is a red flag. It's always good to raise your concerns in any situation. [Ethnic minority patients, mixed gender and age, England South]

However, other participants felt less sure whether they would complain. Participants in this group thought they would worry whether they may jeopardize their own treatment by the service if they officially complained.

That's a tricky one, you don't want them to hold anything against you because you're dependent on them treating you. [Older patients, mixed gender, Scotland]

Maybe it could be anonymous complaint and I wouldn't have to put my name on it. In case they discriminate against me for complaining. [Paired depth, patients with dementia, Wales]

I probably would think twice. It depends on what type of treatment I'm receiving. If I'm receiving my treatment, I don't think I'd mess it up for myself. [Patients with disabilities, mixed gender and age, England North]

In addition, many felt that observing or experiencing discriminatory behaviours may make them less likely to complain about instances of poor care more generally. As participants explained, they may worry whether the professionals behaving in discriminatory ways may treat them unfavourably if they complained. Discriminatory behaviours in health and care, therefore, have the potential to undermine patients' confidence to complain about poor care more generally.

I would be cautious about how bad it had to be to complain. They all know each other of course, so it would be like, would I be neglected in the future? [Female patients, mixed age, Wales]

6. VIEWS ON SANCTIONS FOR DISCRIMINATORY BEHAVIOURS IN HEALTH AND CARE

Participants were also asked to consider how different discriminatory behaviours, both those some participants experienced and those described in the research stimulus scenarios, should be addressed through the fitness to practise process. As the majority of participants had not heard of the fitness to practise process, the following information was shared with them to create some basic understanding:

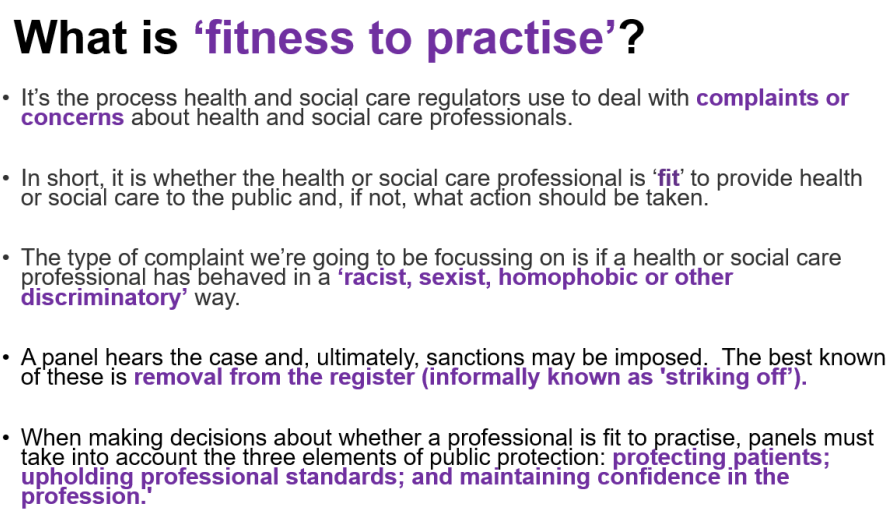

Figure 1: Fitness to practise introduction research stimulus shared with participants in interviews

To further prompt discussion, participants were shown a range of possible sanctions that could be imposed within the fitness to practise process and asked for their views on which of the sanctions were appropriate for which types of behaviours. In asking this question, the research aimed to understand participants' assessments of how serious they thought different discriminatory behaviours were in terms of health and care professionals' fitness to practise. The stimulus used to present a range of different sanctions is shown below, as well as the caveat informing participants that decisions on sanctions would be based on a detailed examination of each case.

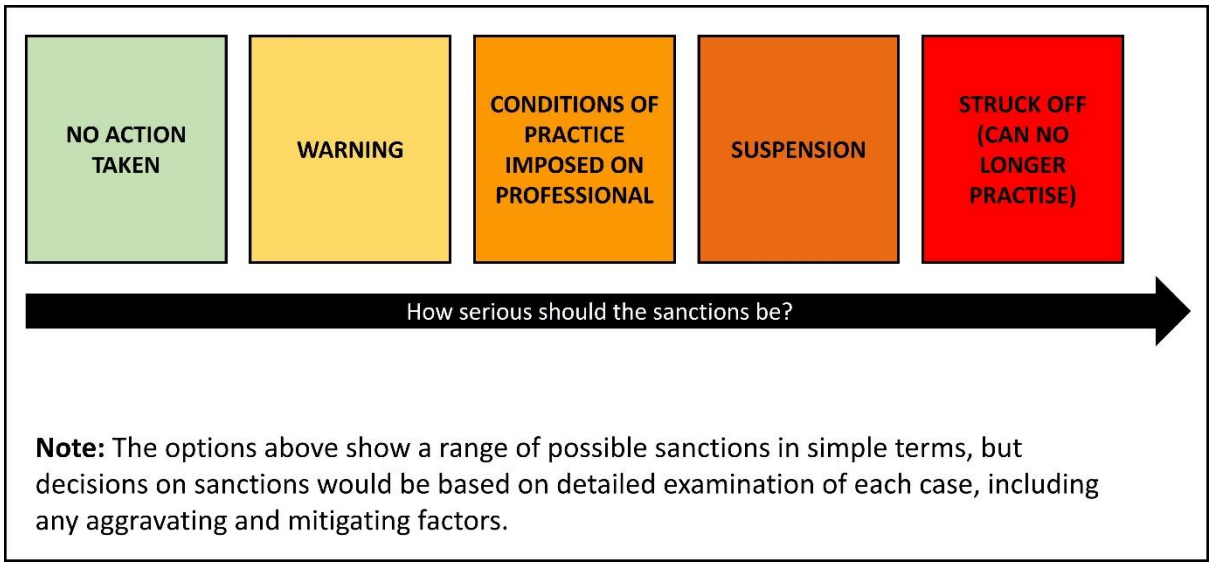

Figure 2: Sanctions research stimulus shared with participants in interviews

When considering the appropriate level of sanctions for different discriminatory behaviours, participants used the same factors they applied to judge the severity of discriminatory behaviours. As discussed earlier in section 4, the main factors used to determine how serious discriminatory behaviours were included: the presence or absence of an intention to discriminate as opposed to making an error; severity of outcomes for patients and how vulnerable the patients were; and frequency of those behaviours. Participants applied these factors when considering appropriate sanctions for different discriminatory behaviours.

> *It depends on the intent and if they meant it to be nasty. [Also] If it was repeated behaviour then the sanction would have to increase*. [Paired depth, patients with dementia, Scotland]

> *If you are in that job your professional head must be on at all times. If you keep on saying it [the wrong pronoun for a transgender patient], it's not an accident. Regardless of who you are, it's very important for them to know that people should be called their correct terminology.* [Paired depth, patients with specific communication needs, Wales]

My instinct is that if it's not intentional, then they should get maybe a warning, and there should be some kind of action plan around how they're going to do better. Then if it was intentional, there could be conditions of practice, especially if it's happening a lot. Definitely suspension as well if it's happening a lot. It depends on how serious it is. [General public, under 30, ABC1, Midlands]

It's about the impact it has on the person, like in the example we heard about - her [another participant's] brother decided he would never go back to a hospital because of what happened, that is a massive impact. [General public, under 30, C2DE, Northern Ireland]

Discrimination is the refusal to give that patient the service because of their parents being gay. What mitigates it from being struck off immediately is if no one's life is imminently at threat. It's more of an ignorance issue, so they just need to be made aware of their mistakes, and they can probably correct. [Ethnic minority patients, mixed gender and age, England South]

On the whole, participants were very aware of the workforce shortages in the NHS and were keen to educate health and care professionals and avoid most serious sanctions where possible. Therefore, milder sanctions were seen as appropriate where discriminatory behaviours were: not intentional; did not result in grave consequences for the patient; and were not repeated. These circumstances were perceived as mitigating factors, which participants felt would make them perceive those behaviours as less serious. A few also raised other potential mitigating factors, including: workload pressures and stress potentially impacting negatively on health and care professionals' behaviours; and organisational and financial constraints limiting how inclusive health and care professionals can be.

Because the NHS is so under pressure anyway, if we got rid of them every time they made a mistake, we'd have no nurses or doctors left. [General public, under 30, ABC1, Midlands]

Somebody who offers food substances to people who don't eat that food, it's not necessarily because they hate that religion. There needs to be some leeway for poor habits or forgetfulness. That's the difference between warning and the next one up. [Patients with disabilities, mixed gender and age, England North]

I agree with warning and then training provided. It may be they didn't have systems in place to help people whose first language isn't English. It might not be their fault

for not providing additional information. So, it's a case of a warning, and providing training. [Patients with disabilities, mixed gender and age, England North]

I'm wondering if any of these healthcare professionals have got traces of PTSD from Covid. It's such an awful thing, and it's not just in warfare. If they've watched people dying as they were and they've just got to get on with it. Covid is bound to have an emotional effect on people. [Female patients, mixed age, Wales]

Examples of discriminatory behaviours that were perceived to be suitable for a milder sanction, such as a warning, potentially included:

- Asking patients to communicate by email only;
- Not explaining treatment options fully to a patient with English as a second language;
- Using a wrong pronoun for a transgender patient.

Just a warning if it's not intentional and they didn't know. [General public, under 30, C2DE, Northern Ireland]

I think it depends on whether its purposeful or not. I have a friend who is transgender, and it took me a while to get used to using the right pronouns. But I don't think it's that hard to remember, it could be. [Paired depth, patients using mental health services, Northern Ireland]

However, each of these behaviours could be deemed to require a more serious sanction if, for example, the impact on the patient was significant or the health and care professional continued to behave in this way having been warned. In that case, many participants thought the next level of sanctions should be applied and that conditions of practice should be imposed on a professional.

If it's the first or second time and it's a mistake then just a warning. But if it happens a lot or it has negative intent, then the second sanction. [Paired depth, patients with learning disabilities/autism, Scotland]

There was a strong educational element to what participants expected these sanctions to involve, as they wanted health and care professionals to be given training in equality and inclusion to change their behaviour.

You would hope there was some training put in place and awareness being brought to the health professional so it wouldn't happen again. I'd want to see something done, trying to educate them. [General public, under 30, C2DE, Northern Ireland]

They should be required to attend a course for training on why their homophobic views are unacceptable. [Paired depth, patients with dementia, Scotland]

You get a warning first, and then it goes up from there. They get a chance to improve and a chance to apologise. [Older patients, mixed gender, Scotland]

Conditions of practice were therefore seen as needed to be imposed where previous warnings and education did not result in a changed behaviour. In addition, conditions of practice were also thought to be potentially appropriate in those cases where intentional discriminatory behaviour was involved, but the outcomes for patient health and wellbeing were not severely negative. For example, some participants thought that a scenario where health and care professionals made discriminatory remarks about patients or colleagues could belong in this category. However, others added that whether this would be an appropriate sanction for such behaviour would depend on what exactly they said and how disparaging or aggressive that was, so imagined there could be cases where a warning and training could be sufficient.

The patients are putting their trust in the healthcare professionals. If they're treating their own colleagues in that way [making discriminatory remarks], then I definitely feel it would be between a warning and conditions of practise. [Ethnic minority patients, mixed gender and age, England South]

As more of the key factors were involved in particular scenarios, participants felt that more serious sanctions may be needed. Their views in this respect were based on assessing certain discriminatory behaviours as severe and posing a risk to patients. Thus, suspension was seen as an appropriate sanction where there was a pattern of repeated discriminatory behaviour and/or grave consequences for patients. For example, making sexually explicit remarks to female patients or refusing treatment to vulnerable patients was often seen as requiring suspension to remove the threat that health and care professional posed to other patients.

[About sexually explicit remarks] *I think suspension is appropriate because it is a very serious situation, it could have put the patient into a state of alarm and fear, and the other sanctions aren't sufficient.* [Paired depth, patients with dementia, Scotland]

If you go somewhere as a patient, as a woman, whether it's a female or a male, you're vulnerable. You don't want anybody making sexual comments. They should be suspended from that role pending further education or restriction of their role that they can't be alone with a female patient. [Patients with disabilities, mixed gender and age, England North]

If there's a danger in some way, then you need to take that doctor out of circulation while there is an investigation going on. [Older patients, mixed gender, Scotland]

Similarly, being struck off was seen as appropriate where different aggravating factors were present, for example, a behaviour was intentional, frequent and/ or with very negative consequences for patients. However, a few participants questioned how likely senior doctors would be to be struck off, due to the difficulties in replacing them and workforce shortages. These participants suspected that senior doctors may be allowed to practise even if they were investigated for serious incidents of discriminatory behaviours.

> *[Refusing to treat a patient who complained about discrimination] goes beyond the conditions of practice. That should be suspension and potentially even be struck off. They can't decide who to treat based on their discriminatory views*. [Paired depth, patients with dementia, Scotland]

Participants did not think that the sanctions should vary between different health and care professions, as they expected all health and care professionals to uphold equality in their work.

> *Regardless of what profession they are in, discrimination is unacceptable. They are all working towards the same aim, to heal people who need their help, and they shouldn't be allowed who they pick and choose to treat*. [Paired depth, patients with dementia, Scotland]

> *I don't think it should matter. The sanction shouldn't be any more or less harsh depending on your role. They should all be judged the same.* [General public, under 30, C2DE, Northern Ireland]

Discriminatory behaviour was therefore not seen as excusable by anyone in health and care, but age, seniority and setting were seen to potentially play a role as aggravating or mitigating factors:

- **Age and cultural competence:** Some participants thought that younger health and care workers may have greater cultural competence and awareness of different needs of different groups of patients than some of their older colleagues. For example, if an older person used a wrong pronoun for a transgender patient, participants were more likely to see that as a lack of understanding that should be addressed through training, than an intentional discriminatory behaviour.

- **Seniority, experience and power:** While discriminatory behaviour was not excused for junior staff, most participants felt it became more severe if it came from a senior health and care professional. Participants felt that someone senior should know better,

wondered how long they have been behaving in that way, and worried about the impact of someone senior with such views.

If it was somebody senior, they must have been doing things for years. It's slightly more excusable if it was somebody junior who's not had the experience. If it's somebody who's been practising for years and still doing this, that makes it worse. [Patients with disabilities, mixed gender and age, England North]

You would expect a consultant to have a lot more experience than a junior doctor. A consultant should know they shouldn't be doing these things. [Older patients, mixed gender, Scotland]

I don't care if it's a consultant or junior doctor. It's unacceptable regardless. It's inappropriate for any level. Whether it's been your life-long career or you've been there 3 weeks. It should be part of the training. [Older patients, mixed gender, Scotland]

- **One-to-one treatment or more social health and care settings:** Discriminatory behaviours in one-to-one settings were seen as potentially more problematic because participants suspected they were more difficult to prove. At the same time, some thought that being a victim of discrimination observed by others was possibly more difficult, as it could also cause the patient to feel embarrassed and humiliated. A participant also suggested that making discriminatory comments in front of patients made this behaviour appear casual, raising concerns over whether staff behaving in this way feel they can do this with impunity at that organisation.

  I think if it's in a private setting, the person receiving it might feel more vulnerable. There's less accountability. They could then deny they said it if you reported it. [Patients with disabilities, mixed gender and age, England North]

  It would probably be more embarrassing and hurtful in a social setting to the person because its drawing attention. [Paired depth, patients with specific communication needs Wales]

- **Non-clinical staff in health and care (e.g. receptionists):** A few participants shared experiences of discriminatory behaviours or insensitivity by receptionists, which in one case also led to a patient avoiding using particular services. While not subject to the fitness to practise process in the same way as health and care professionals, the potential impact of non-clinical staff in health and care should also be considered in terms of its impact on patients' confidence in using health and care services.

7. CONCLUSIONS

The research suggested that the public and patients perceived discriminatory behaviours in health and care as serious breaches of core values and principles that health and care professionals should uphold. Discriminatory behaviours were seen as breaches of a universal duty of care to treat all patients with the same standard of care and respect, but also to undermine inclusion and meeting different needs of different groups of patients.

Most participants felt that discriminatory behaviours could potentially cause significant harm to patients, as well as undermine their confidence in health and care professionals and services more broadly. Such behaviours were perceived to potentially impact on:

- **Patients' mental health and wellbeing**, as direct experiences of discriminatory behaviours could make patients feel uncomfortable, anxious, confused, embarrassed, or distressed, depending on the severity and kind of behaviour in question;

- **Patients' physical health and wellbeing**, as many thought they would attempt to avoid professionals who behaved in this way, which could make accessing health services more difficult;

- **Patients' confidence in health and care professionals**, as discriminatory behaviours were perceived to undermine core values and professionalism expected in health and care;

- **Patients' safety when using health and care services**, as many felt that witnessing such behaviours would make them question whether these professionals may harbour other prejudices that could impact on their treatment too.

- **Patients' confidence to complain about poor care or discrimination**, as some felt they would worry that health and care professionals behaving in discriminatory ways may treat them unfavourably if they complained. Others, however, thought it would be their responsibility to complain about discrimination or poor care, in order to protect other patients.

➔ The research suggests that patients would benefit from clear guidance from health and care regulators and Accredited Registers stipulating that discriminatory behaviours will be treated as serious breaches of professionalism and values at the centre of health and care professions, with the potential to cause significant harm

to patients and undermine their confidence in health and care professionals and services.

➔ The findings also suggest the need to explore how patients could be more supported to feel confident to make complaints, for example, through ensuring an easy way to complain at the time or reassuring patients around confidentiality of their complaints.

While all participants perceived discrimination as a serious breach of a universal duty of care, those aged 30 and younger and/or belonging to minorities (sexual, ethnic or through their disability) had higher expectations of health and care professionals. They were more likely to expect health and care professionals to be trained in inclusion and meeting different needs of different patient groups. These participants were therefore less likely to see a lack of knowledge or intention as a mitigating factor and rather focused on negative outcomes for patients when identifying discrimination. They were also more likely to identify discriminatory behaviours as linked to protected characteristics. Others, however, sometimes felt unsure about how to separate discriminatory from other behaviours perceived as inappropriate in health and care.

➔ The research suggests that raising patient awareness of different forms of discriminatory behaviours and how to complain about them may enable those less confident to identify discriminatory behaviours and complain if they experienced or witnessed such behaviours.

The examples of discriminatory behaviours participants shared suggested this included both more and less obvious cases of perceived discrimination. Obvious examples included health and care professionals making remarks which patients felt were disparaging and linked to their protected characteristics, or in a small number of cases reports of being treated aggressively or being denied certain rights afforded to other patients. More implicit examples involved instances where patients felt they were not being listened to or were being judged by health and care professionals, or that assumptions were made about them, which were linked to their protected characteristics. The latter examples were seen as potentially challenging to prove, as they were often based on health and care professionals' demeanour around patients – how friendly, interested or responsive they seemed to patients – rather than any explicit remarks or obvious inferior treatment of patients.

➔ The research suggests that regulators' guidance and practice in addressing discriminatory behaviours in health and care may benefit from considering how cases of less obvious and explicit forms would be treated and prevented.

Discussions of different actual and hypothetical scenarios of discriminatory behaviours revealed the public and patients used some key factors when considering how serious different discriminatory behaviours were:

- **Intent** – whether a behaviour was intentionally discriminatory or stemmed from a lack of knowledge and understanding;

- **Outcomes for patients and how vulnerable the patient was** – whether the impact was serious and negative for patients, which would be exacerbated if a patient was deemed vulnerable;

- **Frequency** – whether a particular behaviour was an isolated incident or part of a pattern of behaviour.

➔ The findings above would be helpful to consider when reviewing fitness to practise processes employed by different regulators to ensure they reflected key concerns the public and patients had when assessing the severity of discriminatory behaviours and appropriate level of sanctions.

When considering the appropriate level of sanctions for different discriminatory behaviours, participants used the same factors they applied to judge the severity of discriminatory behaviours. Milder sanctions, for example a warning, were seen as appropriate where discriminatory behaviours were: not intentional; did not result in grave consequences for the patient; and were not repeated. These circumstances were perceived as mitigating factors, which participants felt would make them perceive those behaviours as less serious. Other mitigating factors included workload pressures and stress affecting health and care professionals' behaviours and organisational and financial constraints impacting on how inclusive individual professionals can be.

As more of the key factors were involved in particular scenarios, participants opted for more serious sanctions. Thus, suspension was seen as an appropriate sanction where there was a pattern of repeated discriminatory behaviour and/or grave consequences for patients. Similarly, being struck off was seen as appropriate where different aggravating factors were

present, for example, a behaviour was intentional, frequent and with very negative consequences for patients.

➔ The research highlighted public and patient perceptions of mitigating and aggravating factors, which influenced their judgement on the severity of appropriate sanctions. The research suggests these would be helpful to consider when reviewing current fitness to practise processes and guidance.

In addition, there was a strong educational element to what participants expected fitness to practise sanctions to involve, as they wanted the health and care professional to be given training in equality and inclusion to change their behaviour.

➔ The research therefore suggests that equality and diversity education was expected to complement fitness to practise sanctions and could play an important role in restoring patient confidence in the values and professionalism of health and care professionals being investigated for discriminatory behaviours.

Participants did not think that the sanctions should vary across different health and care professions, as they expected all health and care professionals to uphold equality in their work. The same expectation was applied to non-clinical staff in health and care, whose behaviour was also perceived to impact on patient confidence to use health and care services.

➔ The research suggests it is important to ensure any discriminatory behaviours by both clinician and non-clinical staff are addressed in health and care.

Discriminatory behaviours were therefore not seen as excusable by anyone in health and care, but age of health and care professionals, their seniority and health settings in which discriminatory behaviours occurred were seen to potentially play a role as aggravating or mitigating factors. For example, seniority was perceived as an aggravating factor when assessing discriminatory behaviours, whereas incidents that occurred in one-to-one treatment were perceived to pose more challenges for any redress as they were seen as more difficult to prove.

➔ The research suggests senior professionals' discriminatory conduct was potentially more damaging for confidence in health and care services. It also suggests the need

to review processes for investigating complaints about discriminatory behaviours during one-to-one treatments and the extent to which all involved were protected and supported in those instances where evidence was perceived as harder to provide.

APPENDIX 1 – Discussion Guide

2173 PSA PERCEPTIONS OF DISCRIMINATION TOPIC GUIDE (FINAL)

SECTION 1: INTRODUCTION AND EXPLANATIONS (5 MINUTES)

- Introduce self and RWL, an independent market research company
- Explain that we are conducting research on behalf of the Professional Standards Authority who help to protect the public by working with the organisations that register and regulate people working in health and social care.
- Professional Standards Authority want to find out what general public and patients perceive is discriminatory behaviour in health and care.

- Your personal data will be held securely by Research Works Limited for 6 months, then deleted.
- Your personal data will not be shared with any other third party, including our client Professional Standards Authority in any way that would allow you to be individually identified;
- You are also consenting to Professional Standards Authority processing aggregated data from which you cannot be individually identified – in the form of the report we supply for research purposes.

- Ask permission to record the session.
  - *RWL will use and store the audio or video for the purposes of this research project only;*
  - *All audio/video data is kept securely for up to 12 months after project completion, it is then deleted from our systems;*
  - *Audio/video data may be shared with our client, Professional Standards Authority, for sharing research findings internally. It will not be shared with any other third*

party or for anything other than sharing research findings internally without your express permission.

- Explain about the interview process
  - There are no right or wrong answers, we're just interested in what they think so best to be honest and open
  - [Adapt to groups / depths] We have a few topics to cover and would like to hear from everyone so apologise if we sometimes have to move on with the conversation
  - From experience of conducting these interviews, we know it can be quite an intense discussion, so [either we'll take a 5 break in the middle (GROUPS)] please tell us if you need a break or would prefer not to answer any particular questions.

SWITCH ON RECORDING

- Names, location, which health and social care professionals in contact with (as a patient or carer), including those working in accredited professions.

SECTION 2: EXPECTATIONS OF HEALTH AND SOCIAL CARE PROFESSIONALS' BEHAVIOUR (10 MINUTES)

I'd like to start off by briefly discussing our expectations of health and social care professionals' behaviour, particularly in terms of equality, diversity and inclusion.

- Spontaneous: In brief, what is the standard we expect from health and social care professionals' behaviour in terms of equality, diversity and inclusion? This could be either towards a patient or another health or social care professional.
- Prompt on expectations of health and social care professionals e.g.:
  - Not to behave in discriminatory ways?
  - To challenge other people if their behaviour is discriminatory?
  - Actively promote social justice i.e. equality, diversity and inclusion?

SECTION 3: WHAT CONSTITUTES DISCRIMINATORY BEHAVIOUR IN HEALTH AND SOCIAL CARE? SPONTANEOUS (25 MINUTES)

Moderator to explain: *People can experience discrimination on different basis – show* ***Stimulus slide 1*** *– on the basis of gender, age, ethnicity, sexual orientation, disability, gender identity and so on.*

- Have you ever come across instances of health and care professionals behaving in a discriminatory way on any of these grounds? *This can be from your experience or something you're aware of/heard about*
- If so, what happened? Why was their behaviour discriminatory? What do we call this type of behaviour?

- If not / more generally, what would you see as discriminatory behaviour by a health and care professional? *Remind respondents to think about the different ways in which someone could be discriminated against.*
- What do we call this type of behaviour?

- *Moderator: note spontaneously mentioned types of discriminatory behaviour.*
- *Note all spontaneous suggestions, whether focussing on behaviour or protected characteristics.*

- Now <u>prompt</u> participants with examples from **Stimulus slides 4 – 10** that haven't already been discussed. NB: move through direct discrimination examples swiftly.
- To what extent, if at all, do we feel that these are examples of discriminatory behaviour? Why/not? What do we call this type of behaviour?
    - Probe any factors likely to make these examples more likely to be perceived as discriminatory behaviour?
    - Probe any factors likely to make these examples less likely to be perceived as discriminatory behaviour?

<u>SECTION 4: WHAT IMPACT DISCRIMINATORY BEHAVIOUR MAY HAVE ON BOTH PUBLIC SAFETY AND CONFIDENCE (25 MINUTES)</u>

Now I'd like to move on to thinking about the effect of these types of discriminatory behaviours on the public and patients.

- Firstly, let's think about <u>the more direct forms of discrimination</u> e.g. saying or doing things that are discriminatory.
- Imagine that you witness discriminatory behaviour by a health or social care professional:

- How does this make us (i.e. the public and patients) feel when they are using health and care services?
- What impact, if any, does this have on our confidence to use health and care services?
- What impact, if any, does this have on our safety when using health and care services?
- What impact, if any, does this have on our willingness to complain about the quality/safety or health and care within health and care services?
- How likely would we (i.e. the public and patients) be to complain about direct forms of discrimination by health and social care professionals? Why/not?
- Secondly, let's think about <u>the more indirect forms of discrimination</u> e.g. making assumptions about people based on their appearance, microagressions.
- *Repeat questions above.*

- Having discussed these different forms of discrimination, would their impact vary depending on:

    - The profession of a health and care professional behaving in this way? *Probe: whether it was a health or social care profession? Different health professions, e.g. nurses, doctors, physios, psychologists?*
    - Whether his behaviour occurred in a hospital setting or where 1-2-1 treatment and patient-professional interaction is involved? Or in an emergency situation vs routine care?
    - The seniority of the person behaving in these ways
    - Whether this was a one-off incident or repeated behaviour

5 MINUTE BREAK HERE!

- **<u>SECTION 5: FITNESS TO PRACTISE CONTEXT SETTING (5 MINUTES)</u>**

  I'd like to explain what happens if a patient complains to a regulator about the behaviour of a health or social care professional; and the regulator decides to take the health and social care professional through the 'fitness to practise' process.

- Has anyone heard of this term? If yes, what does it mean to you?
- **Show stimulus slide 2.** Any questions?
- Has anyone heard of any examples of health or social care professionals going through 'fitness to practise' processes?

- **<u>SECTION 6: HOW REGULATORS SHOULD RESPOND TO DIFFERENT TYPES OF DISCRIMINATORY BEHAVIOUR? (15 MINUTES)</u>**

Now I'd like to understand what level of sanction/(penalty) would be appropriate, if patients complain about discriminatory behaviours and they end up in a 'fitness to practise' process.

- For two examples of discriminatory behaviour (one direct and one indirect) on **Stimulus slides 4 – 10,** what level of sanction/(penalty) should be imposed from:
    - no action taken; to
    - being 'struck off' the register.
    - **Show Stimulus slide 3**
- Why do we think this level of sanction/(penalty) is appropriate in this case?
    - *Probe any factors likely to influence the level of sanction considered appropriate? For example, frequency with which a discriminatory behaviour occurs? Anything else?*

- Do you think there would be any variations on sanctions that should be imposed for these different discriminatory behaviours depending on:
    - The profession of a health and care professional behaving in this way? *Probe: whether it was a health or social care profession? Different health professions, e.g. nurses, doctors, physios, psychologists?*
    - Whether this behaviour occurred in a hospital setting or where 1-2-1 treatment and patient-professional interaction is involved? Or in an emergency situation vs routine care?
    - The seniority of the person behaving in these ways
    - Whether this was a one-off incident or repeated behaviour

SECTION 7: CONCLUSIONS (5 MINUTES)

- Reflections on the session