'Your CV looks amazing but I am sorry, you didn't get the job': Analysing experiences of global majority physiotherapists aspiring to and working at consultant level practice in the UK.

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Key messages:

1. Managers in positions of power act as 'gatekeepers' upholding discriminatory practices and policies that hinder career progression of physiotherapists from the global majority.

2. Career pathways to consultant level practice for physiotherapists of the global majority are ill-defined, obscure and precarious, so limiting progression.

3. Advancing equitable leadership requires acknowledgment of how racism acting at a macro level influences organisational dynamics, requiring intentional action to account for and disrupt the perpetuation of discriminatory practices.

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ABSTRACT

Effective leadership shapes organisational culture to deliver world class healthcare. Racially minoritised individuals rarely access opportunities leading to leadership positions. This paper expands on themes from qualitative research which explored experiences of qualified physiotherapists from racially minoritised backgrounds aspiring to (or working at) consultant level and co-designed recommendations that challenge inequitable practices which perpetuate unearned privilege.

Methods

The study used critical discourse analysis to understand the experiences of aspirants. Participants were recruited purposively using snowball sampling via professional diversity networks and social media. Semi-structured interviews were conducted remotely. Externally facilitated focus groups supported co-creating research outcomes and strategies for action. Secondary analysis extends our initial analysis to focus on two themes, critically considering these in the context of the role of leadership.

Results

Data drawn from 17 participants from self-identified racialised groups who were either in consultant level positions, or aspiring to be, was included in secondary analysis. Analysis identified structural racism as an enduring social wrong, existing within different levels of organisations. Managerial 'gatekeepers' created barriers to career progression by not recognising skills, knowledge and experience. Pathways to career progression were hidden and unwieldy, operated by managers in ways that restricted leadership opportunities disproportionately to white peers. These challenges created a sense of 'un-belonging' resulting in negative health impacts.

Conclusion

Gatekeepers maintaining racist cultural practices and policies were key in upholding the hegemonic status quo. Collective strategies enabled a sense of ontological belonging and empowerment for participants and may be helpful for those experiencing similar concerns in their workplaces.

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INTRODUCTION

Recent Workforce Race Equality Standard (WRES) data highlighted the persistent inequities faced by racially minoritised staff in the United Kingdom's(UK) health and social care sector (1,2). These include reduced access to non-mandatory training and continuing professional development, higher rates of harassment, bullying and discrimination, and limited opportunities for career progression and promotion to senior positions. Band 5 (entry level for newly qualified staff) is the highest Agenda for Change (AfC) banding for the majority of racially minoritised staff (29.7%) within the UK and only 13.8% hold senior positions considered to include consultant level practice (broadly AfC bands 8B and above) (1). Consultant physiotherapy and allied health professional (AHP) roles are varied and include autonomous clinical, operational, strategic, and clinical academic leadership. Poor representation in the UK professoriate (3) and low numbers of lead applicants for awards from the main UK research councils such as UKRI (4) and NIHR (5) raises additional challenges for racially minoritised people considering academic leadership roles.

The underrepresentation of racially minoritised staff in leadership roles highlights a concerning lack of representation, with implications for staff, and potentially contributing to poor health outcomes for patients (6). While research has explored the experiences of racially minoritised physiotherapists at pre-qualifying level (7), less is known about the experiences of their qualified counterparts in the UK. To address this gap, a participatory research inquiry was necessary to engage with non-white qualified physiotherapists aspiring to or already in consultant roles, and to collaboratively identify solutions for addressing discrimination and achieving equity within the profession. The study's participatory approach aimed to position the researchers as co-enablers rather than dispassionate observers, in order to ensure that the voices and experiences of participants were included in the identification of issues and the development of solutions. The study's findings are specific to physiotherapy but have broader implications for understanding experiences across other allied health professions and for promoting equity in health and social care as a whole. The study's main aim was to explore racially minoritised physiotherapists' lived working experiences and to identify discriminatory or facilitatory practices that influenced their career trajectories.

The objectives were:

1. To explore the lived, working experiences of qualified physiotherapists from racially minoritised backgrounds who were aspiring to or had achieved consultant level practice.
2. To identify current practices in the physiotherapy profession that perpetuate privilege.

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3. To co-design recommendations for physiotherapists who identify from a racially minoritised background who have been excluded from a trajectory to consultant level practice, to be better supported in practice and through policy.

METHODS

The initial study used a critical discourse analysis approach (8) to identify discourses and practices that perpetuate privilege and used a participatory approach to develop strategies to dismantle them (9). The study focused on qualified physiotherapists in the UK either aspiring to be or working at consultant level. The research team are all physiotherapists with broad roles in higher education, clinical practice and research with an interest in leadership and social justice. JW is a Black African woman, immigrant and naturalised British citizen. AW is a Black British Jamaican woman. AA is a British-Black South African, immigrant woman. JH is a White Australian man. GR is a woman of Mixed heritage: Asian and White. Participants were recruited purposively using snowball sampling via social media communities which support those from racially minoritised backgrounds, and professional and diversity networks. Participants included a mix of ethnicities, ages, and genders, and most held senior positions. A fuller description of the study methods is reported in Adonis et al. (10). A summary of our methods and analysis is included for reference below.

Semi-structured interviews, lasting up to 90 minutes, were conducted and audio recorded by JW (DPhil); AA (MSc) and AW (MSc) via teleconferencing, using an interview topic guide. Interview transcripts and field notes were analysed by all authors using a critical discourse analysis framework (8) to identify power relations and inequalities in participants' construction of their experiences. A second stage of analysis was conducted through externally facilitated workshops with the research team and participants. These provided an opportunity to collaboratively discuss the initial analysis and discourses and co-create the research outcomes and strategies for action.

Following a period of reflection since the original research and write up, the research team critically revisited the data and conducted secondary analysis with a specific focus on 'leadership'. We reviewed two of the initial themes to elaborate on the social wrongs and to identify specific implications for leaders / managers. These themes can be seen in the context of our previous findings, specifically we expand on 'individual gatekeepers' and 'structural gatekeepers' (see Figure 1).

Inset Figure 1 here

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Figure 1: How domains of oppression and racism are maintained within healthcare organisations (Adonis et al. 2022)

RESULTS

Full details of the participant characteristics are reported in Adonis et al. (10). To summarise, all 17 participants were from diverse, self-identified racialised ethnic groups including Black, Asian and Mixed heritage with 58% of participants from overseas. Seventy percent identified as female and ranged in age from 23 to 62 years. With the focus on consultant practice, most participants (41%) were at Band 8a to 8c, 18% at Band 7, 12% at Band 6 with 29% in private practice. There were no dropouts and no-one approached declined participation.

The initial research identified a number of themes, coded by all the researchers, and have been reported elsewhere (10), where a discussion on themes related to the enduring emotional and physical impact of racism on individuals can be found. We have deliberately avoided focusing on this theme here, as this will be discussed in a forthcoming article, but also there is a risk that the implications and actions are remedial and inadvertently emphasise a 'deficit' model. The focus of this paper is on those themes that relate to and have implications for leadership cultures and styles. We present and expand the following themes identified from the empirical data.

1. Managers and leaders acting as 'gatekeepers' by not valuing skills, knowledge and experience
2. Pathways to career progression and consultant practice are unwieldy or hidden, limiting opportunities.

The focus of our critical research is to draw attention to the need to i) empower individuals and ii) collectively provide ways to review and disrupt the meso and macro systemic issues we have highlighted. Hence, we are choosing not to use *racialised minority* as a descriptor (from this point on) but to deliberately use 'global majority', centring an alternative decolonised narrative. As Cambell-Stephens suggests:

> "'Global majority' was coined to reject the debilitating implications of being racialised as minorities. In addition, it was then, as it is today, a more accurate descriptor of those labelled as 'ethnic minorities' or 'diverse minority communities'' (11, p4)

Theme 1: Managers and leaders acting as 'gatekeepers' by not valuing skills, knowledge and experience

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The first theme highlights the challenge faced by many global majority physiotherapists who possess valuable skills, knowledge, and experience, but whose attributes are not acknowledged as equivalent or valid by those who hold the keys to career advancement, often referred to as 'gatekeepers'. Contrasted with their white peers, this lack of recognition and validation impedes the progress of skilled physiotherapists hindering their full contribution to health care.

Participants described situations in which their qualifications and experience were seen as inferior, when compared to UK or western perspectives, by their managers.

> "It was quite tough and at times I would cry, because, when I applied for the role I applied for band 6 job but was told, 'Oh no, you need to start as a band 5,' because that was… done thing, but when I was elsewhere, in [*a country in the global south*], I was literally working as a senior physio."

The data also identified where skills were overshadowed:

> "I had applied for permanent posts there but clearly their interview processes are always looking for something else. And, I was always getting…., 'You did really well with the questions, the nervousness came through, but somebody else just answered the questions that little bit better.'"

The participants talked about a number of experiences where they felt they would not put themselves forward for progression opportunities as they did not feel they would be valued or recognised.

> "Informally, you have to study harder, you have to work clinically harder…., even with the tweets and so on, whatever you put it on, it doesn't get recognised"

Physiotherapists from the global majority described adopting self-limiting practices because of the system they found themselves in. For example, participants described situations where this had significant implications such as having to accept low grade jobs because their level of experience was unrecognised.

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

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In some cases they took on more responsibilities or worked beyond their existing grade, often carrying out unseen and unrecognised labour.

> "When you don't have support, you can work as hard as you can, but if the support is not there for someone to recognise that hard work, it is hard"

Participants described situations in which they admitted defeat and accepted that this was 'just the way it is' and in effect were complicit in a 'deficit' narrative, accepting that they needed to work harder. In effect, physiotherapists of the global majority internalised racism, and negotiated their way through the system by adopting sanctioned and normative ways of being, leading them to becoming complicit in maintaining systems of oppression, but also surviving. These social wrongs were enacted at a micro (individual) level within a wider system (figure 1).

Theme 2: Pathways to career progression and consultant practice unwieldy or hidden that limit opportunities.

The second theme exposes how global majority physiotherapists face the challenge of an ambiguous and unclear career progression pathway, which was often contrasted with their white peers. As well as acting as gatekeepers by devaluing skills, managers and leaders held the keys to the hidden cultures and processes that might enable career progression.

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

In some instances participants described differential advice and opportunity in relation to access to funding.

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

The lack of transparency and access to pathways can have financial implications that are disproportionate for those from the global majority as this participant describes:

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> "I've paid a huge price financially by trying to struggle [*across*] both worlds. And so, you know, how do we move people along? The doctors have it so seamlessly. How can we do that within physiotherapy, you know, how do we create this pathway? It doesn't exist, people think it exists, but it doesn't"

These examples demonstrate a significant barrier to professional advancement and an individual's ability to access leadership roles through consultant practice. The absence of visible career paths to leadership opportunities further contributes to the underrepresentation of global majority groups in the physiotherapy profession.

Though reluctant to name it as such, participants described instances of cronyism where gatekeepers with a managerial function would identify more junior individuals (often from white backgrounds), who they then favoured by offering covert and overt support and preferential access to opportunities for career progression. Ultimately, this perceptual misdirection led to stories from the participants of those in power codifying inequities into official policies and procedures (e.g. in interview practices and protocols) thus perpetuating the limitations global majority physiotherapists face when aspiring to consultant roles.

> "Everyone is going for interview, they get shortlisted… it will be based on the interviews, but a lot of time, if it's the same trust, probably it will go to the favourite person of the manager"

In the example presented here, we are referring to structural gatekeepers within an organisational setting (figure 1) such as policies, processes and cultures that are inadequate in preventing racism and discrimination. Managers and leaders have direct power to either support or obstruct global majority physiotherapists' career progression. These examples illustrate a predominant obstruction and obscurity to pathways.

In contrast there appeared to be some steps made to redress this as one participant identified. However this was met with allegations of favouritism and positive discrimination.

> "But a colleague of mine overheard a conversation by a very senior physiotherapist, another Band 7/8 level, who was white, who said to a room full of other colleagues, 'oh what do you have to do around here, do you have to change the colour of your skin to get a promotion"

This emphasises the ongoing persistence of white hegemony and the fragility this exposes when the status quo is in any way disrupted. Other factors that add barriers to career progression include peers, educators, professional networks and social media (10). They can lead to othering and a lack of sense of belonging in the profession.

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> "I noticed that I was left out from a lot of the social gatherings, so whether it was going to the pub or whether it was going for a meal or something similar"

This theme illustrates how career progression can be hindered by long-standing structural racism and racist attitudes perpetuated by managers and leaders who operate under an illusion of fairness and equality. These practices exist in a symbiotic relationship with the wider system to maintain and amplify hegemonic power.

DISCUSSION

The findings of our initial study and this further analysis highlight the persistent restriction of opportunities for global majority physiotherapists in the UK. These findings help to identify some of the reasons for differential progression and representation to senior positions in the NHS WRES data (1, 2). In addition by adopting a leadership lens in this paper, the themes emphasise the significant role managers and leaders can take in either obstructing or enabling progression opportunities for global majority individuals. This is one of the first known studies to identify these issues in later career progression, but reflects the findings of research exploring recruitment practices for first healthcare job post-qualification (12). Hammond et al. (12) found that recruitment managers operated in a facade of 'equality' by accepting that recruitment and selection policies were fair and offered a level playing field, yet the diversity and inclusion data for those organisations suggested otherwise.

Systemic or institutional racism is the context in which the themes in this analysis operate. These structures are based in hierarchies that have their roots in colonialism, where they were implemented to maintain a racial order and ultimately white supremacy (13). They have been sustained for centuries in many UK institutions, including the NHS (14). These findings demonstrate that well-meaning actions and decisions taken by leaders and managers may impact colleagues from the global majority differentially. There is also evidence to suggest that this is amplified when there are intersecting social identities, such as with black women (10), that leads to a negative impact on mental and physical health. This is in keeping with wider feminist social theory that is inclusive of intersectionality, thus bringing a lens to the differential experiences of individuals from multiple marginalised groups in a white majority context (15). Therefore leaders and managers need to acknowledge that systemic racism exists and reflect on decisions that reinforce white privilege which impact individuals differently.

The themes and stories of individuals in this analysis call for providing support for global majority individuals in the workplace (10). This can be by identifying and engaging with their cultural heritage, fostering ontological security, and disentangling from dominant deficit-based colonial

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narratives. Ontological security occurs when "an individual has confident expectations, even if probabilistic, about the means-ends relationships that govern her social life" (16: 345). This is not just the concern of the global majority, but requires distributed action by allies particularly those with leadership responsibilities (14, 17) and has been shown to improve staff well-being and economic outcomes (18).

More recently structural racism and the disproportionate impact on the global majority was exposed by the poor and often undocumented employee experiences within the NHS and HEIs during the Covid-19 pandemic (19). This emphasised a lack of leadership awareness and allyship at senior levels that failed to nurture the global majority healthcare workforce. Parallels are drawn with the findings here and demonstrate the impact on the global majority workforce at many levels. Indeed disrupting systemic racism has the potential to improve the diversity and well-being of all professionals to deliver world class care for patients, caregivers and communities.

Implications and Recommendations

Based on our research findings and this paper, we invite leaders who hold and possess more social capital or power within healthcare institutions to adopt, respond or take up the call of action through the findings and these recommendations. Our recommendations for participants were focused on fortifying their capacity to survive the broken system, and though useful, it is an inadequate strategy required to disrupt endemic/entrenched structural issues. We want to involve and provoke leaders to critically examine the system within which they operate, and in doing so, create conditions that enable those from the global majority to thrive. Our recommendations for leaders and decision makers are for:

1. Organisations to accept that inequities exist within a framework of colonial (white body supremacist) ideology (13) that are maintained and perpetuated in a symbiotic relationship on the macro, meso and micro levels (figure 1).
2. Those with leadership responsibilities to challenge the ideological position of colonial (white body supremacy) ideology that dictates (at the macro and meso levels) policies and procedures which create disadvantage and codify assumptions about those from the global majority. This also acknowledges that what has been put in place to help people of the global majority may in fact be hindering their progression.
3. Employers to recognise a) how power is utilised to influence decisions that impact the career pathways of people of the global majority disproportionately to their white colleagues and b) who the agents in power are to make those decisions.

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4. Leaders and managers to reflect on their own practice and create a culture that critically challenges the operational and policy status quo to create opportunities that recognise and support the diverse needs of those people of the global majority.
5. Teams to be developed including global majority peers to co-create clear, consistent transparent consultant career pathways that are financially resourced and demonstrate equity in how these pathways are understood and accessed.

These recommendations require sustained and systematic effort that have been described in approaches to managing change in healthcare (18,20). Though structural change is slow, immediate actions can be made that can deliver tangible meaningful impacts.

CONCLUSION

This critical analysis of themes with a leadership lens, demonstrates that colleagues in leadership positions can undervalue skills, knowledge, and experience of those global majority physiotherapists aspiring to consultant level practice. The impact is significant and can lead to self-limiting practices, low-grade jobs, and a complicit attitude towards the system of oppression. The role these gatekeepers have is important, with some managers blocking career progression and perpetuating biases that lead to inequitable access to resources, covert and overt support to white individuals, and codifying inequities into official policies and procedures. Moreover, there is a perception that pathways to career progression are unwieldy or hidden, and exclusionary practices lead to an absence of belonging. Without clear guidance and support, it's all too easy for talented individuals to fall through the cracks, especially those who are not part of the traditional "network" that dominates healthcare settings. As a professional leadership audience, it is crucial to recognise and address these issues at the structural level and implement strategies to promote equity, inclusion, and diversity in the workplace to support the career progression of global majority physiotherapists.

This is not just a matter of fairness or diversity, but a matter of social justice and ultimately improving patient care. The structural change we are advocating through focusing on the lived experience of the most marginalised will inevitably facilitate improvements in the career trajectories of all physiotherapists in the UK. As healthcare leaders, there is a responsibility to ensure that all professionals, regardless of their background, have an equal opportunity to succeed and thrive. It's time to disrupt the status quo and co-create pathways to success that recognise experience, qualifications and knowledge without perpetuating and fortifying colonial and white hegemony. Effective leadership is one of the most influential factors in shaping organisational culture. By doing

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so, the diverse skills that global majority peers can be harnessed in the workplace, thereby building a more just and equitable healthcare system that truly serves the needs of all.

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Author contribution

All authors contributed to conducting the research from proposal, planning, data collection and analysis. In writing this manuscript, all authors contributed to conceptualisation, collaborative writing and editing.

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Ethical approval

Ethical approval was received from the Kingston University Research Ethics Committee (Ref No: 2784-BAME) on 14 July 2021 and participants gave informed consent before taking part.

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