Academic Audio Transcription Ltd
International House
109-111 Fulham Palace Road
London W6 8JA
United Kingdom

hello@academicaudiotranscription.com

# Anti-racist Qualitative Health Research: Framing Anti-racist Questions with Wayne Farah

## Speaker information

- Sohail Jannesari (Interviewer) (Sohail)
- Wayne Farah (Speaker) (Wayne)

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00:00:09 Sohail Welcome to the Qualitative Applied Health Research Centre's new series: *Anti-racist Qualitative Research.* In this series, we look at whether, how and to what extent qualitative health research can contribute towards anti-racist and decolonising courses. We take a journey through qualitative research, exploring how theoretical framing topic, process results, sharing findings and impact can give a positive impact in the course of anti-racism. So today we're very lucky. We have with us Wayne. Wayne, would you like to introduce yourself?

00:00:44 Wayne Oh, yeah. Hi, everybody. My name's Wayne Farah. I'm a coordinator of the NHS Confederation BME Leadership Network. And I have over twenty years' experience as a non-executive director within the NHS, sitting on various boards. I have a background as a policy officer, but I've also worked extensively in the third sector and been involved with numerous community organisations and anti-racist campaigns.

00:01:20 Sohail Great. Thanks, Wayne. And just to start us off, what would you like to see from people doing health research using qualitative methods? From sort of your perspective being, really, you know, in tune with what's going on in the NHS as well? Yeah.

00:01:39 Wayne I think, for me, the most important thing is for people to actually start taking a very critical perspective on—how do we put it? On the—on what everybody thinks is kind of quite a comfortable debate. But I think, you know, the whole idea of what anti-racism is within the NHS, or what anti-racism should be, I think people need to sort of be very critical in the way in which they look at the way the NHS frames its debates about anti-racism and what racial equality is. And I think, too often, we have things discussed in terms of disparities, which is obviously a very kind of quantitatively-driven analysis tends to dominate that. And I think a lot of the—a lot of what is being produced there just—is just, you know, if you take large enough data sets, you'll get variables—variation in outcomes, and that's just the kind of function. And, too often, what is then being presented as evidence of racism is, I think, abstract, ahistorical and essentialising. And I think when we—and I think those things need to be challenged in terms of: what's the comfortable dialogue? What's the comfortable, you know, narratives within the NHS? Which, in my opinion, take us too far into an accommodation with race science rather than a race—a scientifically critical analysis of racism. So, I mean, if—I mean, I kind of framed quite a lot of issues there [chuckles] that we might want to unpack. But that would be—you know, my overall view is we need to start challenging what I think is often a very wishy-washy dialogue and narrative about what anti-racism really means in the real world.

00:03:53 Sohail Brilliant. Thank you. Yeah. Loads to get into. So I wanted to go back to what you said around research, and it can be sometimes abstract or ahistorical or essentialising. So what do researchers have to do? What questions do they have to ask themselves to bring, for instance, history back into the conversation around racism in the health sector?

00:04:23 Wayne I think the first thing to do is actually be very clear what definition of racism is being used. I mean, people like to talk about racism, but often they're very vague as to what that thing is. And when they do kind of seek to define or set down what their approach is, it is often a very psychological or personal-based analysis of racial prejudice that tends to dominate the conversation. And so, we get into a lot of—you know, and this—yeah, this is wider. You know, you get into a lot of conversations about, you know, what constitutes, "Was that a racist comment? Was that a racist this? Is that a racist the other?" Okay? And so, we—you know, we break—we tend to break things down into individual attitudes, and I don't think that necessarily takes us into the important issues. I'm not saying that individual experiences are—you know, should be totally neglected, but I think, too often, the individual experience is being extrapolated into meanings beyond where it should be going. And the big issues that are affecting Black

communities and the Brown communities and, you know, different communities, us racialised communities, are being missed because the tendency becomes to focus on, you know, "What's happened to poor Meghan?" And not the deaths of the next young Black man in a mental health setting.

00:06:08 Sohail Okay. So should researchers then think about going beyond sort of individual-level questions and analysis? Should they be, for instance, questioning how institutions are run, questioning management? What's the way forward?

00:06:28 Wayne Yeah. Definitely. That is—you know, we should be looking at individual cases, individual experiences as an indicator of where we really need to focus the research. So it shouldn't—the individual experience should be the starting point of building a critical analysis rather than simply the subject of the research. So I think that, to me, is the important bit. You know, because otherwise you get a continuous repetition describing the problem and no clear insight into how we address the problem and how we go about creating the organisational or institutional or social changes that actually need to be brought about so that we begin to unravel that. So the—you know, the continuous focus—so, you know, within the NHS, I'm always critical that, you know, the first thing that we hear when, you know, another person has died or, you know, another horrendous way in which the NHS has failed to care for our most vulnerable, is, you know, "Oh, we need some unconscious bias training," or, "We need some sensitivity training," or, "We need…" You know, which always brings it back down to the individual as the cause of the failure. Yeah? Where, you know, the organisational structures which have empowered that individual are left unexamined. Yeah? And then—yeah, so it's like—and somebody's individual prejudice needs the organisational structure and needs the institutional arrangements to empower that individual prejudice. Yeah? And always focusing on the individual prejudice rather than what gives that prejudice power, what gives that prejudice the ability to be worked out in an organisational institutional setting. What legitimises? Yeah? What is the context of that individual's ability to abuse, neglect or mistreat?

00:08:47 Sohail Okay. So that's very helpful. I wanted to bring in an example from your work to see how that might actually look in terms of research. So you've done a very, you know, well-cited report on perspectives from the frontline, the disproportionate impact of COVID-19 on BME communities. Part of this—a big part of this was a lot of in-depth interviews with, I think, various BME leaders and a bit broader than that, too. So how did you take those interviews and those individual perspectives and build a more systemic critique?

00:09:29 Wayne I think we tried to do three things. First of all, in terms of the way we went about developing the topic guides, yeah? We didn't just allow—I mean, we actually worked through, "What actually are we talking about here?" Yeah? We are—when we—we're at the front—for us as researchers who were going out into the field, being very clear that what we were not looking to do was to just regurgitate what people had heard on, you know, on the nightly news. Yeah? We actually wanted—because that, to me, is too often the thing. You know, people ask what they think about something, and what they think about something is often not being subjected to a great deal of reflection. So we actually tried to work through a process in terms of the topic guide so that we were inquiring as to people's thoughts, not just asking what comes off the top of their head. I think the second thing that we did was we then actually also went out and spoke to different communities, yeah? So that we had some prism in which to look at our analysis of what leaders in the health service were saying. Yes, they'd been at the frontline but, you know, we couldn't—we didn't necessarily want to allow that to be what was put forward as the explanation from the—coming from the community. So there was actually a need to cross reference what our leadership network was saying, was, "You know, we shouldn't take that for granted." And then in the third instance, what we tried to do in the way we presented the report—obviously, it's been prepared for, you know, other NHS leaders. So there was—yeah, and there is a constant battle then between the way in which you present things that will resonate with your audience, but you are very conscious not to allow the fact of who your audience is and what your audience will be comfortable with to become the ultimate prism through which you filter the research data.

00:11:48 Sohail Okay. Thank you. So maybe building on the last thing you said, I was curious about, I guess, how the report is framed. So it's very much using, for instance, the term BME. And I kind of wanted to ask firstly how you felt about that term and how that term might influence the sort of overall framing and how you communicate those findings to NHS leaders.

00:12:19 Wayne So, I mean, that's the terminology our network is set upon, okay? And I—you know, I just get, like, endlessly frustrated with this debate about terminology. And I wonder—I don't give a monkeys what you call me. What I insist on is you treat me as a human being. You treat me with dignity and respect. Okay? And, you know, this whole framework about, you know, terminology, I mean, you know, I still just—yeah, I'm old enough. I mean, I've just come from an anti-racist movement where, you know, Black people were involved in a fight, and we didn't have the luxury of being broken down into ethnicities. And I always think that if you actually look at the evolution of racism in Britain—and this is where I come back to what I was saying about being ahistorical, okay? So we look at this—you know, this whole debate about language in this, you know, in the sense of being ahistorical. But where did this idea of ethnicity come from? Okay? Because race and ethnicity, they're not real things. Okay? There's not—they're not—you know, you don't belong to a race. Yeah? You don't belong to an ethnicity. These are simply social structures that are created in order to achieve various social ends. Yeah? But there's nothing inherent in you as an individual that is—yeah, this is where I was talking about essentialism. Right? There's no essential thing that makes you—defines your ethnicity. Your ethnicity is not some primordial thing that, you know, that you've inherited. Okay? So these things are worked out social structures for social objectives. Okay? And if you look at, you know, the—where a lot of this comes from, you look back to the 1961 Immigration Act, okay? Which is where the fundamental nationalisation of racism in Britain occurred, yeah? Which is when you had the complete framing of New Commonwealth and Old Commonwealth. Yeah? So the Old Commonwealth or the White Commonwealth: Canada, South Africa. Yeah? And the New Commonwealth, yeah? Was the Black Commonwealth, yeah? Africa, Asia, Caribbean. Okay? And that was where this was first codified into law. Yeah? And then you look at, you know, the whole idea of how different communities were integrated on that basis. Yeah? Ethnicity was—yeah, the closer you looked to white, the easier was your incorporation into the British immigration system. Okay? And, you know, so different communities were racialised slightly differently, but it wasn't until after the Brixton uprisings in the early 80s and then, you know, what we saw with the fightbacks in Brixton and Toxteth and, you know, all across the country. But then you have the Scarman report, which is where they first introduced this idea of ethnic inequality. Okay? So there was no institutional racism in the police. What you had was this proposition of ethnic inequality. Okay? So, yeah, when a—yeah, what—these terminologies are consistently fought over, yeah? And, you know, the fight should be about the racism and discrimination rather than the terminology.

00:15:47 Sohail That's great. And so, basically, it's a bit of a distraction, and if you are a health researcher dwelling too much on this, it isn't going to help your research as much as really just making a beeline for—Sorry, go on.

00:16:08 Wayne It may, or it may not. Okay? Depends what your research is. Okay? But what—to me, the big challenge is that, too often—I'll go back to what I was saying about, you know, too often, we're involved in race science rather than the scientific analysis of racism. By that, what I mean is, you know, this whole idea that race is a biological construct, okay? Which was, you know, at the roots of the whole eugenics movement. Yeah? Which was why you saw what was happening—you know, what ultimately led us to the Nazi death camps, but which was evolved in America and Britain, yeah? Was rooted in the scientific method. Yeah? Voltaire, you know, all these guys at UCL. Yeah? You know, UCL have been through its big decolonising moment, hasn't it? Because of, you know, having to change names, the Galton. Yeah? All these guys who were the eugenics guys who were, you know, the social Darwinists. Yeah? Who, you know, based their idea that, actually, there was a hierarchy of human beings, and guess what? They were all at the top. Okay? [chuckles] You know, so this whole idea of race science, which was, you

know, evolved as the scientific method evolved, and it was, you know, the scientific method was used to justify colonialism and the Transatlantic slave trade. "Of course Black people are slaves. They're Black; therefore, they're slaves. This is the biological inheritance. Yeah? And, of course, we're in charge. We're white. We're born to be in charge." Okay? And this you see creeping increasingly into the NHS, yeah? As—you know, there's been a whole, you know, race realist political movement, okay? Which is about normalising that racism. And that's very prevalent within the current government and terminology, yeah? And I think you can see that in, you know, Boris's ethnic report. Right? This idea of essentialising race but calling it ethnicity. And, to me, ethnicity is just race dressed up as culture. Okay? It's trying to essentialise us and say that our inequality arises not because of social, economic and political processes, but because of our inherent biological weaknesses. Okay? And this—I mean, and then obviously the bell curve being the kind of, you know, the ultimate expression of this, but behind that is a whole series of documents, research reports, et cetera, et cetera, which are based on that premise. Yeah? And I think, you know, too often the NHS is reproducing this because it's slipshod and wishy-washy, and it's not really thinking the issues through because it's taking racism as abstract, ahistorical and essentialist. And that's why we end up, you know, with a situation where they say, "Oh! Yeah. African Caribbeans have hypertension. Asians develop diabetes." Okay? Now, that should be the starting point of our conversation because there is nothing biological that rests in that term 'African Caribbean' or rests in that term South Asian. So what is going on that lasts behind those immediate figures? But everybody can get quite well off as researchers just continuously to reproduce more evidence that that is what happens rather than saying, "That's happening. How do we understand that other than to simply ascribe that to some biological essentialism which doesn't exist?"

00:19:52 Sohail Thank you. And also, supposedly, the other follow question is: how can we do something about it? And that kind of brings me a bit to another guide you've written on combating racial discrimination against minority ethnic nurses, midwives, nursing associations. So can you talk me a bit through how the—you know, what questions did you ask to get answers around how you combat racial discrimination in NHS settings?

00:20:27 Wayne So I think that wasn't an—I mean, that's kind of been a guide that's been generated by us collecting the views of nursing leaders. Okay? So that—well, you know, so I think that's slightly different. And that's a draft document at the start of a process to get us something that could be released to nurses on the front line so that we could then evolve the document so it became a really meaningful document. So I think that document is still in the process of being developed. So it isn't—you know, it's a starting point rather than the end point. So we've got a whole process that we're working to do over the next four to six months that will, you know, be doing that. But, I mean, we did commission some research, you know, from King's around, you know, what was being said around health systems around the world about these issues.

00:21:29 Sohail Great. Thanks. And just to—I guess because this podcast is trying to think a bit about the starting point, as you said, and you kind of said, you know, the starting point needs to be a bit beyond, "Okay, there are differences in health outcomes," and trying to get to a bit more of the 'why' and maybe the 'how' and what to do about it. So I kind of wanted to get at what sort of research projects would you want to see qualitative health researchers doing? You know, we have a listener base, most of who are qualitative health researchers. What questions aren't they asking that perhaps they should be?

00:22:14 Wayne I think it's three things. I think, you know, it's kind of getting into the question of what is the accepted wisdom? Yeah? And I think it's kind of like, "Well, why is that the accepted wisdom? Why…" [chuckles] Because—so, throughout the NHS, we continuously see reports. So let's take an obvious one. You know, experiences of Black men in mental health services, you know, consistently being reported. I mean, I remember back to, you know, the 1980s campaign, you know, around Cartoon Campbell, consistently being reported. Yeah? Much later access. More likely to be sectioned. You know, more likely to, you know, to receive a whole series of negative experiences and, you know, and have worse outcomes. Yeah? So what's the benefit of

another report telling us that that's the experience? Yeah? What might be helpful is, "What has happened to all the reports from the last forty years? And why have none of them actually made a difference to the outcome for these people? You know? And, you know, what is the link?" For example, "Oh, we see far worse outcomes for Black women, South Asian women in maternity." Yeah? "It's been reported for years." Well, what's going on there? Why are we not looking at the relationship between that and the Windrush legislation? Yeah? You've got—if you win—the NHS claims to be an anti-racist—or committed to anti-racism, but the legislative programme says that we are required to discriminate. Okay? You know, and so, you know, that—we run the hostile environment. Yeah? We've seen the NHS turning out sick people with cancer and let them die. Right? That's what we do. We've thrown our employees out of jobs. Right? So what kind of impact is that having on people who came into the NHS because they actually wanted to look after anybody and everybody, but now they're also having to be immigration controls. What's the—what does that mean to them? What does that mean to their Hippocratic oaths? What does that mean to their ethical concerns? You know? What is being—what does that mean in terms of the cognitive dissonance? If we want to get into, you know, the psychology of this thing, why aren't we talking about what happens to people? So it's a different way of framing it, yeah? But racism, you know, is about what is being done to people, not how people feel about what somebody says about them or how they describe them or what box they've got to tick. Right? I'm not dismissing that, but I'm saying if we're focusing on that at the same time as the NHS is leaving people with cancer to die, we're missing a trick. There's a racism that discriminates that must be challenged, but there's the racism that kills. And we mustn't lose sight of that fact when, you know, when we are concerning ourselves. You know, I remember—I mean, all the debates that we were having during COVID, you know? Yes, we were seeing where COVID was striking first. Okay? And there was no surprise in that. I mean, Marmot had said, you know, "The data will tell you. Where you are the poorest, the most vulnerable, that's where it will do the most damage." Okay? But it was like—not every Black person was at risk. I wasn't at risk. The NHS had me set up on my computer. I spent, you know, the lockdown, fine. Anything I needed—I got a good job. I live in a nice big house. I'm not overcrowded. Anything I needed, somebody—some poor person would bring to my door. Okay? So we got to stop looking at the problem as those who have power would like us to look at it and start looking at the question of, "Well, what are the questions those who have power would not like us to ask? What are the questions that those people who are actually on the rough end of this brutality, what are the questions they would like us to ask to the people who've got it comfortable and are well off?" And I think, you know, if we look at, you know, the NHS—I mean, you know, we look back to all—look at all the crises that we've had over the last twenty years. Yeah? Every—you know, the South Staffordshire, yeah? Bristol Royal Infirmary. You know, all these huge catastrophes that the NHS has shown itself to be brutal in treating the most vulnerable in our community. Yeah? Brutal in its disregard, you know? Brutal in, you know, letting people dehydrate. Yeah? And then we look back, and we say, "Well, what's going on here?" Yeah? We actually have to start questioning, you know, beyond the NHS is, "You know, we're wonderful. We're inclusive." Well, actually, all evidence is to the contrary. Yeah? We have lots of examples here. And I suspect that when we look at the data about racial disparities, and we look at the data about what kind of service is being delivered to the poor, we will end up having to take a look back right back to the Black report in 1980s, which first laid out all this data about health inequalities. And even further than that, the whole idea of the inverse care law. Yeah? The greater the need, the less resources go into. And what the—you know, that was quite simply—you know, the marketisation of health care leads to the concentration of health resources to those people who have the least need. Yeah? And since 1980—since 1979, every government has been involved in further marketisation of the NHS. And lo and behold, as they've done that, the services and the care to the most vulnerable and the most disadvantaged of all colours, all races, all ethnicities has got worse. And yet, where is the research on this? The research is all about describing, "Oh, look, here's another example of where these poor people didn't get a good deal," rather than, "This is what is driving the NHS away from its core principles."

00:29:17 Sohail Thank you so much for that. That's really, really key, and I hope our listeners are taking that in. I wanted to just, I guess, follow up on this and say it seems to me that you need a good knowledge of politics and political history as a qualitative health researcher if you are going to do effective work. So is—one of the points coming out of this is that we perhaps need broader skills, broader education, and you can't teach qualitative health research in a vacuum.

00:30:00 Wayne Yeah, yeah, for sure. And—you know, and I think, you know, we're all kind of—and we all go through a process, don't we? You know, I mean, education's about teaching more and more about less and less, isn't it? On one level. Yeah? That we become so focused in on the specifics of the subject. But there is always that need to, "Actually, where are we getting—where do we get the alternate view?" You know? "How far are we all—you know, how far as researchers and academics is everybody comfortable with, you know, their own grand narrative?" You know—so, you know, I was talking about the NHS because, you know, that's where I'm located, but, you know, when I worked in the education system [chuckles], you know, it was similarly challenging because, you know, these things are happening, you know, across the narratives. You know, these narratives—these common narratives are being developed, and, you know, we do have to look outside of, you know, "Where's the alternative view here? Where—you know, where is—you know, if we're only looking at one analysis of racism, where else should—might we be looking?" I mean, I—you know, I've being involved with the Institute of Race Relations for many years, and so, you know, I come from a—I've been educated, you know, in anti-racist campaigns through the 80s, you know? So some of that comes through when—you know, that was before we had the internet, folks. [chuckles] There really was a time—and I'm old enough to remember—yeah, that actually you had to get out. You had to be organising in communities. You had to be working with communities. And I think that, you know, if you're not an anti-racist campaigner, an anti-racist organiser, I don't think you can be an anti-racist researcher because knowledge is not produced in the academy. Knowledge is produced in communities by those who are being impacted by the discrimination and the prejudice that the academic wants to talk about. But if you're not there with people, and your research is—you know, as an old adage, the people that you write for are the people that you fight for. And I think, as a researcher, you know, if you're only writing to impress those people further up the chain rather than to empower those people below you, your ability to produce effective anti-racist research will be severely curtailed.

00:33:05 Sohail Brilliant. Thank you so much for that. I just wanted to end—I think that's perfect, you know, to end on, by the way. But the final question is just if someone is interested in doing anti-racist qualitative health research, if they are trying to take on some of the points you've made throughout this podcast, what resources—are there a few key resources that they can go to, have a read and start the process of educating themselves more widely?

00:33:34 Wayne Well, I mean, yeah, as I said, you know, the Institute of Race Relations would be the first place. And I would say that, wouldn't I? I, you know—I—you know, a lot of my education has come through the institute. But there would all—there are also, like, lots of resources on the internet. I mean, I think—you know, when I'm looking at some of this, I think some of the best stuff that I'm seeing, for example, coming out of the USA—I mean, I know, you know, that's kind of I'd be critical about our tendency to look. But I think if you look at the work that Barbara Fields and her sister have been doing, the Fields Sisters, you know, they're doing some really good work as a sociologist and a historian; two sisters working together. And I think, you know, if you look up the Fields Sisters, google the Fields Sisters, you'll see a lot of their stuff. I think Adolph Reed is producing, you know, a lot of stuff that I found particularly informative, you know, and I think, you know, they would be—you know, the two—the Fields Sisters and Adolph Reed in terms of the USA would—you know, I think if you google them, they will start generating some—taking you down to all, you know, potentially interesting routes, particularly some of the stuff Adolph Reed has done about health disparities and racial disparities in terms of, you know, deaths in police custody and that kind of thing. I think he brings down a really interesting analysis. But, you know, I think there are so many organisations that are deeply rooted in their communities. I mean, the

Monitoring Group, Southall Black Sisters, you know, they're all—these are organisations that are deeply rooted in their communities. That, you know, if you're going to be looking at, you know, what's going on in a particular area—you know, obviously, you've got the Grenfell networks as well. You know, they're deep-rooted community organisations that can be a place for you to go to check out your thinking quite early on. So I think, you know, get in touch, you know, use the resources at the institute, you know, but also use the resources of the communities around you and make the effort to reach out to those communities because they just might give you a different lens to look at the problem through.

00:36:16 Sohail Brilliant. Thank you so much. I love that idea of good places to check out your research. Like, "See if you are in tune with the people you would like to fight for," I think is an excellent piece of advice. So thank you so much, Wayne. That was really, really excellent. I learnt a lot from it. And thanks to all our listeners. Next episode, we are going to be drilling down into the research process with Dr Gargie Ahmad, [downtempo electronic music fades in] talking about reflexivity and how identity might affect the process of doing anti-racist research. So please join us then. Thank you so much. [music fades out]

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