The impact of ethnicity on doctors' responses to Employee Engagement practices in English NHS hospital Trusts

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Abstract

The NHS is the fifth largest employer in the world and has heavily depended on a foreign skilled labour force since its inception. This has resulted in the NHS employing the highest number of ethnic minority staff in the UK, with 41% of hospital doctors identifying as belonging to an ethnic minority. There is a call for research to investigate Employee Engagement (EE) in relation to different ethnic groups, to contextualise EE, and to define both EE and ethnicity through insights from the experiences of social actors.

The thesis propounded here investigates the impact of ethnicity on the variations in doctors' responses to EE practices. It explores firstly, the factors influencing the self-perceived ethnicity of doctors; secondly, the experiences of EE of doctors working in English NHS hospital Trusts; and thirdly, the influence of doctors' ethnicity on their responses to the EE practices.

Based on the literature reviewed, ethnicity is conceptualised as an identity which is self-perceived, fluid, subjective and contextual. The social experience of living with an identity, even if it is entirely internally defined, involves an external attribution of characterisation that can vary subject to the constitution of the audience. The consolidation of all such internal and external processes are, in this research, collectively referred to as the dual nature of ethnicity. EE is conceptualised as a two-way relationship, where hospital Trusts aim to create a conducive environment that is in alignment with the 'professionalism in action' guidance for doctors by the General Medical Council (GMC). This should, in turn, encourage doctors to advocate for their Trusts as a place of work and treatment, as well as to participate in improving its performance.

The research follows an interpretivist philosophy based on subjectivist and social constructionist epistemological and ontological assumptions. It draws upon the findings of 56 semi-structured in-depth interviews with doctors, which are thematically analysed, along with insights from a research diary, field notes, documentation and archival records.

The findings reveal that identification of self-perceived ethnicity, without using a predefined list of ethnicities, can enable a unique context to be expressed by the participants. The primary data supports the argument that individuals can express or

identify themselves subject to the setting, and could selectively consider their country of birth, ancestry, and the culture and language they adopt based on their exposure. The change in exposure can impact self-perceived ethnicity, supporting the argument that it is fluid.

Analysis of the empirical evidence indicates how a high-pressure work environment, as well as certain protocols and systems can frustrate doctors. These frustrations, along with a lack of resources can hinder the creation of a conducive environment for EE. Findings also suggest that encouraging patients to appreciate their doctors' work, supporting collegiality and providing training or information about the impact of the business context on the Trust, can be beneficial in creating a conducive environment for EE. Such an environment could encourage doctors to advocate for their Trusts, hence supporting the argument that EE is a two-way relationship. It was found that altruism and collegiality are the key motivating factors for participation in improving the performance of the Trust, rather than as a direct response to a conducive environment for EE.

Overall, the findings reveal that the dual nature of ethnicity can impact doctors' responses to EE practices and policies. In particular, doctors of non-British ethnicities were sometimes found to be less aware of the business context, but potentially more resilient to the factors that could hinder the creation of a conducive environment for EE due to the exposure that they have outside of the NHS. These ethnic minority doctors risked facing discriminatory policies and behaviour from staff and patients. Collegiality was also sometimes found to be at risk due to misunderstandings caused by varying communication approaches, which could negatively impact doctors' responses to EE practices. Nonetheless, analysis also revealed that some shared values and beliefs held by participants, along with heightened cultural awareness, seemed to have a positive impact on their responses to EE. Evidence suggests that some ethnic minority doctors can feel the need to perform well intrinsically and some doctors of Asian ethnicity gave greater emphasis to education as well as respecting the elderly and women. In both situations, a positive impact was found on their responses to EE.

This study contributes to our knowledge and understanding of ethnicity, EE and the relationship between them. It identifies practical implications for managing EE of a

multi-ethnic cohort of doctors working in English NHS hospital Trusts. It contributes to the ongoing endeavour of the NHS to maximise the benefits of ethnic diversity and addressing the challenges of integration along with identifying avenues for further research.

Declaration of Authorship

I, Tejal Luv Nathadwarawala, declare that this dissertation entitled 'The impact of ethnicity on doctors' responses to Employee Engagement practices in English NHS hospital Trusts' and the work presented in it are my own.

I confirm that:

This work was done wholly while in candidature for a PhD at the University of Hertfordshire;

Where I have consulted the published work of others, this is always clearly attributed;

Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this dissertation is entirely my own work;

I have acknowledged all main sources of help;

Part of this work has been presented as a poster at:

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Signed: _____   Date: 01 May 2018

  Tejal Luv Nathadwarawala

Acknowledgements

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तस्मादादौ सर्वकार्ये सर्ववस्तुसमर्पणम् ।

(Thus, I dedicate all deeds and all things to the Almighty)

विवेकधैर्ये सततं रक्षणीये तथाश्रयः ।
विवेकस्तु हरिः सर्वं निजेच्छातः करिष्यति ॥

(Whatever happens, happens for a reason, with the will of the Almighty)

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I am unable to express my gratitude fully for my supervisors as words cannot express my true inner feelings. Prof. Keith Randle and Dr. Steven Shelley have relentlessly worked with me through this journey of my PhD studies which, to say the least, has not been very straightforward. Their support saved me from breaking internally, due to my lost self-esteem and confidence. Particularly, because of my background, these studies were a way of proving my worth, and without my supervisors, I would have never made it. Their support, guidance and feedback has been invaluable.

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The stories from my participants were not only insightful but also reassuring, reaffirming the value of this research. My acknowledgements would not be complete without me thanking them for their participation. Colleagues from the university, some friendships that developed during the RDP sessions, have been really positive for me and that has immensely helped me to get through my research. I would also like to express my profound gratitude to the administration team at the university who have been very supportive and helpful throughout my journey.

My prayers to the almighty to bless everyone around me to support me for my post-doctorate and future research projects. God bless.

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1. Introduction

1.1. Prologue

I was born in Gujarat, a state in the western region of India. Both my parents also hail from the same region and I have been brought up in a traditional 'Kathiyawadi'[1] household. This entailed instilling religious beliefs and values of respect to elders, treating guests and teachers as deities, and learning household skills to be able to become a 'grown lady' who knows her limits and responsibilities yet is skilled enough to survive in the 21st century. Moreover, my mother, a Bachelor of Arts level educated homemaker and my father an engineer by education and assistant general manager in a power plant by post consistently pushed me towards academic excellence. Throughout my schooling, I was always passionate about my studies, and I managed to hold the top position in the school, all the way through to my 12th board exams (A-levels equivalent). This academic foundation allowed me to pursue my chosen course of further studies and I was able to attain the top rank in my university in both BBA (Honours) and a postgraduate diploma in clinical and community psychology courses. At this point, my exposure was limited, and I did not have any other ethnicities to contrast my values and beliefs with and did not fully appreciate variations in approaches to life, as everyone around me was similar.

Although I have been exposed to my large extended family, which includes family members who live in the UK, USA, Africa and India, it was not until I moved to the UK after marriage, at the age of 23, that I witnessed first-hand, what it meant to be a member of the ethnic minority and an immigrant. Throughout my MSc course at the University of Hertfordshire, I came across a range of individuals who hailed from extremely varied ethnic backgrounds. We worked in teams, and I quickly realised that what seemed normal for me, was not necessarily perceived the same way by others. Moreover, even the approach of my lecturers was significantly different to what I had been used to back in India. This was the first instance where I came to appreciate the impact of ethnicity in people responding to the same situation differently. Although my studies back home were in English, I initially struggled to adapt to the expected styles required to achieve good grades in the UK. Nonetheless, with the support and guidance of my husband, who has lived most of his life in the UK, I managed to

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[1] Kathiyawad is the western region of Saurashtra district in Gujarat and its culture is referred to as 'kathiyawadi'

complete my master's degree with a distinction. In the university, I witnessed how individuals would identify as African, Chinese, American, Indian etc. and at home and in the community, I came across identities such as British Indian, East-African Indian, US Indian. I realised that although my husband and I are both born in India, his extended exposure in the UK meant his adoption of culture and language was different to mine. It was during this course of time that I became intrigued by these differences.

In particular, my research as part of my MSc dissertation examined the antecedents and consequences of Employee Engagement (EE) but didn't explain the stories my father in law who is an Emergency Department (ED) (previously referred to as Accident and Emergency (A&E) department) consultant would invariably narrate to me. He would, many times, come home from work and explain how he loves his job and is always full of energy. He would explain how certain groups of colleagues approached the same work very differently and how this impacted the overall outcome for the department. This encouraged me to consider the role of ethnicity in the varying responses, and hence I decided to research this further through my PhD thesis. Furthermore, the stories from my father and mother in law (who is also a consultant doctor working in the NHS) led me to consider conducting my research in the NHS. My insider and outsider status helped me in eliciting data that might otherwise not have been as easily forthcoming as discussed in the axiology section (5.2.2) of chapter five.

1.2. Background of the study

The thesis looks to explore the impact of ethnicity on the variations in responding to EE. EE has been found to have gained momentum in both HRM and psychology literature (Macleod & Clarke, 2009; Shuck et al., 2013) due to the positive impact that research has shown it can have on organisational outcomes (cf. Maslach et al., 2001; Schaufeli et al., 2002; Harter et al., 2002; Luthans & Peterson, 2002; Saks, 2006; Arakawa & Greenberg, 2007; Macey & Schneider, 2008; Welbourne, 2011; Purcell, 2012; Townsend et al., 2014; Purcell, 2014). In HRM, in particular, EE is believed to have not only revitalised old debates that inform better policy and practice, but it is considered to put employees, their beliefs, values and behaviours and experiences at work, at the centre of mainstream HRM (Purcell, 2014). This thesis contributes to such debates.

Similarly, ethnicity is considered a relevant subject as it characterises not only the challenges but also the opportunities (Healy & Oikelome, 2011; Putnam, 2007) prevalent in the increasingly multi-ethnic workforce (United Nations Statistics Division, 2009; Giddens, 2009; Bisin et al., 2010). The UK is now considered 'super-diverse' (Finney & Simpson, 2009; Vertovec, 2007) due to the significant inflow of migrants to fulfil the labour needs (Hussein et al., 2014). This increasing ethnic diversity of the workforce requires organisations to respond appropriately and supports the relevance of this thesis. The NHS was selected as an appropriate organisation for its merit of being the fifth largest employer in the world (NHS, 2013) and being an employer with the most ethnically diverse staff (NHS careers, 2011). NHS England has documented its policies which are divergent from Wales, Scotland and Northern Ireland (Alvarez-Rosete et al., 2005) and hence registered medical practitioners of any ethnicity, working in English NHS hospital Trusts have been selected as the appropriate purposive sample for this research.

Potentially, the findings of this research will contribute to the efforts in resolving the *'mounting deficits, worsening performance and declining staff morale'* (Evans et al., 2015:1). NHS hospitals in England spend 70% of their annual budget on staff (ONS, 2016) making their engagement a key concern and 41% of hospital doctors have been identified as belonging to an ethnic minority (NHS Digital, 2017) further supporting the relevance of the focus of this research. The intention here is not to particularly investigate the characteristics of different ethnic groups, but rather to explore how the ethnic identity of a doctor impacts his/her response to EE. It may not be practical for any organisation to develop different policies and practices for different groups of people. Nonetheless, understanding the varying needs and the basis for responding to different policies and practices allows the organisation to potentially ensure that the policies and practices are inclusive, and the support needed for different ethnic groups is made available.

Literature accepts the fact that employees respond differently to EE practices (cf. Kinnie et al., 2005; Nishii et al., 2008; NHS Employers, 2013b; Picker Institute Europe, 2015). Considering the wealth of literature examining EE and gender (cf. Lockwood, 2007; Robinson, 2007; Kular et al.,2008; Denton et al., 2008; Crush, 2008; Alfes et al., 2010; Lowe, 2012; Dromey, 2014), age (cf. Robinson, 2007; Lowe, 2012; Schaufeli, et al., 2006; James et al., 2011) and, length of service (Robinson, 2007; Lowe, 2012),

this research will address the call of NHS Employers (2013b), Truss et al. (2013) and Bailey et al. (2015, 2017) to investigate the role of ethnicity for this varying response. Additionally, an email conversation (appendix 1) with a policy manager of the NHS reveals that there is scope for useful research that examines the relationship between EE and ethnicity.

1.3. Research aims and objectives

The general aim of the thesis is to make a theoretical and empirical contribution to understanding the impact of ethnicity in the variations in doctors' responses to EE, in English NHS hospital Trusts.

The specific research objectives are:

i. To explore the factors influencing self-perceived ethnicity of doctors;
ii. To explore the experiences of EE of doctors;
iii. To investigate the influence of doctors' ethnicity on their responses to the EE practices

1.4. Structure of the dissertation

The dissertation is organised into nine chapters. Following this introduction, the second and third chapters review the literature of the key concepts for the thesis of this research, ethnicity and EE.

Chapter two presents the significance and relevance of ethnicity in the modern world where social, political and technological advancements have resulted in the workforce being more multi-ethnic than ever before. It examines the debates that reveal the contextual nature of ethnicity. The literature is used to present and justify a working definition of ethnicity. It goes on to consider the process of ethnic identity formation, which highlights the subjective nature of ethnicity. The chapter examines the differences between ethnicity, nation and race, as well as the intersection of ethnicity with culture before moving on to deliberating on models of ethnic integration. The discussions here about ethnicity at work are concerned with what it means to live with an ethnic identity, and how the combination of internal and external processes affect its identification and expression, i.e. internalisation and impact of the external environment. The fluid nature of ethnicity is discussed here in detail.

Chapter three examines the nomenclature problem and other related concepts associated with EE and argues that EE is not only conceptually distinct but also a valued addition to HR practices and policies by being a comprehensive concept. The chapter goes on to discuss the origins and conceptualisations proposed by various authors over two decades and reveals the challenges faced in the development of a robust account of EE. The contemporary debates and critical perspectives on EE result in adopting the notion that organisations can create an environment conducive for EE. This then forms the foundation for the contextualised working definition of EE to be used in investigating the thesis. It is contextualised using 'professionalism in action' guidance for doctors by the General Medical Council (GMC). This definition conceptualises EE as a two-way relationship where NHS Trusts implement policies and practices that create a conducive environment for EE and encourages doctors to advocate for their Trust as a place of work and treatment and participate in improving its performance by working individually and as a part of a team which includes working with or as management.

Chapter four is concerned with literature about the NHS. The chapter starts by providing a short historical perspective on the major structural and organisational changes that form the foundation in the contextual understanding of the work environment of the participants of this research. The current debates of the NHS reveal the organisational level scenario and acknowledge the challenges. The chapter deliberates on the changing relationship between doctors and the NHS, and their constrained professional autonomy due to them being managed and being pushed to become managers. The changes within the NHS have impacted the nature of the professions within it. In particular, the changing role and duties of a doctor are discussed. Building from chapters two and three, the final two sections before the chapter concludes, are concerned with the literature about EE and ethnicity in English NHS hospital Trusts; the critical need for EE is discussed, and the call of literature to research the impact of ethnicity in relation to EE is presented. The chapter then discusses the reasons why ethnicity is such an important topic for the NHS along with the debates in the literature on how ethnic diversity is currently being managed. The conclusion section of chapter four reinforces the research focus and brings together the assumptions based on the literature reviewed in chapters two, three and four. These assumptions are used as a foundation for data collection.

Chapter five presents the theoretical and methodological considerations in investigating this thesis. It justifies the use of interpretivist philosophy along with the subjectivist and social constructionist epistemological and ontological assumptions in addressing the research objectives. The axiology section documents my values and ethics that have influenced all the stages of the research process. The chapter goes onto justify the use of the generic inductive approach, based on its merits of not restraining research findings and allowing inherent, significant and frequent themes from the data to emerge. It outlines the research strategy that employs non-probability sampling with snowball technique to recruit participants for the research. The data collection technique is detailed which uses semi-structured in-depth interviews to collect data. Additionally, a research diary, field notes, documentation and archival records are also used. The process employed for thematic data analysis is discussed and shows how data from the interviews and other sources have been used to identify themes. Considerations for trustworthiness, rigour and quality are presented.

Chapters six, seven and eight present the analysis and discuss the findings thematically. Chapter six draws on evidence from the profile of participants and empirical evidence to justify using self-perceived ethnicity that is identified without restricting participants to a predefined list. Building from the working definition of ethnicity presented in chapter two, it explores the factors affecting self-perceived ethnicity and the role of ancestry, along with the impact of exposure and resultant adoption of culture and language. Other factors that emerged during data analysis, though not so frequently, are also discussed. The chapter goes on to consider the evidence of internal and external processes of ethnicity and how this impacts identification of self-perceived ethnicity. The final section of this chapter uses the findings presented to modify the definition of ethnicity that in essence addresses the first research objective and forms a foundation for investigating the impact of ethnicity on EE which is the concern of chapter eight.

Chapter seven is concerned with the insights from doctors' experiences of EE. It presents the findings of the roles and responsibilities and organisational context of the participants. This aids deep contextual understanding of the challenges faced by the doctors on a day to day basis. These findings are used to support the themes that emerge as significant in understanding EE for doctors working in English NHS hospital Trusts. Firstly, the findings of the awareness of the business context are discussed,

followed by the factors that contribute to the creation of a conducive environment for EE. In particular, it reveals how patient appreciation, lack of resources, protocols and systems and teamwork impact EE. The two-way relationship of EE conceptualised in chapter two is explored using the empirical evidence relating to advocating for the Trust as a place of work and treatment and participating in improving the performance of the Trust as an individual, as part of a team and as a part of or with management. Additionally, factors innate to the profession are discussed because it emerges that the changing role of doctors working in the NHS is restricting the satisfaction gained from patient contribution, in turn impacting EE. The final section is concerned with the conclusions from the insights from doctors' experiences of EE that not only address the second research objective but also contributes to the overall thesis.

Building from the discussions in chapters six and seven, chapter eight deliberates on the empirical evidence that explores the impact of internal and external processes of ethnicity on doctors' responses to EE practices. The factors pertinent to ethnicity that emerge as impacting the components of the working definition of EE are discussed. In particular, the impact of exposure outside of the UK, the reasons for doctors of some non-British ethnicities to put in extra efforts at work, the impact of certain values and cultural characteristics consistent with various ethnicities and discrimination are discussed in detail. The role of personality and professionalism as per the 'professionalism in action' guidance for doctors by the GMC is also explored as they emerge as moderating the interplay between ethnicity and EE.

Finally, chapter nine summarises the main findings and uses the literature discussed at the outset to present the conclusions addressing the three research objectives individually. The outcomes of the thesis are discussed drawing out the contributions to our knowledge along with identifying publications in which the findings could be presented. The practical implications for NHS Employers to develop policies and practices are presented. It reflects on the limitations of the research undertaken here and suggests avenues for future research on the subject.

2. Ethnicity

2.1. Introduction

This literature review begins with an evaluation of the significance and relevance of ethnicity for organisations (section 2.2) that are employing an ethnically diverse workforce. It examines the dynamics and contemporary characteristics of multi-ethnic societies with an aim of understanding and revealing the 'super-diverse' state of the UK and, in particular, the NHS. This examination forms the foundation for the contributions to be made in this research as it documents the importance and relevance of research on ethnicity. This chapter then discusses work, nature of ethnicity and the debates pertinent to defining ethnicity in section 2.3. Ensuing from the aforementioned discussions, the working definition of ethnicity to be used as the basis of investigations in this research is presented in section 2.4. Section 2.5 explores the process and dynamics of ethnic identity formation and expression, i.e., when and how the identity is formed and what it means to identify as a particular ethnicity. The literature explored here not only aids justification of the use of self-perceived ethnicity in this study, but it also forms the foundation to investigate the impact of ethnicity on EE in a work setting, such as the NHS, the focus of the research. This is followed by a discussion in section 2.6, about the related concepts; race, nation and culture, which intersect with ethnicity. This discussion aids in understanding the overlaps and distinctions between the aforementioned concepts, contributing to a clearer investigation of ethnicity. Sections 2.7, models of ethnic integration and 2.8, ethnicity at work, are concerned with literature that explores the processes by which multiple ethnicities interact and ethnic diversity management. The discussions contribute to not only contextual understanding but also aid in identifying avenues of investigation. The chapter concludes by synthesising the themes emerging from the literature review resulting in conceptualisation of ethnicity as an identity which is self-perceived, fluid, subjective and contextual. This identity forms the basis for the empirical investigations of the first and third research objectives.

2.2. The significance and relevance of ethnicity for organisations

Ethnicity is considered as an important economic, global, social and political subject as it characterises the challenges and opportunities prevalent in contemporary societies (Healy & Oikelome, 2011). There is an increase in the multi-ethnic workforce

due to social, political and technological advancements (United Nations Statistics Division, 2009; Giddens, 2009; Bisin et al., 2010) which, in turn, supports immigration and demographic shifts (Ferdman, 1992). '*One of the most important challenges facing modern societies, and at the same time one of our most significant opportunities, is the increase in ethnic and social heterogeneity in virtually all advanced countries*' (Putnam, 2007:1). The realisation that increased interactions facilitate the dynamic nature of the social world has resulted in an increase in analytical attention for 'ethnicity' (Karlsen, 2006). Social action in certain circumstances and societies is guided by ethnic identity and catalysed due to migration (Fenton, 2010). The UK in particular has hosted a mixture of ethnicities for many decades, largely due to the migration from former colonies after world war II followed by significant inflows to fulfil labour needs (Hussein et al., 2014). Resultantly the UK is referred to as a 'super-diverse' country (Finney & Simpson, 2009; Vertovec, 2007).

Initial review of literature made it apparent that the terms migration, ethnicity and diversity overlap and intersect, and yet there is evidence (cf. Bhopal, 2004) that they are distinct concepts. Authors sometimes use the term 'diversity' purely referring to ethnic diversity (cf. Vertovec, 2007; Nazroo & Karlsen, 2003; Jong, 2016) whereas others (cf. Bradley & Healy, 2008; Guillaume et al., 2017) use the term diversity relating to a combination of factions of identity; ethnicity, gender, age, sexual orientation or disability. There are also some authors (cf. Avery & McKay, 2010 in Hodgkinson & Ford, 2010; Jehn et al., 1999) who do not explicitly state the context in which they are referring to the term. It is not intended to conflate these terms; however, the boundaries are not always explicit. The focus of this research remains on ethnicity, and the overlap is taken into account in the discussions in this research. In general, the concept of diversity is concerned with matters of difference and inclusion (Konrad et al., 2006), which in itself is distinct to discrimination, where the latter holds a legal connotation (Prasad, 2001). In contrast, at its core, ethnicity is an identity that an individual adopts subject to the context that projects a sense of 'us', as discussed later on in section 2.3.

Management research seems to have shifted away from investigating implications of ethnic diversity in terms of how multi-ethnic teams generate innovation (Simons et al., 1999) or increase conflict (Jehn et al., 1999) and is now focused on how and when ethnic diversity yields positive organisational outcomes (King et al., 2011). In general,

ethnic diversity is strongly advocated by academics (cf. Bagilhole, 1997; Mason, 2000; Parekh, 2001). In particular, organisations are keenly exploring options in the context of optimally managing ethnic diversity at the workplace (cf. Adler, 1991; Cox, 1991; Kilborn, 1990a, 1990b). Recently, Hunt et al. (2014) analysing data from 366 companies found that organisations with greater ethnic diversity are more likely to see above-average financial returns, supporting the argument that ethnicity is a significant and relevant topic for organisations. The importance of needing to focus on ethnic diversity and performance is likely to grow with 30% of babies in 2011 born to parents of non-European ethnicity (Coleman, 2013). Furthermore, ethnic minority numbers in employment in the UK has more than doubled from 1,448,000 being employed in 2001 to 3,735,000 in 2017 (ONS, 2018). Hence, issues relating to ethnicity can be considered to be of profound importance not only because of the evidence that suggests ethnic diversity yields positive outcomes but also because the number of individuals in the labour force who identify as an ethnic minority is increasing.

The healthcare sector in the UK has historically depended on migrant workers and is characterised by these ethnic minority individuals in addition to the heterogeneous multi-ethnic domestic workforce (Healy & Oikelome, 2011). Since its inception in 1948, the NHS has not been able to recruit the required number of healthcare professionals from the UK and has heavily depended on a foreign skilled labour force (Batnitzky & McDowell, 2011). This has resulted in the NHS becoming an employer with the highest number of ethnic minority staff in the UK (NHS careers, 2011). The breakdown and further details are discussed in chapter four. Overall in the NHS, 17% of the workforce identify themselves as non-white ethnicity, using the NHS ethnicity code list (appendix 2), whereas the percentage of hospital doctors is much higher with 41% who identify themselves as of non-white ethnicity (NHS Digital, 2017). This relatively high number of doctors, who identify as non-white ethnicity, arguably increases the value of the potential contribution of this research. However, despite these high figures, there is scant research on how ethnicity of doctors impact their responses to the policies and practices of the NHS. Policies, practices and research related to ethnicity in the context of the NHS are discussed in detail in chapter four. The following section is concerned with the etymology of ethnicity.

2.3. The etymology of ethnicity

The term ethnicity is claimed to have no solitary definition or theory for the formation of ethnic groups (Baumann, 2004; Fenton, 2010). Nevertheless, categorisation by ethnicity was accepted in reporting of the 1990 UK census, after which it was grounded in the minds of the public through the official use of the term (Banton, 2000). In the past, the term 'ethnicity' has been, to an extent, dishonoured as it has its alliance with the term 'race', and the former is sometimes used as a euphemism for the latter (Senior & Bhopal, 1994). However, the terms are considered distinct, and section 2.6 examines the differences between ethnicity, nation and race along with its relationship with culture. This section is concerned with defining ethnicity which is conceptually integral to the thesis.

In the past, country of birth data used to be collected in censuses and surveys (Aspinall, 2001). Sometimes, it was used as an indicator of ethnicity, not only because it provided an objective and stable character, but also because it aided external classification (Stronks et al., 2009). However, the use of country of birth as a proxy for ethnicity is no longer appropriate (The Scottish Public Health Observatory, 2016) due to its lack of validity in incorporating other dimensions such as culture, ancestry and language (Stronks et al., 2009).

Sociologists, anthropologists, historians and organisational psychologists have been discussing 'ethnicity' for a long time (cf. Ferdman, 1990; Phinney, 1990; Barth, 1969; Despres, 1975, 1984 in Maybury-Lewis, 1984; Fishman, 1983, 1989; Spickard, 1989). The term 'ethnicity' is derived from the Greek word 'Ethnos', referring to people of a nation, tribe, band or group (Betancourt & Lopez, 1993, Baumann, 2004, Senior & Bhopal, 1994). The extremely voluminous literature on the subject of ethnicity builds from the work of some key authors researching the nature of ethnicity, most notably; Weber (1968 in Roth & Wittich, 1968), Barth (1969), Schermerhorn (1970), Geertz (1973) and Horowitz (1985).

Max Weber has been credited with introducing the term ethnic group which he defines as;

> those human groups that entertain a subjective belief in their common
> descent because of similarities of physical type or of customs or both, or

> *because of memories of colonization and migration (...) it does not matter*
> *whether or not an objective blood relationship exists* (Weber, 1968: 389 in
> Roth & Wittich, 1968)

This definition reiterates the subjectivity at the core of the concept of ethnicity which can arguably be closely linked to how an individual identifies himself/herself based on the characteristics of a group to which he or she feels they belong to.

Barth (1969) articulates ethnicity to be a process encompassing boundary preservation. Here, he emphasises that the process is a result of interaction between individuals where ethnic identity is either generated, confirmed or transformed based on subjective cultural features which are regarded as significant. Social actors decide on emblems of differences and features to play down or deny (Barth, 1969). Hence, the boundaries are a result of a combination of who they think they are and how others perceive them (Ratcliffe, 2004; Nagel, 1994). As discussed later in this section, the cultural features are non-static and contextual. The impact of perception of others is twofold, where a group evaluates its cultural features with those of other groups and holds a positive self-image in situations where its features compare more favourably, and where society views any central features of the groups' identity as negative, the group may also critically self-evaluate (Ferdman, 1992).

At a similar time to Barth, Schermerhorn (1970) also incorporated symbolic elements in his definition of ethnic group where he defined the term as

> *a collectivity within a larger society* [who] *have real or putative common*
> *ancestry, memories of a shared historical past, and a cultural focus on one*
> *or more symbolic elements defined as the epitome of their peoplehood*
> (ibid:12)

Here, kinship, physical contiguity, religious and/or tribal affiliation, language, phenotypical features or any combination of these were the symbolic elements. In line with Weber and Schermerhorn, Horowitz (1985) conceptualised ethnicity in an ascriptive sense where common origin, skin colour, appearance, religion and/or language were the required features of an ethnic group. Such conceptualisations led to theoretical issues arising in context of the relationship of ethnicity or ethnic groups and race, due to the phenotypical facets (Ratcliffe, 2014) discussed further in section

2.6. In a less ascriptive perspective, ethnicity is believed to be, primarily, a mode of interaction between various cultural groups sharing a mutual background, acknowledged by the actors, maybe because of similar physical situation or migration or customs or by a variety of combinations (Cohen, 1974 in Sollors, 1996). Cultural hybridity and diasporic identities are claimed to be responsible for such social interactions which are vital to modern transnational groups (Cohen, 1994, 1997; Back, 1996). Here, ethnic identification is a result of the interaction of at least two collective parties that identify within themselves who is and who is not a member of a group (Jenkins, 2008). Hence, ethnicity is associated with both a label identifying a unique social category and distinguishable cultural features such as beliefs, values and behaviours which are prevalent among its members (Ferdman, 1992).

Ethnicity has also been referred to as an association of a group that is usually characterised by culture or vice versa, to diffuse culture through interaction among the group members (Betancourt & Lopez, 1993). With birth, there are persisting elements of ancestry, culture and language (Fenton, 1999). The group members would define the cultural characteristics themselves despite ethnicity being attributed at birth (Baumann, 2004). Senior and Bhopal (1994:327) explain that ethnicity

> *'implies one or more of the following: shared origins or social background; shared culture and traditions that are distinctive, maintained between generations, and lead to a sense of identity and group; and a common language or religious tradition.'*

Such definitions which have incorporated religion in determining the ethnic identity of an individual, adopt a primordial approach, most notably building from conceptualisation by Schermerhorn (1970) and Horowitz (1985). There are situations where devout believers consider their religion and faith their primary indicator for belongingness, resulting in a supranational identity being formed where cultural, societal and historical context become secondary (Ratcliffe, 2014). In such situations, '*religion is subsumed in ethnicity, and religious labels become markers of ethnic group*' (Ruane & Todd, 2010: 2). However, in the context of secularism, the values of the societal context are predominantly embedded in one's ethnic identity (Ratcliffe, 2014). Notably, in this context each ethnic group puts emphasis on different features, which varies with time and is usually context specific. For example, one group may depend

on language, while another may feel that certain family values are distinctive and a third group may find its members' dressing or religious practices more emblematic (Ferdman, 1992). The essentiality of shared distinctive cultures and traditions, which are maintained between generations, is a primordialist line of thought and arguably unsuitable in the complex modern societies where the movement has led to a 'melting pot' of culture, as discussed in section 2.7.

Glazer et al. (1974) report that the theories of ethnicity are divided into two groups; the naturalist/primordialist and the rationalist/instrumentalist. Historically, the term 'primordialism' was first used by Edward Shils (1957), influenced by his readings of religion and based on particular observations on the relationship of sociological research to theory, which was then adopted by Clifford Geertz (1963) (Hutchinson & Smith, 1996; Eller & Coughlan, 1993; Barth, 1969). The term 'instrumentalist' is used many times in the literature, (Hutchinson & Smith, 1996; Ratcliffe, 2004; Cohen 1969, 1994, 1974 in Sollors, 1996; Bhabha, 1990; Bentley, 1987), however, there seems to be a lack of explanation of where this term has been developed from.

The primordialists consider ethnicity as a normal occurrence based on kinship and locality (Geertz 1963, Shils, 1957), whereas instrumentalists suppose ethnicity to be socially created, leaving the boundaries open for individuals to alter their ethnic ascriptions depending on circumstances and environment (Barth, 1969). Instrumentalists accept merging different ethnic customs and cultures to form a personalised group or individual identity (Hutchinson & Smith, 1996). Naturalists or primoridalists take the stand that ethnicity is constant, fixed and primordial in nature, where, conservatism and retention of tradition are inherent to boundary maintenance (Barth, 1969; Wallman, 1986 in Rex & Mason, 1986). Rationalists or instrumentalists believe ethnicity is fluid and determined by individuals bearing in mind their needs, economic and social interest (Hutchinson and Smith, 1996; Glazer et al., 1974; Ratcliffe, 2014). Ratcliffe (2004) suggests that this fluidity, which is constructed situationally, is derived from the social interactions stimulated globally, nationally and locally. The instrumentalist perspective is not only more appropriate for this research as the focus is on investigating ethnicity in a specific context (work), but it also is in line with the subjective constructionist approach adopted in this research as will be discussed in the methodology chapter (chapter five).

In line with the instrumentalist perspective, Jenkins's (2008) social anthropological model of ethnicity highlights the notion that cultural differences and similarities are at the core of collective social identity. However, 'culture' here is used with a shared set of meanings that are produced and reproduced and change at the same pace in the context in which they are set. He contends ethnicity as being an identification that is both collective and individual, where it is '*externalised in social interaction and categorisation of others and internalised in personal self-identification*' (ibid:14). Along a similar school of thought, according to Giddens (2009), the cultural traditions and the attitudes of the group of people who differentiate 'them' from 'others' is referred to as ethnicity. Fluidity and elasticity have led authors to insist that ethnicity is a highly contested term (Anthias, 1998) and difficult to not only define accurately and consistently (Mason, 1995; Cashmore et al., 1994) but also to operationalise (Ahmad, 1992). However, the concept of ethnicity has been incorporated in everyday discourse and become integral to politics and administrations of group differentiation in modern, culturally diverse societies, globally (Jenkins, 2008). The debates pertaining to internalisation and external attribution are dissued in detail in section 2.5. The following section builds from the themes emerging here and is concerned with presenting a working definition of ethnicity for the purpose of this research. In particular, the discussions below aid in identifying gaps in our knowledge and avenues for potential contributions of this research.

2.4. A working definition of ethnicity

Building on the literature reviewed in section 2.3; this section discusses a working definition of ethnicity and justification for adopting each component. The intention is to synthesise existing themes and present a working definition which can be used to interrogate the findings. A thematic analysis of the literature (cf. Cohen, 1974 in Sollors, 1996; Eller & Coughlan, 1993; Betancourt & Lopez, 1993; Nagel, 1994; Hutchinson & Smith, 1996; Ratcliffe, 2004) revealed that ethnicity is an association of a group that is usually characterised by a common culture that may exist because of mutual backgrounds, similar physical situations or customs, or by a variety of combinations or intersection of these. The cultural characteristics are continuously in a state of modification by its members, while the distinctive nature of the group as a whole is maintained (Baumann, 2004; Cohen, 1974 in Sollors, 1996). It is self-perceived based on the exposure and situation of an individual (Waters, 1990; Nagel,

1994; Barth, 1969). Self-perception, or attribution of ethnicity, is frequently implicated in the other in an ongoing process of identification (Jenkins, 2008). Ethnicity is a significant component of an individual's social identity (Babad et al., 1983; Tajfel & Turner, 1986 in Worchel & Austin, 1986) and hence it forms an important basis for deciding who they are and who they are not (Ferdman, 1992).

All the above components have not been incorporated into a single definition previously. Also,

> *the evidence base suggests there is no true measure of ethnicity that can be applied in a wide variety of contexts and consequently no way that it can be fixed or easily measured. Rather, its contingent, complex and labile nature demands that the means of measurement should be related to the purpose of the research.* (Aspinall, 2001:34)

Additionally, along the same lines as Aspinal (2001), Bhopal (2004) insists every researcher should stipulate their own definition of ethnicity to allow research on ethnicity to remain useful to future generations where it can be compared and used to conglomerate. Hence, for the purpose of this research, based on the literature reviewed, ethnicity is defined as:

> *The identity that individuals give themselves, based on ancestry, culture and language that they have been exposed to and the traits they decide to adopt based on their setting.*

The definition adopts self-perceived ethnicity which is widely accepted in contemporary research, including the UK national census and government social surveys (Aspinall, 2001; Stronks et al., 2009). It is mandatory for NHS organisations to use the ethnic monitoring codes based on the Office of National Statistics (ONS) 10 yearly census, and currently utilises the category codes from the 2001 census (NHS England, 2015). However, *'the need for flexibility in ethnic categorisation is recognised in the 2001 Census question by the inclusion of a free text option'* (Aspinall, 2001: 30). Collecting data on ethnicity is complex as it is self-defined, subjectively meaningful and multi-faceted to the individual (NHS England, 2015). Hence, for the purpose of this research, an open-ended and self-perceived identification of ethnicity, that is not subject to any predefined ethnicity list, is adopted. The advantages of this approach

to defining ethnicity are discussed in section 2.5 and the outcomes of adopting this approach are the concern of chapter six.

The working definition is used to investigate the factors frequently implicated in self-attribution of ethnicity, addressing the call within the literature (McKenzie & Crowcroft, 1996; Bhopal et al., 1991; Ahdieh & Hahn, 1996) in defining ethnicity through experiences of social actors by incorporating 'exposure', while avoiding the danger of reifying difference, yet remaining flexible to be relevant while populations shift (Bradby, 2003). This is in line with Bolaffi et al. (2003) and Karlsen (2006), who point out that the concept of ethnicity should not be considered static or inflexibly bound by genetic, historical or linguistic lineage, although individuals may choose to consider such characteristics in identifying themselves as part of one or more ethnic groups. Additionally, social actors can identify with equal strength with a particular ethnicity, yet significantly differ in the attributes they choose to rely on in determining their ethnic identity (Ferdman, 1992).

Ancestry has been considered an integral component in defining ethnicity (cf. Fenton, 1999, 2010; Hutchinson & Smith, 1996). Ancestry, or sometimes referred to as ethnic origin, is considered to be innately stable (Aspinall, 2001). However, the subjectivity to this is that social actors may decide to venerate some or discard other members of their network of kin (Fenton, 1999). Nevertheless, ancestry incorporates the 'roots' or 'heritage' and background, which may also include the country of birth of ancestors (Aspinall, 2001). Country of birth of parents or grandparents have been used in the past as a proxy to ancestry, however, both factors are conceptually distinct, with the former losing its utility in groups that have had extended exposures in host countries (Aspinall, 2001).

In addition to ancestry, culture has been incorporated into the working definition as some of its dimensions are instrumental in creating ethnic group boundaries (Fenton, 1999). Subjective elements of culture such as social norms, values and beliefs are often implicated in an individuals' self-perceived ethnicity (Triandis et al., 1980). Moreover, culture is considered to be non- static and the associated customs, symbols and ways of life, which include birth, death, marriage, food and dress, are variable and negotiated within the groups' context, resulting in a constant ongoing definition and redefinition (Fenton, 1999).

Similarly, language plays a pivotal role in not only the psychological processes involved in self-attribution of ethnicity but also the socialisation among populations who speak the same language (Fought, 2006). The relationship between ethnicity and language is not direct, as the importance of language does not simply imply its widespread use but similar to culture, it is subjective (Fenton, 1999). The recourse to language by individual members of the same ethnicity can be different due to life histories, which includes exposure or context (Fought, 2006). Hence exposure is incorporated in the working definition to allow for such subjectivity. The definition of ethnicity presented here is used as a basis to investigate what factors participants consider important in identifying their ethnicity. The results are the concern of chapter six. The following section discusses how this identity is formed and transformed, subject to the audience, which aids understanding the dynamics of this identity.

2.5. The dual nature of ethnic identity and its fluidity

Although the working definition presents factors implicated in the identification of self-perceived ethnicity, what it means to identify or live with this identity needs understanding in order to address the research objectives and is the concern of this section. This is integral to aid contextual understanding of ethnicity and is also used in interrogating the findings. In particular, as the research is being conducted in a work environment, it is important to discuss the possible impact external settings might have on identification of self-perceived ethnicity. Additionally, how age and exposure impact identification of self-perceived ethnicity is examined.

Identity and culture are considered to be the two basic building blocks that form ethnicity where the collective group shape and reshape their self-definition and culture (Nagel, 1994). The formation of ethnic identity is believed to begin from late childhood, where the ability to recognise and differentiate themselves from others based on ethnic labels develops (Umana-Taylor et al., 2014). During adolescence, individuals are known to assess the ethnic identity of their parents, along with societal perceptions, and develop an identity for themselves (Phinney et al., 1990 in Stiffman & Davis, 1990; Waters, 1996). The process is believed to begin with awareness of differences between groups and self-identification leads them to categorise themselves into a group (Laursen & Williams, 2002 in Pulkkinen & Caspi, 2002). Hence, the ethnic identity development leads to a conscious identification of their own cultural values,

beliefs and traditions (Chavez & Guido-Dibrito, 1999). Erikson (1968) describes identity formation as a primary psychosocial task of adolescence, which can be considered as a stable characteristic after the formative years. At this stage, individuals tend to be aware of stereotypes assigned by others and identities of the other ethnic groups they have been exposed to (Weber, 1978 in Roth & Wittich, 1978). This forms the foundation for ethnic identity development (Laursen & Williams, 2002 in Pulkkinen & Caspi, 2002).

Ballard (2002) points out that both culture and language, are socially in contrast to being biologically transmitted, despite being 'inherited'. He gives an example of a child born to European parents, who is brought up by Chinese foster parents in China. This child would theoretically be able to; speak Chinese fluently and relate to Chinese culture equally as well as his/her step-siblings, who were born of Chinese parents. Highlighting the importance of a person's psychological context in the construction of personality, Kurt Lewin (1939) emphasised that race and ethnicity are instrumental. Concurring with Lewin (1935), personality is defined as a *'phenomenological process in which cognitions and perceptions mediate links between the individual and the environment'* (Laursen & Williams, 2002: 204 in Pulkkinen & Caspi, 2002). Here, ethnicity appears to be pivotal in self-identification which can impact an individual's subjective reality and objective behaviour. A study by Hickman et al., (2005) revealed that individuals can experience issues with ethnic identification as a consequence of having a mixed heritage where social actors take into account differences, they consider prominent.

Ethnic identification is also influenced by other groups' identities as well as any stereotypes imposed by them (Weber, 1978 in Roth & Wittich, 1978; Smaje, 1996; Gilroy, 1987). The process of identification that defines oneself as a part of an 'us', in contrast to an 'other/them', necessitates the existence of an ethnic 'majority' where there is an ethnic 'minority' (Karlsen, 2006). It is believed that members of the minority group have a greater sense of ethnic identity in comparison to the majority group (Phinney,1990). Similarly, research by Laursen and Williams (2002 in Pulkkinen & Caspi, 2002) reveals that ethnic minorities rely on ethnic identity more than members of the majority group in navigating the psychological environment. The external imposition can impact the social experience of living with a given identity, and interaction with others, particularly with those who have 'more power', can result in the

identity being externally controlled and fluid, depending on the context (Ville & Guerin-Pace, 2005).

This fluid identity, ethnicity, is formed and transformed subject to the audience and the actual or expected reaction of the audience, especially for ethnic minority communities (less powerful), where opportunities for the manifestation of ethnic identity can be restricted by the majority (Karlsen, 2006). Similarly, Jenkins (1997, 1994) highlights the dual nature of identity, where there is a consolidation of both internal and external processes, i.e. who is and what it is to be a member of a particular social group. Here, even if the identity is entirely internally defined, the social experience of living with that identity will mean an external attribution of characterisation that can vary subject to the constitution of the audience (Ville & Guerin- Pace, 2005). The socially contextualised array of ethnic choices changes, resulting in a 'layering' (McBeth, 1989) of ethnic identities combining the ascriptive and negotiated nature of ethnicity (Nagel, 1994). Here, the expressed ethnic identity is a result of the social actors' perception of its meaning to his/her audience, its relevance and purpose in any given social context and setting (Nagel, 1994). All such social interplay between ethnic identity and its audience are, in this research, referred to as the dual nature of ethnicity.

Building from this, although some components like language, dress or food, may already be present, there are still many self-selected traits that an individual might use to self-identify his/her ethnicity (Nagel, 1994; Hutchinson & Smith, 1996). In addition to choosing which attributes to rely on in identifying their own ethnicities, social actors can also choose to exhibit cultural features coherent to ethnicity in varying degrees (Boekestijn, 1988; Ferdman & Hakuta, 1985) and these are subject to change in different situations (Hutchinson & Smith, 1996; Salamone & Swanson, 1979). Such dynamics related to ethnicity are pertinent to the research focus because, in a work setting, the context and audience impact the expression of ethnicity. Documented themes of ethnicity at work are discussed in section 2.8.

The balance of personal choice and external attributions of ethnicity is explained well by Nagel (1994). He emphasises how ethnic categories, usually quite limited and constraining, available to social actors in a particular situation, restrict the choices available to them in identifying their ethnicity. These predefined categories, that are usually socially and politically derived, typically carry stigma or advantage with them

in varying degrees. Such external attributions are also contextual, for example, '*white British people see South Asians as 'Indians', but individuals from South Asia perceive a multitude of different ethnicities*' (Miles, 1982:49). Similarly, an individual could be considered Welsh in England, British in Germany, European in Thailand and White in Africa (Peach 1996). In the UK, the ethnic categories have been established through a national census (cf. Office for National Statistics, 2012) where the rationale is to collect data which is comparable over the years and is useful in assessing inequalities and discrimination (Ratcliffe, 2014).

Official instruments, such as the national census, tend to lag behind social change due to the pressure of retaining comparability with previous measures as seen in the UK, where a 'mixed category' was only added after evidence of increased levels of mixed marriages (Ratcliffe, 2014). Ethnic groups can be determined by societal demands and emotional wants, which are difficult to categorise (McKenzie & Crowcroft, 1994). In effect, having these multiple ethnic categories is realistic, as a single category cannot cover all the finest disparities within the group of people (Woolf et al., 2011). For the purpose of this research, self-perceived ethnicity that is not confined to any predefined ethnicity list is used during analysis of the data. This is because the focus to investigate the impact of ethnicity on EE is not only sociocultural in nature (Ratcliffe, 2008; 2013), but also because the subjectivist constructionist position adopted allows for nuances to emerge. The working definition acknowledges the influence of societal characteristics that shapes an individual's own identification of ethnicity, through exposure. Having detailed the formation of ethnicity as an identity and its use, how the dual nature of ethnicity plays out in a work setting and how it impacts identification of self-perceived ethnicity will be investigated through analysis of the empirical evidence. The section below is concerned with the overlap and intersection between the terms; race, ethnicity, nation and culture. This discussion aids clearer analysis of the empirical data.

2.6. Ethnicity and its associated terms

Ethnicity has been suggested to be '*a ubiquitous mode of social identification*' and race '*a homologous phenomenon*' that can be understood as '*a historically specific allotrope*' (Jenkins, 2008:77). This section critically examines and explores these arguments in detail. The intersection of culture and ethnicity, and the differentiation

between nation or nationalism and ethnicity are discussed. The earliest use of the term 'race' appears to date back to the sixteenth and seventeenth century, where it was used to characterise people on the basis of their appearance and behaviour, mostly to contrast between the supposedly 'civilised' European explorers who discovered populations that were considered 'uncivilised' and 'immoral' (Jordan, 1982 in Husband, 1982). In the eighteenth century, in the study of evolution, the concept of race was used as a classification of humans that was not only in-depth but also easy for people to understand (Senior & Bhopal, 1994). Unfortunately, it is well known that historically scientists during the era of European colonialism identified races and ranked them based on biological and social value, with European race always being at the top (Gould, 1984). This division of populations into sub-species used physical and visible characteristics, with an underlying notion that biological determinants dictate social position, leading to justification of slavery and imperialism (Bhopal, 1997).

> *Before the slave trade in Africa, there was neither a Europe nor a European. Finally, with the European arose the myth of European superiority and separate existence as a special species or 'race'… the particular myth that there was a creature called a European which implied, from the beginning, a 'white' man* (Jaffe, 1985: 46)

However, after World War II, the concept of race and its integrity was questioned (Cohen & Kennedy, 2000; Giddens, 2009). This was because the Nazis along with their political beliefs of German racial superiority had been defeated (Olson, 2002). Many authors (cf. Sheldon & Parker, 1992; Bhopal, 2004; Giddens, 2009) agree with the contention that race is:

> *… a system of domination and subordination based on spurious biological notions that human beings can be fitted into racially distinct groups. … both 'race' and racism come to be economic, political, ideological and social expressions. In other words, 'race' is not a social category which is empirically defined: rather, it is created, reproduced and challenged through economic, political and ideological institutions.* (Bhavnani, 1997: 28 in Robinson & Richardson, 1997)

Race and its concomitant racism have been argued to only exist with a purview of keeping others 'in their inferior place' (cf. Knowles & Mercer, 1992 in Donald &

Rattansi, 1992; Benedict, 1943). Contemporarily, there is an ongoing debate about the study of race and ethnicity to determine which term is appropriate, courteous and non-stigmatising to address (Bradley & Healy, 2008). The terms 'race' and 'ethnicity' are often used interchangeably (McKenzie & Crowcroft, 1994), and definitions lack consistency (Sheldon & Parker, 1992). The assumption that both terms describe the same category of populations has been disapproved by many authors (Bhopal, 2004). Race is claimed to be biological, and ethnicity, cultural (Sheldon & Parker, 1992). Similarly, Giddens (2009:632) states race to be a *'set of social relationships, which allows individuals and groups to be located and various attributes or competencies assigned on the basis of biologically grounded features'*. Kaplan and Bennett (2003:2710) propose race to be *'a biological basis for socially constructed categories and implies genetic homogeneity within broadly defined, heterogeneous population groups'.*

Race has been argued to be a categorical identification of 'them' based on physical characteristics, in contrast to ethnicity being an identification of 'us' based on cultural similarities (Banton, 1983, 1988). This argument is not uncommon (cf. Jenkins, 2008; Rex & Mason, 1986; Erikson, 1996 in Hutchinson & Smith, 1996) and Lyon (1972) explains this core difference between race and ethnicity using Barth's (1969) concept of boundary maintenance. He insists that race is a concept that incorporates boundaries for exclusion and ethnicity raises boundaries for inclusion. He explains that an ethnic group is defined culturally; it independently raises the barriers between different groups, and it fulfils collective interests through unity, in contrast to a racial group being defined physically; compulsorily expelling people, and lacking unity. This means that the 'ethnic' group membership is, to some extent, characterised by people themselves as the membership can be chosen, whereas the 'racial' categories are considered to be characterised externally, and its' membership is automatic (Banton, 1983). In ethnicity, the identities are believed to be negotiable and characteristics fluid, with no compulsory recourse required to the knowledge of genealogy (Jenkins, 2008).

The concepts of race and ethnicity are not only diverse but are also presumed to be significant (Weissman, 1990). Ethnicity has been argued to be a broader concept in comparison to race (Jenkins, 2008) and should not be perceived as synonymous (Senior & Bhopal, 1994). In particular, it is considered that, not only can individuals not change their assumed inherited traits defined in racial groups, whereas they can adapt

their culture and can identify themselves as a different ethnicity, but also cultural distinctiveness and social cohesion are more relevant to ethnicity, whereas genetic similarities are pertinent to race (Eriksen, 2010). It appears that it is these cultural characteristics of ethnicity that causes confusion about the relationship or distinctiveness between culture and ethnicity.

Betancourt and Lopez (1993: 631) highlight that ethnicity is sometimes interchanged with culture, where actually, '*ethnicity is used in reference to groups that are characterised in terms of a common nationality, culture, or language*'. Here, culture has been incorporated as an umbrella term for aspects of behaviour, attitudes and lifestyles. Fenton (2010) argues that not only is the term culture more vague, but it also has a greater amount of crossover between groups in contrast to ethnicity. The confusion arises because culture is often discussed in terms of tradition and continuity similar to the subjective descent of ethnicity (Conversi, 2000 in Ghai, 2000). However, in contrast to ethnicity, culture is not necessarily associated with descent, for example, youth or class culture (Fenton, 2010).

Rohner (1984) describes culture as a changing set of ways of life that are common to an identifiable group of people and is usually diffused to future generations. This definition explains culture coherent with the highly regarded Herskovits's (1948) definition that stipulates culture as a human-made part of the environment. Triandis et al. (1980) reformulated this definition by adding elements of subjective culture like social norms, values, beliefs and roles. The ethnic identity of a person can reveal the culture and vice versa the cultural background of a person is considered integral to his/her ethnicity (Betancourt & Lopez, 1993). Hence it can be argued that, culture and ethnicity are distinct yet interrelated where the former characterises the appropriate and inappropriate elements of the latter like language, religion, values, art, dress, traditions, and lifeways (Nagel, 1994). Here, culture is more of an internal process where preservation and modification are continuously ongoing, and ethnicity is more external in a sense that it separates 'others' from its members.

Another ideology that uses cultural similarity and draws boundaries to define insiders and outsiders is nation or nationalism, where the differentiation between ethnicity and nationalism is that the latter relates to the relationship to the state (Eriksen, 1993). However, there is no universally accepted general definition or theory of 'nation',

'nationality' or 'nationalism' (Nazir, 1986). Due to geographically-based communities being referred to as a nation, and described by a collective name, a distinctive shared culture, along with a sense of solidarity due to the association with a specific territory (Smith, 1986), it has been argued that 'nation' can be considered a particular form of an ethnic group (Karlsen, 2006). However, the nation is, in fact, argued to be the foundation to the formation and organisation of the state (Brah, 1994) and '*nationalism holds that political boundaries should be coterminous with cultural boundaries, whereas many ethnic groups do not demand command over a state*' (Eriksen, 2002:7). Moreover, nationalism refers to political membership and participation, which has been termed as citizenship by Verdery (1993).

Having distinguished the differences between ethnicity, race and nation as well as the intersection with culture, the focus of this research will remain on ethnicity, while being cognicent of the overlaps and intersections. This in turn helps clarify the research focus and also aids in clearer analysis of the empirical data. The following section discusses processes through which different ethnicities interact further contributing to contexul understanding of ethnicity.

2.7. Models of ethnic integration

Ethnic integration is a process by which a society that is characterised by multiple ethnicities, usually as a result of inward immigration from other nations, interact with each other. In such scenarios, transnational migrants may face the awkward feeling of 'home' as there might be a deep sense of resemblance with more than one country of residence (Bhachu, 1985). Additionally, many individuals tend to encounter a different culture at home, in the community and at work or school/ college/ university, resulting in a mixed culture (Dosanjh & Ghuman, 1998). In such circumstances where individuals of different ethnicities come in contact, there is a possibility of ethnic integration.

Most countries in the world are now multi-ethnic, and three theoretical models of ethnic integration exist, i.e., assimilation, melting pot and cultural pluralism (Giddens, 2009). Here, assimilation refers to immigrants abandoning their original values to match the majority, whereas the melting pot model allows a new culture with evolving patterns to be seen, where differing values and norms are brought in and adopted, along with existing social values and norms being blended in from the pre-existing population.

Cultural pluralism encourages ethnic groups to live in harmony and practice their own values and norms while having a sense of belonging and willingness to respect and cherish deep cultural differences (Parekh, 2001). As an example of assimilation, Henslin (2002) believes that, sooner rather than later, the Caribbean and the Asian migrants would become 'acculturated' and the 'primary settlers' absorbed, into the mainstream culture. An example of the second model, melting pot, is the formation and merger of new, developing cultural patterns, within the UK that has been strongly influenced by Asian immigrants' cuisine (Giddens, 2009). It has been found that 'chicken tikka masala' is the favourite dish in Britain, in contrast to its predecessor 'fish and chips' and the British Asian food industry has become a larger contributor to the economy than steel, coal and shipbuilding industries, all combined (Marr, 1999).

There is a growing consensus among academic and policy articles that shows ethnically diverse communities as being characterised by low levels of cohesion, distrust and disputes especially in the context of equitable provision of public goods (Alesina & Ferrera, 2000; Costa & Kahn, 2003; Goodhart, 2004; Phillips, 2005; Putnam, 2007). On the other hand, frequent interpersonal contact (as seen in the work environment) between diverse members of the community has found to play a pivotal role in increasing trust and cohesion (Sturgis et al., 2014), increasing the need for studying ethnic integration and management of ethnic diversity.

Integration and ethnic diversity are usually products of economic and political circumstances, where governments routinely shape and reshape the ethnic fabric of the state through immigration and other policies (Nagel, 1994). Immigration is considered to be a major driver in shaping ethnic groups of a country, because the immigrants of today tend to add new dimensions to the current ethnicities generating new ethnic groups in the future (Hein, 1994). In the UK, the ground-breaking Parekh report (2000) on 'the future of multi-ethnic Britain', which was supported by the Commission on the future of multi-ethnic Britain, set out to analyse the prevailing scenario, and to investigate and suggest strategies for addressing racial discrimination and '*making Britain a confident and vibrant multicultural society at ease with its rich diversity*' (ibid: viii). It argued that England, Scotland and Wales were at crossroads where they could either become communities with rifts or develop into societies where differences are welcomed and celebrated. To achieve the latter, the report highlighted that

> *radical change was required in; developing a balance between cohesion, equity and difference; addressing and eliminating all forms of racism; rethinking the national story and national identity; reducing material inequalities; understanding that all identities are in the process of transition; and building a pluralistic human rights culture (ibid: xiii).*

Overall, the report recommended modifying the concept of 'Britishness' that assisted ethnic relations and citizenship education (Olssen, 2004). It also suggested that 'black British', 'Asian British' and other such similar use of British in referring to sub-groups of the society was more appropriate in the context of multi-ethnic Britain (Davies, 2001). Recently, Mathieu (2018) analysed UK's multicultural policy spanning across 15 years from the Parekh report. He found evidence that the policy has gone from 'modest' in 2010 to 'strong' in 2015 where, despite introduction of certain assimilative civic integration policies like 'sufficient knowledge about life in the United Kingdom', language proficiency and introduction of 'a citizenship pledge to be taken during citizenship ceremonies', multiculturalism is still prevalent in the UK. In essence, this confirms that the cultural pluralism model of ethnic integration is being encouraged by the government. However, members of society are arguably going to follow assimilation and melting pot in certain situations.

Here, it is important to note that the integration of individual members of an ethnic group does not necessarily reflect that of the group as a whole (Ferdman, 1992). This is because individuals are free to adopt cultural characteristics from other groups and this might not be reflected collectively as a group. In the case of immigrants, an individual who has recently moved may exhibit the cultural values of the ethnic group in a different way to which members of the same group who migrated longer ago (Ferdman, 1992). Kallen (1925 in Postiglione, 1983) presented four phases through which immigrants pass in the process of 'settling in' to a new place. He identifies the first phase akin to cultural assimilation, where superficially, immigrants assimilate in order to camouflage the differences in speech, clothing and manner that might handicap them in securing a sound economic future. In the second phase, assimilation slows down or completely stops, in part due to prejudice, discrimination and exploitation experienced in pursuit of economic independence, reinforcing 'aliency', which leads to the third phase. In this phase, customs along with ancestry become emblems of ethnic affiliation, highlighting group distinctions. The fourth phase is almost

a reverse of the first phase, where the differences and ethnic cultures are transformed from disadvantages to distinctions. Such cultural pluralism is highly prevalent in the UK (Hutnik, 1991), however, not equally experienced in the various generations of immigrants. 'First generation' refers to the foreign-born immigrant, 'second' and 'third generations' refer to their children and grandchildren respectively (Waters, 2014).

In general, self-perceived ethnicity is considered stable only for those adults who have had significant duration of exposure with the host population, whereas recently arrived immigrants find themselves in an on-going process of identity formation, where affinity to one's own traditional culture versus host culture is subject to duration of exposure to the host country and age at the time of immigration (Nekby & Rödin, 2010). Although members of the ethnic minority do not completely become assimilated into a homogeneous identity, at times certain aspects of culture, especially language, is usually lost by first and second generations, which might result in an altered ethnic identity which is still identifiable as distinct (Glazer & Moynihan, 1970). In particular, first and second-generation immigrants usually have distinctive language and values, where the latter invariably assimilate more with the host country (Alba, 2005). Hence, the duration of stay in the UK impacts individuals' acceptance of their 'Britishness' with newly arrived immigrants almost never accepting themselves as British, whereas the longer the duration the greater the probability of accepting the British component of their identity, with those born in Britain, irrespective of ethnicity, accepting the 'British' component of their identity (Manning & Roy, 2007).

So, in essence, 'immigrant generations' can be significantly different to historical generations (Waters, 2014). For example, both a 21-year-old Indian arriving in the UK in 2018 to study and a 45-year-old Indian who immigrated during the era of British colonialism in pursuit of economic gains would be classified as the 'first generation'. However, their experiences of the society they left behind in India and their integration in the UK would be significantly different. This also reveals that in addition to the era that an individual immigrates, the age at which they immigrate also impacts their integration.

Rumbaut (2004) differentiated generations as 1.25, 1.5 and 1.75. Here, children who immigrated before receiving any formal schooling in their home country were the 1.75 generation and children who had received some formal schooling but moved mid-

childhood (aged 6-12) were 1.5 generation. The 1.25 generation were those adolescents who had received a significant amount of formal education in their home country to the extent that considerable beliefs, values and behaviours would have become set. However, such categorisation has found less support in contrast to the analysis that uses years since immigration or a measure of exposure to the host country, which has been found to be most accurate in assessing the impact of duration in the context of ethnic integration (Waters, 2014). Irrespective of immigration status, age has been found to be a moderating factor between diversity and social cohesion, where growing up in a multi-ethnic society, witnessing the positive role of ethnic minorities, pushes attitudes and behaviours of ethnic majority youth in a pro-diversity direction (Stolle & Harell, 2012). Such choices, and in particular the extent to which an individual chooses to follow the typical culture of an ethnic group, can be an indicator of the degree to which he or she has integrated, and would be coherent with either model of integration.

So, in essence, the literature reviewed here highlights the challenges and importance of ethnic integration. There is evidence that governments and organisations can and do actively try to facilitate or shape this integration. However, it remains to be seen how the integration models and measures discussed here are identifiable through analysis in this research. Nonetheless, these themes not only support the value of this research but understanding the dynamics of integration contributes in contextualising the responses allowing thoughtful analysis. In particular, the impact of exposure on self-perceived ethnicity remains to be explored in chapter six. The following section discusses the issues of how the ethnicity of workers impacts such organisational settings.

2.8. Ethnicity at work

Paramount to the focus of this research is how ethnicity is played out in a work setting. How ethnic diversity is managed and how the ethnic identity of a worker impacts his or her interaction with colleagues, management and with the organisation, is important not only for the overall research but particularly also for the third research objective of investigating the impact of ethnicity on doctors' responses to EE practices. As previously mentioned, UK has a 'super-diverse' community primarily as a result of the labour shortages. However, these migrants and even British non-white ethnicities

continue to face racism and discrimination at work (Healy & Oikelome, 2011). Literature about 'ethnicity at work' suggests that overt and covert racism and discrimination in the workplace are key topics of concern, particularly for those ethnic minority groups that have visible markers (Holgate, 2005; Doyle & Timonen, 2009; Cangiano et al., 2009; Hussein et al., 2010; Stevens et al., 2012).

Overall, in the context of employment, discrimination against migrants began at the behest of historically rooted racism, where even white migrants were looked down upon as objects, however, their migrant status diluted overtime, while descendants of non-white migrants were still regarded as the 'other' (Healy & Oikelome, 2011). Discrimination has been found at both individual and institutional level (Dovidio et al., 1996 in Macrae et al., 1996) which incorporates overt behaviour or institutional norms, practices and policies that create an environment of exclusion or unequal access for an ethnic group or its members, be it verbal, non-verbal, intended or unintended (Konrad et al., 2006). There is significant literature documenting the 'ethnic penalty' either due to reduced access to training and discriminatory career progression opportunities (Bach, 2003; Decker, 2001 in Coker, 2001; Humphries, et al., 2013; Bobek & Devitt, 2017) or workplace racism or discrimination (Alexis et al., 2006; Likupe, 2006) or differential treatment by management or exclusion and discrimination from peers (Winkelmann-Gleed, 2006; Bobek & Devitt, 2017). In particular, Heath and McMahon (1997 in Karn, 1997) found that even second-generation ethnic minorities suffered an 'ethnic penalty', where their chances of being employed were significantly lower than their British peers. Moreover, there is recognition that ethnic minority women face a double disadvantage of gender and ethnicity that has yet to be appropriately addressed (Rao, 2014).

Ethnic diversity has been argued to be a movement to validate systems that provide compensatory justice on the basis of ethnicity, and hence has been criticised as positive discrimination (Edmonds, 1994; Cockburn, 1995). Here, the advantage given to ethnic minority individuals, even if it was minimal and not exclusive, contradicted the merit principle based upon which employment opportunities were to be offered to the best candidate in the context of scarce resources (Blakemore & Drake, 1996; Edwards, 1995; Johns, 2004). However, ethnic diversity in the workforce has been credited with positive outcomes (Johns, 2004) as discussed in section 2.2. In particular, significant literature documents the benefits of diversity in the context of

team working which includes improved creativity, innovation, decision making and even financial efficiency (Hunt et al., 2014; Herring, 2009; Phillips, 2014; Phillips & Apfelbaum, 2012 in Neale & Mannix, 2012). Additionally, there is evidence that diversity in management positions not only enhances better understanding of the needs of users and staff, but it is also a catalyst for creative problem solving and innovation, leading to improved organisational performance (Nath, 2016a). This also contributes to enhancing the opportunities for an ethnic minority to have their ideas heard and considered in organisational decisions (Farndale et al., 2011). 'Meso' factors, related to the job and organisational characteristics, are pivotal in empowering or disempowering minority groups (Syed & Özbilgin, 2009). Such factors are usually considered under the ambit of 'diversity management'.

The term diversity management emphasises the need of acknowledging differences between groups of employees and adapting organisational policies to allow for such variances (Thomas, 1990). Diversity has been defined as '*differences between individuals on any attribute that might lead to the perception that another person is different from self*' (van Knippenberg et al., 2004: 1008). Research investigating the relationship of group and organisational level performance with diversity is inconclusive (Horwitz & Horwitz, 2007; Shoobridge, 2006; Van Knippenberg & Schippers, 2007), mainly because diversity is highly contingent on how it is managed (Avery & McKay, 2010 in Hodgkinson & Ford, 2010). Nonetheless, social integration in the workplace can be challenging due to language barriers, cultural differences, bullying and discrimination (Batnitzky & McDowell, 2011; Likupe, 2006; Magnusdottir, 2005).

As well documented (cf. Cox & Blake, 1991; Dass & Parker, 1999; Barak, 2016) diversity needs to be managed, and a core component of this is the diversity brought into the workplace by members of various ethnicities. Different ethnicities have different values, for example, Indian, Pakistani, Bangladeshi and other mixed backgrounds have a greater emphasis on education (cf. Stokes et al., 2015) with particular focus on attainment to secure employment and further educational opportunities (cf. Kingdon and Cassen, 2010; Wilson et al., 2011). Known variances between ethnicities include the differences between individualistic and collectivist culture (Triandis, 1989 in Berman, 1989; Hofstede, 1980; Bond & Wang, 1983 in Goldstein & Segall, 1983; Bontempo et al., 1990). For example, collectivist ethnicities

have a strong focus on family and preference of personalism over achievement (Triandis, 1989 in Berman, 1989) as well as valuing cooperation over competition (Triandis et al., 1985; Diaz-Guerrero, 1984 in Cox et al., 1991). Markus and Kitayama (1991) give examples of contrasting values prevalent in American and Japanese cultures. They highlight how in America 'the squeaky wheel gets the grease' is a popular belief in contrast to Japan, where the belief is that 'the nail that stands out gets pounded down'. They suggest that such divergent construals especially independent and interdependent approaches influence various aspects of cognition, emotion and motivation impacting behaviour at work. Similarly, the focus of this research investigates divergent behaviours of doctors of different ethnicities in the context of EE.

Another important consideration in the context of 'ethnicity at work' is the concept of 'situational ethnicity'. As discussed in section 2.3, ethnicity is considered to be contextual and subjective, and in situations where an individual incorporates values and beliefs of more than one ethnicity, he or she then chooses how to respond taking cues from the context (Cox et al., 1991). So, although there appears to be ample literature documenting the prevalence and impact of discrimination at work, there seems to be scant research discussing the impact of discrimination at work on self-perceived ethnicity. In this research, this aspect of the selective expression of ethnic values is investigated keeping in mind the professional context of doctors working in English NHS hospital Trusts by analysing the responses considering the 'professionalism in action' guidance provided by the GMC. Similarly, building from the themes in the literature, the analysis will aim to uncover any potential benefits of ethnic diversity for the NHS. Also, practices of the NHS in relation to ethnic diversity are of interest and are discussed in chapter four.

2.9. Conclusion

There is evidence that the already super-diverse workforce in the UK is likely to grow and, in the NHS, 41% of hospital doctors are of non-white ethnicity, justifying the focus of this research. It is possible that the support for cultural pluralism at a national level by the UK government would encourage organisations to embrace the benefits of ethnic diversity. There is significant scope for the NHS to embrace cultural pluralism which in turn can potentially enhance EE. This is further explored in chapter four.

The thematic analysis of the literature concerned with defining ethnicity discussed in this chapter leads to a working definition of ethnicity to be used for the purpose of this research. It reads as

> *The identity that individuals give themselves, based on ancestry, culture and language that they have been exposed to and the traits they decide to adopt based on their setting.*

This definition is based on literature which suggests that the nature of ethnicity is contingent, complex and labile, requiring researchers to stipulate their own definition to ensure the research remains comparable and useful. The instrumentalist perspective that insists ethnicity is socially created, context-specific and fluid, is in harmony with the subjectivist constructionist approach of this research discussed further in chapter five and is more appropriate than the primordialist perspective in studying ethnicity in the work context.

The contemporarily widely accepted notion that ethnicity is self-perceived is adopted along with incorporating the influence of exposure which has been proven to be the most accurate in assessing the impact of interaction with others. The resulting definition allows exploration for the subjective elements of culture and language which are often implicated in identifying with an ethnicity. The innately stable component, ancestry, is also included in the working definition due to its utility in identifying an individual's 'roots' or 'origins'.

The literature of ethnic integration and ethnicity at work supports the argument that ethnicity is fluid, contextual and a subjective identification. The social experience of living with an identity even if it is entirely internally defined involves the external attribution of characterisation that varies subject to the constitution of the audience. The consolidation of all such internal and external processes are collectively referred to as the dual nature of ethnicity to aid the investigation in this research. The process of ethnic identity formation is both internally and externally stimulated, impacting an individual's subjective reality and objective behaviour. The socially grounded process results in an ethnic identity that is fluid and subject to the setting in which it is expressed. The expression is often constrained due to predefined categories, such as those used in the national census, which has a purview to compare inequalities and

discrimination over time. However, such categorisation would potentially not allow for nuances and disparities within groups to emerge.

Using the working definition, the thesis will primarily explore if ethnicity has a role to play in the variation of the behaviour of doctors in responding to EE practices. The research objectives are addressed in light of the theories of ethnic integration and literature of management of ethnic diversity in a work setting. The findings will look to contribute to the literature that discusses the responses by organisations to the increasing ethnic diversity, as well as resultant opportunities to improve achievement of business goals and handle the challenges of discrimination in the workplace.

There is a potential to contribute to our knowledge, in proposing a definition of ethnicity, that incorporates the component of exposure not previously found in other definitions. The extensive literature reviewed also lays the foundation for empirical investigation into the factors frequently implicated in the self-attribution of ethnicity. The findings look to interrogate the factors which social actors perceive as important while identifying their ethnic identity. In turn, the findings contribute in addressing the call within the literature (McKenzie & Crowcroft, 1996; Bhopal et al., 1991; Ahdieh & Hahn, 1996) in defining ethnicity through insights from experiences of social actors. Additionally, data on self-perceived ethnicity will be collected, both with and without the NHS ethnicity code list (appendix 2). The outcome and contribution to our knowledge of not limiting respondents to a predefined ethnicity list is the concern of chapter six.

So, in essence, having discussed the importance of inclusion in a work setting and the relevance of ethnic diversity at a national level as well as for the NHS, the conceptualisation presented above will be used to interrogate the findings. In particular, the dual nature of ethnicity and utility of self-perceived ethnicity will be explored. The following chapter is concerned with the literature about EE.

3. Employee Engagement (EE)

3.1. Introduction

This chapter discusses the literature pertaining to EE and its' nomenclature challenges, origins and conceptualisations and contemporary debates that in turn support a contextualised working definition to be used to explore doctors' experiences of EE. As discussed in the prologue section in chapter one, the first exposure that I received to literature regarding EE was when I was studying for my Masters degree. Currently, as part of my Doctoral studies, I am able to appreciate the depth and breadth of the scope of research regarding EE. In order to appropriately address the research aim, and to develop an in-depth insight into the concept, it became prudent to explore the origins of EE and examine the related debates. The section on nomenclature and related challenges (3.2) lays the foundation for the working definition and clarifies my standpoint on anomalies that can lead to confusion about EE. The literature documents numerous definitions without any agreement and consensus among authors (Saks & Gruman, 2014). This becomes evident on examining the origins and various conceptualisations of EE, which is discussed in section 3.3. Literature reviewed here informs the working definition and the approach adopted in this research.

Despite the challenges faced in agreeing on a robust account of EE, it continues to attract a high level of interest among researchers and organisations, mainly because research continues to highlight the positive influence it has on organisational outcomes. The contemporary debates, critical perspectives and developments in the field of EE are discussed in section 3.4. The intention here is to understand the call from literature and make an informed decision on the approach of EE to adopt for this research before creating a contextualised working definition, which is the concern of section 3.5. The final section (3.6) concludes that the NHS has an opportunity to create a conducive environment for EE, which should, in turn, encourage doctors to advocate for their Trusts and participate in improving its performance. The working definition of EE is contextualised using the 'professionalism in action' guidance for doctors by the General Medical Council (GMC). This definition forms the foundation to investigate the research objectives.

3.2. Nomenclature and related challenges

In engaging with the literature of EE, it became evident that scholars and practitioners have failed to reach a consensus regarding the meaning and the distinctiveness of EE (cf. Bakker et al., 2011; Cole et al., 2012). This lack of consensus is partly due to the overlap with other more established concepts like job satisfaction, involvement, commitment, burnout, workaholism, (cf. Schaufeli, 2014 in Truss et al., 2014; Macey & Schneider, 2008; Little & Little, 2006; May et al., 2004), Organisational Citizenship Behaviour (OCB) (cf. Robinson et al., 2004), flow (cf. Schaufeli & Bakker, 2010 in Bakker & Leiter, 2010; May et al., 2004), psychological contract (cf. Robertson-Smith & Marwick, 2009), job passion (cf. Ho & Astakhova, 2017), extra-role behaviour, personal initiative and positive affectivity (cf. Schaufeli & Bakker, 2010 in Bakker & Leiter, 2010). These concepts are either presented as an alternate to or assimilated with EE, diminishing the value of the latter as a distinct concept. The core reason for such debates is the fact that the literature relating to the emergence of EE contains various disagreements of its actual form (Schaufeli, 2014 in Truss et al., 2014).

This section examines the aforementioned debates critically and establishes the ensuing position taken in this research pertaining to the meaning of EE. The work undertaken in this chapter forms the foundation for the working definition of EE, which is the concern of section 3.5. Furthermore, based on literature reviewed (cf. Shuck & Wollard, 2010; Welch, 2011; Shuck, 2011), it has been identified that 'Work engagement', 'Employee engagement', 'Job engagement' and 'Personal engagement' are all terms used to describe engagement of an employee in a work environment. In particular, employee engagement and work engagement are typically used interchangeably (Schaufeli, 2014 in Truss et al., 2014). However, there is also an argument that these terms have distinct meanings (Schaufeli & Bakker, 2010 in Bakker & Leiter, 2010). The argument is that the term 'work engagement' is concerned with the relationship between employees and their work and EE additionally encompasses the relationship of the employee with the organisation (Schaufeli, 2014 in Truss et al., 2014). As evident from the literature reviewed in the next section, this distinction between work engagement and EE is not always explicit. Majority of the authors of the literature reviewed in this study use the term 'EE' to mean the engagement of an employee with his or her work as well as with the organisation. Hence, for the purpose

of this research, EE will consistently refer to the relationship that encompasses both the organisation and work of the employee.

Examining the uniqueness of EE in comparison to job satisfaction, Shuck et al. (2013) argue that the measures used for both concepts are very similar resulting in conclusions that the former is a repackaging of the latter. Nimon et al. (2016) assert that the semantic equivalence inherent in measures of both concepts is not surprising due to the focus on work and employee emotions. The similarity of measures is particularly evident in studies showing a strong correlation between EE and job satisfaction (cf. Yalabik et al., 2013; Wefald et al., 2011). In practice, the use of EE and job satisfaction is conflated in some cases (Nimon et al., 2016), where both concepts have been used interchangeably (Macey & Schneidar, 2008) or EE has been specifically defined as satisfaction-engagement (Harter et al., 2002). In contrast, Shuck et al. (2013) assert that job satisfaction is more of a static fulfilment state whereas EE is a progressive behavioural output. The empirical and operational uniqueness of EE is documented in the literature with meta-analytic work by Christian et al. (2011), evidencing the constructs to be statistically distinct. Additionally, Rich et al. (2010) and Saks (2006) only found moderate correlation between EE and job satisfaction, reiterating that although there may be an overlap, they are unique concepts.

Some authors (cf. May et al., 2004; Saks, 2006) also dispute whether job involvement is limited to the cognitive judgement about the job itself, whereas EE is believed to be broader and more inclusive in the sense that in addition to cognition, it is characterised by energy (behaviour) and enthusiasm (emotions) towards a job (Christian et al., 2011; Kahn, 1990; Rich et al., 2010). Based on these aforementioned discussions, EE is arguably a distinct concept and according to May et al., (2004), EE is also considered an antecedent to job involvement. Moreover, Hallberg and Schaufeli (2006) used confirmatory factor analysis to show that these are two distinct constructs that have only a week conceptual relation to one another.

The meta-analysis study by Halbesleben (2010) supports other research (cf. Schaufeli & Bakker, 2004; Schaufeli & Salanova, 2008 in Naswell et al., 2008; Hakanen et al., 2008) concluding that EE is related to, but distinct from organisational commitment. The distinction stems from the school of thought that although organisational

commitment resembles attachment to the organisation, it does not embody the attachment of the employee to the work that they do as part of the organisation, as is the case for EE (Shuck et al., 2013). Similarly, although Organisational Citizenship Behaviour (OCB) overlaps with EE, it does not incorporate the two-way relationship as seen in EE and is more concerned with the behaviour of the employee in contrast to the efforts of the organisation (Robinson et al., 2004).

Since the burnout antithesis approach presented by Maslach et al. (2001), a litany of research (cf. Byrne et al., 2016; Cole et al., 2012; Newman et al., 2010 in Albrecht, 2010; Shuck et al., 2017) has investigated the distinctiveness between burnout and EE. Building from this research, most recently, Goering et al. (2017) insist through a meta-analytic study that the conceptualisation of Schaufeli & Bakker (2004) that EE and burnout are distinct concepts despite being negatively related, stands correct. The key finding from Goering et al. (2017) highlights that the antecedents to both these constructs are different and as a result, the implication for policy is that the strategies to increase EE are not the same as to reduce burnout. However, they insist that although the research seems to be conclusive on the distinctiveness of these concepts, how they differ needs further research.

In a similar way, Schaufeli (2014 in Truss et al., 2014) clarifies that EE is fundamentally different to workaholism on three counts. First, he refers to the measures (cf. Taris, et al., 2010 in Bakker & Leiter, 2010; Schaufeli et al., 2008) for both these concepts and points out that despite some overlap, they are measured independently. Secondly, supporting the idea that EE is perceived as good and workaholism as bad, research shows that engaged employees score favourably in contrast to workaholics on performance (Taris et al., 2010 in Bakker & Leiter, 2010), distress, psychosomatic complaints and self-rated health (Schaufeli et al., 2008), quality of sleep (Kubota et al., 2011) and life satisfaction (Shimazu et al., 2012). Thirdly, the motivation for engaged employees is intrinsic, in contrast to the external requirement of self-worth and social approval (Van Beek et al., 2012) in the case of workaholism.

Another psychological state that has been debated in the literature (cf. Schaufeli & Bakker, 2010 in Bakker & Leiter, 2010; May et al., 2004) as overlapping with EE is the concept of 'flow'. Despite both being characterised by 'employment of self', flow is more of a cognitive short-term peak experience (Csikszentmihalyi, 1990) in contrast

to the varying cognitive, emotional and physical experience (Kahn, 1990) of EE (May et al., 2004). Along the same lines, Ho & Astakhova (2017) have argued that although job passion is conceptually similar to EE, it is distinct in more than one way. Firstly, they point out that job passion is considered more stable than EE, where the latter can change on a day to day basis subject to situational context (Sonnentag, 2003), in contrast to the former that may respond to targeted interventions (Forest et al., 2012). These fluctuations would not be on a daily basis, nor would they be linked to the 'moments' of work. Secondly, they argue that employees who experience passion normally define themselves by their work roles, whereas even though employees in the context of EE experience similar positive psychological states (Christian et al., 2011), they do not identify in the same way.

The psychological contract has also been argued to have links with EE (cf. Robertson-Smith & Marwick, 2009). The psychological contract has been described as a series of implicit mutual expectations between an organisation and an individual where perceptions of rights, duties, obligations and privileges have an impact on employee behaviour (Kelley-Patterson & George, 2002). Conceptually, it appears to resemble EE mainly because both depict a two-way relationship, but despite this shared characteristic, EE is more comprehensive (Robertson-Smith & Marwick, 2009). This argument is supported by research which has shown that EE mediates the discretionary behaviours exhibited by employees due to their perceived obligations and the negative impact of psychological contract breach are reduced with EE (Kasekende, 2017).

Overall, examining the eight concepts: extra-role behaviour, personal initiative, organisational commitment, job involvement, job satisfaction, positive affectivity, workaholism and flow, Schaufeli & Bakker (2010 in Bakker & Leiter, 2010) conclude that, despite a partial overlap, these concepts do not fully encompass all aspects of EE, or are conceptually distinct, where EE has additional value in terms of being a comprehensive concept. So although the literature reviewed here seems to support the distinctiveness of EE, researchers still critique the concept of EE on various counts, which is further discussed in section 3.4. The origins of EE and the debates surrounding its conceptualisation are first discussed below, followed by an evaluation of the current literature.

3.3. The origins and various conceptualisations of EE

As stated in the previous section, the confusion surrounding the concept of EE can be attributed to the lack of consensus among authors in defining it. This lack of consensus is believed to be a result of the multiple origins and varied conceptualisations of EE. These variations in interpreting and defining EE is the main focus of this section. The seminal review is a prudent way to gain a depth of understanding, context and insight into the evolution of EE (Shuck & Wollard, 2010). The insights and context discussed in this section are used to inform the working definition of EE which in turn is to be used in exploring the experiences of participants.

Kahn (1990), has been largely accredited (cf. May et al., 2004; Kular et al., 2008; Shuck & Wollard, 2010; Schaufeli & Bakker, 2010 in Bakker & Leiter, 2010; Welch, 2011; Shuck, 2011; Truss et al., 2014) as the founder of the concept of EE. He designed an in-depth approach with an aim to develop a grounded theoretical framework that addresses the question of how individuals present (engage) and absent (disengage) themselves to varying degrees, i.e. the use of their selves, physically, cognitively and emotionally. Kahn (1990) conceptually builds from Goffman (1961), who suggested that attachment and detachment of people, to their roles, vary. He insisted that an individual's adjustment of self-in-role is personal engagement and disengagement.

These concepts integrate Maslow's (1954) and Alderfer's (1972) idea of individuals requiring self-expression and self-employment in their work lives, without the individual consciously contemplating whether they want it or not (Kahn, 1990). He identified three psychological conditions as influencers to an individual's engagement as; *'psychological meaningfulness* [which] *is the sense of return on investments of the self-in-role performances, psychological safety* [which] *is the sense of being able to show and employ the self without fear of negative consequences, and psychological availability* [which] *is the sense of possessing physical, emotional and psychological resources for investing the self in role performances.'* (ibid:705). Building from this, in 1992, Kahn conceptualised personal engagement at work. Here, the psychological conditions are mediated through an individual's psychological presence before it manifests into moments of personal engagement at work as seen in figure 1 (Kahn, 1992).
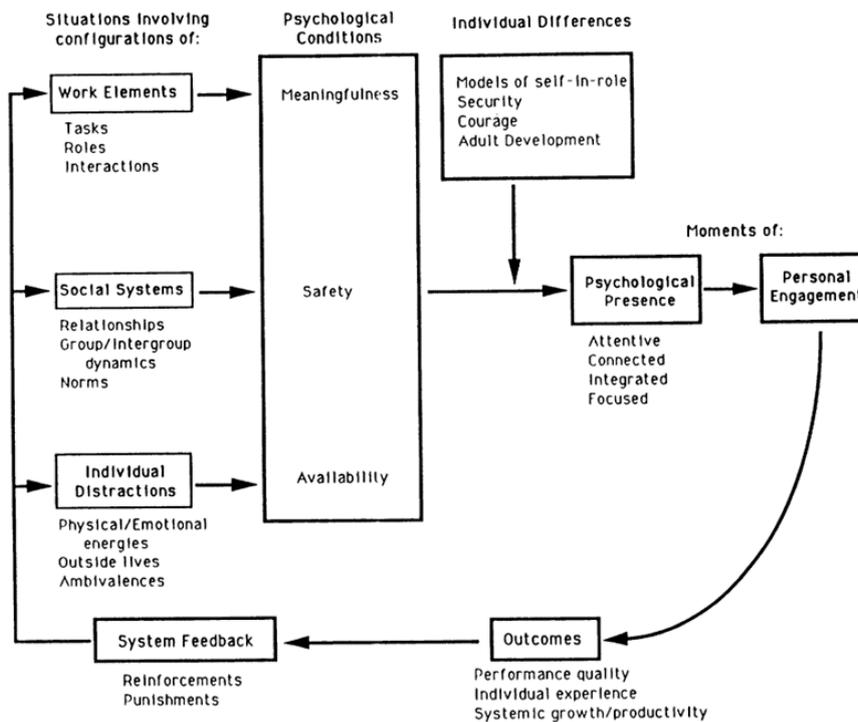
Figure 1: Recursive model of psychological presence (Kahn, 1992:340)

Following the work of Kahn (1992), the next publication concerning EE was five years later, where Maslach and Leiter (1997:102) stated that *'focusing on engagement means focusing on the energy, involvement and effectiveness that employees bring to a job and develop through their work'.* However, the authors use the term engagement only as an antonym to burnout, and to provide a strategy to prevent burnout. Buckingham and Coffman of the Gallup Consultancy Firm were credited with coining the term EE in 1999 (cf. Welch, 2011; Schaufeli, 2014 in Truss et al., 2014; Endres & Manchno-Smoak, 2008; Little & Little, 2006; Schaufeli & Bakker, 2010 in Bakker & Leiter, 2010; Truss et al., 2014). The term was used in their book 'First break all the rules' that discussed good management techniques that led to engaged employees. The authors base their discussions around the Q12 Gallup engagement questionnaire which they insist measures conditions for EE. The focus of the book is this questionnaire and the organisational performance benefits of EE. The recommendations in the book were based on interviews with 80,000 managers conducted by Gallup. In essence, the initial academic research on EE remained limited to the work of Kahn, 1990 and 1992. Subsequent research (i.e. May et al. 2004) using the work of Kahn (1990) was not conducted until over a decade later (Guest, 2014 in Truss et al., 2014).

The sharp increase in the number of publications between 2000 and 2010 (cf. Maslach et al., 2001; Harter et al., 2002; May et al., 2004, Welch, 2011, Schaufeli, 2014 in Truss et al., 2014) is broadly accredited to the positive psychology movement (Seligman & Csikszentmihalyi, 2000) that encouraged academia into research on engagement. There was an alignment between the focus of positive psychology and EE where attention is diverted away from the deficits and weaknesses and given to the strengths and positive aspects of flourishing individuals, groups and organisations (Youssef-Morgan & Bockorny, 2014 in Truss et al., 2014). The work of Maslach et al. (2001) is documented (cf. Welch, 2011; Shuck, 2011; Shuck & Wollard, 2010) as the next significant academic literature, where EE is operationalised as the reverse scores on the Maslach Burnout Inventory-General Survey (MBI-GS; Maslach & Leiter, 1997). The burnout antithesis approach is routed in occupational health psychology and is debated to have two schools of thought (Schaufeli, 2014 in Truss et al., 2014).

The first school of thought is that burnout and engagement are endpoints of a single continuum, where a high level of engagement would mean low on burnout, and vice versa (Maslach & Leiter, 1997; Maslach et al., 2001). Here, engagement is characterised by energy, involvement and efficacy, which are considered the direct opposites of the three burnout dimensions, exhaustion (emotional and physical overexertion to the point beyond recovery), cynicism (negative employee approaches) and ineffectiveness (a sense of inadequacy linked to low confidence) respectively (Maslach et al., 2001). Maslach and Leiter (1997) and Maslach et al. (2001) do not define or explain the meaning of energy, involvement and efficacy. However, this approach has received significant criticism as discussed in the previous section with most recently Goering et al. (2017) concluding that both burnout and EE are distinct. The second school of thought is that EE is a distinct concept that is negatively related to burnout, where engaged employees have *'a positive, fulfilling, work-related state of mind that is* characterised *by vigour* (high levels of energy and mental resilience)*, dedication* (high level of involvement) *and absorption* (deeply engrossed and concentrated)*'* (Schaufeli et al., 2002: 74). The main difference between the concept of EE presented by Schaufeli et al. (2002) and by Kahn (1990) is that the latter presented EE as a qualitative behavioural transitory experience, whereas the former viewed EE as a more stable attitude that could be quantitatively measured (Bailey et al., 2017). Here, an employee not being burned-out does not necessarily imply that

they are engaged or, vice versa, when an employee is not engaged, it does not mean that the employee is burned-out (Schaufeli & Bakker, 2003).

Based on the second school of thought, Schaufeli and Bakker (2003) developed the Utrecht Work Engagement Scale (UWES), using the research and empirical evidence available to them. The scale measures engagement independently in contrast to the negative scores of MBI (Shuck, 2011). The authors argue that the third aspect of burnout, inefficacy, is not the direct opposite of absorption because engagement is *'particularly characterised by being immersed and happily engrossed in one's work – absorption'* (Schaufeli and Bakker 2003: 5) in contrast to being characterised by efficacy. The empirical evidence (Maslach et al., 2001; Shirom, 2002) suggests that inefficacy plays a less prominent role in burnout. Hence, Schaufeli and Bakker (2003) insist burnout and engagement should be assessed independently and are two distinct concepts. On conducting a systematic synthesis of narrative evidence involving 214 studies, Bailey et al. (2017) found that UWES was used in 86% of studies. However, despite a large number of studies supporting the validity and reliability of UWES (Schaufeli, 2014 in Truss et al., 2014), Wefald et al. (2012) insist that the three-factor structure of the measure is not robust and there is no evidence to show discriminant validity with job satisfaction (Viljevac et al., 2012).

Looking at the antecedents of burnout, Demerouti et al. (2001) developed the Job Demands-Resources (JD-R) model of burnout, which was then modified by Bakker and Demerouti (2007) to incorporate the impact of job resources on motivation or EE while job demands are high. The JD-R model elucidates that where there are high levels of job related and/or personal resources, there are better chances of higher EE (Bailey et al., 2017). The JD-R model became a popular basis for research on antecedents and consequences of EE (Saks & Gruman, 2014). However, not only does JD-R operate as a linear model that fails to incorporate the effects of heterogeneous micro and macro level contextual factors (Bailey et al., 2017), but it also is unable to explain behaviour in a complex setting as seen in the medical profession (Bargagliotti, 2012).

One of the earliest definitive pieces of practitioner literature on EE (Shuck & Wollard, 2010) was by Harter et al. (2002), who used meta-analysis to examine the relationship at the business unit level between employee satisfaction, EE and business outcomes.

Drawing upon Kahn's (1990) conceptualisation, they concur that engagement occurs when employees are emotionally connected to their colleagues and cognitively vigilant about their own work. The authors define engagement as *'an individual's involvement and satisfaction with as well as enthusiasm for work'* (Harter et al., 2002:269). The study concluded that employee satisfaction and engagement related to meaningful business outcomes like employee turnover, customer satisfaction-loyalty and safety at a magnitude that is important to organisations. Harter et al. (2002) identified that organisations are more focused on the positive business outcomes from having engaged employees in contrast to having a state of engagement at an individual level, which is actually also the tendency in contemporary research (Alfes et al., 2012).

Also using Kahn's (1990) theoretical framework, May et al. (2004) empirically tested how the elements impact the three psychological components and resultantly EE. They found a positive relation between Kahn's (1990) psychological components; meaningfulness, safety and availability and EE. From the findings, the implications for managers included designing jobs and selecting appropriate employees to foster meaningfulness, establishing employee-manager relationships that improve employees' perception of safety and encouraging employees for self-development in order to better their psychological availability.

On the practitioner front, Hewitt Associates LLC, (2004) linked high engagement to high business performance through a multifaceted research study and concluded that engaged employees drive business growth. In another professional body publication study by the Institute of Employment Studies (IES), Robinson et al. (2004), stated that the organisation should create a conducive environment for EE on the basis of a two-way relationship between the employer and the employee. The authors acknowledge that, despite the popularity of the term EE among practitioners, relatively scant academic research has been conducted on this topic. Saks (2006) attributes this lack of research and the fact that EE is closely associated with other terms as the reason it has a faddish appearance or is considered to be 'old wine in a new bottle'. This is further discussed in section 3.4.

Countering the growing criticism for EE in this era, Saks (2006) conducted empirical tests of the antecedents and consequences and insisted that it was a serious construct rather than a mere buzz word. This was the first-time that academic research aimed

at testing antecedents and consequences of EE (Shuck & Wollard, 2010). Saks (2006) found that Perceived Organisational Support (POS), job characteristics and procedural justice were the antecedents where job satisfaction, commitment, reduced intention to quit and organisational citizenship behaviour were the consequences of EE. However, Macey and Schneider (2008), on the basis of reviewing relevant literature (no literature explicitly listed), insist that academic researchers and practitioners are ambiguous about the meaning of EE. Nonetheless, the authors note that integral to the notion of engagement is the concept that it encompasses both attitudinal and behavioural components, and that it is a desirable condition characterised by organisational purpose, involvement, commitment, passion, enthusiasm, focus and energy.

Professional body interest and consultancy usage of the concept increased in this period and as a consequence, academic research strengthened, resulting in publication of two handbooks in 2010, namely, Engagement: A handbook of essential theory and research by Bakker & Leiter and Handbook of employee engagement: perspectives, issues, research and practice by Albrecht (Welch, 2011). In the latter, Kahn (2010 in Albrecht, 2010) summarises and discusses the lessons from thirty years of involvement in the field of engagement. Referring to his earlier work, he emphasises that EE is dynamic and subject to fluctuation, which means that management can play a role in influencing the determinants of engagement. The concept of organisations having the ability to impact EE is adopted in the working definition and discussed in section 3.5. In the same year, Shuck and Wollard (2010:103), conducting a literature review of 159 articles, defined EE as *'an individual employee's cognitive, emotional, and behavioural state directed toward desired organisational outcomes'*. This definition encompasses Kahn's (1990), Maslach et al.'s (2001) and Schaufeli et al.'s (2002) research on engagement and is grounded in the frameworks proposed by Macey and Schneider (2008) and Saks (2006) (Shuck, 2011). Shuck and Wollard (2010) felt that their work offered a template from which an organisation and its employees could potentially define their relationship.

The challenges facing the development of a robust account of EE are reflected in its evolution over two decades (Shuck & Wollard, 2010). Authors (cf. Briner, 2014; Guest, 2014 in Truss et al., 2014) challenge its validity mainly on the basis that numerous varying definitions (cf. Newman et al., 2010 in Albrecht, 2010; Shuck & Wollard, 2010;

Robertson-Smith & Marwick, 2009) leave it as folk theory (cf. Macey & Schneider, 2008). The critique of EE leads to its meaning becoming an umbrella term (Saks, 2008) or old wine in new bottles (Macey & Schneider, 2008), even if it is a mixture of different old wines (Newman & Harrison, 2008). Such debates are the concern of section 3.4. However, in both HRM and psychology literature, EE has continued to gain momentum (Macleod & Clarke, 2009; Shuck et al., 2013), possibly due to the repeated positive influence that research (cf. Maslach et al., 2001; Schaufeli et al., 2002; Harter et al., 2002; Luthans & Peterson, 2002; Saks, 2006; Arakawa & Greenberg, 2007; Macey & Schneider, 2008; Welbourne, 2011; Purcell, 2012; Townsend et al., 2014; Purcell, 2014) has shown it has on organisational outcomes. Continuing the discussions that aid understanding EE with an aim to inform the working definition, the following section discusses the current debates in literature.

3.4. The contemporary debates on EE

EE has, in recent times, become one of the most popular topics in management and yet the literature remains characterised by a lack of consensus on meaning, measurement and theory (Saks & Gruman, 2014). Quoting the link between EE and positive organisational outcomes, professionals and consultancies are bending EE to suit their own agenda (Truss et al., 2013). The consultancy viewpoint of EE according to Keenoy (2014 in Truss et al., 2014) is more focused on the Unique Selling Position (USP) that the links between positive change and EE provide. Discussing the consultancy literature (cf. Gallup, 2012a; Mercer, 2012, MacLeod & Brady, 2007; Kenexa, 2012; Rich et al., 2010; Gallup, 2012b; Aon-Hewitt, 2012), Keenoy (2014 in Truss et al., 2014) highlights the lack of methodological detail and dependence on large sample size without examining the validity of data.

Guest (2014 in Truss et al., 2014) uses the criterion of Abrahamson (1996) to examine whether EE is a fashionable fad or a long-term fixture. The longevity EE has shown in academic writing leads him to argue that it cannot reasonably be described as a passing fad or fashion yet, and it should now be considered an evolving concept with a theoretical underpinning, and not a construct. However, he highlights the challenge for EE is to demonstrate that it has the potential to improve the future and find champions or fashion setters to support its sustainability.

Despite these weaknesses, in the current context, EE is unlikely to be abandoned as a fad because it is widely resonant in both academic and practitioner literature (Guest, 2014 in Truss et al., 2014). This is the 'fixing' referred to when Truss et al. (2013: 2657) label EE as '*a concept susceptible to fixing, shrinking, stretching and bending*'. The authors insist that EE is shrinking from its original multifaceted meaningful experience (Kahn, 1990) and is being stretched into bordering domains to overlap with similar concepts. Keenoy (2014 in Truss et al., 2014) addresses the practitioners of EE as social actors or discursive midwives brought in to bring EE to life. Acknowledging the pivotal role of CIPD, he accuses the professional body of fighting a battle for survival and hence creating a version of EE that is aimed at maintaining their autonomy. The frontline practitioners are left with no choice but to embrace the 'buzz word' and work out a way to enact it (Keenoy, 2014 in Truss et al., 2014).

Keenoy (2014 in Truss et al., 2014) also insists that not only have academicians lost control on the identity of EE but also on its direction. The core academic articles on EE have been authored by writers with a link to consultancies that could enforce a certain agenda, perhaps through funding. Hence, he concludes that identity of EE has been socially constructed with the individual agendas of social actors. Nonetheless, many authors (cf. Bates, 2004; Baumruk, 2004; Harter et al., 2002; Richman, 2006 in Saks, 2006; Bakker, 2009 in Burke, 2009; Schaufeli & Salanova, 2007 in Bakker & Demerouti, 2008; Lockwood, 2007) contend that good EE precedes positive employee outcomes like productivity, feeling safer and healthier, reduced absenteeism, reduced turnover intentions and more willingness to engage in discretionary efforts (Buchanan, 2004; Fleming & Asplund, 2007; The Gallup Organization, 2001; Wagner & Harter, 2006). Meta-analysis research (Harter et al., 2002) and diary studies (Tims et al., 2011) demonstrate that positive outcomes are the cause for high levels of interest in the field of EE. MacLeod and Clarke (2009), point out that it is this idea of positive outcomes, that has led the mainstream school of management studies to assume the benefits of EE initiatives for staff beyond question.

In contrast, Keenoy (2014 in Truss et al., 2014) insists that EE has been politically stimulated, where Lord Mandelson of the UK government initiated the stimulus by highlighting the work of MacLeod and Clarke (2009) as evidence to the notion that organisations with engaged employees yield outstanding innovation, productivity and

performance, followed by the then Prime Minister, David Cameron, in 2011, creating an EE task force. Critiquing the founding document (MacLeod & Clarke, 2009) to this political stimulus, Keenoy (2014 in Truss et al., 2014) questions not only the relatively short time frame in which the report was created (8 months) but also the methodology used to collect evidence. He points out that the narrative is based on a disjointed and broad variety of data coupled with weaknesses in their analysis. He insists that despite the use of academic niceties, the main intention of the report was to inform and inspire public policy.

The literature from psychology perspectives highlight the drivers of engagement but do not acknowledge the influence of the *'organisational approach to people management as well as how this coheres with the complex external and internal contexts which local management navigate'* (Jenkins & Delbridge, 2013: 2688). Despite the concept of EE originating from the field of psychology, for HRM, it has revitalised old debates that inform better policy and practice (Shuck, 2011), and hence it is now considered important for all areas of HR practice (Wollard & Shuck, 2011). Referring to the importance of EE in HRM, Purcell (2014) asserts that, despite close association with long-established theories of involvement, organisational commitment and job satisfaction, EE has not only revitalised old debates that inform better policy and practice, but also puts employees, their beliefs, values, behaviours and experiences at work at the centre of mainstream HRM or employee relations, which has not been seen before. HRM interest has only recently picked up, and it is now believed that EE can be an *'effective focus within employment relations and necessary component of HRM'* (Purcell, 2014: 251).

It is important to clarify that the HRM supporters of the concept of EE (cf. Purcell, 2014; Truss et al., 2013; Valentin, 2014; Sparrow, 2013; Shuck, 2011; Wollard & Shuck, 2011) are supporting the notion that organisations can create an environment conducive for engagement (Valentin, 2014) or effective engagement culture (Wollard & Shuck, 2011), which Truss et al. (2013) refer to as focussing on 'doing engagement' in contrast to 'being engaged'. It appears that authors examining EE in the context of the NHS also adopt a similar conceptualisation of EE, as do the authors writing from an HRM point of view (cf. Valentin, 2014; Dromey, 2014). Valentin (2014) examined HRD as a driver for EE by conducting a critical literature review and a qualitative study in the NHS. The research concluded that EE is complex, contextual and multifaceted

and not in control of the organisation, however, organisations can create an environment conducive for EE. This approach is adopted in the contextualised working definition and discussed further in section 3.5.

Another recent study examining EE, by Bailey et al. (2015), conducted a systemic narrative synthesis of 214 studies with an attempt to bring coherence to the nascent body of literature. They identified that EE has been defined and measured in a variety of ways, resulting in a lack of comparability and making generalisations difficult. In the last couple of years some studies are still questioning EE and continuing to debate its academic standing (cf. Shuck et al., 2016, 2017; Fletcher et al., 2016; Bailey, 2016; Madden et al., 2017) as well as any overlap with other concepts (cf. Anthony-MacMann, et al., 2017; Shuck et al., 2017). However, a large body of publications are accepting EE in some form or another and are looking at how to apply it in practice better (cf. Gupta & Sharma, 2016; Huang et al., 2016; Graban, 2016; Binyamin & Carmeli, 2017; Smith & Bititci, 2017; Mitchell, 2017).

Research has called for EE to be contextualised (Truss et al., 2013; Jenkins & Delbridge, 2013; Valentin, 2014; Purcell, 2014), to be explored in relation to collectivist forms of representation (Townsend et al., 2014; Purcell, 2012), to be explored in relation to different ethnic groups (Truss et al., 2013; Bailey et al., 2015) and to be explored in culturally sensitive context (Wollard & Shuck, 2011). Hence, the main focus of the research will investigate the impact of ethnicity on the workers' responses to the EE practices in the NHS with an aim to contribute to policy and practice enhancement and also addressing the call within the literature.

The following section builds from the arguments and critical perspectives on EE presented in this section to come up with a working definition of EE. In light of the above discussed critiques, the approach taken for the purpose of this research is the same as what is reflected in the HRM literature (cf. Purcell, 2014; Truss et al., 2013; Valentin, 2014; Sparrow, 2013; Wollard & Shuck, 2011). Hence, the working definition embraces the notion that organisations can create an environment conducive for EE or effective engagement culture (Wollard & Shuck, 2011) and uses the insights from the experiences of the participants to explore the 'constructed subjective' reality of EE. This approach and its rationale is further discussed in the following section.

3.5. A Contextualised working definition for EE

As seen in the discussions above, various definitions of EE exist, and none without criticism. Majority of the research till date has not accounted for the setting in which the study takes place and has focused on testing psychological models (Bailey et al., 2017). EE as a management practice is not only a new and emerging area of interest (Truss et al., 2013), but conceptualising EE in this way '…is distinct from engagement as a psychological state and lies *more squarely within the established field of interest around involvement and participation*' (Bailey et al., 2017:36). Taking into account that the majority of criticism is when it is considered just an individual disposition, i.e. 'being engaged' (cf. Macey & Schneider, 2008; Guest, 2014 in Truss et al., 2014), the working definition considers it as an approach taken by organisations to manage their workforce, i.e. 'doing engagement' (cf. Truss et al., 2013; Alfes et al., 2010). This approach is also well documented in delivering positive organisational outcomes (cf. Purcell, 2014; Truss et al., 2013; Valentin, 2014; Sparrow, 2013; Wollard & Shuck, 2011). Additionally, this perspective addresses the limitations of the unitarist discourse and focuses on the interventions aimed at improving EE along with incorporating the employees' subjective experience of these interventions (Bailey et al., 2017).

Shuck (2011) insist that in the same way that a research method is chosen, the approach used to investigate EE should be in line with the research question. Although there was potential for the NHS Employers' (2013d) definition of EE to be used, it was not appropriate for this research as it is generic and not specifically for doctors (participants of this research). Moreover, Purcell (2014), drawing from a significant amount of literature (cf. MacLeod & Clarke, 2009; Dromey, 2014; Francis, 2013) concludes that the definition of EE from NHS Employers (2013d) lacks direction for policy and practice development by managers. So, although research by Robinson, (2007), Kahn (2010 in Albrecht, 2010), NHS Employers, (2013d) and Dromey, (2014) is used as a foundation for the working definition, the conceptualisation of EE has been adapted to give direction for policy and practice.

In essence, considering the focus of this research and the research setting, the definitions that already exist in the literature are inappropriate. A working definition that is apt for this study not only allows contribution to the current body of literature, but it also provides a foundation from where the investigations can begin. In line with the

research approach discussed in chapter five, EE is not only contextual but also subjective and the working definition aids in exploring the experiences of the participants.

Kahn's (2010 in Albrecht, 2010) concept that organisations have an ability to impact EE, and the conceptualisation of EE by NHS Employers (2013d) and Dromey (2014) as given by the Institute of Employment Studies (IES) (Robinson, 2007) are used. Here, EE results in a positive attitude towards the NHS and its values, the employees are aware of the business context, and work with colleagues and teams to improve performance. The NHS Trusts are required to develop policies and practices to create a conducive environment for EE. In return, the employees can choose to advocate for the Trust that they work in, involve themselves and remain motivated (West et al., 2011), hence forming a two-way relationship (Robinson, 2007; NHS Employers, 2013d; Dromey, 2014). The response to the conducive environment for EE is subject to how the policies and practices are perceived by each individual or group (Robinson, 2007). This, again, suggests that the varying response or perception of EE practices might be subject to ethnicity and is investigated in line with the main focus of this research.

Based on the above arguments and explanations, for the purpose of this research, EE is defined as:

> *Creating a conducive environment through policies and practices which are in alignment with doctors' professionalism. The doctor would be aware of the business context and would advocate for his/her Trust, as a place of work and treatment, ensuring that he/she participates in improving the performance of his/her Trust by working individually and as part of a team (including working with or as management).*

The above definition acknowledges that engaging employees is not largely controlled by the organisation (Francis & Reddington, 2012). The organisation does, however, have the opportunity to implement specific policies and practices that will create a conducive environment for EE (Dromey, 2014; Valentin, 2014; NHS Employers, 2013d). While creating a conducive environment for EE, policies and practices need to remain continuously flexible to adjust to the ever-changing business context

(Hunter, 1996; Ham & Murray, 2015), move away from the 'one size fits all' approach (Mailley, 2011) and be locally negotiated (Jenkins & Dlebridge, 2013; Ham & Murray, 2015). Here, 'local' is best attributed to an individual NHS Trust (NHS Choices, 2015; NHS England, 2014) and the required drivers for EE are known to vary based on the local context and even the role (Robinson et al., 2004) reaffirming the value of a definition specific to doctors working in the NHS. Internal and external environments including political environment, economy, societal demands, funding, resources and budgets are collectively referred to as the business context (Kuipers et al., 2014). Robinson et al. (2004) argue that without an appreciation or understanding of this context, an employee would not be able to relate their role and decisions of the organisation to the outcomes. In an environment conducive for EE, employees are involved in decisions that affect them (Alfes et al., 2010). Involving doctors in the policy and practice development process means that their awareness of the business context is essential and impacts EE (Jenkins & Delbridge, 2013; Dromey, 2014; Robinson, 2007).

Involvement of frontline staff in shaping and defining values is found to be pivotal in the commitment to these values and their impact (Dromey, 2014). Hence, a conducive environment for EE should involve doctors in this context. Research (cf. CIPD, 2013; Dromey, 2014; MacLeod & Clarke, 2009) has also found that an environment where employees are heard, are able to participate in decisions that affect them and are able to voice their concerns without any fear is integral to EE. In such an environment, it is believed that the communication needs to be open and two-way where after hearing the employees' 'voice', feedback and updates need to be provided including how their role is impacting the wider business context (Robinson et al., 2004). In addition to policies and practices focusing on the environment 'between' the organisation and professional employees, research by Robinson et al. (2004), has found that often in the NHS, doctors require the environment between them and their patients and colleagues to be characterised by appreciation to be conducive for EE.

A report about medical professionalism in the changing world stated, *'the future for professionalism in medicine depends on creating an enabling environment for professional values to flourish'* (Royal College of Physicians, 2005: 43). The working definition encourages the development of policies and practices that are in alignment

with the doctors' professionalism. For doctors' professionalism to be supported, a working environment that is conducive for EE would include a focus on training, encouragement for good relationships with patients and colleagues, including respecting the rights to privacy and dignity of patients to daily practice and effective measures to ensure doctors remain honest, trustworthy and act with integrity and within the law. This would aid doctors to uphold their responsibility as stipulated by the General Medical Council (GMC) (2013) in the good medical practice guidance which discusses 'professionalism in action'. Moreover, the policies and practices need to acknowledge the multifaceted roles and responsibilities of a doctor. In a contemporary context, not only are doctors required to fulfil their clinical duties, but they are also expected to partake in management duties (Bethune et al., 2013; GMC, 2014), which without EE would probably lead them feeling overburdened (Lambert et al., 2014). The notion of professionalism of a doctor adopted in this research along with the roles and responsibilities are discussed in chapter four.

Continuing to concur with various authors (cf. West et al., 2011; NHS Employers, 2013c; Dawson et al., 2010; Topakas et al., 2010), advocacy of the organisation has been incorporated in the definition not only as an indicator but also as an important component of EE. The NHS staff survey showed that Trusts with high levels of EE also have staff who advocate for it, both as a place of work and treatment (NHS Employers, 2013c). The working environment within English NHS hospital Trusts is such that no service is independently provided. For example, to achieve the goal of providing treatment, all members, both medical and non-medical have to contribute to the process (O'Daniel & Rosenstein, 2008). The working environment of doctors working in the NHS is discussed in detail in chapter four. The definition incorporates the research by IES (Robinson, 2007, Robinson et al., 2004), where good team working (Jenkins & Delbridge, 2013) and participating in improving the performance of the organisation (Dromey, 2014; Purcell, 2012) is considered to be an indicator of EE. In this context, a conducive environment would be one where employees are encouraged to voice their suggestions for improvements, and they would receive feedback or see results from their suggestions (Dromey, 2014).

Robinson et al. (2004) highlight that a conducive environment for EE encourages employees to be respectful and helpful to colleagues. Additionally, Macey and

Schneidar (2008) contend that in such an environment, employees demonstrate initiative and proactively seek opportunities to contribute, and not be limited to the expectations of the role. Moreover, research by West (2013) in the NHS, has found that working in 'real teams' can positively contribute to bringing down mortality rates. Here, 'real teams' are defined as those that have shared objectives, hold meetings to discuss team's effectiveness and have close communication to achieve the team objectives. Additionally, working in such teams would make members feel involved, which in itself is linked positively to EE (West et al., 2005). Also, being able to voice opinions and having confidence that they are being heard is integral to encouraging participation in improving the performance of the Trust, as an individual, as part of a team and with or as management (Purcell, 2014 in Truss et al., 2014). Although only three percent of employees are classified as managers in the NHS, over thirty percent have managerial responsibilities (Staff Care, 2014). Hence, essential to creating a conducive environment for EE is ensuring that these doctors are also heard and empowered (Dromey, 2014). In order to encourage participation in improving the performance of the Trust, West et al. (2005) argue that managers at all levels need to relinquish some control and empower frontline staff to take action within safe limits to ensure they can provide better patient care. These themes are investigated through the experiences of doctors using the contextualised working definition.

Not only does the contextualised working definition provide a basis for investigating the research aims, but it also contributes to the current body of literature on EE. Moreover, Bailey et al. (2017) call for studies to clarify the meaning of EE employing the HRM perspective. In its current form, the application is limited to the doctors working in the NHS. However, further research is required in order to produce a more generalised definition of EE.

3.6. Conclusion

This chapter has examined the literature on EE. As a result of this examination, it has been identified that EE lacks an agreed definition. This chapter, however, also points to EE as a unique concept that has the potential to yield positive organisational outcomes. The literature reviewed in this chapter reveals that various conceptualisations have resulted in the concept of EE being highly criticised on various counts. Despite these criticisms, however, the longevity of EE as a concept has led

academicians, policy makers, practitioners and consultancy firms to debate and research the concept extensively. The critiques and debates discussed above inform the decisions in conceptualising EE while keeping the research focus in mind. The HRM perspective which accepts EE as an organisational approach is adopted in this research not only due to its academic merits but also because the NHS adopts a similar approach. It is apparent from the literature that EE as an organisational approach, is contextual and subjective. This subjectivity of EE is in line with the methodological assumptions that are discussed in chapter five.

In this HRM perspective of EE, the organisation has an opportunity to create a conducive environment for EE. The working definition of EE stipulates that the policies and practices should be in alignment with doctors' professionalism as per the GMC guidance. The intention of the organisation would be to create a two-way relationship. In response to a conducive environment for EE, doctors would advocate for their Trust and participate in improving its performance while being aware of the business context. Hence, the investigation will inquire into the factors impacting a conducive environment for EE, particularly, taking into account the 'professionalism in action' guidance for doctors by the GMC. Additionally, in chapter seven, insights from the experiences of doctors will be used to investigate the extent to which they are currently aware of the business context and what factors influence their advocating for their Trust and participating in its improvement. The working definition is also used to address the third research objective in investigating doctors' responses to EE as they may be influenced by their ethnicity. The working definition is contextualised and specific to the doctors working in the NHS, addressing the calls within literature (Truss et al., 2013; Jenkins & Delbridge, 2013; Valentin, 2014; Purcell, 2014; Bailey et al., 2015, 2017).

Specifically, Truss et al. (2013), Jenkins & Delbridge (2013), Valentin (2014) and Purcell (2014) call for EE to be contextualised to particular organisational settings. Additionally, Bailey et al. (2017) highlight the need for using qualitative research methods to enable deeper insights to this contextual aspect of EE. Furthermore, there is a wealth of literature examining EE and gender (cf. Lockwood, 2007; Robinson, 2007; Kular, et al.,2008; Denton et al., 2008; Crush, 2008; Alfes, et al., 2010; Lowe, 2012; Dromey, 2014), age (cf. Robinson, 2007; Lowe, 2012; Schaufeli et al., 2006;

James et al., 2011), and length of service (cf. Robinson, 2007; Lowe, 2012). However, there was a gap in the literature with regards to the impact of ethnicity in relation to EE. There is also a call for research from NHS Employers (2013b), Truss et al. (2013) and Bailey et al. (2015, 2017) to explore EE in relation to different ethnic groups. This research looks to address these gaps in our knowledge. Additionally, having accepted EE to be contextualised and subjective, the analysis of the perception of the work environment will also be undertaken. The roles and responsibilities of doctors and the multifaceted nature of their roles and responsibilities along with the contemporary work environment in the NHS are integral for the above investigations and is the concern of the next chapter.

4. The NHS

4.1. Introduction

Having discussed the literature pertaining to the key concepts of this research, ethnicity and EE, this chapter discusses the literature about the NHS relevant to this research. The previous chapters discussed 'context-specific' nature of the concepts, and the 'context' of the doctors working in English NHS hospital Trusts is discussed here. The chapter begins with a short discussion on the major historical changes within the NHS, section 4.2, that shaped the contemporary context, which is the concern of the following section, 4.3. The historical and contemporary contexts are used as a foundation to understand the macro level specificities of the NHS as well as to inform the methodological considerations, as discussed in chapter five, where doctors working in English NHS hospital Trusts have been selected to be the participants of this research. Section 4.4 builds from the debates discussed in previous sections to investigate the changes that have taken place over time in the relationship between the doctors and the NHS as an organisation.

All the macro level discussions in this chapter form the basis of understanding the micro level changes that have taken place in the professional life of a doctor, and this is the concern of section 4.5. The notion of 'professionalism' adopted in this research is documented here, followed by a discussion on the current debates on the day to day working conditions of doctors in the NHS. The following two sections, 4.6 and 4.7 explore the literature on the NHS with reference to EE and ethnicity respectively. The call for literature to investigate EE in relation to different ethnic groups is documented. The intensity of and reasons for the ethnic diversity in the NHS examined in section 4.7 reveals the relevance of the focus of this research. The issues faced by doctors of ethnic minorities along with the endeavours of the NHS to reduce discrimination and increase inclusion are also discussed. The conclusion section, 4.8, brings together the assumptions from the literature reviewed in this chapter. These assumptions along with the concluding points from chapters two and three are discussed to form a foundation for data collection.

4.2. Setting the Scene: NHS Historical context

The purpose of this section is to provide a short historical perspective on the major structural and organisational changes rather than an in-depth analysis of all health

care policy changes since the inception of the NHS. In doing so, this section reveals the journey that has resulted in the current scenario of the NHS, thus providing context in relation to the working environment of the participants of this research.

On 5th July 1948, Aneurin Bevan, the health minister of the newly elected Labour government at that time, created the new National Health Service (NHS) with the aim that it would be free at the point of use, available to everyone and funded from general taxation (Tweddell, 2008). This new NHS was a conglomerate of all clinics and hospitals previously run by councils and local authorities, but General Practitioners (GPs) were allowed to run their practices as small independent businesses (McSmith, 2008). Since the establishment of the NHS, there have been significant changes in 1973, 1982, 1990, 1999, 2004 and 2013 in the way the services are structured.

After publication of a series of reports; Bradbeer (1954), Guillebaud (1956), Hospital Plan (1962) and Green Paper (1968) that debated structural changes, the NHS Reorganisation Act (1973) replaced the tripartite with a unitary structure, where regional, area and District Health Authorities (DHA) substituted the Regional Hospital Boards (RHB). The intention was to unify health services as well as to achieve better coordination between health and other local authorities (Ham, 1992). In 1982, the area tier was merged with the DHAs with a hope to have a simpler structure (Nuffield Trust, 2017). The NHS and Community Care Act (1990) converted the health authorities and hospitals into purchasers and providers, creating an internal market. The internal market intended to function with the government providing the funding but maintaining a sense of competition between suppliers (Grand, 1999). It was hoped that this would increase efficiency and cost-effectiveness (Brereton & Vasoodaven, 2010). GPs and local authorities were the budget holders until 1999, after which, around five hundred Primary Care Groups (PCGs) were delegated the responsibility of commissioning care on behalf of their local communities (Nuffield Trust, 2017).

The devolution process that took place in 1999 included the transfer of powers of Health from the UK parliament to assemblies in Wales and Northern Ireland, and the Scottish Parliament (BBC News, 2010). The National Audit Office (2012) reveals that the amount of funding received by the four devolved nations is primarily based on historical data with annual changes calculated using the 'Barnett Formula' wherein; if there is an increase or decrease in funding in England, the three other nations receive

the same increase or decrease in per person funding. However, the devolved administrations are free to spend the funding as per their local priorities (National Audit Office, 2012). Each nation is still tax-funded and provides universal coverage with similar values and goals, but the policies have diverged (McKenna & Dunn, 2015). A significant change during this time was the fact that the commissioners and providers of health services have been reintegrated in Wales and Scotland removing the internal market in contrast to Northern Ireland and England (Gorsky, 2008).

Most hospitals in England today are part of foundation Trusts that are managed by a board of governors, that include patients, staff, members of the public, who are free to plan the future of the organisation and allocation of assets strategically (NHS choices, 2017). Between 2004 and 2013 there were Acute Trusts, Ambulance Trusts and Mental Health Trusts whereas, in the contemporary setting, these services are provided through NHS Foundation Trusts (NHS choices, 2017). In the past, reforms have had a greater dependency on external stimuli such as targets, inspection, regulation and competition, in contrast to contemporary approaches that encourage improvement driven from within the establishment, along with standardisation, innovation and collaboration (Ham, 2014). Having discussed the historical context, the contemporary working environment in NHS England is arguably better understood and is the concern of the section below.

4.3. The contemporary context: NHS England

Having documented historical context at the organisational level, the discussion below is concerned with the contemporary context in the NHS. Clinical Commissioning Groups (CCGs) comprised of GPs, consultants and nurses, are a statutory NHS body that are currently responsible for the planning and commissioning of healthcare services as per their local area needs (NHS Choices, 2018). These groups receive direction and funding from NHS England which is responsible for ensuring that organisations are effectively spending the allocated funds (NHS Choices, 2018).

In 2014, NHS England prepared the 'Five-year forward view' (NHS England et al., 2014:9), as a vision document for the steps required to achieve a better NHS. It discloses that although the NHS is at its best, '*of the people, by the people and for the people*', it is currently operating as a factory for health, where there is untapped potential to engage better with patients, communities, employers and local

government bodies. In pursuit of this, the document recommended dissolving traditional boundaries between GPs, community services and hospitals and moving away from a one size fits all model to creating a number of new care models that can be deployed in different combinations in order to enhance local autonomy. Apart from giving more control to local leadership and aligning national leadership, an integral part of the document is the focus to support staff. This support includes the health and wellbeing of frontline staff, providing opportunities that are inclusive and non-discriminatory, and ensure grievances are heard and acted upon quickly by managers. The paper acknowledges that various improvements had taken place in the fifteen years leading up to the report, which led to shorter waiting periods and higher patient satisfaction. Nonetheless, the paper noted that challenges for the future include, addressing variable quality of care, preventable illness and changing patient needs. In addressing the challenges and uncertainties, Ham (2015) points out that it will be important to have a period of stability in contrast to top-down reorganisations, to allow a greater focus on the NHS's core activity of improving patient care.

Evans et al. (2015:1) document that *'mounting deficits, worsening performance and declining staff morale leave the NHS facing its biggest challenges for many years'*. The King's Fund Quality Monitoring Report by Murray et al. (2016) highlighted that the foundation for the transformation set out in the NHS Five-year forward view is becoming more out of reach, with 29% of the Trusts planning to reduce their clinical headcount, resulting in no increase to the quality of care that was intended. Recent figures show that only 90.1% of patients were seen within four hours in all EDs in October 2017, which is well below the 95% standard that was last achieved in July 2015 (NHS England, 2017a). Although the NHS will receive 1.1% increase in funding (above inflation) under the current spending plan, this is considerably lower than the approximately 4% average increase that it has historically received since its establishment (The King's Fund, 2017). In essence, it means that, despite the NHS managers declaring that the existing level of funding is no longer adequate, the per capita funding is estimated to fall further (Leys, 2017). This is because the determination of spending for the NHS is not entirely based on the needs of the patients but on what is affordable in the context of tax revenues generated and allocated (Harker, 2012). Most recently, the chief executive of NHS England, publicly highlighted the fragility of the current budget and insisted that the sustainable levels of

wherewithal is lacking and quoted the Care Quality Commission's (CQC) warning that the NHS is already overstretched and on the brink of a crisis where there will be declining standards of care (Ham, 2017).

Unfortunately, Brexit (the exit of the UK from EU as a result of the referendum in June 2016) has brought a period of significant political and economic uncertainty, and it is difficult to forecast the impact on the NHS (NHS European Office, 2017). Staffing, regulations and funding will all be affected (McKenna, 2016). The resultant risk of Brexit is a decline in income for UK citizens, which could compound the ongoing NHS financial crisis (Kmietowicz, 2016). There are mixed messages from politicians; Moberly (2016) reports that the chair of parliamentary health select committee is insisting that the workforce from the EU should feel welcomed and are not going to be asked to leave, whereas, the health secretary has pledged that the UK will be self-sufficient post-Brexit (Stewart & Campbell, 2016). Currently, the UK has a relatively low ratio of doctors to citizens (Buchan et al., 2016) and does not train enough doctors to meet the demand (Royal College of Physicians, 2016) augmented by fewer medical students than there were in 2010 (UCAS, 2016). Despite political statements, Brexit has in fact negatively impacted retention and recruitment of European Union (EU) staff in the NHS (O'Carroll & Campbell, 2017). Not only has the number of nurses coming in from the EU dropped by 89% (NMC, 2017) in the last year, but, 45% of respondents to a British Medical Association (BMA) survey have indicated that they are considering leaving UK as a result of Brexit (BMA, 2017). Acknowledging the current scenario at the organisational level, the interviews aim to investigate how doctors perceive their working environment and its impact on EE. The following section discusses the changing relationship between doctors and the NHS.

4.4. The changing relationship between doctors and the NHS

This section builds from the macro context discussed in sections 4.2 and 4.3 and highlights how the relationship between the NHS and doctors has changed. The debates here form the foundation for understanding doctors' professional roles and responsibilities and day to day working environment which is discussed in section 4.5.

> *My job is to give you all the facilities, resources and help I can, and then*
> *to leave you alone as professional men and women to use your skills*

> *and judgement without hindrance. Let us try to develop that partnership*
>
> *from now on* – Aneurin Bevan, (The Lancet, 1948 in Tweddell, 2008)

Although Mr Bevan emphasised that doctors would be allowed to work without hindrance, the reforms and changes that took place, impacted their autonomy. The Porritt report in 1962 and the Cogwheel report in 1967 both highlighted the need for better management and involvement of clinicians in policy making (Rivett, 2016; NHS Support Federation, 2016). Reforms from the late 70s in the NHS have seen significant reductions in the autonomy of doctors and increased accountability not only for treatment but also for service and cost outcomes resulting in an emphasis on numerical targets, efficiency and volumes of work (Edwards et al., 2002). Before the reforms by the Thatcher government, there was a notion that the NHS severely lacked any management (Griffiths et al., 1983).

> *If Florence Nightingale were carrying her lamp through the corridors of*
> *the National Health Service today, she would almost certainly be*
> *searching for the people in charge.* (ibid)

The reforms in 1984 based on the Griffiths report aimed to create a greater central managerial control. The Griffiths report (1983) insisted that managerial appointments at regional, district and unit level should be used to provide leadership, consistency and performance control within the NHS. This meant that administrators were to be replaced by line managers (Waring, 2013). Medical professionals were expected to combine their clinical and managerial skills with emphasis on cost consciousness, performance and efficiency (Griffiths et al., 1983). Although the reforms were to respect the opinions of the medical professionals, as documented in the Griffiths report, the BMA suggested that general managers should be doctors to safeguard their autonomy (Leverment, 2002). However, very few doctors could demonstrate the required managerial skills and hence the majority of the appointed managers did not have a medical background (Leathard, 1990). There was also a sense of unwillingness to partake in management, due to the perception that it conflicts with professional duties and also adds unnecessary work (Atun, 2003). Although a new working relationship was an essential requirement of the Griffiths era, in reality, there were contrasting values with managers looking for cost efficiency and doctors taking a patient centred approach (Harrison, 1988 in Maxwell, 1988).

Smith (1991), reveals in his article, Management in NHS, that much of the reforms that were based on the Griffiths report did not result in the way they were intended. Contrarily, the post-Griffiths NHS was accused of shutting out medical professionals from management (Lycett, 1985). Relevant recommendations, like involving doctors in management and not retaining the roles that were initially developed for planning, implementation and control did not get actioned (Leverment, 2002). The introduction of clinical governance empowered managers to implement the restructuring of clinical services without the consent of doctors (Pollitt et al., 1998). This resulted in medical professionals openly criticising the government in its handling of the NHS and leading Margret Thatcher to announce yet another major review (Klein, 1995). The white paper, Working for patients (1989), was heralded as the most radical review in the history of the NHS, where creation of the internal market, as discussed in section 4.2, and emphasis on consumerism and quality of care left doctors with greater responsibility in a consumer-facing role (Wheeler, 1990). There was still a potential for the NHS to work with the government in developing a dialogue that educates patients of '*the limits of healthcare, nature of medicine, its uncertainties and dangers of a blame culture*' (Edwards et al., 2002:324). Although medicine remained a highly trusted profession (Ferriman, 2001), the number of negative news stories had increased (Ali et al., 2001).

An analysis of medical hegemony by Harrison et al. (1994) in the NHS post-Griffiths and White paper eras reveals that despite managers controlling the intensity of work patterns, budgets and contracts, control of clinical practice remained in the hands of doctors. A threat to medical dominance led to clinical directors extending their jurisdiction through managerial assimilation, where this re-professionalisation by doctors attempted to balance the shifting power between the medical profession and managers in the NHS (Thorne, 2002). Doctors seemed to have negotiated their autonomy and maintained their professional position probably through their involvement in policy development (Numerato et al., 2012).

The new coalition government documented its plan and vision through the NHS White Paper called Equity and Excellence: Liberating the NHS in 2010 (The King's Fund, 2016). The document builds on the original core values set out by Aneurin Bevan in 1948 and highlights how patients' health can be kept at the heart of continuous improvements planned for the NHS (Department of Health, 2010). The aims

highlighted in the paper are to empower patients to be able to choose and control decisions about the care they receive, to replace bureaucratic targets and processes with a measure of success based on health outcomes and, to support frontline doctors and nurses to take ownership of critical judgements for bettering patient health (Department of Health, 2010). However, the Francis report in 2013 emphasised that management priorities have degraded professional standards and failed to fulfil the interests of patients and community (Francis, 2013). In particular, the report held that governors and senior managers of the Mid Staffordshire NHS Foundation Trust were incompetent and incapable (Kelley-Patterson, 2012). Overall, the Thatcher government introduced a number of policy initiatives, to incorporate more management that set the NHS on a course from which it has not yet deviated (Scott – Samuel et al., 2014). Hence, Waring (2013) stated that,

> *if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be asking the people in charge if they know what they are doing?* (ibid: 250)

Contemporary policymakers are attempting to have less management and more leadership, where clinicians lead using their greater understanding of the needs of patients (Waring, 2013; Kuhlmann & Knorring, 2014). The policy initiatives acknowledge the diversity across NHS Trusts in England and aim to enhance local autonomy (NHS England et al., 2014). However, doctors still feel like puppets in the hands of managers despite having been trained to think and work for the betterment of patients' health and wellbeing and make judgements based on clinical outcome (Chambers, 2017), not finances (Harris, 2017). Avery (2017) points out that decisions made top-down are not welcomed by doctors and moving forward a greater collaborative approach is required. Doctors feel that the people creating the policies do not understand the issues they face on a '*day to day, and minute by minute, basis*' (Moberly, 2015:1). There is a priority now for UK healthcare administrations to improve patient safety and deliver compassionate care (Kelley-Patterson et al., 2016). Issues that the NHS has failed to grapple with in the past are now becoming critically important for doctors in their day to day role, for example, ensuring patients' stay healthy in the community and out of the hospital (Hunter, 2017).

The UK government and the medical profession's trade union, BMA, have failed to resolve a dispute about the new contracts for junior and consultant doctors over the last two years (Goddard, 2016). These disputes led to the first-ever all-out strikes in the history of the NHS (Telegraph reporters, 2016) with junior doctors using the contract issue to vent the angst that was being built up for some years (Horton, 2016). The impasse with junior doctor contracts has seen leaders of the royal medical colleges issuing a joint statement highlighting the importance of solidarity and insisting that senior doctors must support junior doctors in this challenging period (Moberly, 2016).

Overall, medical leaders supported by or as health policymakers are changing the way doctors enact their role to fit the uneasy equation to ensure the needs of both individual patients and the entire population are met (Plochg et al., 2009). Contemporarily, a productive consultant requires '*grounding in leadership, management, research, appraisal and quality improvement*' (Oliver, 2016: 358). These managerial duties make clinicians feel that juggling the demands between both roles makes the core expertise of a doctor less employed, and for senior clinicians, the wealth of knowledge gained through years of clinical practice was deemed worthless (Oxtoby, 2016).

The themes emerging in this section provide a contextual understanding which is integral for analysing the participants' responses in line with the methodology discussed in chapter five. Additionally, the themes will be used to compare the experiences of doctors with an aim to contribute in addressing the second research objective. The changing role of a doctor working in the NHS is discussed further in the section below.

4.5. The changing role of a doctor

As seen in the sections above, the NHS has undergone several major changes which have impacted the nature of the professions within it. Professions are described as '*occupation-based structures of authority that are vested with responsibility for overseeing specific domains within society*' (West, 2003: 14). So, in essence, professionals are people who are not only intellectual and learned but also have a practical output that is focused on a definite purpose (Flexner, 2001). Professionalism is, therefore, the '*conceptualisation of the expected professional obligations, attributes, interactions, attitudes, values and role behaviours*' (Swisher & Page, 2005:

2). Professionalism entails applying knowledge to either a particular need or an ongoing search for ways in which these needs could be better satisfied (West, 2003).

The profession of medicine could mean that doctors apply their medical knowledge to treat or better the treatment of patients; a core component of a doctor's profession is diagnosing and assessing the consequences followed by planning a treatment (Calman, 1994). Altruism and collegiality are claimed as major components of medical professionalism and its evolution, self-regulation and self-interest are in response to the market (Johnson, 1972). The Hippocratic oath, written nearly 2500 years ago, has historically been the oath by which a qualifying doctor commits to upholding medical professionalism (Oxtoby, 2016). More recently, medical professionalism has been referred to as the set of values, principles and behaviours that are integral for a doctor to apply knowledge, clinical skills and judgement to protect and restore patient well-being (Royal College of Physicians, 2005). In the absence of a standardised practice of taking the Hippocratic oath throughout the UK (Oxtoby, 2016), and with the General Medical Council (GMC) being held responsible for monitoring the professionalism of doctors in the UK (GMC, 2018), the notion of professionalism as stipulated by the GMC is the most significant guiding factor for doctors.

The notion of professionalism adopted in this research is as per the Good Medical Practice (GMP) guidelines provided by the GMC against which the professional standards of all doctors are ascertained (Dearman et al., 2017). The good medical practice guidance by the GMC (2013) discusses 'professionalism in action' to include the responsibility of doctors in keeping knowledge and skills up-to-date, maintaining good relationships with patients and colleagues, remaining honest and trustworthy, acting with integrity and within the law, respecting the rights to privacy and dignity of patients. In essence, GMC insists that in addition to the clinical knowledge, the behaviour of any doctor defines his or her professionalism (GMC, 2016).

The current situation in the NHS is such, that due to the pressures because of the lack of resources and funding issues (Goddard, 2016), doctors are no longer being able to leave work with the satisfaction and pride of having done a good job (McCartney, 2016), arguably resulting in the nadir of morale of clinicians. The strain due to the lack of resources can put doctors at a higher risk of burnout (Oliver, 2016). Research in the past has shown that pay and workload are obvious reasons for low morale, however,

systems with higher pay and lower workload are not enough on their own to guarantee high morale (Edwards et al., 2002), which could make EE a need of the hour for the NHS, further discussed in section 4.6.

The contemporary duties of a doctor in the NHS are complex, having shifted from focusing on the individual patient to the patient community at large (Aronson, 2016). This could lead to doctors having difficulty in making day to day decisions to treat an individual patient to the best of their ability (Rosen & Dewar, 2004). The changing societal demands currently have a negative impact on patient satisfaction (Iacobucci, 2017; Godlee, 2017). The shift in patients' becoming more active consumers resulting in them expecting enhanced services, coupled with an increased availability of health information could be contributing to causing dissonance in doctor-patient relationship (Edwards et al., 2002). Harris (2017) identifies factors that are threatening hegemony of the medical profession. He points out that medical information is readily available to the general public and is aimed at non-specialists, contributing to a narrowing knowledge gap between a doctor and a patient. This is resulting in educated patients challenging the authority of doctors and demanding certain treatments. There is an increase of sub-specialisation causing medical professionals to rely on colleagues in order to make a diagnosis reducing their individual autonomy. Also, the supremacy of medical knowledge to provide cures to everything is diminishing. Lastly, but probably most notably, he highlights that the increasing medical costs are pushing doctors to have greater accountability for the NHS' funds. Doctors feel that patients need to be more aware of the limited powers of medicine and need to take more control of their own health and politicians need to project a realistic viewpoint in contrast to giving extravagant promises (Smith, 2001). Moving forward, among the managers in the Trusts, there is an awareness that blame culture needs to be removed, and that staff needs to be motivated and engaged to do their jobs to the best of their ability (CQC, 2017).

The CQC has identified that chronic levels of stress have reduced the ability of staff to give close attention to patients and to respond thoughtfully and emphatically (West, 2016). Often doctors would not be able to find enough time to go back to an unfinished task (Ross et al., 2013). Both patients and doctors are being put at risk due to these severe working conditions. Moreover, even if the patient is rude or aggressive, the doctor must ensure that he or she is treated (Bingham, 2012). The doctor has the

recourse to call in either the security or the police where needed, but in any case, cannot refuse treatment.

A recent Royal College of Physicians survey showed that 80% of trainee doctors reported having excessive stress with work

> *…with three quarters going through at least one shift a month without drinking enough water and more than a quarter (28%) having worked four shifts a month without a meal... 95% of doctors in training reported poor staff morale as having a negative impact on patient safety in their hospital* (Royal College of Physicians, 2016:11)

Jones, (2017) pointed out that teamwork in day to day working is increasing where doctors need to work with other healthcare staff. Due to hierarchical culture, junior doctors are sometimes uncomfortable with questioning treatment plans or prescriptions stipulated by colleagues or other members of the multi-disciplinary team (Lewis &Tully, 2009) because not only is it against the norm but also they assume that they lack experience (Ross et al., 2013). Although working well in teams emerged as positively impacting EE, skills required for team working are not ubiquitous in the medical profession (Sexton et al., 2000). This positive impact that good team working has on EE, creates a potential opportunity for Trusts to invest in training doctors in this context. Additionally, working in teams is known to help in coping with stress (Firth-Cozens, 2000). A new role called 'chief registrar' was implemented in all Trusts in England in November 2016 and was aimed at supporting registrars to gain management experience as well as bridging the gap between junior doctors and senior managers (Oxtoby, 2017).

The constant pressure of needing to discharge patients quickly, so that beds are available for new admissions, could contribute to poor practices such as discharge letters and prescriptions either being rushed and inappropriately completed (Ross et al., 2013). Additionally, all doctors are responsible for meeting targets, however, ED doctors have a 4-hour target in which the patients need to be seen, admitted or discharged (Hawkes, 2017). The situation seems to be getting worse, for example, since the formation of the NHS 111 service in 2013, which is designed to provide fast information in urgent, but not life-threatening situations, 20,000 more people a month are now being sent to ED (BMJ, 2017). Recognising the crisis in EDs due to the

overload of patients, the government has instructed Trusts to implement a front door streaming GP led triage system by October 2017 (Iacobucci, 2017). Such endeavours are pivotal in attempting to reduce the burden on the doctors in the ED. However, research by Hurst et al. (2017) reveals that attending the ED is strongly correlated with GP satisfaction data in non-London CCGs and diverting patients may not be as straightforward as previously believed. In essence, the NHS is in dire need of a significant increase in funding to deal with the current situation (Royal College of Physicians, 2016).

The discussions in all the sections above reveal the context of the participants of this study, which is integral to investigating the impact of ethnicity on workers' responses to EE practices. This context is also explored from the participants' perspectives. The Health Careers website (2017) for the NHS that presents the role of doctors discusses the variation between specialities but doesn't expand on the nuances of daily work that vary between roles. Hence, the data that will be collected as part of this research will investigate the working environment of the doctors in order to get a deeper contextual understanding of the day to day roles and responsibilities. It is integral not only because of the subjectivist constructionist approach adopted in this research (disscussed in the following chapter) but also because both concepts of ethnicity and EE are context specific, as discussed in chapters two and three respectively. In line with this 'context-specific' nature of the key concepts for this research, the following sections are concerned with debates in the literature that focus on EE and ethnicity in NHS Trusts in England.

4.6. Employee Engagement (EE) in NHS Trusts, England

Building from the literature reviewed in chapter three; this section is concerned with the debates specific to the NHS and EE. Research on the NHS has shown there are links between high levels of EE with overall organisational and financial effectiveness, patient satisfaction, better health and wellbeing of the staff (NHS employers, 2013b; Ham, 2014), lower levels of patient mortality and better use of resources (West & Dawson, 2012) and better quality of care for patients (Jones, 2016). Using the data from the NHS staff survey, NHS Employers (2013a) suggest that effective staff engagement is crucial to help the organisation meet its financial challenges and improve productivity. Along the same lines, based on research by Spurgeon et al.

(2008) and further investigation using data from 30 NHS Trusts, Spurgeon (2012) insists that there is a motivational aspect to medical engagement that pushes doctors from a competence stand of 'can do' to an engaged level of 'will do'. NHS Employers (2018) continue to insist that EE is pivotal in addressing a 'range of challenges' that the NHS faces.

The five-year forward view (NHS England et al., 2014), as discussed in section 4.3 envisions new care models and acknowledges the importance of active engagement of clinicians. In the report of the review of EE and Empowerment in the NHS by Ham (2014), engaged staff have been documented as a need to have, in contrast to, nice to have, to address the growing service pressures and tightening finances. Citing case studies from four Trusts, Jones (2016) reiterates the importance of making staff feel involved, supported and empowered, well informed and valued for successful staff engagement. Creating such an environment for ethnic minorities has been challenging and is an ongoing endeavour of the NHS (NHS England, 2017b) which is further discussed in section 4.7. The findings from this research have the potential to contribute to this endeavour by investigating doctors' experience.

The NHS has been actively trying to influence how their employees feel and act at work to improve performance since the early 1900s and now view the concept of staff engagement as an integral part of their HRM systems (NHS employers, 2013b). An 'employee engagement toolkit' was jointly developed by the Department of Health and the NHS employers and tested with 400 HR managers in the first half of 2011 (NHS employers, 2013c). A concept called the 'staff engagement star' (Appendix 3) was developed based on discussions with staff and analysis of the staff survey (NHS employers, 2013c). The NHS considers staff engagement to be a result of *'what happens when people think and act in a positive way about the work they do, the people they work with and the organisation they work in'* (NHS employers, 2013b:8).

Nonetheless, as discussed in the previous chapter, the definition of EE from NHS Employers lacks direction for policy and practice for managers (Purcell, 2014) and hence although the conceptualisation of EE by the NHS is used as a foundation, the working definition presented in the previous chapter is used to investigate the research objectives. It is grounded using the notion of professionalism as per the 'professionalism in action' guidance by the GMC, making it contextually specific for

doctors working in the NHS. NHS employers recommend that at the local level, staff survey results should be analysed by equality characteristics and the variations of levels of engagement should be addressed and that the policies of staff engagement need to be adapted to encompass the unique makeup (NHS employers, 2013b). However, there is no guidance on how the policies can be adapted. There is a wealth of literature examining EE and gender (cf. Lockwood, 2007; Robinson, 2007; Kular et al., 2008; Denton et al., 2008; Crush, 2008; Alfes, et al., 2010; Lowe, 2012; Dromey, 2014), age (cf. Robinson, 2007; Lowe, 2012; Schaufeli et al., 2006; James et al., 2011), and length of service (Robinson, 2007; Lowe, 2012). Nevertheless, there is no research on the impact of ethnicity in relation to EE. NHS Employers (2013b), Truss et al. (2013) and Bailey et al. (2015) emphasise the need for EE to be explored in relation to different ethnic groups which is the intended contribution of this research. The section below discusses the reasons why 'ethnicity' is such an important topic for the NHS followed by debates in the literature on how ethnic diversity is being managed.

4.7. Ethnicity in the NHS

The staff in the NHS has been characterised by migrant workers and a heterogeneous domestic workforce (Healy & Oikelome, 2011). The discussions here are concerned with International Medical Graduates (IMG), immigrant doctors, and doctors who identify as belonging to an ethnic minority but are not necessarily first generation immigrants. The issues faced by all groups are not always clearly distinct, and the focus of this research remains on investigating the impact of ethnicity. Nonetheless, where an issue arises as a direct consequence of immigration, an attempt has been made to make it clear. Also, as discussed in chapter two, self-perceived ethnicity without a pre-defined list is adopted in this research in order to allow for integration into society, and differentiation between immigrants and British nationals to emerge through participants' identification. The outcome of adopting this approach is the concern of chapter six.

The state of ethnic diversity in the NHS is found to be a result of its inability to recruit the number of required healthcare professionals from the UK since its inception in 1948, depending heavily on a foreign skilled labour force (Batnitzky & McDowell, 2011). Post world war II, doctors from ex-British colonies in South Asia and nurses

from the Caribbean were actively encouraged to move to the UK to fill the gaps in positions for expanding the NHS (Jayaweera, 2015). This trend continued throughout the 1960s to 1980s to meet the demand in the healthcare sector, despite increased restrictions on immigration for other labour migrants (Snow & Jones, 2011). In the early 2000s, the NHS witnessed British born doctors emigrating to other countries (cf. Goldacre et al., 2001) and investment into the NHS for expansion leading to continued labour shortages, which had to be filled by active recruitment from abroad (Jayaweera, 2015). The processes here were facilitated by the liberalisation of the service sector and growth of free trade blocks (OECD, 2002a), resulting in an increasingly integrated global labour market where healthcare professionals' migration caused volatility in human resource planning (Bach, 2003). Contemporarily, efforts to meet future demands with 'homegrown' health professionals, as well as further increasing restrictions on entry and stay of highly skilled migrants with the points-based system has not managed to curb the dependency on foreign-trained doctors (Jayaweera, 2015). This in part is due to, the healthcare sector being characterised by long lead times for training of professionals (Bach, 2003) and partly due to an ageing population, increased emphasis on prevention and management of long-term medical conditions, austerity and emphasis on 'safe staffing levels' (Jayaweera, 2015; NHS Employers, 2014; Migration Advisory Committee, 2013).

In addition to the above UK-context 'pull' factors, other 'push' factors impact an individual's social and economic context, influencing healthcare professionals to emigrate (Bach, 2003). These include better professional development, career opportunities, working conditions including infrastructure, job security and wages (OECD, 1997; Buchan et al., 2003; Ahmad, 2005; Bach, 2003; Irwin 2001). Some countries have faced an oversupply of doctors (cf. Jinks et al., 2000), while others have experienced economic collapse, wars, human rights violations, political, religious and ethnic tensions resulting in emigration (OECD, 2002b).

Currently, the conservative government is attempting to dissuade organisations to employ workers from outside the European Economic Area (EEA) by levying a surcharge of £2000 per year per immigrant worker, which is directly affecting the NHS with an additional burden of £7 billion a year (Limb, 2017). In effect, this surcharge penalises NHS Trusts for attempting to fill staff shortages in order to maintain safe patient care (BMA, 2017). Such policies, and the ever-increasing stringent standards

for registration of medical professionals in the UK, in addition to the immigration laws, have finally resulted in a slowdown of new and recently arrived IMGs (Jayaweera, 2015).

Despite this trend, as discussed in chapter two, the NHS employs the highest number of staff in the UK who are identified as part of an ethnic minority (NHS careers, 2011). In particular, investigating ethnic diversity in the staff group of interest for this research, the September 2017 statistical breakdown by ethnicity in NHS Trusts, England reveals that there are 53.1% white doctors and 6% have not stated their ethnicity, and out of the non-white hospital doctors, 26.1% are Asian or Asian British, 3.7% are Black or Black British, 2.3% are Chinese, 2.8% are Mixed, 3.7% are of any other ethnic group and 2.4% are of unknown ethnic group (NHS Digital, 2017). Hence, 41% of hospital doctors are identified as belonging to an ethnic minority. Moreover, 70% of the spending of these Trusts is on staff, making their productivity a key concern for the long-term sustainability of the NHS (Charlesworth & Lafond, 2017). Such ethnic diversity among hospital doctors working in English NHS hospital Trusts, and the need to investigate their EE, increases the value of the focus of this research.

The NHS incorporates equality, diversity and inclusivity at the core of its strategy (NHS employers, 2017a), saying that,

> *Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. Inclusion is about an individual's experience within the workplace and in wider society and the extent to which they feel valued and included.*

There is evidence that an ethnically diverse workforce that feels valued can positively be linked to good patient care (West et al., 2012; Dawson, 2009). In particular, contemporary medicine is considered global due to an increased ease of travel, which has resulted in diverse communities and populations (McKimm & McLean, 2011). Hence, there is potentially an additional benefit to the NHS from doctors who have trained or worked outside of the UK and come here to practice (GMC, 2014). For doctors to truly be global health practitioners, awareness of others' cultural norms and values is believed to be integral (McKimm & Wilkinson, 2015). There is evidence that foreign-trained health professionals generally improve the intercultural competencies

of workspaces (Mladovsky et al., 2012) and it leads to a skills exchange, improving performance of employees (Christian et al., 2006) usually through a better understanding of ethnically diverse patients (Cohen et al., 2002). Cultural differences can become more prominent with end of life issues (McKimm & Wilkinson, 2015). There is even a call for medical graduates to think globally in order to adapt to the changing societal needs (McKimm & McLean, 2011). Most pertinent to this research is the finding that positive staff experiences that are a result of ethnic diversity, yield better outcomes for EE (West et al., 2012).

Although there is no research that directly investigates the impact of doctors' cultural values in the care they provide, literature (cf. Sin, 2007; Mirabelle, 2013; North & Fiske, 2015) investigating cultural differences in the care of the elderly acknowledges distinct trends impacting the outcome. In particular, one study found that White British respondents have a significantly lower expectation from their children in supporting them in old age, in contrast to Asian Indian respondents, who showed extremely high levels of expectations to be supported by their children and family members (Sin, 2007). The traditional beliefs of filial piety, highly prevalent in eastern cultures in contrast to a lower prevalence in western cultures, has been found to be shifting with modern attitudes (North & Fiske, 2015) being impacted by multiple factors such as changing relations between state and family, along with contemporary demographic contexts (Sin, 2006; Daly & Lewis, 2000).

However, in addition to the benefits of IMGs as discussed above, there are challenges. It has been found that ethnic minority doctors who have qualified outside of the UK have a higher than average likelihood to receive a warning, mostly due to poor communication rather than their technical skills (McKimm & Wilkinson, 2015). Literature also accepts challenges that arise due to language, terminology, idioms, understanding indigenous accents and other socio-cultural aspects of communication (Allan & Larsen, 2003; Baumann et al., 2006; Buchan, 2002; Konno, 2006; Tregunno et al., 2009). There is also evidence in the literature that IMGs have a limited understanding of the required professional standards, and often they do not get the opportunity to become accustomed to the ethical and legal policies and practices before beginning to work in the NHS (Bhat et al., 2014). Not only are doctors of an ethnic minority expected to adopt new working styles appropriate to the NHS (Bhat et al., 2014), but they may also need to unlearn behaviours based on their ethnicity

(McKimm & Wilkinson, 2015). Also, *'a shared "doctor identity" may not be enough to overcome more powerful differences in social identity and may lead to problems in team working and communication'* (McKimm & Wilkinson, 2015: 840). There is evidence that doctors from the same ethnicity form groups at the workplace, due to their shared interests (Smith et al., 2006; Winkelmann-Gleed, 2006).

There is also evidence for the rates of discriminatory, bullying or harassing behaviour from either managers, team leaders, colleagues, or patients and relatives being higher towards ethnic minority staff in comparison to their white counterparts (Stevenson & Rao, 2014; Bécares, 2008; Naqvi et al., 2016). A recent report found that black employees experienced the highest levels of discrimination, with all other non-white ethnic groups were far more likely to face some form of discriminatory behaviour in contrast to their white colleagues in NHS Trusts in England (West at al., 2015). In particular, this contributes to the pay differentials and career opportunity disparities between whites and non-whites in the NHS (Healy & Oikelome, 2011; Oikelome, 2010 in Healy et al., 2010). It also appears that an 'outsider', receives less support in comparison to an 'insider' (McKimm& Wilkinson, 2015). Here, an outsider would be a person who is not considered to be a colleague from the UK. There is significant literature documenting the 'ethnic penalty' faced by IMGs due to an improper recognition of medical qualification and experience from their home country (Buchan et al., 2005; Larsen, 2007; Shuval, 1995; Wolanik Bostrom & Ohlander, 2012). Both in the past and present, ethnic minority doctors have only attained a low level and the least prestigious specialisations (Anwar & Ali 1987; Gerrish et al., 1996; King's Fund, 1990, 2001; Limb, 2014). Discrimination on the basis of religion has been found to be prevalent in the NHS with Muslims by far being the most affected (West et al., 2015). Any prevalence of discrimination has been found to be conversely proportionate to patient satisfaction, where higher levels of discrimination mean lower levels of patient safety and satisfaction (West et al., 2011; Limb, 2014). Economic efficiency and quality of healthcare are also believed to be reduced when senior leadership is not proportionately representative of the ethnic diversity of the communities they serve (Salway et al., 2013; NHS Leadership Academy, 2013).

There is evidence that ethnic diversity in management positions not only enhances understanding of the needs of users and staff, but it is also a catalyst for creative problem solving and innovation, leading to improved organisational performance

(Nath, 2016a). This also contributes to creating a conducive environment for EE by increasing opportunities for an employee from an ethnic minority to have their ideas heard and considered in organisational decisions (Farndale et al., 2011). In particular, in the absence of procedural and distributive justice, EE is not possible (Purcell, 2014 in Truss et al., 2014). Being able to voice one's opinions and having confidence that they are being heard is integral to encouraging participation in improving the performance of the Trust as an individual, as part of a team and with or as management (Purcell, 2014 in Truss et al., 2014).

However, there is still a lack of representation of ethnic minorities in NHS management positions and in senior leadership roles (Kline, 2014; Stevenson & Rao, 2014; Kalra et al., 2009; Kline, 2017), leading to a sense of lack of support (Stevenson & Rao, 2014; Nath, 2016a). In 2015, only 8.8% medical directors, 19.5% clinical directors, 19.9% non-executive directors and 5.8% board level directors in NHS Trusts in England were of non-white ethnicity (NHS Digital, 2015). Discrimination has been noted to be a key reason for lack of representation at managerial level (Esmail & Everington 1993; Iganski et al., 1998; Mason, 2000; Drew, 2018). Resultantly, at an academic level (Karmi, 1993; Mason, 2000; Healy & Oikelome, 2017 in Özbilgin & Chanlat, 2017) there is a call to diversify senior and policy-making positions in the NHS and above. However, there has still only been 4.8% of doctors from ethnic minority backgrounds, in comparison to 13.8% of white applicants, successfully securing a senior hospital doctor role, and discrimination in training and recruitment is still being experienced (Jaques, 2013; Kline, 2017).

The NHS has acknowledged that historically action plans have failed, requiring a mandatory standard to be put into force, as of April 2015, that is measured using nine indicators (Priest et al., 2015). Each NHS organisation has to publish data on these indicators annually, and those who fail to show any progress will not only be at risk of being judged as not 'well led' by regulators such as the Care Quality Commission, but the organisation will also be in breach of the NHS standard contract (Passman & Kline, 2015; NHS England Equality & Health Inequalities Team, 2015). These nine indicators, formally called 'Workforce Race Equality Standard' (WRES), are derived from workforce data, national NHS staff survey findings and representation on boards as shown in Table 1 below.

Table 1: Indicators for the workforce race equality standard (Adapted from Naqvi et al., 2017)

	Workforce indicators For each of these four workforce Indicators, compare the data for white and BME staff
1.	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-Clinical staff • Clinical staff - of which - Non-Medical staff - Medical and Dental staff
2.	Relative likelihood of staff being appointed from shortlisting across all posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for white and BME staff
9.	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

Such mandated endeavours, to promote ethnic diversity by the NHS, that have legal and funding consequences, are likely to have better outcomes in contrast to non-mandated policies (Priest et al., 2015). Additionally, policies and processes that assist in creating environments that have open communication without the fear of negative consequences, inclusion, reduced conscious or unconscious biases, stereotypes and discriminatory behaviour, are found to support ethnic diversity (Devine et al., 2012; Singh et al., 2013; Nath, 2016b). Data from the WRES reveals that much work is still required and, in particular, the 'voices' of ethnic minority staff need to play a more critical role, especially because of the varying experiences different ethnic minorities have (NHS England, 2017b). Although evidence on the success of interventions that support ethnic diversity from within the healthcare sector in the UK is scant, there is consistency in findings in other contexts that suggest that the NHS could benefit from leadership that articulate diversity as a high priority, with strategies at multiple levels with mandated targets or actions (Priest et al., 2015).

The NHS is currently using staff networks (also known as employee or diversity networks) to represent inequality and discrimination matters on the organisation, where formal structures support their peers in identifying needs relating to specific groups, ensuring the NHS remains true to the goal of inclusion and diverse representation (NHS England, 2017b). The credible and collective voice that these staff networks provide not only aid in keeping ethnic diversity as an important topic on the agenda of the NHS but also helps in creating an environment that is conducive for EE (NHS England, 2017b).

In this context, and pertinent to the focus of this research, it is important to acknowledge the unique features of the work setting in the NHS. Building from this, chapter seven discusses the findings related to contextual specificities in detail contributing to addressing the second and third research objective. However, it is important to note how the dynamic nature of this environment, in which continually changing team compositions either due to progression or movement in roles and schedules (Klien et al., 2006), affects the interactions between colleagues and patients (King et al., 2011). In these situations, especially due to the constrained duration of interaction, differences in ethnic identities are known to be salient and problematic (Harrison et al., 2002). The interactions are often characterised as anxious and uncomfortable, mainly because individuals are concerned with the impression they are

making (Hebl & Dovidio, 2005). Moreover, as discussed in chapter two, individuals from different ethnicities are either accustomed to individualistic or collectivist cultures, and hence such differences would guide their behaviour while working in teams. The problems with the use and understanding of common language and terminology can cause communication problems (Michalski et al., 2017). Cultural differences between ethnicities also impact day to day decisions and interaction with patients, for example, dealing with and the role of family members, information sharing, consent and end of life decisions (Slowther et al., 2012; Chaturvedi et al., 2009; Mobeireek et al., 2008). The themes emerging here in this section indicate the nuances in managing ethnic diversity in the NHS and are explored further in chapter eight using the experiences of participants with an aim to address the third research objective.

4.8. Conclusion

Having reviewed literature pertinent to the research focus, it is apparent that despite the NHS being the fifth largest employer in the world, with 70% of it's spending allocated to staff, and 41% of doctors identified as hailing from an ethnic minority, it has arguably still not managed to reap the benefits of ethnic diversity. It is evident that structural reforms have attempted to shape and reshape the 'management' of the NHS to meet the aims it initially set out to fulfil of being a universal healthcare provider, free at the point of use and funded by general taxation. However, the mounting deficits have resulted in an environment where there are chronic high levels of stress on frontline staff, increasing the risk of burnout and diminished morale.

Having discussed the context-specific nature of ethnicity and EE in the previous chapters (two and three respectively), context of the participants of this research has been examined in this chapter. It reveals that historical changes in the way in which the NHS is structured have resulted in the medical autonomy of doctors being threatened, resulting in a strained relationship between managers and doctors, mainly due to targets and protocols. This additional burden of meeting targets and being accountable for the NHS' funds seems to shift doctors' focus away from the individual patient to the community at large. The changing relationship between doctors and the NHS has reached a stage where doctors feel undervalued without a voice and less empowered, in comparison to managers, who do not understand the issues faced on a daily basis in the minds of doctors. Additionally, the core altruistic component of

being a medical professional is potentially left unsatisfied, due to high workloads in an environment characterised by lack of resources.

The number of ethnic minority employees in the NHS is found to be a direct result of its inability to fill staff shortages, and there is evidence that shows that an ethnically diverse staff is linked with good patient care. However, the work environment appears to be worse for ethnic minorities who face distributive injustice through discrimination in opportunities for progress, and the absence of 'representatives' has become a key concern for the NHS. Previous measures have failed to create an environment where the ethnic minority are heard, resulting in a mandated standard (WRES) being implemented by the NHS in 2015. In line with the UK government's support for cultural pluralism, as discussed in chapter two, there are attempts to create an inclusive, fair and diverse environment that not only pushes the NHS towards reaping the benefits of ethnic diversity, but it also aids in creating a conducive environment for EE. The current body of literature, and even the policies discussing ethnicity in the context of the NHS, focus on discrimination and inclusion with a lack of literature on ethnic integration of staff.

In the current work environment for doctors, that appears to be characterised by stress and the risk of burnout, the intended contributions from this research become more valuable as they might inform policy and practice, in turn contributing to tackling challenges. The work environment related themes are investigated further in chapter seven using insights from doctors regarding their experience of working in English NHS hospital Trusts. In particular, the impact of such a work environment on EE is considered. In addition, findings from this research aim to contribute to the endeavour of the NHS in reaping the benefits of ethnic diversity and integrating international medical graduates by documenting the experiences of doctors. For the purpose of this research, as discussed in chapter two, ethnicity is conceptualised as an identity which is fluid, subjective and contextual. Data on self-perceived ethnicity will be collected, both with and without the NHS ethnicity code list. In particular, the working definition of ethnicity will first be used to investigate the factors affecting self-perceived ethnicity. These findings will aid the investigation into the impact of the dual nature of ethnicity on the varying responses to EE. However, before this impact of ethnicity can be investigated, the insights from the experiences of doctors are used to explore EE. In particular, as discussed in this chapter, the behaviour of doctors is guided by the notion

of professionalism as provided by the GMC which is incorporated in the working definition of EE presented in chapter three. The HRM perspective is adopted, and EE is conceptualised as a two-way relationship where the organisation creates a conducive environment for EE which encourages doctors to advocate and participate in improving the performance of their Trusts. Doctors working in English NHS hospital Trusts are used as participants for this research, not only because of the personal reasons discussed in chapter one but also because, as seen in this chapter, their EE heavily impacts the overall outcomes of the NHS. The NHS acknowledges the importance of EE and its pivotal role in addressing the financial crisis, and calls for it to be investigated in relation to different ethnic groups. In particular, the investigations that form a part of this research are conducted by recruiting doctors from English NHS hospital Trusts because, as seen in section 4.2, NHS England has divergent policies and practices from the other parts of the UK. GPs are not directly employed or subject to EE policy and practices by the NHS Trusts, and hence they are excluded from the selection criteria. The research strategy and data collection processes are discussed in detail in the following chapter, which is concerned with the methodology used in this research.

5. Methodology

5.1. Introduction

This chapter discusses the methodological considerations and decisions of this research. The purpose is to draw on methodological approaches that have been developed by others, and to refrain from getting entangled into a philosophical debate to locate a contribution to knowledge in the area of methodology. Nonetheless, justification and clear stipulation of the assumptions adopted in using the appropriate research methodology are presented. In particular, the research aims are considered which requires exploring complex social phenomena – namely, Employee Engagement (EE) and ethnicity. The research philosophy section (5.2) documents the view of how knowledge is developed, and consequently the nature of reality (ontology) and knowledge (epistemology). In line with the interpretivist philosophy, the last part of this section reflects on values and ethics (axiology) that have impacted all the stages of the research process.

The research approach section (5.3) discusses the procedure used for this study, keeping in mind the aim to address the research questions (Liu, 2016). Based on this, the research strategy section (5.4) justifies the use of snowball, purposeful and self-selection sampling techniques for data collection. The considerations and processes for using semi-structured in-depth interviews as part of the generic inductive approach are presented in the data collection section (5.5). The following section (5.6) is concerned with the thematic analysis of the data collected. Section 5.7 deliberates on the overall quality, rigour and trustworthiness of this research. The final section (5.8) summarises the methodology for this research.

5.2. Research Philosophy

Creswell (2013: 16) states that *'philosophy means the use of abstract ideas and beliefs that inform our research'*. This section underpins the research strategy and the methods chosen incorporating assumptions of how the development and nature of knowledge is viewed (Saunders et al., 2009). Subsequently, beliefs about ontology (the study of the nature of reality) and epistemology (the study of the nature of knowledge) have guided the choice of methods of data collection and analysis (Creswell, 2013; Janićijević, 2011; Burrell & Morgan, 1979).

Employee Engagement (EE) and ethnicity are considered complex terms due to their subjective nature, as discussed in chapters two and three, and interpreting the experiences of social actors' aids in understanding their relation (Bryman & Bell, 2007; Burrell & Morgan, 1979). Discussing the two basic approaches, objectivistic-positivist and subjectivistic-interpretive (Martin, 2002; Lin, 1998; Ponterotto, 2005), the characteristics of a positivist are that the researcher accepts the reality that can be observed, resulting in generalisations similar to natural scientists (Remeneyi et al., 1998). The positivist philosophy believes that results of research can be tested (Bryman & Bell, 2007). In this stance, the researcher is an objective analyst of social reality that is tangible (Remeneyi et al., 1998; Bryman & Bell, 2007; Easterby- Smith et al., 1993; Gray, 2014). Hence, Remeneyi et al. (1998) state that this approach cannot provide a deep understanding of complex problems in social sciences and in particular business and management studies.

In contrast, interpretive philosophy incorporates the values of a researcher (axiology) (Saunders et al., 2015) and insists that social research and natural sciences need different approaches, whereby social research incorporates the subjective meanings of social action (Bryman & Bell, 2007). Saunders et al. (2007) highlight that researchers who critique positivism on the basis of its lack of ability to deal with the complexity of the social world, are interpretivist. However, the subjectivity of interpretive research means that the ability to generalise to other situations is limited as there are usually scant scientific procedures of verification (Mack, 2010). Nonetheless, the interpretivist philosophy is adopted in this research because it resonates with my beliefs as a researcher more than positivist philosophy. Interpretivist philosophy also exhibits innate merits to address the research question as this involves exploring complex social phenomena. The sections below discuss the ontological and epistemological considerations that are being employed (Martin, 2002; Lin, 1998; Ponterotto, 2005; Bryman & Bell, 2007).

5.2.1. Epistemology and Ontology

Concurring with Crotty (1998), ontology and epistemology are discussed in confluence as each theoretical assumption will detail my understanding of the nature of reality and of knowledge. The importance of epistemology is not only limited to the fact that it allows me to clarify what knowledge I consider as legitimate and adequate, but it also guides the gathering and analysis of data, along with assisting in understanding which

research designs will help in achieving the research aims (Gray, 2014; Easterby-Smith et al., 2002).

Ontology is the study of the nature of reality, where my assumptions in relation to the way the world operates are questioned, either in terms of

> *objectivism*, [which], *portrays the position that social entities exist in reality external to social actors concerned with their existence'*, [or in terms of] *subjectivism,* [where], *the social phenomena are created from the perception and consequent actions of those social actors concerned with their existence.* (Saunders et al., 2009:110)

Objectivism infers that social reality exists independently from individuals in society, their actions and activities, as well as being independent from the researcher (Errikson & Kovalainen, 2008). In contrast to objectivism, the subjective ontological position infers that social reality exists as a result of the social interactions of individuals, where social actors can change their views and understanding of social reality depending on the social interactions (Errikson & Kovalainen, 2008; Crotty, 1998).

This research aims to understand the phenomena of ethnicity and EE through meanings and insights from complex experiences of doctors by taking their point of views (Choudrie et al., 2016; Schwandt, 1998, in Denzin & Lincoln, 1998) through dialogue and interpretation. As an interpretivist, the meanings given by doctors are then interpreted (Schwandt, 1998, in Denzin & Lincoln, 1998).

> *"To say of something that it is socially constructed is to emphasize its dependence on contingent aspects of our social selves. It is to say: This thing could not have existed had we not built it; and we need not have built it at all, at least not in its present form. Had we been a different kind of society, had we had different needs, values, or interests, we might well have built a different kind of thing, or built this one differently"* *(Boghossian, 2001: 1)*

Looking to examine the workers' responses to EE practices of NHS Trusts, the subjective ontological position requires examination of the social interactions of doctors (Crotty, 1998). Like any other social actors, doctors, do not necessarily adhere to social arrangements and cultural norms but actively shape and reshape these

constraints on behaviour (Howe, 1998). This means that social phenomena are in a constant state of revision (Bryman & Bell, 2007; Saunders et al., 2009). Social actors are not individually contained information processors, but are social beings who go through *'inherent immersion in a shared experiential world with other people'* (Andy & Strong, 2010: 5). Hence, doctors' experiences and any historical and contemporary context of their work environment is integral to this research (Remeneyi et al., 1998).

An assumption is that the meaning of reality is constructed through interaction with other realities (Crotty, 1998). As acknowledged in the axiology section (5.2.2) below, my own intrinsic involvement in the research process results in co-production of knowledge between myself and my participants (Burr, 2015). The social constructionism perspective adopted in this research accepts that the universal truth is unknown, and individual stories about the truth are accepted as reality (Galbin, 2014; Burr, 1995; Berger & Luckmann, 1966; Lincoln & Guba, 1985). Hence, the interview responses are accepted as evidence that allows me to construct the reality where meaning is not discovered but constructed (Crotty, 1998). Here, the construction is nothing but a semiotic paradigm where I navigate through the map of reality using continuous negotiation (Galbin, 2014). In contrast to positivism, constructionism does not accept that assumptions of the world can be observed, but it cautions to be inquisitive of the apparent observations (Burr, 2015). Importantly, the aim of this research is not necessarily to document knowledge that is stagnant or universally valid, but to create an appreciation of various possibilities (McLeod, 1997). The socially constructed meanings are therefore fluid and dynamic (Gergen & Gergen, 2012) and created through daily interactions (Burr, 1995).

Social constructionism accepts knowledge to be historically and culturally dependent (Burr, 2015). Additionally, criteria used to identify behaviours, events or social actors are usually confined by culture, history and social context (Gergen, 1999). My beliefs naturally concur with Anderson and Goolishian (1988) who insist that no real external entities can be apprehended, and facts and other such assumptions are actually social constructions. The social constructions are not limited to external entities but are also based on our beliefs about them (Hacking, 1999). Relativism and incommensurability are sometimes referred to as limitations of the subjectivist viewpoint (Holden & Lynch, 2004). However, subjectivists argue that reality is personal and community specific,

and hence many versions of reality, which are equally valid, are accepted (Rosenau, 1992). Similarly, social constructionism supports that there are 'knowledges' rather than 'knowledge' and each *phenomenon or event can be described in different ways, giving rise to different ways of perceiving and understanding it, yet neither way of describing it is necessarily wrong* (Willig, 2001:7).

Potentially relevant to this study is the attempt to understand self-perceived ethnicity as a concept, which is similar to social constructionism, where the content of consciousness is informed by our culture, society and others around us (Owen, 1995; Camargo-Borges & Rasera, 2013; Burr, 2015). EE has varying definitions, and from a social constructionist point of view, this could be because of social actors experiencing the same phenomena but interpreting it in different ways (Berger & Luckmann, 1966). Macey & Schneider (2008) argue that EE is subject to the employee's vantage point on the world and specific situations. Concurring with these epistemological assumptions, EE is explored in context to doctors' situations and personal experiences (Bryman & Bell, 2007).

So, in essence, not only are subjectivist and social constructionist ontological-epistemological assumptions in agreement with my own beliefs, as discussed below in the axiology section (5.2.2), but they also appear to be appropriate for exploring the key concept of ethnicity and EE. Additionally, the constructionist theory is able to address the rapidly transforming context (Galbin, 2014), which is significant to the research question due to the changes constantly taking place affecting the work environment in English NHS hospital Trusts.

5.2.2. Axiology

My values and ethics have influenced all stages of the research process, right from selecting the topic, through to the choice of research philosophy, and resultant methodology (Saunders et al., 2015; Heron & Reason, 1997). Significantly, how I interpret values and responses of my participants in conjunction with my own beliefs impacts the analysis and conclusions from my data (Sixsmith, 1999). Honouring my social constructionist- interpretivist perspective, I have acknowledged in the prologue section in chapter one, introduction, and later on in this section, my values and experiences in the context of not only ethnicity but also EE (Ponterotto, 2005). Furthermore, reflexivity, as explained by Burr (2015), encourages me to explicitly

acknowledge my personal values and perspectives that impact my research. Through the interview process, I used familiar grounds to build rapport, and during the analysis, I accept my biases (Ponterotto, 2005).

In particular, I take into account the various identities I hold, in the research context, that allowed me to be both an insider and an outsider (Dwyer & Buckle, 2009). Communicating my identity influenced the willingness of participants and how they felt about me during the interview (Richards & Emislie, 2000). To reflect on my insider/outsider position is important (LaSala, 2003; Watts, 2006) because epistemologically, it has a direct bearing on the knowledge co-created between myself and the participant (Griffith, 1998). The intersection of identities includes me being a young married woman, an Indian, an immigrant, a daughter-in-law to doctors, an academic researcher and an interviewer (Fish, 2008). Resultantly, I would dynamically (Sixsmith et al., 2003; Serrant-Green, 2002) journey through identities without clear delineation (Humphrey, 2007; Hayfield & Huxley, 2015; Mullings, 1999).

'*Borders define outsiders and insiders, but they do much more – they also actively legitimate insiders*' (Mohanty, 1997, p. xiii). Having an insider identity, because of my personal background, allows me to be relatively more aware of the lives of doctors, resulting in me holding an advantageous position while designing the interview schedule and recruiting participants (Hayfield & Huxley, 2015; Nowicka & Ryan, 2015). I was an insider where I belonged to the same group as the participant in terms of gender, religion, ethnicity and immigration status, and an outsider because I am an interviewer, I am neither a medical professional nor am I working for the NHS and, in some instances, because I am an immigrant (Hayfield & Huxley, 2015, Gair, 2012). For example, while interviewing a female doctor, an immigrant from Hungary, she acknowledged shared experiences of being able to compare the NHS with other health care systems around the world. Similarly, as an insider, some Asian doctors did not hold back in using Hindi words and expressions like "*aapko to pata hai na*" meaning as you are aware/ as you already know (Perry et al., 2004). Moreover, a shared sense of culture allowed them to give examples which they felt I would be able to relate to. In particular, participants from ethnic minority backgrounds felt reassured that their voice was being heard by someone who 'understood' what they were trying to express. Moreover, they narrated experiences as if they were pouring their heart out to a confidant.

During the data collection and analysis process, I endeavoured not to overlook parts of the data by taking for granted its content due to my insider status (LaSala, 2003; Perry et al., 2004). I remained aware that despite shared social or situational characteristics with participants, their perspectives and lives might be considerably different (Bridges, 2001). The referrals from my parents-in-law allowed the participants to feel comfortable with me (insider), nevertheless, because of my interviewer identity and not working for the NHS as a doctor (outsider), I could ask naive questions which allowed me to gain in-depth responses (Tang, 2007) as they shared personal experiences and gave them confidence that I would not divulge personal reflections on their responses (Sixsmith et al., 2003). During the analysis write-up, I have paid particular attention to identifying my interpretations from the participants' responses. This is discussed further in the thematic data analysis section 5.6. The following section is concerned with the research approach adopted in order to address the research question.

5.3. Research Approach

Building from the adopted interpretivist research philosophy, and subjectivist and social constructionist ontological-epistemological assumptions, this section discusses the research approach that is determined with an aim to address the research objectives (Strauss & Corbin, 1998). Considering that the research objectives require producing an interpretive analysis that details a deep understanding of the experiences of doctors and impact of their ethnicity in responding to the EE practices of English NHS hospital Trusts, the hypothesis development or testing, the requirement of any deductive approach, appears to be less appropriate (Thomas, 2003). In contrast, the generic inductive approach seems more appropriate as, primarily, the interpretive nature of this approach satisfactorily fits the research focus. Moreover, induction processes empirical reality into valid knowledge (Bendassolli, 2013). In the context of traditional approaches for qualitative research, phenomenology may be considered as an appropriate approach because it aims to identify the phenomenon through actors' perceptions in a situation (Gray, 2014). Nevertheless, the grounded theory might be suitable because it aims to describe basic social processes (Charmaz & Mitchell, 2001 in Atkinson et al., 2001; Glaser, 1978). Investigating the impact of ethnicity is benefitted from telling stories of individual doctors' experiences, making narrative research also apposite (Creswell, 2009).

However, for this research, exploring different facets of the experiences of doctors requires different qualitative methods, which would suggest that it is inappropriate to adopt any single traditional qualitative approach. Consequently, not being guided by the afore-discussed established qualitative methodologies, the justification for the approach being employed here as a generic inductive approach is reiterated (Creswell, 2009). Moreover, Liu (2016) points out that excessive emphasis on using established methodologies carries a risk of insufficient attention being attributed to important findings of social reality. Nonetheless, the limitation of using a generic inductive approach is that the burden of locating the research within the broad theoretical stance of interpretivism is on the researcher, as there is no definitive theoretical perspective that is associated with this approach (Kahlke, 2014).

Pertinent to the research objectives, the generic inductive approach aims to understand the phenomenon, process, perspectives and context of the social actors (Cooper & Endacott, 2007). It can be said that the generic inductive approach is very similar to grounded theory as the latter also aims to provide an insight into the actions and changes to the real-life settings (Glaser, 1992). However, in contrast to grounded theory, the generic inductive approach limits its findings to the presentation and description of the most important themes, without aiming to build theories (Thomas, 2003). Additionally, the end of data collection is data saturation for this approach in contrast to theoretical saturation as required by the grounded theory (Liu, 2016).

In contrast to traditional structured inductive methodologies, the generic inductive approach does not restrain research findings and allows inherent, significant and frequent themes to emerge from the raw data (Thomas, 2006). This approach aims to build a clear connection between research objectives and research findings in addition to safeguarding transparency and defensibility of the research design (Liu, 2016). In particular, the working definitions of ethnicity and EE, presented in chapters two and three respectively, aid in fulfilling this aim without constraining the findings. This is achieved through summarising the raw descriptions of the experiences of the participants into important themes that aim to explain the underlying processes that are being investigated as part of this research (Thomas, 2006). Here, the participants are also purposefully selected to ensure that their inputs contribute to appropriate data (Jupp, 2006). This is discussed in detail below.

5.4. Research Strategy

It is not uncommon for qualitative studies to use non-probability sampling strategies like snowball, purposeful and self-selection sampling techniques (Chang et al., 2010), and the generic inductive approach requires contingent or a priori purposive sampling strategy (Liu, 2016). Hence, the participants of this research are purposefully selected to increase the chances of gathering data that is relevant to the research aims (Onwuegbuzie & Leech, 2007; Mays & Pope, 1995). Doctors working in English NHS hospital Trusts were purposefully selected because of the fact that Trusts in England follow similar practices and policies to each other in contrast to the devolved Scottish, Welsh and Northern Irish Trusts, as discussed in chapter four. A purposeful attempt was made to recruit participants from a range of ethnicities, specialities and posts in order to maximise sample variation (Gobo, 2004 in Seale et al., 2004). Additionally, an effort was made to ensure that participants from Trusts in various regions were represented, including those within and outside London. Such maximum variation is ideal for this research as a holistic overview of the phenomena is sought (Kitto et al., 2008). Sample variation was integral to the research objectives and due to the inductive nature of this research (Kuzel, 1999 in Crabtree & Miller, 1999). The profile of participants (Table 2, pg. 108) and findings discussed in chapter six reveals the goal of sample variation was satisfactorily met. Caelli et al., (2003), point out the importance of explaining what data saturation means for each researcher and in the context of this study, data saturation was achieved after which no new significant or disparate stories were emerging (Lamont, 2005).

In order to recruit participants for this research, the initial convenience sample (Berg, 2001) were the available subjects (friends and family), who were easily accessible and appropriate (registered medical practitioners working in English NHS hospital Trusts). Using the snowball technique, this sample was then used to generate referrals for other appropriate participants, who in turn again generate another set of referrals and this process is repeated (Gray, 2014). This technique has inbuilt security features because the referrals are known and trusted to the participants (Lee, 1993). By the very nature of this technique, the requirement of previous knowledge of insiders is a limitation (Gilbert, 2001), however, because there was a convenience sample available, this did not affect my research. Nonetheless, similar to the situation with my convenience sample, the participants may share information to their referrals. I was

clear that participants should not to discuss their experiences of participating in the research. My intention was to ensure that bias is prevented that may be caused by previous knowledge of the questions that are being asked in the interview. Other biases that may arise due to the participants knowing me personally would be the limitation of this research. In general, all participants get a background on my research (Participant Information Sheet, Appendix 4). I provide a standard introductory email (Appendix 5) to my contacts, participants and referrals to help them communicate with their contacts, which acts as a brief about participating in my research.

In this qualitative and interpretive study, I am directly involved in the data collection and analysis (Creswell, 1998; Klein & Myers, 1999; Morgan & Smircich, 1980; Morse, 1994 in Denzin & Lincoln, 1994) where, my interaction with the participants makes me a party to the social actors during analysis (Guba & Lincoln, 1994 in Denzin & Lincoln, 1994). This opportunity to attain deep insight into the context and phenomena being investigated is a key advantage of this strategy (Crabtree & Miller, 1999; Andrade, 2009). The stories of the participants enable me to better understand their actions (Lather, 1992; Robottom & Hart, 1993). The research questions, working definitions and relevant literature have been used in defining the boundaries (Crowe et al., 2011). The following section presents the considerations and processes used in collecting the data.

5.5. Data collection
5.5.1. Semi-structured in-depth Interviews

Due to the increasingly complex arena that doctors work in today, new ways of conducting research have led to qualitative approaches opening access to areas not amenable to quantitative research (Pope & Mays, 1995; Pope et al., 2002). Moreover, qualitative studies, within social sciences, are preferred in situations where a person's everyday behaviour is to be explored (Matthews & Ross, 2010; Silverman, 2011). Within the NHS, various studies investigating the behaviour of doctors use qualitative methods and particularly interviewing (cf. Elwyn et al., 2012; Dumelow et al., 2000; Duncan et al., 2012; Gollop et al., 2004; Carter et al., 2013; Department of health, 2008; Willcocks, 1997). However, studies investigating EE within the NHS use either mixed methods or quantitative methods, and qualitative research is scant (cf. Spurgeon et al., 2011; Jeve et al., 2015; Lowe, 2012; Buchanan et al., 1997). In this research, qualitative methods are well suited because the aim is to investigate the

phenomena within its context to uncover links between concepts and behaviours (Glaser and Strauss 1967; Miles and Huberman 1994; Crabtree and Miller 1999; Morse 1999; Ragin, 1999; Sofaer 1999; Patton 2002; Campbell & Gregor 2004; Quinn 2005). Interviews are particularly useful as they allow doctors to talk about their experiences without having to commit themselves in writing, especially because they consider the information confidential (Gray, 2014).

Interpretivists investigate social phenomena in its natural setting by interpreting the meanings that the concerned individuals bring to the phenomena (Denzin & Lincoln, 2005). This justifies the use of interviews in this study, employing interpretivist philosophy. Interviews can be challenging as they involve human interaction, where between posing questions, listening to the responses and taking note of non-verbal language, there is a risk of error (Gray, 2014). Nonetheless, interviews are considered particularly useful in investigating relatively unexplored phenomena that are most likely to be the sum of unique individual experiences, despite having a common social interpretation (Arksey & Knight, 1999). With this rationale, one to one, face to face semi-structured interviews are used, consisting of several questions that are aimed at exploring the areas important to the research question, while allowing either the participant or myself to diverge where more detail is required (Gill et al., 2008). A consistent line of enquiry is pursued, in contrast to a rigid set of questions (Rubin & Rubin, 2011).

Interviews allow the participants to clarify the questions (Fontana & Frey, 2000) and be flexible and spontaneous in giving voice to their experiences (Arksey & Knight, 1999). Interviews also facilitate probing or asking the participant to clarify (Gray, 2014; Khilji & Wang, 2006). The interviews augmented the elicitation of the 'why' and 'how' of the responses to EE practices of the NHS Trusts and the impact of ethnicity. The core idea of semi-structured interviews was to allow the participants to share their experiences in their own words (Matthews & Ross, 2010) which is integral to the multi-faceted nature of the research objectives where insights from experiences are to be used. The following section discusses the interview schedule that has been used in this study, providing structure to the interview (Berg, 2001).

5.5.1.1.   Designing the Interview schedule

The interview schedule aids standardisation *'to facilitate comparability between respondents during analysis'* (Barriball & While, 1994:333). In particular, the investigation of varying responses to EE practices between doctors of different ethnicities required comparing replies to the same line of inquiry. Using the literature discussed in chapters two, three and four in conjunction with the aims and objectives of the research presented in chapter one, seven themes were identified that led to the creation of the main and probing questions in the form of an interview schedule (Berg & Lune, 2004). This initial interview schedule (Appendix 6) was used for the initial 11 pilot interviews, after which significant changes were made. The changes were based not only on the responses of the pilot interviews but also because a contextualised working definition of EE was developed. The improvised interview schedule used the literature with an additional focus on the professionalism as per the 'professionalism in action' guidance for doctors by the GMC. The pilot interviews significantly helped me drop or re-formulate the questions that were incomprehensible or consistently failed to elicit a relevant response (Cassell & Symon, 2004).

The new interview schedule (Appendix 7) explores components of the working definitions of EE and ethnicity (Macey & Schneider, 2008). In both cases, open-ended, neutral, sensitive and understandable questions (Gill et al., 2008) relevant to the themes/components were included (Berg, 2001). A combination of fully formed questions for the main questions, and just topic headings for the probing questions, were used to ensure I remain responsive to the interviewee and also remain protected from becoming over immersed in the interaction that I start using closed or directive questions (Willig, 2001; Cassell & Symon, 2004). The probing questions were designed to help doctors relate to examples in contrast to discussing abstract generalities (Cassell & Symon, 2004). Due care was taken to avoid jargon and ambiguous language (Gray, 2014). Additionally, the questions in the interview schedule were discussed with supervisors to eliminate possible bias (Berg, 2001). The responsibility of ensuring that each respondent understood each question, in the same way, was on me as the interviewer (Barriball & While, 1994).

The first set of questions aimed at rapport building and understanding the background of the participant (Gill et al., 2008), enabling me to draw out any inferences with the

beliefs of the participant in context to their ethnicity and background. Attention was given to gain the trust of the participant. As Glesne and Peshkin (1992) point out:

> *Trust is the foundation for acquiring the fullest, most accurate disclosure a respondent is able to make. . . In an effective interview, both researcher and respondent feel good, rewarded and satisfied by the process and the outcomes. The warm and caring researcher is on the way to achieving such effectiveness.* (ibid:79, 87)

The interview schedule also remained open to improvisation (Wengraf, 2001) to allow for probing, context, and time relevant topics that were either not relevant at the time of creating the interview schedule or had emerged spontaneously during the interviews (Cassell & Symon, 2004). For example, the impact of the new junior doctors' contract and associated strikes along with the UK leaving the EU as a result of the referendum (Brexit) became a common probe after becoming prominent in the news headlines. In summary, questions 1 and 2 were used for rapport building and understanding the participants' professional and educational background and experience along with their career aspirations. Questions 3 to 6 investigate the participants' experiences in reference to the components of working definition of ethnicity. All these questions give a contextual understanding to the responses of the following questions (7 to 11), which are mapped to the various components of the working definition of EE. Before commencing data collection, ethical considerations and approval were attained as discussed in the following section.

5.5.1.2. Ethics

Initially, interviews were going to be conducted in the respective NHS Trusts that the participants worked in. Keeping this in mind, as per the guidelines of the research ethics policy of the University of Hertfordshire (UH), ethics approval from the ethics committee was taken. Before data collection commenced, ethics approval was also required from the Trusts not only using their internal process but also the Integrated Research Application System (IRAS).

From the very initial stages, there were obstacles encountered which included obtaining formal approval from the Trusts' Research Ethics Committee (REC), care organisation and sponsor (University) (Kerrison et al., 2003). Each Trust required a duplication of effort, where a 'research passport form' had to be filled, which acted as

a letter of access. Moreover, *'although the NHS research ethics process is based on the Helsinki declaration and is clearly geared towards clinical research, this is the same process that needs to be used by social researchers'* (Richardson & McMullan, 2007: 20). This means that a significant amount of irrelevant documentation had to be completed for this research to take place in NHS Trusts. Importantly, because health/medical and social research ethics are divergent, and NHS ethics committees use the health and medical ethics model for decision making, qualitative research approaches are disadvantaged (Ramcharan & Cutcliffe, 2001).

I had a similar experience to Richardson and McMullan (2007), who insist that the NHS Research Ethics process is time-consuming, clinically oriented and inconsistent across different committees, and also that there is a lack of understanding between committee members. A systematic comparison of 18 purposively selected applications was carried out by Angell et al. (2006), which were reviewed by three different RECs in a single strategic health authority, wherein inconsistency was found in seven applications. Additionally, I found that the application and its related process is very complex, jargon-rich, bureaucratic and resultantly the access to conducting research in NHS Trusts is very limited. Authors (cf. Angell et al., 2006; Edwards et al., 2007) call for further research on the reasons and importance for these disparities among the RECs and Edwards et al. (2007) urge that there is a requirement for an investigation into the way in which RECs make judgements.

The NHS ethics and access approval process was more complicated, lengthy and time-consuming than initially expected. This led to a significant delay in commencing data collection. Resultantly, the strategy had to be changed to collecting data at the discretion of the participants outside their work hours. A revised application for ethics approval was submitted to the UH ethics committee, highlighting the change in strategy. Based on this ethics approval, data collection commenced.

The Consent Form (Appendix 8), as approved by the UH ethics committee, was provided to all the participants for them to read and sign before the interview commenced. The form clarifies that interviews would be audio recorded, and that participants had the right to withdraw from the study at any time without having to give a reason (Kleinman, 2007). It also highlighted that by signing this form, they are consenting to their anonymised data being stored for five years, following the

completion of this study, and that it may also be used in future for ethically approved studies. Additionally, the participants confirmed receiving the Participant Information Sheet (Appendix 4), as well as information about how the data collected will be handled, used and kept secured. The participant information sheet documented the aims, method and design of the study, while also providing contact details for myself.

I ensured that confidentiality was maintained throughout the study, and where participants were interested in knowing what their colleagues had shared with me, I refused to discuss it with them (Edwards & Mauthenar, 2002). Interviews have been audio recorded on my personal phone, and saved on a 'cloud drive', both of which are password protected (Kvale, 2007). Anonymity was ensured by removing participants' names and only keeping a participant number to identify them. The consent forms were also securely stored in the password-protected cloud drive, and the hard copies have been shredded. The field notes and research diary were stored in a secured cabinet at home (Miller et al., 2012).

5.5.1.3.   Interviewing

58 recorded interviews were conducted with doctors from a range of ethnicities, Trusts, hospitals and specialities. Out of those 58 interview recordings, two interview files became corrupted, and only 56 interviews could be transcribed. The details of the profile of participants are the concern of section 6.2 in chapter 6. The first interview was conducted in July 2014 as part of the pilot phase, and the last interview took place in April 2017. The goal of sample variation, and in particular gaining access to senior grade doctors, significantly accounts for the resultant prolonged data collection phase. Although snowball technique ensures that the participants are known to me through referrals, on many occasions, doctors would either require several follow-ups before an interview could be scheduled or would keep postponing without actually agreeing on a mutually convenient date. There were instances, in particular with middle and senior grade doctors, where appointments would be cancelled last minute despite reminders and would need rescheduling. The reasons for cancellations included forgetting about the appointment or being too tired.

As the intention was to collect data from Trusts across England, in some instances due to my limitations of not being able to drive, and other scheduling difficulties due to either distance or availability, interviews were conducted on skype. Whenever

possible, I would arrange to meet the participant at a mutually convenient time and place, which ranged from hospital canteens, consulting rooms, doctors' mess, their accommodation, at the home of a family friend or my in-laws' house. In all settings, I would ensure that we would find a place to conduct the interview with minimal disruption, all the while being able to maintain confidentiality. Mostly, one interviewee would be available on any given day and only on a few occasions did I manage to arrange either two or three interviews on the same day. Majority of interviews lasted approximately one hour, with a few shorter interviews with participants who refrained from expanding, and some longer interviews with participants who either had a lot to express or took their time in articulating their sentences due to a lack of English proficiency.

In addition to being able to share experiences in their own words, interviews allowed participants to expand on areas they felt passionate about. This was particularly useful while investigating the factors affecting self-perceived ethnicity, as it indirectly revealed cultural elements that were close to the participants' hearts. During the interviews, I remained sensitive to the fact that interviewing across cultures requires time (Kvale, 2007) to allow the participant to explain themselves fully. Also, the guidelines for high-quality semi-structured interviews proposed by Kvale (2007) were followed. The second interview schedule, as discussed above, used open-ended, short questions which elicited spontaneous, rich, specific and relevant answers. In general, the responses were significantly longer than the questions, and I verified or clarified with the participants the meanings or relevant aspects of their responses. In particular, when a participant struggled to articulate a response, either due to language barrier or use of tacit expressions, I would summarise and look to get their confirmation. This also aided spontaneous interpretations that were interviewee verified, allowing for relevant further probing.

Following the work of Vazquez- Montilla et al., (2000), I remained sensitive and cognizant of the potential multicultural ethnic perspectives to ensure authenticity, affinity and accuracy through culturally responsive interviewing. References to foods, cultures, and characteristics of my ethnicity were shared to support authenticity and affinity. To enhance accuracy, idiomatic expressions or culturally sensitive words were probed to ensure the meaning was correctly understood. To allow the conversation to

seem natural, the order and phrasing of the questions remained flexible; I also let the interview appear as if it was going off track along with sharing similar or different experiences (Arksey & Knight, 1999). Although interviews remained the predominant source of data, observations documented in the research diary and the use and value of field notes is discussed in the section below.

5.5.2. Research diary and field notes

In line with the research philosophy where reality is constructed, not only is the researcher an integral part of the research setting, but their ideas, feelings and perceptions also become part of the data (Gray, 2014). To protect against what Silverman (2000: 193) calls a *'seamless web of ideas'* that don't correctly reflect the complex experiences of the researcher, maintaining a research diary aids in developing a reflexive stance (Miles et al., 2013). This reflexive writing is accepted as a research tool to acquire data that is not necessarily captured by the audio recordings (Özbilgin & Woodward, 2003). The research diary includes my positive and negative experiences of approaching doctors and making contact, as well as reflections, observations, overall experience and relevant disposition regarding the participants and thoughts before, during and after the interviews (Gray, 2014; Haynes, 2012). In particular, non-verbal aspects of the participants were noted, which helped in contextualising the background of the interview (Nadin & Cassell, 2006). Importantly, the discussions that took place before or after the interview, off the record, were also succinctly noted. These reflections and field notes aided the analysis of the interviews by enabling me to create inferences to the development of ideas (Mauthner & Doucet, 2003). Along with the field notes, documentation and archival records have also been used for data triangulation as discussed below.

5.5.3. Documentation and Archival records

A documentary review of a heterogeneous set of literature, documentation and archival records are used to triangulate the data by using them to augment and corroborate it with evidence from other sources (Yin,2014). This documentary review was integral to allowing me to gain a better understanding of the policies and practises of the NHS Trusts and contextual factors that would be affecting EE. Inferences are used as indicators for further investigations in contrast to definitive findings (Yin, 2014). While reviewing any documentation, the fact that they were written for a specific

purpose and audience, and not this study or even a business researcher, was kept in mind (Bryman & Bell, 2011).

Examples of secondary data reviewed include NHS employers' and Trusts' annual reports, reports of Care Quality Commission (CQC), as well as information from sources such as Office for National Statistics, British Medical Journals (BMJ), General Medical Council (GMC), National Institute of Clinical Excellence (NICE), conference proceedings, newspapers, government publications etc. This data was identified and analysed as and when convenient and relevant (Creswell, 2009). How the data was deliberated on is discussed in the thematic data analysis section below.

5.6. Thematic Data Analysis

During the data collection phase, data analysis was ongoing to allow for reflection and adjustments to subsequent data collections (Kvale, 2007). This analysis aided the pursuit of emerging avenues of inquiry in greater depth and identification of deviant cases (Pope et al., 2000). For example, the majority of initial interviews were with doctors of Indian ethnicity. Then, I identified that most of the participants were working in the ED, and that too in the same Trust. This led me to deliberately seek referrals that were from a variety of ethnic backgrounds, Trusts and specialities. This sample variety allowed me to uncover a range of insights and experiences in reference to the impact of ethnicity on the workers' responses to the EE practices. The steps used to analyse the data, as discussed below, are transcription of interviews, familiarisation with the data, generating initial codes, organising codes into emerging themes, refining and rearranging themes based on the linkages and associations, and at the end, writing up analysis (Braun & Clarke, 2006).

The interviews were audio recorded to ensure accuracy of the data that was subsequently transcribed (Silverman, 2011). I used the 'Easy Record Transcription' Android application to help me with playback of the audio recordings and Microsoft Word to type up the script. These transcriptions are verbatim to the audio recording, with not only the words spoken being transcribed but, as far as possible, a record of the tones and other non-verbal communication, such as coughing or laughter or other such expressions, was made as well (Saunders et al., 2009). The transcripts identified what was spoken by me and the participant, where I commented or coughed or laughed during the response of the participant, and this was documented in brackets

in the paragraph of the participants' response. Vice versa, where there was a short input or reaction from the participant, this was documented in brackets in the same paragraph of my verbatim. Where I could not understand the recording, three question marks were used. Lengthy pauses were documented by using a series of dots. This process significantly re-familiarised me with the data (Riessman, 1993), which also led me to start interpreting the meanings of the responses in contrast to mechanically typing the verbatim (Lapadat & Lindsay, 1999). The transcriptions, along with the field notes, research diary and documentary material, are the available textual data for this research (Pope et al., 2000; Pope & Mays, 2006). Hence, although the participants' narratives were the primary source for analysis, information from the research diary and the field notes was also considered.

A combination of literal, interpretive and reflexive data analysis approaches is used (Mason, 1996). The use of particular language or grammatical structure was considered (literal), along with interpreting what the participant is trying to communicate (interpretive), augmented by my own contribution to the data analysis process (reflexive). Care was taken to ensure that contribution of each approach was clear. In the write-up of the analysis, quotes in italics are used to present literal meaning, and interpreted expressions are followed with reference in square brackets. The reflexive constructed meaning has been made evident through unambiguous writing style.

The very initial list of ideas of what the data contains along with what is interesting was documented (Braun & Clarke, 2006). It was then decided that computer-assisted qualitative data analysis software (CAQDAS) (Gray, 2014) would be used for managing and organising the data (Smith & Hesse-Biber, 1996) and not for analysing (Yin, 2009). The transcripts, in Microsoft Word, were imported into NVivo (CAQDAS) and 'cases' were made for each participant. NVivo was particularly useful in facilitating attribution of what was said by whom about all relevant aspects of the research question (Morison & Moir, 1998; Richards & Richards, 1994 in Bryman & Burgess, 1994). The case classification sheet documented the participant number, NHS ethnicity code, self-perceived ethnicity, gender, position and country of birth. The information from this sheet is presented in table 2 in chapter six. Initial codes that identify a short segment of the data were then created in NVivo (Kelle, 2004; Seale,

2000 in Silverman, 2000), termed 'nodes'. These codes aided in organising the data into usable groups (Tuckett, 2005; Silverman, 2011).

The initial codes/nodes were identified based on components of the working definitions of ethnicity and EE. Other contextual and sub-nodes were created based on the information emerging from data relevant to the research questions. Where applicable, data was coded to more than one node and also removed or moved to or from a node if, during the process, it became apparent that it would be appropriate (Braun & Clarke, 2006). During this process, the 'memos' feature of NVivo was useful in linking parts of participants' responses to particular emerging themes (Welsh, 2002). Using memos, singular or a combination of nodes from the node tree, themes were identified. The full list of nodes (coding using NVivo), memos and a sample transcript with coding strips created in NVivo are presented in appendix 9, 10 and 11 respectively.

The last stages of the process included writing up the analysis, in chapters six, seven and eight, where themes were further refined and rearranged based on the research focus. This process allowed me to form main overarching themes and sub-themes within them, as well as to cohere them together meaningfully (Braun & Clarke, 2006). These final collated themes use empirical evidence from the semi-structured in-depth interviews, research diary and field notes. In selecting quotes as evidence to support the analysis, care was taken to use sources that presented the argument in a coherent and precise manner. As participants were recruited from a variety of ethnicities, some participants could not necessarily present their thoughts precisely and in some situations, using quotes from these sources would mean quoting very large chunks of verbatim. This is not to say that the themes are purely based on the evidence from the sources quoted. In fact, themes emerged as a result of various sources stating similar view points. Where analysis is based on a small number of sources, this has been made explicitly clear in the write up. These findings were then analysed in conjunction with relevant literature and other data sources such as documentary review and archival records in chapter nine. Having presented all the above methodological decisions, the section below is concerned with the reliability and validity of this research.

5.7. Trustworthiness, Rigour and Quality

Methodological discussions of the quality of research, if they have any use at all, benefit the quality of research by encouraging a degree of awareness about the methodological implications of particular decisions made during the course of a project. (Seale, 1999: 475)

Some authors (Bryman, 1988; Golafshani, 2003) argue that the concept of reliability and validity stem from quantitative (Campbell & Stanley, 1963) and positivist traditions, and qualitative researchers should resist labelling quality matters in this manner. In qualitative research, reliability and validity have been seen as trustworthiness, rigour and quality where the researcher's truthfulness about the social phenomena and biases are clearly set out (Denzin, 1978). As discussed above, in section 5.6, the data analysis was conducted in a transparent manner using NVivo (Morison & Moir, 1998), adding rigour to the research (Richards & Richards, 1991 in Fielding & Lee, 1991). Reflexivity highlights that the researcher is not a neutral observer or a disinterested bystander, and that my beliefs are implicated in the construction of knowledge (Gray, 2014). In this context, epistemological and personal reflexivity are documented in sections 5.2.1 and 5.2.2 respectively.

Keeping in mind the constructionist viewpoint which accepts knowledge to be socially and contextually constructed, the reliability and validity of the data are augmented with data triangulation (Golafshani, 2003; Johnson, 1997). Data triangulation, using documents, archival records, interviews and research diary as convergent evidence, strengthens construct validity (Baxter & Jack, 2008; Yin, 2014; De Massis & Kotlar, 2014). Through documents and archival records, the wider social and political environment is taken into account usefully, allowing a critical and reflective perspective (Doolin, 1998). Not only are doctors selected as appropriate participants, but also, EE for doctors working in English NHS hospital Trusts, and ethnicity have been operationally defined to further strengthen construct validity (Gray, 2014). The threat to internal validity, due to the inferences made from the data, are addressed by formulating working definitions as discussed in chapters two and three, by supporting empirically observed themes and by verifying findings with relevant literature wherever applicable (Gibbert et al., 2008). The depth and detail of the analysis provided to the reader should be sufficient to make the conclusions credible (Merriam, 1998), resulting in the increased credibility of the research (Yazan, 2015). For data validation, Stake

(1995: 108) notes that *'most qualitative researchers not only believe that there are multiple perspectives or views of the case that need to be represented, but that there is no way to establish, beyond contention, the best view'.*

In this research, data triangulation is the procedure by which convergence among multiple and varied sources of information lead to theme validation (Creswell & Miller, 2000). The convergence is not necessarily towards a single viewpoint, but multiple constructed realities about the same theme (Seale, 1999). Additionally, the data is triangulated using time triangulation, where data collection was spread over a period of time, and space triangulation, where the data was collected from multiple sites (Denzin, 1989). The reliability of the interview data is increased due to the use of an interview schedule (Gray, 2014).

Considering the extent to which the constructions of this research are grounded in the constructions of the participants (Flick, 2009), I have adopted a self-critical reflexive stance (Hall & Callery, 2001), through which my influence on the research has repeatedly been checked (Whittemore et al., 2001). For example, during the interviews, I checked with the participants if I had understood what they were trying to say correctly, and in the analysis section, my interpretations are clearly laid out. Using the checklist presented by McMillan and Schumacher (1997), I employed the following techniques to demonstrate validity in qualitative design; the data collection phase was prolonged to allow for interim data analysis, the interviews were voice recorded and the research diary and transcriptions documented precise accounts of participants' inputs and situations. Negative cases or discrepant data are analysed and reported in the analysis chapters. Descriptive validity is maintained through not only stringent recording and transcribing practices but also by clearly denoting quotes from the participants, and interpretations from me as a researcher (Maxwell, 1992).

In context to generalisability of the data, Lincoln & Guba, (1994) argue that there can be no true generalisation. Replication from multiple respondents justifies the stability of the findings (Miles et al., 2013). The findings should be considered suggestive in contrast to being conclusive (Dey, 1993), and further research could show that the results from the context of doctors working in the NHS could be transferred to another context (Gray, 2014). In the case of this research, the direct generalisability is limited

to the current period and the doctors working in English NHS hospital Trusts (Payne & Williams, 2005).

During the data analysis and write-up phase, care was taken to use techniques that demonstrate validity (Gray, 2014). In line with techniques suggested by Whittemore et al. (2001), a literature review was conducted to compare findings with previous studies; evidence is used to support the interpretations along with acknowledging my own perspectives. Additionally, *'providing context encourages more confidence that the interpretations that have been made are valid'* (Gray, 2014:624). Internal reliability was also enhanced through discussions with my supervisors about the coding schemes and interpretations from the data to ensure agreement and consistency (Gray, 2014). Thick descriptions are used for presenting the data to provide a detailed account of the context and procedures from the beginning to the end (Brink, 1993), which in turn also increases the auditability of this reasearch where any reader can understand the considerations for and progression of events within this research (Lincoln & Guba, 1985).

In particular, as detailed in section 1.2 (background of the study), initially there was only a general notion of the research themes. These themes were then researched using the literature search process as detailed in Gray (2014). The intention was to synthesise and analyse, in more detail, the main themes resulting in an in-depth understanding of the history, debates and key sources and authors. Care was taken to focus on high quality research and not be reliant on second hand interpretation by others. The literature search process aided in defining and narrowing the research focus, for example, it quickly became evident that culture would be too broad a topic to research and ethnicity was more appropriate. This process augmented further investigations as the research focus aided in narrowing search terms.

Within the range of available source materials, priority was given to peer-reviewed journals and books. The quality of the journals were assessed using the impact factor and scoring from the Academic Journal Guide by Chartered Association of Business Schools (CABS). Reference sections from these sources were then used to widen the review. Additionally, the investigations required recourse to government publications and reports, articles from professional journals and theses. A variety of public (eg. PsychINFO) and private (eg. PubMed) bibliographic databases were used to source

articles, alongside using Google Scholar. Although the NHS is a well-written about organisation, there were instances where I had to proactively communicate with individuals within the NHS to extract specific information. At all times criteria that ensured the relevance of the information were used. In the final stages of the literature review process, themes were synthesised and search results integrated to identify areas where there were research gaps and unaddressed recommendations for further research were highlighted.

5.8. Conclusion

This chapter has explained the interpretivist philosophy adopted in this research, along with the subjectivist and social constructionist epistemological and ontological assumptions, and the use of the generic inductive approach. It also acknowledges the influence of my values on all stages of the research process, including my insider-outsider status, along with the congruence between the research focus and my position as a researcher. The research strategy employs purposive sampling using convenience and snowball techniques to recruit participants from English NHS hospital Trusts who are interviewed using semi-structured in-depth interviews. Thematic analysis of the empirical evidence from interviews, insights from the research diary and field notes, along with documentation and archival records are used to address the research objectives. Trustworthiness, rigour and quality considerations incorporated epistemological and personal reflexivity. The following three chapters present the findings and chapter nine then discusses these themes using the literature to address the research objectives and provides conclusions for this research.

6. Self-perceived ethnicity

6.1. Introduction

This chapter presents the findings relevant to ethnicity from the semi-structured interviews. The analysis in this chapter aims to contribute to address the first research objective by exploring the factors considered in the identification of self-perceived ethnicity, as well as presenting evidence that has the potential to contribute to fill knowledge gaps in the context of ethnicity, as presented in chapter two. The chapter begins by documenting the profile of participants, section 6.2, that supports the maximum sample variation strategy discussed in the previous chapter. Section 6.3 uses the detailed demographics of the participants that documents ethnicity as identified both with and without using the NHS ethnicity code list to argue the utility of self-perceived ethnicity, without confining the respondents to any predefined ethnicity lists.

Section 6.4 presents findings pertinent to the components of the working definition of ethnicity, that are documented in chapter two. Each subsection of this section is concerned with the evidence relevant to individual components, with subsection 6.4.1 discussing how and what ancestry is considered by participants in the identification of self-perceived ethnicity. Similarly, subsection 6.4.2 investigates the importance of country of birth, whereas subsection 6.4.3 examines how culture and language impact self-perceived ethnicity. Subsection 6.4.4 examines how exposure in general, and exposure received due to the country in which the participants were brought up in, impacts ethnicity. The final subsection, 6.4.5, discusses factors that emerged as being considered in self-attribution of ethnicity, but were not found to be significant.

Section 6.5 discusses the subjective, context-specific and fluid nature of ethnicity along with experiences of participants of living with an ethnic identity and how the dual nature impacts self-perceived ethnicity. The findings presented in this section contribute to understanding the dynamics surrounding ethnicity which, in turn, forms the foundation for investigating the impact of ethnicity on EE, which is the concern of chapter eight. The final section 6.6 presents a modified definition of ethnicity based on the findings that incorporate the subjective and context-specific nature of ethnicity along with the factors that social actors selectively consider in the identification of their self-perceived ethnicity.

6.2. Profile of participants

Chapter five detailed the goal of sample variation with an aim to try and recruit a range of ethnicities and grades for this research. This section presents the actual demographics of the doctors who participated in the interviews, supporting the argument that the goal of sample variation has been met.

The 31 female and 25 male participants worked in a variety of Trusts (20), hospitals (24) and specialities (18) at different grades (levels/positions). Figure 2 shows the mix of grades of the participants. This sample includes the full spectrum of junior, middle and senior grade doctors, which in turn ensures the interpretations are not biased to any single grade of doctors. Further details about the grades and the variations in roles and responsibilities are discussed in chapter seven. The detailed demographics for each participant is presented in Table 2.

Grades

- Junior: 34%
- Middle: 52%
- Senior: 14%
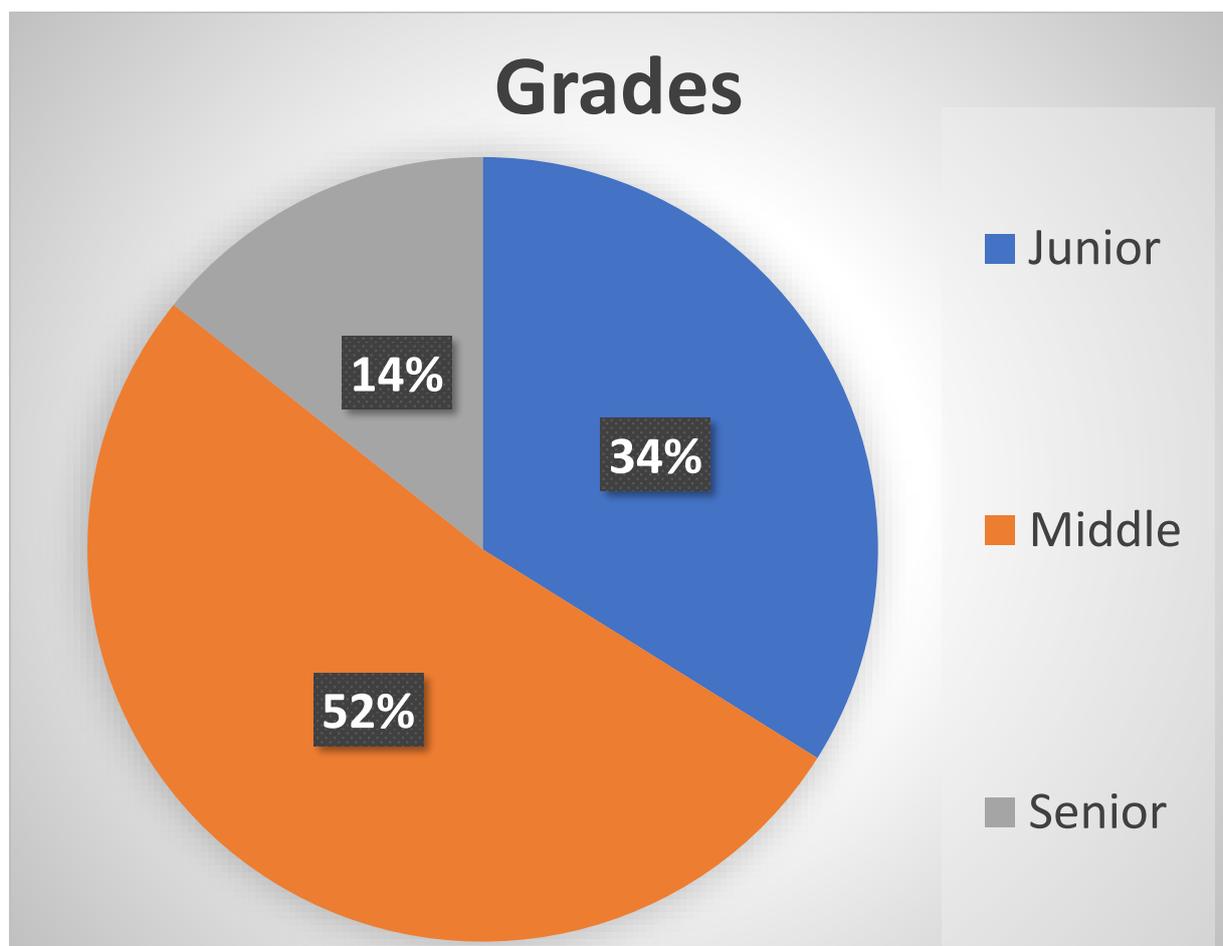
Figure 2: Grades (levels) of participants

Table 2: Detailed demographics for each participant (sorted using column 2)

No.	NHS ethnicity code	Self-perceived Ethnicity	Gender	Position	Country of Birth
30	Any other ethnic group - S	Libyan British	Female	Junior	UK
41	Asian or Asian British - Any other Asian background - L	British Iraqi	Female	Middle	Iraq
47	Asian or Asian British - Any other Asian background - L	British Sri Lankan	Female	Middle	UK
38	Asian or Asian British - Any other Asian background - L	Burmese	Female	Middle	Burma
50	Asian or Asian British - Any other Asian background - L	Indian	Female	Middle	UK
11	Asian or Asian British - Any other Asian background - L	Korean	Female	Middle	Korea
37	Asian or Asian British - Any other Asian background - L	Malay	Female	Middle	Malaysia
51	Asian or Asian British - Any other Asian background - L	Tamil Sri Lankan	Female	Middle	Sri Lanka
44	Asian or Asian British - Any other Asian background - L	White Asian	Female	Middle	Iran
2	Asian or Asian British - Indian - H	Asian Indian	Female	Senior	India
18	Asian or Asian British - Indian - H	Asian Indian	Female	Junior	UK
24	Asian or Asian British - Indian - H	British Asian	Female	Junior	Kenya
3	Asian or Asian British - Indian - H	British Asian Indian	Male	Senior	Kenya
15	Asian or Asian British - Indian - H	British Indian	Female	Junior	India
10	Asian or Asian British - Indian - H	British Indian	Male	Middle	UK
19	Asian or Asian British - Indian - H	British Indian	Male	Junior	UK
22	Asian or Asian British - Indian - H	British Indian	Male	Junior	UK
1	Asian or Asian British - Indian - H	Indian	Male	Senior	India
12	Asian or Asian British - Indian - H	Indian	Female	Middle	India
25	Asian or Asian British - Indian - H	Indian	Female	Junior	India
27	Asian or Asian British - Indian - H	Indian	Male	Junior	India
28	Asian or Asian British - Indian - H	Indian	Female	Junior	India
54	Asian or Asian British - Indian - H	Indian	Female	Middle	India

16	Asian or Asian British - Indian - H	Indian	Male	Junior	Uganda
4	Asian or Asian British - Indian - H	Indian	Female	Senior	UK
31	Asian or Asian British - Indian - H	Indian British	Female	Junior	India
40	Asian or Asian British - Indian - H	Indian British	Female	Middle	India
58	Asian or Asian British - Indian - H	Indian British	Female	Middle	UK
13	Asian or Asian British - Pakistani- J	Asian	Male	Middle	Pakistan
7	Asian or Asian British - Pakistani- J	Muslim Asian	Male	Senior	Pakistan
6	Asian or Asian British - Pakistani- J	Muslim Pakistani	Male	Senior	Pakistan
29	Asian or Asian British - Pakistani- J	Pakistani	Male	Junior	UK
23	Asian or Asian British - Pakistani- J	Pakistani British	Female	Junior	Pakistan
33	Asian or Asian British - Pakistani- J	Pakistani British	Male	Junior	Pakistan
14	Black or Black British - African - N	Black African	Female	Junior	Africa
35	Black or Black British - African - N	Black African	Female	Middle	Africa
57	Black or Black British - African - N	Black African	Female	Middle	Africa
45	Black or Black British - African - N	Bura Nigerian	Male	Middle	Nigeria
26	Black or Black British - African - N	Nigerian	Male	Junior	Nigeria
56	Black or Black British - African - N	Ugandan African	Female	Middle	Uganda
5	Mixed- Any other mixed background-G	White mixed	Male	Senior	South America
32	Other Ethnic Groups - Chinese - R	British Hongkong Chinese	Male	Junior	UK
9	Other Ethnic Groups - Chinese - R	Chinese	Male	Senior	Hong Kong
20	Other Ethnic Groups - Chinese - R	Chinese	Female	Junior	UK
43	White - Any other white background - C	Caucasian	Male	Middle	Hungary
34	White - Any other white background - C	French British	Female	Middle	UK
17	White - Any other white background - C	Greek	Male	Junior	Greece

39	White - Any other white background - C	Greek Palestinian	Male	Middle	Germany
36	White - Any other white background - C	Hungarian, Caucasian	Female	Middle	Hungary
55	White - Any other white background - C	Israeli Argentinian	Male	Middle	Argentina
49	White - Any other white background - C	Italian	Male	Middle	Italy
52	White - Any other white background - C	White mix background	Male	Middle	South America
42	White - British - A	British	Male	Middle	UK
53	White - British - A	White	Male	Middle	UK
46	White - British - A	White British	Female	Middle	UK
48	White - British - A	White British	Female	Middle	UK

As seen in table 2, out of the 56 participants, using the NHS ethnicity code list, the majority identified themselves as Indian – H (19), followed by Any other White background – C (8), Any other Asian background – L (8), African – N (6), Pakistani – J (6), British – A (4), Chinese – R (3), Any other mixed background – G (1) and Any other ethnic group – S (1). This breakdown is presented graphically in Figure 3 which shows the mix and percentages. The mix of ethnicities of the participants in this research supports the maximum sample variation strategy as discussed in the methodology chapter. The intention was not to recruit proportionate representation from each ethnicity, but to ensure that a mix of ethnicities participated to represent the wider population of doctors working in English NHS hospital Trusts. Chapter four documents the statistical breakdown by ethnicity of the doctors working in NHS Trusts in England. Furthermore, for example, one participant mentioned, *'...it's nice that the staff come from all over the world...'* [Black African, Middle, P14].
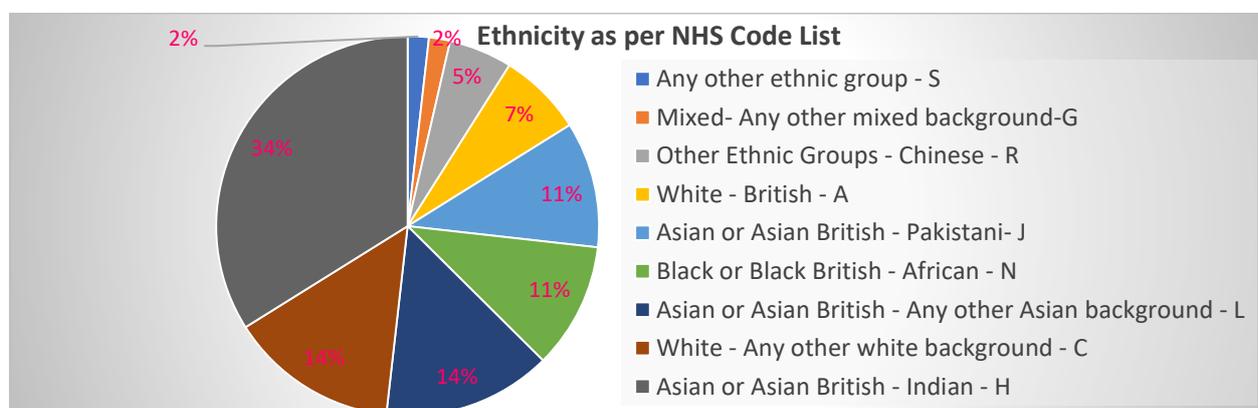
Figure 3: Ethnicity of participants as per NHS ethnicity code list

6.3. Self-perceived ethnicity without the code list

Data on self-perceived ethnicity that the participant would identify with was collected through the semi-structured interviews without the NHS ethnicity code list to investigate its utility and support the potential contribution as discussed in chapter two. Table 2 presents the corresponding ethnicities that the participants identified themselves as belonging to, with (column two) and without (column three) the NHS ethnicity code list. Building on the literature discussed in chapter two, Table 2 presents the empirical evidence that shows how self-perceived ethnicity, that is not confined to a predefined ethnicity list, allows for nuances to emerge. The responses listed in the self-perceived ethnicity column reveal how a variety of identities can be camouflaged when using predefined lists. In particular, categories 'L' and 'C' which are known as Asian or Asian British – Any other Asian background and White – Any other White background respectively in the NHS ethnicity code list have been selected by participants who actually have significantly varied backgrounds, which become evident from the self-perceived ethnicity column. For example, some participants who selected category L from the NHS ethnicity code list identified themselves as British Iraqi, British Sri Lankan, Burmese, Korean and some of them who selected category C identified themselves as Italian, Greek, White mix background, Israeli Argentinian.

Similarly, where the identification using the NHS ethnicity code list are categories 'H', 'J', 'N' and 'R', viz, Asian or Asian British - Indian, Asian or Asian British - Pakistani, Black or Black British - African and Other ethnic groups - Chinese, the 'British' element of their ethnicity could not be differentiated. For example, some participants who selected category H from the NHS code list identified themselves as British Asian, British Indian, Indian, Indian British. Whereas, in the column of self-perceived ethnicity, there is greater clarity in the context of who considers the 'British' element integral to their identity and who does not. This is important because, as discussed in later sections in this chapter, the factors that social actors rely on in implication of self-perceived ethnicity have been found to be significantly influenced by exposure. When participants included 'British' in their self-perceived ethnicity, it was either because they have had enough exposure, along with adoption of culture and language, or due to birth, and resultantly considered it significant enough to incorporate it in their identity.

Moreover, certain categories in the NHS ethnicity code list are extremely broad and have, arguably, very little meaning to any reader. For example, categories 'G' and 'S' are called Mixed - Any other mixed backgrounds and Any other ethnic group respectively. Where these categories were selected, using the NHS ethnicity code list, the participants gave responses like White mixed and Libyan British. Hence, not only could the latter responses mean more to any reader, but they could also reveal more information about the respondent. Hypothetically, respondents who select option G could potentially identify as White Chinese or African Indian. Although both of these respondents could be confined to the same category using the NHS ethnicity code list, it can be surmised that their backgrounds would be far from the same. Similarly, respondents who select S might come from a range of backgrounds, but would nevertheless be clubbed together had they to identify their ethnicity using only the NHS ethnicity code list. For example, participants stated,

> *…if you look at the ethnicity list that you have sent me, you know ethnicity and also when you apply for jobs, I mean they have the same list that you have – Irish, British, white, any other background? … its an interesting list, I have never understood if its like pure racism (laughs) or there is something else going on, because you know white is white, but not really, because it could be British, it could be Irish, it could be white from a different place, like I am white, but I am not British, I am not Irish, so it's a bit weird …umm so I don't know, I mean the list that you have there, sorry not your list, I don't think it reflects …* [Israeli Argentinian, Middle, P55]

> *… an Asian person can be from Iran, or it can be from Afghanistan, we are both Asians, but have two different cultures (hmm) if ethnicity if both are Asian because, because our country in Iran, but we have two complete different cultures* [White Asian, Middle, P44]

Such responses support the argument that self-perceived ethnicity without a predefined ethnicity list more appropriate for this research. It also appears that this approach is also preferred by social actors. For example, one participant was emphatic,

> *…this is the problem, this is the problem you are trying to create these boxes, to fit people in. The truth is, these boxes don't, well they shouldn't exist. And I don't think, I do not fit in your box and I think that is the deeper question. That is the answer. There is no box. (no I mean) I am this fluid…* [Ugandan African, Middle, P56]

Some other participants felt 'forced' to select an option through deduction of not fitting in any other category. For example, one participant concluded '*ohh…*[after a very long pause]*…I think G….I think so…because I'm not British, I am not completely white…*' [White Mixed, Middle, P5]. Hence, self-perceived identification of ethnicity that is not confined to a predefined ethnicity list is considered more useful in this analysis, as it gives the participant more flexibility to incorporate nuances that they perceive to be important while identifying their ethnicity. Self-perceived ethnicity without a predefined list also provides a unique context that is specific to the participant. This is in line with the literature discussed in chapter two that reveals ethnicity is subjective and context-specific. So, in essence, self-perceived identification of ethnicity that is not confined to a predefined ethnicity list will be adopted in this research and the consequent findings will aim to contribute to the literature using empirical evidence. The following sections of this chapter discuss various other factors affecting self-perceived ethnicity, which reveal why participants like 6, 7 and 32 have identified their ethnicity as they have, when they are not confiend to a predefined ethnicity code list.

In this dissertation, quotes or references from responses by participants are followed by an indication of the corresponding participants' self-perceived ethnicity, grade and participant number. For example, [White British, Junior, P46] corresponds to a participant who identifies himself/herself as White British, which is their self-perceived ethnicity without using the NHS ethnicity code list, working as an FY2 at the time of the interview, and has been given the pseudonym P46. This in-text indication allows the response to be contextualised, contributing to more in-depth insight into the interpretations. Self-perceived ethnicity and grade have been included rather than other demographic information that is collected, as there is most variation that is relevant to the research focus among these two categories. The variation in roles and responsibilities based on the responses in this context are discussed in chapter seven. The following section presents the empirical evidence pertinent to the factors considered important in the identification of self-perceived ethnicity.

6.4. Factors affecting self-perceived ethnicity

This section discusses the responses of participants that are relevant to each component of the working definition of self-perceived ethnicity, presented in chapter two, and other related emerging themes. On investigating factors affecting self-perceived ethnicity, it was found that country of birth, ancestry, culture, language and exposure, which includes the country in which a person has been brought up in, were the most prominent factors that the participants considered in identifying their ethnicity. Additionally, the other factors that emerged, though not so frequently, were religion, passport/nationality, upbringing and skin colour, and these are discussed in subsection 6.4.5.

6.4.1. Ancestry

On investigating the factors that participants considered important in the identification of self-perceived ethnicity, it was found that ancestry was invariably used. For example, one participant insisted, '*I think the most important is for ethnicity is the origin of family*' [White Asian, Middle, P44]. Along similar lines, others also stated;

> *…where your forefathers come* [from] *…ummm to be precise, from Amritsar, which is now a part of India (ok) so my forefathers are from Amritsar (ok), and then after partition, they went to Pakistan…* [Muslim Asian, Middle, P7]

> *…what your parents' ethnicities are…* [Malay, Junior, P37]

> *…yes, my parents, my grandparents are African descents, my parents are African…* [Black African, Middle, P14]

> *…I guess people probably do it based on, where their parents are from… where your parents were born, I suppose if my parents were born in another country, I might consider myself partially that ethnicity and partially British…* [White British, Junior, P48]

> *…I am Indian, and that's where my parents are from … you know that's the home of my ancestors…* [Indian British, Senior, P58]

Such responses are examples of how participants from various backgrounds and situations could rely on tracing their ancestry in identifying their own ethnicity. It was

found that participants considered their parents' and/or grandparents' place of birth, their ethnicity, and even 'origins' as ancestry. In particular, one participant clarified, '*I know we are like second generation Indians, not even my parents lived in India, but its where we are originally from*' [Asian Indian, Junior, P18]. Here, the participant has considered the ancestral origins and has decided to discount the fact that her parents have not lived in India. Moreover, despite being born in the UK, she decided to identify herself as Asian Indian. The subjectivity of factors implicated in the identification of self-perceived ethnicity is discussed in section 6.5. Nonetheless, the evidence presented above supports the argument that ancestry is considered an important component while identifying self-perceived ethnicity and its inclusion in the working definition is justified. The role of country of birth is discussed in the section below.

6.4.2. Country of birth

Many participants considered country of birth to be an important factor in identifying self-perceived ethnicity. For example, a participant was emphatic, '*…your birthplace is one of the important factors*' [Black African, Middle, P57]. The analysis revealed that various generations of migrants, and even non-migrants, felt that the country of birth affected their decision in identifying to a particular ethnicity. For example, a non-migrant participant said '*…because I was born … in England*' [White British, Junior, P46]. Another participant, who is a migrant, identified as 'Korean' because she was born in Korea [Korean, Middle, P11]. Additionally, it was found that the country of birth enabled some second and third generation migrants to justify identifying with either a different ethnicity to their parents or grandparents, or a mixture of ethnicities. For example, one participant put it as,

> *if you were to say Asian and Indian alone, then someone may derive that you are, you are actually born and brought up in India, and I have come here (sure) but that can't be correct either because I was born here, I was brought up here and so, therefore, I am British Indian …. land of birth was UK* [British Indian, Junior, P10].

This quote supports three arguments: firstly, 'what others think' can play a role in identification of self-perceived ethnicity and this is discussed further in section 6.5; secondly, country of birth is considered to be important and can help social actors differentiate themselves between first and second generation migrants and thirdly, the

country in which they have been brought up in is also found to impact the identification of self-perceived ethnicity, and is discussed further in subsection 6.4.4. Overall, the evidence presented in this section suggests that the country of birth is a factor that participants consider important in identifying their self-eprceived ethnicity and should potentially be included in the definition of ethnicity. This is addressed in the conclusion section, 6.6.

6.4.3. Culture, Language

In addition to the above components, culture and language also emerged as factors that participants considered important for identification of self-perceived ethnicity. For example, one participant said, '*I adapted some good things from British culture and also, I have that Pakistani culture, so because of I like both the cultures and I am kind of, I think I am a mixture*' [Pakistani British, Middle, P33]. Here, the participant bases his perception of mixed ethnicity on his mixed culture. Similarly, other participants pointed out that they consider their own culture and its components in identifying their ethnicity. Components of culture such as social norms, values and beliefs along with food, dressing and festivals were mentioned by participants in referring to their adopted culture. For example, participants said,

> *…I suppose the food that you eat, clothes that you wear, the celebrations, that you celebrate every year…* [Malay, Junior, P37]

> *…that's where our cultures and traditions and our thoughts and our way of life is just from, so that's probably where we identify our ethnicity from…* [Asian Indian, Junior, P18]

> *…British Iraqi because ummm and I say British first because I think I, I am closer to the British perception culture than I am to the Iraqi perception of culture…* [British Iraqi, Junior, P41]

The importance of culture in identifying ethnicity can be significant, for example, one participant clarified,

> *… my parents took me back to Hong Kong every single year, I was pretty immersed in, at every opportunity in umm in the Chinese culture, I think my parents were just worried that being brought up abroad, in a western country, that I wouldn't, that I might lose that sort of touch with, with umm*

> *our ethnic roots, so they were very very keen for us to keep our connections. So, it was always like playing with you know my cousins who are also living in the nearby village and going to Chinese schools and you know things like that. So, I do sort of related; I do relate more towards my Chinese culture than so the English culture.* [Chinese, Senior, P20]

This participant, despite being born and brought up in the UK, does not identify as British Chinese but just Chinese mainly because she feels that she can relate more to Chinese culture rather than British culture. There is an element of exposure evident here, where the participant has been exposed to the Chinese diaspora and also her home country. The impact of exposure is discussed in the following subsection (6.4.4) in detail.

Similar to culture, language was also found to be integral in identification of self-perceived ethnicity of participants. For example, one participant explained '*I know both the languages*' [Israeli Argentinian, Middle, P55] and he uses this to justify his identity as Israeli Argentinian. Other participants stated;

> *…language is also important…* [Burmese, Middle, P38]

> *…Hungarian because you know of course I talk in English, but I think and read in Hungarian…* [Hungarian Caucasian, Junior, P36]

> *…there are no other languages I speak…* [White British, Junior, P46]

The above quotes reveal how participants consider the languages they know and how they use them, in identifying self-perceived ethnicity. One participant was emphatic,

> *...my language, actually any language defines the way you see the world (hmm) you define your reality ...because you define your reality from that point of view, with that rules that are given by your language (hmm)...if your mother tongue is Hindi you, in your head you will define the world by Hindi terms so if your mother tongue is English you will define the world in English term, it doesn't matter you speak other languages... so the first thing that defines my ethnicity is my Spanish... important thing is*

> *the language, because that's what defines what you are...*[White mix background, Middle, P52]

Here, the role of language is arguably explicit and reveals its utility not only in identifying self-perceived ethnicity but also in terms of being a medium of understanding. This, in turn, could impact the dual nature of ethnicity which could also be pivotal in the adoption of any culture. For example, one participant said,

> *…I think I suppose to some extent language is quite important like if I, if I suppose if I couldn't speak French as like you, then I may not feel as connected to France, may not feel as worthy to call myself French (hmm) ummm as I do umm I think that you have to kind of experience and lived in a culture long enough to be able to say that you understand how the people live there and that you feel integrated enough to, to feel as one with that country and so I suppose for myself, I have lived all my life in England, so that's why I feel culturally attached to England, and to Britain and but then obviously I have always gone to France, during my half terms and I have spent a large part of my life going to France, so I also feel that I have spent enough time there, so I know what the French way of life is and to culturally say that I feel French as well.* [French British, Junior, P34]

So, in essence, the analysis reveals that there is a circular link between language, culture and exposure, with each one impacting the other. The quote above reveals how British and French exposure of the participant has led her to adopt both cultures, and without the tool of language this would not have been complete. Nonetheless, without exposure it is also possible that the adoption of language would not have been as strong, supporting the argument that they are interlinked. Overall, it is evident that culture and its components and language are factors that participants considered important in identifying ethnicity and that there is a role of exposure, which is discussed in detail in the subsection below.

6.4.4. Exposure

As seen in the previous section, the culture and the language/s adopted by participants appear to be influenced by exposure. Exposure was found to relate to either diaspora sharing the same ethnicity and/or to 'home' and/or 'host' country. In particular,

exposure to the country in which the participants were brought up in emerged as a significant factor impacting their self-perceived ethnicity. One participant gave a very impactful example that highlights the importance of the country of residence during childhood and early adolescence;

> *…there is a very famous Indian actor called Tom Alter who is very clearly Caucasian and yet speaks the most perfect Urdu and he is a wonderful actor and so ethnically, I mean racially his race is clearly not Indian and yet he is very Indian because he was as far as I know born and brought up there* [Indian British, Senior, P58]

In the example above, the participant is referring to someone who she categorises as 'Caucasian' because of his ancestry, yet due to his upbringing in India, she insists that '*he is very Indian*'. This example highlights the importance of exposure.

Similarly, another participant revealed how, despite being born to a British mother and being raised with British ways of life, the fact that she grew up in Uganda, Africa, and resultant exposure to Africa during her childhood, meant that she identifies herself as 'Ugandan African'. She explained,

> *… my mother who is the primary caregiver, raised me to speak English and likely with the norms, umm or the respect or the language techniques of a British person, likely, (right). But I was physically present, in an African society which means that when I came out of the home and had to engage with my fellow African people, I had to behave in a certain culturally accepted way, and I learnt these culturally accepted ways. (hmm), when I returned home, at, to a now a primary caregiver with an English culture, again, I had to adapt to that culture. Also, my mother wasn't the the person who really tried to learn the local language and integrate with everybody, ha, so luckily, or unluckily. So, she never gave me that tool either. She never gave me the local language skills; she didn't motivate to learn it either, because she, she didn't think they were of great importance either. So, I am very, I am astutely aware of the Ugandan culture and the African culture and beliefs and norms in general because I have lived there, I have practised medicine there.*
> [Ugandan African, Middle, P56]

This example reveals the impact of external environment and how, during childhood, exposure can change the way in which someone identifies themselves. Another participant pointed out that although she was born in Iraq, she feels more British because she was brought up in the UK. She said, '*I was born in Iraq, but I was brought up here…I feel like I match these British people more than I do with the Iraqi people*' [British Iraqi, Junior, P41]. Similarly, talking about the importance of the country in which he has been brought up in, a participant stated,

> *… you study lot of Italian culture in when you are in Italy, and umm I still feel that I understand more the Italian people than the British people. (hmm) so I think I wouldn't feel comfortable umm by being, by belonging to, by identifying myself as British since I still think that some things of the British culture are far from me or not really…* [Italian, Middle, P49]

This suggests that one of the reasons for why exposure, emerged as significant is because of the fact that during schooling, the culture of the country can become very familiar.

In line with the literature of ethnic identity formation, discussed in chapter two, there is evidence to show that the exposure during childhood can impact ethnicity. For example, participant numbers 1, 2, 16, 20, 28, 45, 51 all have been in the UK for more than 5 years, substantially exposed to British ways of life, but partly due to their non-British exposure during childhood they don't include the 'British' component in their self-perceived ethnicity, supporting the argument that exposure due to the country in which they were brought up in significantly impacts identification of self-perceived ethnicity.

This is not to say that exposure during adulthood has no bearing on ethnicity, it can. For example, one participant stated,

> *…I am half Palestinian, half Greek … I was born in Munich in Germany, and I lived most of my childhood life in Palestine till finishing school and then moved to Greece, where I did my medical degree* [Greek Palestinian, Senior, P39]

Evidently, here the exposure during childhood and adulthood are both integral to this participant and he has ignored his country of birth, which reveals the subjectivity in all

the factors individuals use in identifying their self-perceived ethnicity. Subjectivity is further discussed in section 6.5.

The exposure that is received in adulthood is not just limited to the 'host' country, but exposure to the 'home' country also was found to play a role. For example, a participant who identifies herself as Indian British does so partly because of the culture she has adopted based on her exposure to her 'home' country. She said,

> *...we still have family there* [India]*, we still go back regularly, I have a house in India, so yes. Although I was born in, in west London, I am a west London girl, through and through umm we still have very close ties to India... I dream in both languages* [English and Urdu]*, I talk in both languages, I read both languages, I write both languages, I write Hindi as well... we eat Indian food, we eat, it's a very cosmopolitan kind of lifestyle, you do everything, you have everything, but at the end of the day, I would never dream of wearing a dress without leggings underneath it. I would not show my legs off; I wouldn't wear a chudidaar, pyjama without dupatta[2] kind of thing, that's (hmm) I wear, when I go out if I dress up, I wear a saree* [Indian British, Senior, P58]

The quote above exemplifies how culture and language both play a pivotal role for this participant in identifying as Indian British. In particular, her exposure both in the UK (due to birth and long residence) and India (due to regular visits and family ties), has influenced her self-perceived ethnicity. Similarly, another participant who has had significantly less exposure in the UK insisted that this was the reason that he would not consider identifying the 'British' component in his ethnicity. He said,

> *…I cannot really understand them* [Britishers] *yet. (hmm) So this is why I would still say that I am Italian because this is the I have been Italian for 30 years and umm kind of this new condition has just been there for 3 years, so (hmm) I think my personal history and what I studied and umm the environment I have been living in, umm, as well as not living*

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[2] Chudidaar, pyjama and dupatta are a traditional Indian ladies outfit and not wearing the dupatta (scarf)is considered as inappropriate and sometimes shameful as it's core utility is to cover the chest of women.

> *enough in the UK yet umm makes me more Italian than British.* [Italian, Middle, P49]

Here, there is a possibility that this participant could consider himself 'Italian British' with time, re-emphasising the role of exposure, as well as the subjective and fluid nature of ethnicity, discussed further in section 6.5. Reiterating the importance of exposure, one participant clarified,

> *…because like the way I lived, I shared this 2 countries quite strongly and they influence me, there are many people who maybe half-half, but they lived all their life in one place, and they belonged to that and our kids, my daughter maybe in 20 years, she will say I am English, because all her life if she lived here, she has nothing to do with Palestine or Greek, so it depends on what influence. I have been influenced by those two countries quite a lot, in a significant way that I feel I belong to them in a significant manner, is that why I would say I am Greek Palestinian, rather than one of them.* [Greek Palestinian, Senior, P39]

In the example above, the participant's wife is Arabic whereas he identifies himself as Greek Palestinian, and yet he acknowledges that his daughter might consider herself to be English (downplaying the role of ancestry). The findings here support the argument that exposure can impact identification of self-perceived ethnicity. Also, it was found to influence the subjective and fluid nature of ethnicity which is discussed further in section 6.5.

6.4.5. Other factors

In addition to the factors discussed above, other factors such as religion, passport/nationality, upbringing and skin colour emerged as important to some participants in identifying self-perceived ethnicity. About 15% of the participants considered their religion in the process of identifying their ethnicity. As evident from table 2, in particular, participants of the Muslim faith have considered their religion as an integral part of their identity. Other participants also pointed out that religion was a component that they consider in identifying self-perceived ethnicity. However, they did not include it in labelling their ethnicity. For example, participants said,

> *…one of the important stuff that makes me Hungarian is also that I went to a Catholic church back in Hungary…* [Hungarian Caucasian, Junior, P36]

> *…my country is a religious country that more than 95% of more than 95% of Persian people are Muslims, so there are things that uuuu are different here. Ummm from their actual religious, from the religious background of my culture. Ummm it's not actually Iranian culture, uu but it comes after the, after this religion…* [White Asian, Middle, P44]

> *…I think ya … in terms of you know whether I feel more Tamil or British, I am not sure British is the right word, I definitely feel it a miss… I feel like my religion is most important, I feel Hindu…* [British Sri Lankan, Junior, P47]

Here, the evidence highlights how some participants consider their religion in the identification of self-perceived ethnicity. However, there is also a suggestion of religion being a component of or being linked to culture. Analysis revealed that elements such as food, dressing and festivals are often shaped by religion, but are referred to as cultural elements.

Upbringing was mentioned by around 10% of participants as important in shaping their ethnicity. However, their references to upbringing significantly overlap with their culture adopted based on exposure. For example, participants said,

> *…I was brought up in an Indian background…* [British Asian, Junior, P24]

> *… It's all from the culture that I have brought up…* [White Asian, Middle, P44]

> *…. what your parents or the people who brought you up, taught you and there's this element of inheritance as well, because you can have, there's a lot of people who belong to a country, but their parents have sort of feed them since childhood that actually we belong to somewhere else, so this is the aspect you have Greeks in Australia, they tell their kids no we are Greek and they live all their life in Australia, you may have sort of people from the east living in London, but they feed their kids that we belong to there and this is where we, our roots are, this is where we are,*

> *this is where we will go back, and this is a temporary thing.* [Greek Palestinian, Senior, P39]

Evidently, exposure of a child can be controlled by parents, which is considered a feature of upbringing. This reiterates the importance of exposure in self-perceived ethnicity.

The other two factors that some participants considered important in the identification of self-perceived ethnicity were Nationality (around 12%) and skin colour (around 18%). However, as discussed in chapter two, such factors are often confused with ethnicity, despite them being distinct. In particular, skin colour is a biological component associated with race. Nonetheless, it is not surprising that participants referred to skin colour in the identification of self-perceived ethnicity because even the NHS ethnicity code list (Appendix 2) uses terms like 'white' and 'black'. The dual nature of ethnicity is the concern of the following section, and the conclusion section uses all the arguments discussed above in conjunction with empirical evidence to suggest a definition of ethnicity that contributes to the current body of literature.

6.5. The dual nature of ethnicity

Although the core focus, as per the research objectives presented in chapter one, was to investigate the factors implicated in self-perceived ethnicity, this section builds on literature discussed in chapter two and is concerned with the empirical evidence pertinent to the dual nature of ethnicity. Dual nature of ethnicity was found to be a significant aspect of living with or identifying as a certain ethnicity. The social experience of living with an identity, even if it is internally defined in its entirety, involves the external attribution of characterisation that may vary subject to the constitution of the audience. The consolidation of all such internal and external processes are collectively referred to as the dual nature of ethnicity. This dual nature, in turn, is arguably important to understand because ethnicity is defined as an identity, as discussed in chapter two, and the primary focus of the research is to investigate the impact of ethnicity on EE. Here, the impact is not of the identity but the experiences of the social actors who live with this identity.

Analysis of the responses from participants reveals that ethnicity is not static. The discussions in the sections above present how exposure impacts the adoption of culture, language and, resultantly, ethnicity. This suggests that ethnicity is fluid, and,

with a change of exposure, identification of self-perceived ethnicity can also change. For example, one participant said,

> *…I have to kind of stick by where I was born and where I was brought up…so but that's very different to the culture you identify yourself with because that can obviously change!* [British Indian, Middle, P15]

Here, the participant acknowledges the fluidity of culture and also refers to the more stable components such as country of birth and the country where they are brought up in. Although the latter two components are considered non-fluid, there is evidence to show that individuals subjectively consider these components in the identification of self-perceived ethnicity. So, for example, as seen in table 2, participant 39, was born in Munich but does not consider this to be an important element in his identification of ethnicity. This participant was unequivocal in saying it '*depends on every person what does it mean*' [Greek Palestinian, Senior, P39], supporting the argument that identification of self-perceived ethnicity is subjective, where each individual can place varied levels of importance on elements that pertain to identifying their ethnicity. The subjectivity is not only limited to the factors, but the actual meaning of any given identity can equally vary, subject to the context. For example, one participant pointed out,

> *…so I have been to Iraq a few times, and I don't think I fit in as much even though I still recognise myself as Iraqi, but being Iraqi Iraqi is very different from being a British Iraqi, and I think anyone from any other country would agree, it's different if you are living in your country and following your country's culture, when you live outside the country and follow your country's cultures.* [British Iraqi, Junior, P41]

This subjectivity is sometimes brought to the forefront by using self-perceived ethnicity, which is not confined to a predefined ethnicity list, as discussed above in section 6.3. Additionally, it was also found that the expression of ethnicity is contextual. For example, participants said,

> *…my beliefs, my culture, my role at home when I am most comfortable in my own environment, is most definitely Indian…* [British Indian, Middle, P19]

… Ummmm with sometimes, I am more British than I am anything else (hmm), umm but a British Asian rather than say white British or British Irish [Tamil Sri Lankan, Middle, P51]

I find it very difficult because I think having, if you've been brought up in a country, your whole life, obviously I am very influenced by things, that I have seen or may be on TV, the way I have been educated in England, and so my education just stems from an English background and so probably my medical understanding of things would be based on English perspectives (hmm) and the NHS, how the NHS work is very different from how anything would work in France, it's more of a private system in France umm but I think in terms of ummm the way that I may be behave outside of medicine, and in terms of my diet and the way I like the activities I enjoy doing, that's probably from a more French culture.
[French British, Junior, P34]

The quotes above reveal how social actors who identify with more than one ethnicity can and do, sometimes, express themselves differently in different contexts. In particular, it is evident that social and work contexts can impact the expression of one's ethnicity. At home or in a social setting there is sometimes, as seen above, an 'exposure' to ethnic values and ways of living. In such settings, ethnic minority individuals could feel comfortable expressing their non-British ethnicity. In a work setting, it was found that participants feel more comfortable downplaying some of their non-British expressions and try to adapt to British working styles. Arguably, in such varying contexts, the social actors sometimes base their decisions in expressing their identity subject to how others might respond. For example, a British Indian might prefer to express his/her 'Indianness' in a social or home setting due to the perceived benefit of homogeneity, but in a work setting, perhaps due to the fear of discrimination or wanting to portray an integrated identity, he/she might downplay the 'Indianness' and attempt to express their 'Britishness'. Moreover, a work setting can sometimes restrict the expression of ethnicity, and this is discussed further in chapter eight with a particular focus on EE.

The discussions and conclusions chapter allows juxtaposing the findings from this chapter with the literature discussed in chapter two. It is evident that language is one

of the factors that is subjectively expressed with English being the predominant language of communication in the UK, especially at work. One participant stated,

> *…we became bilingual, umm you know so they always had Chinese TV programs that were recorded back in the days while my grandparents will then send them over to, so we grew up with a lot of ummm you know Cantonese speaking TV and programs you know… in the house, my siblings would all speak Cantonese, ummmm and that's what I have adopted from them* [Chinese, Senior, P20]

As discussed above, language is an important factor in the identification of self-perceived ethnicity, and its expression and/or use also plays a vital role in the internal and external processes of ethnicity. The participant in the quote above identifies as Chinese, and it is evident that she has had the opportunity to use the language in her social or home setting, which further facilitates exposure and adoption of Chinese values and culture. Exposure can also impact the use and adoption of the language of the host country and, as discussed above, this resultantly can impact ethnicity. Understanding the dual nature of ethnicity aids the analysis process, and although it does not directly contribute to addressing the research objectives, analysis of the research material would arguably be incomplete without considering it. The themes emerging here pertinant to role of language in ethnic integration and the dual nature of ethnicity are discussed further in chapters eight and nine.

6.6. Conclusion

This chapter has focused on the investigations and empirical evidence of self-perceived ethnicity and its dual nature. The primary goal has been to address the first research objective, while simulatenously forming a foundation on which further investigations are built. There is empirical evidence that supports the use of self-perceived ethnicity without using a predefined list of ethnic categories, which provides enhanced utility by allowing a richer context to be revealed about the participant. On the basis of the findings discussed in this chapter, the working definition of ethnicity initially presented in chapter two is modified to be,

> *The identity that individuals give themselves subject to the context and considering selectively their country of birth, ancestry and the culture and language they adopt based on their exposure.*

Other factors, such as religion and upbringing have not been included in the definition because they are already represented through culture and exposure respectively. Moreover, passport/nationality and skin colour were not found to be appropriate components of ethnicity mainly because skin colour is more pertinent to race, and passport and nationality are conceptually distinct to ethnicity despite having an overlap, which is discussed in chapter two.

The findings support ethnicity being defined as an identity which is self-perceived, subjective, contextual and fluid. There is evidence to show that the factors that individuals consider in the process of identifying their ethnicity is subjective and so is the expression. In particular, individuals who consider themselves to be multi-ethnic, in different contexts, may decide to express their identity subject to the expected response of the audience. It was found that social actors may subjectively consider their country of birth and ancestry, along with the culture and language they have adopted based on their exposure, in identifying their ethnicity.

It was found that exposure during childhood and early adolescence also has a bearing on ethnicity. Moreover, this early exposure component, along with country of birth and ancestry, are considered to be non-fluid. This is not to say that they are not subjective; social actors were found to selectively rely on these components in identifying their ethnicity. It was found that downplaying either of these components in identifying their ethnicity was usually a result of significant exposure that negates the importance of these components.

Hence, from these findings, it is argued that exposure plays a pivotal role and impacts the language, and the culture individuals adopt. Here, although the adopted language is subject to exposure, it is also a limiting or facilitating factor which impacts exposure itself, and even the adoption of culture. The adopted culture and language were found to be significant considerations in identifying ethnicity. Culture and language were also found to be integral components that impact the dual nature of ethnicity. All the themes deliberated on in this chapter are discussed further in chapter nine using the literature reviewed in chapter two. Before presenting the analysis of the impact of ethnicity on EE, which is the concern of chapter eight, the following chapter discusses the insights from the experiences of doctors pertinent to EE, working in English NHS hospital Trusts.

7. Insights from the experiences of EE

7.1. Introduction

This chapter is concerned with the analysis of the findings pertinent to EE that aid in addressing the second objective of this study, i.e. to explore the experiences of EE of doctors. The findings described in this chapter also contribute to the contextual understanding which is integral for this research. Section 7.2 details the roles and responsibilities of the doctors working in English NHS hospital Trusts and section 7.3 discusses their work environment which reveals the day to day challenges. As discussed in the methodology chapter, five, in line with the interpretive philosophy, the subjective meanings of social action are taken into consideration in conjunction with the context. Hence, the discussions in sections 7.2 and 7.3 provide contextual insights that contribute to the better understanding of the interpretations discussed in the following sections.

Sections 7.4, 7.5 and 7.6 discuss the findings pertinent to the components of the working definition of EE, as presented in chapter three. Section 7.4 presents the findings of the awareness of the business context. Section 7.5 explores how Trusts could benefit from amending policies and practices to encourage patients to appreciate their doctors' work, address lack of resources, remedy certain protocols and systems, as well as supporting good team working, in an effort to create a conducive environment for EE. Section 7.6 investigates the two-way relationship conceptualised as part of the working definition. This section discusses the response to a conducive environment for EE, where doctors advocate for their Trusts as a place of work and treatment and participate in improving its performance. Section 7.7 presents the themes that emerged as being significant for EE of doctors, that are, nevertheless, innate to the medical profession.

7.2. Roles and responsibilities of participants

An overview of the contemporary role of a doctor working in the NHS, and how that has changed over the years, has been discussed in chapter four. In this section, insights from participants about their experiences of daily duties are presented to provide context to the analysis of their responses in interviews, with an aim to address the second and third research objectives. For the purpose of this research, the semi-structured interviews included questions about their roles and responsibilities to

enquire about their background, to build a rapport, and also to gain a better understanding of the working lives of the participants.

The findings indicate that the roles and responsibilities of doctors do not appear to vary significantly in different Trusts across England. These roles and responsibilities were found to vary slightly from department to department, but more as the doctors' levels (Junior, Middle and Senior) progress. As discussed in the previous chapter, six, the levels of the participants are included in the in-text references. The findings suggest that as doctors progress through their careers, the degree of responsibility that they are required to take changes. Doctors in Trust grade or non-training posts, where the roles and responsibilities are similar to training posts, do not have scope for progression in levels. It was found that the progression of levels is only feasible when the doctor is in a training role. This progression, along with other related contextual themes, is discussed below. To simplify, there are junior (FY1 and FY2), middle (core, speciality training, Registrar and Trust grade) and senior (Consultant) level doctors.

Starting from the most junior level of a doctor, foundation year 1 and 2 (FY1, FY2) participants revealed that they go '*through rotations*' [White British, Junior, P46], where they get exposure to various departments in the hospital. FY1 and FY2 doctors are expected to manage clerical and administrative tasks like '*doing bloods or sending request to investigations… we participate in ward rounds… we go around with consultants, registrars*' [Pakistani British, Middle, P33], '*I am kind of the interface between the patient, the doctors, the nurses, so the physios... there are several teams that put input… and you are like… one of the main organisers… who oversees what kind of work is going on between the teams…*' [Hungarian Caucasian, Junior, P36]. Such responses from junior doctors highlight the multiple duties they have to deal with at any one point in time during their shift.

Additionally, FY1 doctors,

> *… will be the first people initially called to see those patients and so they will do an assessment and then if we are concerned in any way, then we are expected to call for more senior help. We can initiate some basic management that umm, I mean we wouldn't be expected to go any further than that* [British Hong Kong Chinese, Junior, P32]

and

you can't really send patients home without senior review as now [as an FY2 doctor] I could just see a patient and send them home and not have to involve anyone else, but I mean I could, obviously I could ask for help but umm you know it's within my remit now that I am able to do that!
[British Sri Lankan, Junior, P47]

Hence, although there is a slight increase in responsibilities from FY1 to FY2 doctors, in general, the findings reveal that junior level doctors can only take limited decisions, and the treatment plan of a patient is decided by either middle grade or senior doctors. Some junior doctors look forward to progressing and being able to make decisions without senior support. For example, one participant clarified,

I will be more senior by then; I will have more responsibility, so I would be worried at the moment, every time I come up with a plan, I have to go and check it with a senior person. In 5 years' time, I will be the person checking other people's plans, so I probably be more involved in kind of supervising other people rather than the person who needs supervising
[White British, Junior, P48]

Nevertheless, responsibility and independence appear to vary depending on other factors, for example one doctor mentioned '*also depends which [department], and which consultants you work with. So, your level of responsibility or independence changes umm according to who you are working with!*' [Israeli Argentinian, Middle, P55].

So, in essence, the responses from participants suggest that as a doctor progresses from FY1 to FY2 and then onto core or speciality training, right up to the consultant level, the balance of deciding the treatment and taking advice from seniors changes. Moving up the progression ladder was found to mean more authority over decisions and less dependency on 'sign-offs'. For example, at middle grade, one doctor explained,

…I am really expected to not only see patients and provide senior advanced care and decision making but also umm mentor younger doctors, teach younger doctors and be responsible for overall flow and organisation of a… department. So, what I mean by that is, I am

frequently the senior person, I am always, if I am on the night shift, the senior person on. [Ugandan African, Middle, P56]

Another middle-grade doctor pointed out that their responsibilities also included:

…thinking about other non-clinical responsibilities, so umm as you get more senior, you have to do a lot more governance, so ummm, I am currently the lead for the junior doctors' forum, so that involves gathering uuu juniors' views and then talking through them with consultants and trying to build a bridge that way, uu and as part of that, audit uu and quality assurance come into it as well… [British Indian, Middle, P19]

Evidently, middle-grade doctors have increased medical responsibilities while also being responsible for mentoring and supervising junior doctors. At this level, the responses revealed that there are variations between doctors who are either on training or non-training posts, with little significant difference in roles and responsibilities. This, however is not the case for General Practitioner (GP) speciality training.

It was found that if a doctor decides to progress onto GP Speciality training, the roles and responsibilities at registrar level can be significantly different, because they are usually not based at a hospital but a GP practise/surgery. A middle-grade doctor at this level clarified the differences.

… you book the home visits, telephone consultations, umm which is quite different from the hospital setting umm we don't regularly consult by telephone and for hospitals you don't go but obviously patients in their homes, find about their problems or contacting district nurses and ummm understand the things available in the community umm for the patients' benefit which primarily you do that in the ummm in the practise setting…
in the general practice, it was most of the patients have chronic conditions umm so there's issue of continuity of care, so any acute setting you manage briefly, send them back to the GPs, or the GP there's nobody to send them back to – laugh – so you send them back to yourself then (ya) which is quite different from what has been going on in the, in hospital… [Black African, Middle, P35]

This quote highlights the contrastingly different work environment of a GP to that of a hospital doctor, and so is not relevant to the focus of this research, which is to investigate phenomena in the work environment in English NHS hospital Trusts. Hence, one of the reasons why GPs have been excluded from this study is that GPs tend not to work in a hosptial environment, as discussed in chapter five, and so their work falls beyond the scope of this research.

At consultant level, findings reveal that responsibility is higher, where actions of all doctors in the team below them are their concern. One doctor put it as, *'...becoming a consultant in England is less about medicine and more about managing people and managing the shop floor...'* [Israeli Argentinian, Middle, P55]. Participants reported that consultants have the most interactions with management, whereas junior and middle-grade doctors have little or none. For example, a doctor explained,

> *… you also have the managerial responsibilities at making sure the department works, you have the official supervision responsibilities for the junior doctors, for example, references and forms and portfolio filling out and when they make a mistake or when they are in distress, and you would have to look after them or when they are unwell, you have to look after them, and it's the same for umm all of the other things, ya everything that comes in, it's much more… it's an overview. You do still have somebody senior, so I then have my clinical director who... and divisional director who then has medical director. So, I suppose at the end of the day; the overall... is the medical director. But you are, you are significantly responsible for many things.* [Indian British, Senior, P58]

Consultants are also responsible for meeting '*government target waiting times, new incentives for the hospital, all of those sorts of things come as an extra, as extra responsibilities*' [Chinese, Senior, P20]. The responses above reveal how, unique to the consultant level, doctors have the greatest amount of non-medical responsibilities along with their clinical role. The impact of consultants' 'juggling' of demands has been discussed in chapter four, and the findings support that this is one of the most significant variations between grades. The roles and responsibilities above consultant level are not within the scope of this research.

As previously mentioned, the roles and responsibilities of doctors vary slightly in each department, whereas findings suggest that there are a few responsibilities that are unique to the ED. In particular, although all doctors are responsible for meeting targets, ED doctors have a 4-hour target in which the patients need to be seen, admitted or discharged. Analysis of the responses revealed that this target is not only a guiding factor to all the decisions made in this department, but also a factor that makes the role of an ED doctor more challenging and pressurised. For example, one of the participants said that it

> *… makes you sometimes be less caring towards the single patient you have got in front of you (hmm) ….since you have to provide a sustainable service... they make decision whether to make everything which is possible to be done for the single patient in front, they have got in front of them or to make the best average, umm the decision that provide the best average care …. you have to kick out a patient from the A&E within 4 hours because there is this 4 hours target* [Italian, Middle, P49]

The statement above highlights the pressures of working in an ED, as well as the multiple considerations that doctors need to make on a day to day basis. In particular, the competing priorities of meeting targets and delivering good quality healthcare becomes evident. The statement could be interpreted to reveal doctors' subconscious awareness of the fact that they sometimes need to compromise the care of a single patient in order for the system to remain sustainable.

Another participant pointed out that as a doctor working in the ED,

> *…you need to decide whether that patient is going to be under the medical doctors, under the surgical doctors, and I find that there is often a lot of umm..it's almost like playing tennis though, one specialty doesn't want them, the other specialty doesn't want, so we have to keep going back and forth* [British Asian, Junior, P24].

All the discussions above highlight how a lot of work that doctors do involves teamwork, which is discussed further in the following section. However, the situation which can prevail in some EDs clarified in the quote above, indicates that there are times where doctors expeience a lack of co-operation from other departments and/or team members. It appears that this lack of co-operation is not always intentional. As

clarified in the following section, the lack of resources sometimes compel doctors to make decisions on the basis of resource availability, instead of clinical judgement.

Additionally, findings suggest that all doctors also have an overall role to ensure that patients are happy with the service they are receiving. For example, one doctor clarified,

> *I think* [it] *is important that patients are happy, because just that you are in a business it's important to keep your customers happy, umm it's important in a hospital to keep your patients happy because you know part of the, part of their illness is being unhappy, you know that makes the illness worse, that makes their quality of life worse and it makes them come back in the hospital, so it doesn't work for anyone* [British Iraqi, Junior, P41]

This consideration was found to be an additional responsibility, where doctors believe that not only will a happy patient get better quicker, but it is also important that patients are satisfied with the service they are receiving. The comparison in the quote above, suggesting the need for businesses to keep their customers happy, arguably discloses the awareness that although the patients are not paying for the service they receive at the point of use, there is a responsibility for the doctor to meet the patients' needs. The participants were found to be aware that they '*are in a very customer facing role*' [White, Junior, P53].

The contextual findings presented in this section not only provide valuable insights about the varying roles and responsibilities of the participants but are also important in addressing the research objectives, as they allow an understanding of how variations in roles and responsibilities can impact doctors' responses to EE practices. This contextual understanding also allows for differentiation or association of the impact of ethnicity on roles and responsibilities while analysing the participants' responses. The following section presents the themes related to the work environment.

7.3. The work environment of participants

The discussions here, pertaining to the work environment of the participants, provide further insights into the context of what impacts participants on a day to day basis. Understanding this context is in line with the research approach, and allows for clearer

analysis in the following chapters while addressing the research objectives. The findings from this chapter reveal that the working hours, shift patterns and working environment vary slightly from Trust to Trust, between departments and between levels. However, in general, it was found that the state of affairs are similar in all English NHS hospital Trusts, and the differences that emerged are discussed at the end of this section.

Analysis of the empirical evidence revealed that the majority of the work of doctors involves teamwork, where coordination, delegation and cooperation is required between hospitals, departments, wards, doctors, nurses, porters, and other various staff. For example, a participant explained,

> *…you are doing the best you can individually, but that is also as a part of the team. So you do have to kind of, you all work together a lot, you kind of delegate the patient between you and try and kind of split things up so that people get seeing quickly and efficiently, so umm and that sometimes come down to the consultants to sort of delegate things, and say right can you do this and can you do that. And sometimes it's within yourselves, so you are sort of see someone and then say can you help me out with this, so that I can do something else, so it's kind of, you have to have really good team working* [White British, Junior, P48]

This quote suggests that such teamworking requires good communication and understanding between colleagues. A participant stated that *'...health care is complex, but there's so many people around … that really I think is the other softer skills that… make or break the workplace'* [Ugandan African, Middle, P56]. It was a common perception that, in addition to clinical knowledge, medical professionals need to be a good team worker in order to be a good doctor. Nonetheless, between the various teams, it was found that there can be disagreements that can hinder smooth functioning. For example, one participant pointed out,

> *…there have been some cases where there is a debate between a surgical or a medical admission based on the fact that we do initial investigations … and sometimes they are not entirely conclusive, so the diagnosis could be surgical, could be medical, and it's important we get the right diagnosis the first time, like I said earlier, so there is a lot of kind*

> *of call this person, he says call the other person, call that person he says*
> *call that person and then we have to find the middle ground...* [Chinese,
> Middle, P9]

Such situations could arguably frustrate doctors and also impact patient care. Although in the example in the quote above, a 'passing the parcel' situation is suggested to be on clinical grounds; however, it was found that sometimes it is also due to lack of resources, usually a lack of available beds to admit the patient. The impact of a lack of resources on EE is further discussed in subsection 7.5.2. Working as a part of a team is discussed further in subsection 7.5.4.

Participants pointed out that to enable smooth functioning and management of responsibilities, NHS doctors can have an extensive hierarchy. A doctor clarified that *'…juniors are right at the bottom and consultants are right at the top and sometimes it can be a very much like boss and employee kind of relationship'* [White British, Junior, P48]. In this hierarchical culture, as discussed in the previous section, it was evident that junior doctors are expected to follow the treatment plans as set out by senior colleagues. In such situations junior doctors, maybe due to their lack of experience, can feel uncomfortable in challenging treatment plans.

NHS Trusts in England have doctors present in hospitals twenty-four hours a day, seven days a week throughout the year. However, it was found that the number and seniority of doctors are less out of the normal 9-5, Monday – Friday working hours. For example, one doctor explained,

> *…so basically 9-5 is the normal sort of social hours, ummm so obviously*
> *if it's outside of that, those hours, we will be considered on call, cause*
> *it's out of hours – laughs – umm there will be considerably less doctors*
> *(ok) umm so you still need some doctors but we sort of rotate between*
> *ourselves on who be on call during night. Umm, we as F1s don't do*
> *nights, ummm or like overnight on calls in London, but they do in different*
> *other parts of the UK (hmm) so we normally just do it until 10 pm then*
> *go home, but if you are … someone more senior than an F1 then you*
> *can do, if you are on nights, then you will be there over the night. You*
> *start around 9 then you finish at 9 (hmm) the next day* [Malay, Junior,
> P37]

Here it is evident that the working patterns can vary depending on seniority and what Trust it is. However, in general, it was apparent that all doctors have shift work with junior and middle level mostly doing the night shifts.

The analysis revealed that unique to Emergency Department (ED), the allocation of tasks can be unpredictable and that '*it's a bit more intense than it was in when you work in the ward jobs*' [White British, Junior, P48]. Another doctor working in an ED said,

> *…we don't know where we are in the morning. We are allocated, ok either you go to the resus [resuscitation] station bay, or you go to the assessment bay, or you go to majors or minors or paeds [paediatric], it depends on where they want us to be…* [Black African, Middle, P14]

Hence, it can be argued that that the allocation of roles and responsibilities in the ED can be slightly more fluid than other departments, and as seen in the previous section, it is the responsibility of the consultants to allocate roles.

Overall, it was found that the workload can change where it can be extremely challenging due to a shortage of doctors. For example, one doctor explained,

> *…you need to cover seven wards! I was like how a doctor can cover seven wards from 9 in the morning till 5 in the afternoon, and it was, they are not even in one building, you know hospitals are different buildings (hmm) and they just, they gave me a pager and then I didn't understand then the time passed, I didn't have the time to eat, to eat my lunch, I didn't have time to go to the toilets, and in the other day I had, I had it for two days and in the second day, I had patient who was septic and I was with him for two hours and a half, and I was thinking about if I had another septic patient, in one of the wards that I had to cover, how can I cover two septic patients in different wards?* [white Asian, Middle, P44]

This description above indicates the possible risks for patients as well as for doctors in terms of their working conditions. Although the situation mentioned in the quote above is an extreme case, general analysis of the responses from participants indicates that normally, the overall workload is high for doctors, which could contribute to them 'always being stressed'. Despite such high-stress levels, it was found that

doctors working in the NHS are made to believe that commitment is displayed through full time or more, as a basic requirement. For example, one doctor explained, '*... we are sold this story that you know, if you have, you know if you are not at work full time, dying yourself, then you are not a committed doctor (awwww), so we are sold this lie ha that anything less than full time and a less than 100% commitment is not commitment'* [Ugandan African, Middle, P56]. So, arguably not only is there work pressure due to 'ground realities', but management also seems to be adding to doctors' stress. Moreover, participants perceived that there is a constant pressure of litigation augmenting heavy workloads. For example, one doctor explained,

> *... lady who presented with that 17-year-old boy with one instance of diarrhoea and vomiting and was well would not be seen at all he was sent back (hmm) but now because all the fear of litigation and all that (hmm) ummmm nobody is bold enough to just send them back like that until they have got to be seen, so it puts undue pressure (right) on the services that are available (hmm) because you are struggling to maintain this and then the Trust is also scared...* [Black African, Middle, P35]

A participant pointed out that this pressure is terrifying for them, because even unintentional mistakes can lead to imprisonment [White British, Junior, P46]. In addition to the national laws, participants revealed that they need to adhere to the '*guidelines and local Trust policies*' [Indian British, Middle, P31]. Within the Trusts, the policies and practises were found to be created by managers where doctors felt that '*they don't put themselves into our shoes … so they don't understand because they are not doctors*' [Black African, Middle, P14]. So, in essence, this supports the argument that policies are, at times, created for doctors without their agreement. The situation can arguably be further aggravated because doctors feel;

> *…that [where] the service fails is that the people that do the work have no involvement in decisions of how they do the work … you know the health service is full of buzzwords like partnerships, but they are meaningless if there is no partnership.* [White, Junior, P53]

This apparent lack of involvement could threaten doctors' professional autonomy and was found to be a significant characteristic of the work environment in NHS Trusts. In this context, the same doctor explicitly expressed that he would like to get involved in

management with the hope that his experiences would help them make better decisions. However, this sentiment is not equally shared by all doctors, as another participant insisted,

> *…there is a lot of pressure from both the sides and we are stuck in the middle… it is pointless to go higher… because the NHS is a failing organisation… in which your decisions are really run by the government… they have been promising us new buildings since last 15-20 years… it's so hard to work in sewage coming through ceilings, and everything breaks down constantly* [Indian, Senior, P25]

The statements here highlight the frustration of doctors and the plight of some Trusts. It is evident from the quote above that some doctors seem to have lost hope and are not happy with the decisions taken externally by the government and promises made to them broken or unfulfilled. Their altruism seems to be pushing them to do their best for their patients, but the infrastructure and organisational support are arguably lacking.

On a broader perspective, there are different types of Trusts, as discussed in chapter four, and the focus of some of these Trusts can vary, for example,

> *…district general hospital, has... has a different agreement, they are more interested in high volume umm management of patients and these are patients with common conditions ummmm who can be easily managed locally uuu, so that is quite different from the super-specialised practice that we uu offer in these hospitals, so it's a very different standard of care it's very different, standard of speciality uuu that we are able to offer…* [Indian, Senior, P16]

However, these differences seem to be focused on the 'type' of the patient that they deal with, and so, arguably the work environments do not differ drastically. As mentioned at the beginning of this section, the work environment can also sometimes slightly vary from Trust to Trust, irrespective of the 'type'. For example, participants said;

> *…you know most of the Trust, umm they are understaffed, Trust* [A] *was really good in that, they were well organised, they were well staffed and*

with some good senior support … Trust [B] *is a, they are well staffed, but they are not very well organised…* [Pakistani British, Middle, P33]

I think …this particular Trust has probably, the worst systems I have seen; I am talking about like you know the electronic umm clerking, umm the procedures like when you discharge a patient... this Trust, in particular, they have umm at least 5, I think like 5 or 6 hospitals, so the specialities… every speciality is in ummm the Trust [C]*… and hospital* [A] *is one of the smart hospital, so you know we don't have plastics* [plastic surgery]*, we don't have you know surgery, we don't have many things like as a Trust …* [Israeli Argentinian, Middle, P55]

The differences revealed by participants emphasise why some Trusts are characterised as 'good' and others as 'bad'. Importantly, they highlight what aspects can be frustrating for doctors. Moreover, there was a perception that Trusts which have a bad reputation have difficulties in recruiting good doctors [Pakistani British, Middle, P33].

There is evidence that, on a national level, the NHS is under much financial pressure, and long-term predictability is uncertain. For example, one doctor highlighted, '*it's really hard at the moment to be a doctor… in terms of* [where]*, the NHS is going to be in the next 10 years; I see it becoming eroded…'* [Tamil Sri Lankan, Middle, P51]. Another doctor stated, '*NHS is in such a… mess that I don't think you can predict what NHS will be like in 5 years*' [White British, Junior, P46]. The sentiments of these doctors working in the NHS currently appear to be pessimistic. Furthermore, variations in the work environment have allowed me to gauge an understanding of both good and bad Trusts as well as the ones in the middle. This contextual variety was useful as it allows for a comprehensive analysis of the impact of the work environment on EE to be presented in section 7.5. The work environment related themes discussed above are integral in the interpretation of the responses, as they provide contextual insights and form a foundation for analysis that aim to address research objectives two and three. The following section presents the findings relating to the awareness of the business context.

7.4. Awareness of the business context

The working definition of EE presented in chapter three incorporates the notion that doctors should be aware of the business context in which the NHS Trusts operate. Here, 'business context' refers to factors such as the political and economic state, societal factors, funding, budgets and resources. The findings discussed below aim to contribute to addressing the second research objective by exploring the experiences of doctors relating to each factor of the business context.

Around 50% of the participants were aware of how societal demands impact their Trusts. It was found that they were aware of the makeup of their Trusts' patient population and the prominent illnesses. For example, one doctor pointed out that *'…lots and lots of elderly population with different kind of problems in terms of joint pains and you know chronical illnesses, heart failures, COPD, respiratory problems, umm drug problems'* [Indian British, Middle, P31]. Moreover, participants clarified how this then impacts the Trusts;

> *…with the Trust themselves, they have to look at the local demographics, the kind of plan, what they are doing so I know that they in terms of things like umm the kind of umm treatments that they will invest in, the kind of programs that they will kind of set up and the kind of local antibiotics guidelines is all based demographically! So, they do look at things like ethnicity and age and the general kind of makeup of the population to decide what kind of umm health care issues is it going to be more predominant in that area and then they kind of tailor services to see that.* [White British, Junior, P48]

> *County* [X] *is a very multicultural place like 80% of the population comes from different countries, and it is a very young population, so the average age is between 30-40 and there are lots of births … like this hospital has the most number of births in the whole of UK, so it is really overspent ... I think County* [X] *is the tuberculosis capital of Europe, so the rate of tuberculosis is the highest here and of course it has to do with people who come from different country but also there are some really inner district areas of County* [X]*, like there are poor people, homeless people, jobless people, so I think that generally the health, the overall health of*

the people are poorer here. So, I think that the Trust has more tasks, more things to do with these patients because you have to sort out not only the medical aspect but also social things and mental issues. [Hungarian Caucasian, Junior, P36]

So, it can be surmised that a detailed understanding of societal demands could help doctors understand why certain Trusts set up services in the way they do.

Around 60% of the participants had an opinion about the impact of politics on NHS Trusts. This is not surprising as it is believed that the NHS is one of the most popular election topics for politicians. For example, one doctor explained,

…the NHS, it's *a huge political football, so every time there is an election, they will have with some kind of big thing about what they are going to change with the NHS to make it better, and every 4 years things get completely turned over and stuff again and it goes backwards and forwards all the time and so the Trust is always under pressure from different political plans.* [White British, Junior, P48]

Similar political rhetoric is not uncommon and, as already seen in sections 7.2 and 7.3, doctors are aware that decisions are made top-down with the government being at the top of the tier. Moreover, the analysis revealed that changes or improvements promised in election manifestos are commonly thrust upon doctors to deliver. The government sets targets [British, Junior, P42] and dictates working patterns [British Sri Lankan, Junior, P47]. Another participant said,

I mean the NHS I think has to please whoever is in government at that time and I don't think it has a choice because it's kind of controlled by politicians so whatever the government wants kind of has to happen eventually. Ummm and so I think the government of the day will affect how the NHS is run and how it's structured. [British Hong Kong Chinese, Junior, P32]

There was a general consensus among participants that the decisions made by the government directly impact doctors' day to day work and, hence, they are aware of the impact that politics can have on the Trust's processes and systems. Prominent political issues that were found to be affecting doctors during the data collection phase

included introduction of the new junior doctor contract and 'Brexit'. For example, participants shared their experiences and, referring to the junior doctor contract, said,

…I know why everyone's upset about it, but I try not to sort of get myself involved too much with it… and I couldn't afford to miss a whole week of work … I have nothing against striking, umm and if it's one or two days, then I would join my colleagues in striking, but it was for 1 week of unpaid leave, that's just too much for me and I can't afford it, cause I live here on my own [Malay, Junior, P37]

…we are going to get the contracts imposed, or our contract will be changed in the next 6 months, and we will get paid, we will get like a very real pay cut like even over the actual money that there is … that is saying something very ya umm serious to the staff you know, and it's not just the doctors it will be everyone you know it will be absolutely be everyone that gets affected slowly and umm that will affect how people work, people will disengage when they feel they are not valued, that's the problem [White British, Junior, P46]

Evidently, participants perceive such politically driven changes that affect their day to day working, and although all doctors might not know the full details about the impact, they are aware that political factors can affect the Trust and their work. Similarly, participants were also aware that Brexit might impact the NHS in many ways, for example, a participant mentioned,

well at the moment, I think the effect is small, but in the long term, …when Brexit will happen, … I think the… number of foreign doctors and the number of foreign nurses and other staff working in an NHS will decrease at some point, but the bigger change will be the, the ratio of the European staff and the non- European staff, I think, but it's in my opinion, it's hard to, to say what's gonna happen because we don't really know what exactly (hmm) is going to happen at the Brexit (right right) I think. [Caucasian, Middle, P43]

The analysis revealed that awareness in the context of political decisions impacting the Trust was high, and participants were also aware that funding is often politically driven. For example, doctors said,

> *…it's not a secret that the conservatives and the NHS's model for delivering health care uuuuu is not a very cost-effective model* [Indian, Senior, P16]

> *…sometimes the political landscape of the country dictates certain things are more, you know certain things have a higher priority than other things or certain things are in demand* [White, Junior, P53]

The quote above supports the argument that doctors are aware of the influence of politics on funding and budgets, but they are also aware that it affects other areas of the Trust's functioning. For example, participants said,

> *…funding and budgets have a huge impact … so the government funding or government budgets ... impact on how … Trust work (hmm) … how can we save money, what different things can we do, please don't use this equipment, think about prescribing these drugs or these drugs…* [British Indian, Middle, P19]

> *well, money is the most important factor… and in general none of the Trusts that I work with have enough money to do the job that they need to do properly (hmm) and that affects the way they work umm we are constantly trying to push the barriers umm so that we don't affect patient care but still provide very good care uuuu and you know often money isn't there to do what we want to do…* [Indian, Senior, P16]

> *…guess they try to do their best but still, cannot, cannot keep up with the like the number … always feel like you know it's just not enough all the time and then they spend so much money for the locum nurses, they earn more than consultants per month (ok) so I can't really understand what system wise…* [Korean, Middle, P11]

As already deliberated upon in section 7.3, and discussed further in section 7.5, the quotes above reiterate the perceived significant impact of lack of funding which affects the doctors' day to day work. Analysis of the data reveals that most doctors seem to be aware that Trusts do not have an unlimited budget but, as evident from the last quote, some decisions do not necessarily 'make sense' to them. Nonetheless, many

participants were found to be aware of the general impact and in particular, the detrimental effect it has on resources. In this context, participants clarified,

> *…ten patients, all of them waiting for x-rays (hmm) and maybe two patients going at one time and there is a long queue in the radiology!* [Muslim Asian, Middle, P7]

> *…lack of doctors, lack of nurses, they are short staffed all the time* [Indian British, Middle, P31]

Participants expressed that the lack of resources, which include physical space, limited equipment and workforce, can impact their work on a daily basis. They are constantly reminded of the strain due to the issues that can arise as a result of the lack of resources. The lack of resources could be attributed to economic factors. However, despite this evidence, only around 10% of the participants were aware of the impact of economics on the Trusts' functioning. Out of the doctors who were aware, two participants explicitly mentioned that they were aware of the impact due to the economics module they had opted for during their studies. For example, participants explained,

> *…I don't think the NHS is sustainable… you know there isn't a public organisation in the world that has a completely free you know health care system at the point of delivery* [British Indian, Middle, P15]

> *…the emphasis of austerity and saving money hasn't been always been as acute… I think the general economic narrative of saving money, is important of what we do in the day to day… both in terms of from top down, so you know managers or whoever will be pressurising clinicians to save money, but also just basically reading the newspapers and in the news every day, you are yourself more aware that you are working in a public service organisation, in the public sector and I think you probably trying to make little cuts here and there anyway, even if you weren't told to, just because you think the organisation might be running out of money* [British Hong kong Chinese, Junior, P32]

It can be reasoned that doctors who are aware of the impact of economic factors on the Trust might appreciate the reasoning behind certain decisions, and the situation of

resources, funding and budgets. This supports the suggestion that there is a potential here for the Trust to educate or communicate the impact of economic factors to the doctors. Although awareness of the other factors of the business context was overall, found to be reasonable, the findings support the argument that there is still scope for Trusts to further increase the level of awareness of all factors of the business context. This is discussed further in the conclusion section, 7.8, bringing together all the findings in relation to the experiences of EE of the participants. The following section deliberates on the findings significant for creating a conducive environment for EE.

7.5. Policies and practices conducive to EE?

The semi-structured interviews investigated the experiences of doctors pertinent to EE with an aim to address the second research objective. Analysis of the responses revealed certain factors from the work environment that impact the creating of a conducive environment for EE. These factors are the receiving of appreciation from patients, lack of resources, protocols and systems and teamwork. All these themes are discussed in detail below. The working definition discussed in chapter three highlights that organisations that implement specific policies and practices could create a conducive environment for EE (Dromey, 2014; Valentin, 2014; NHS Employers, 2013d). Hence, the examination of the insights from the experiences in this section potentially looks to contribute to better policy and practice in creating a conducive environment for EE.

7.5.1. Patient Appreciation

It was found that doctors value any appreciation expressed by patients or their relatives. For example, a doctor said '*you know putting in more effort with the patient and them appreciating it, or the patient you know being treated quicker because of it or the family saying thank you for the way I managed something'* [White British, Junior, P46]. Another doctor put it as '...*it's just so lovely when people appreciate the amount of time and effort that you put into looking after them. Ummm it makes it worthwhile … it's those little things that perk you up...'* [Chinese, Senior, P20]. It was apparent that the happiness from the appreciation of patient is not only limited to when there is a good patient outcome, for example,

> *…even if I have not made a difference, like umm getting a thank you*
> *card from uuu because we had a thank you card from a relative, of a*

> *patient who died, so it's not a good outcome, but they said thank you for all the care we have given them, and they died without any pain, so that makes me happy actually, and just the acknowledgement of it* [Malay, Junior, P37].

One of the doctors explained,

> *…having a patient say thank you again really really makes me very happy, but that doesn't happen often, because Bangladeshis don't say thank you, umm they are too frightened – giggles – and it's not in their culture, you know they just, it's not a thing, I think generally my observation and people from the Indian subcontinent, myself included, often don't, you are not polite, you don't say things like please and thank you, you just kind of think it's assumed, but it makes a huge difference ummm to somebody else's day if you do say those things umm because it means you are acknowledging their time, their effort, that sort of thing...*
> [British Indian, Middle, P15]

Interpreting this observation by the participant could mean that Trusts that have a larger population of ethnic minority patients might benefit by promoting appreciation for their doctors more than other Trusts. However, this would possibly need further investigation and assessment of differences among patients of different ethnic groups, which is not in the scope of this research. Nonetheless, considering the factors that could encourage patients to express their appreciation to a doctor reveals the opportunity for policy and practice to positively support patients, to the effect that their whole experience in interacting with the Trust is good. It was found that when a patient sees a doctor, invariably, they have already been influenced by the ease of access, which can include administration as well as infrastructure, the attitude and behaviour of other frontline staff and the media and marketing that they have been exposed to. This could impact the patients' likelihood of expressing appreciation. For example, one doctor pointed out, '*…the thing about NHS that people, because it's a free service, people expects uu you know, expect everything really!'* [Chinese, Senior, P20]. In the same context, another participant put it as,

> *...they systematically destroy any confidence that the general public has in the medical profession. It is a slow disintegration; it's an effort to slowly*

> *disintegrate what I think is the medical profession. You know I think, I I am yet to see a good NHS story in the last 4 years, 5 years. I have not seen one. All you hear are the horrors, is who killed who accidentally, its who got stroke off, there are no positive messages out there...* [Ugandan African, Middle, P56]

It became evident from such responses that news and media campaigns may have a negative impact on doctors. Hence, this supports the arguement that an effort by the NHS to portray their doctors in good light, and also educate patients on the limitations of the healthcare system, can potentially be beneficial in creating a conducive environment for EE. This could lead to patients being better informed and potentially harbouring manageable expectations. In particular, it was found that the frustration of doctors working in the NHS could be aggravated by patient expectations. One participant pointed out, *'…patient who has unrealistic expectations (hmm) ……. Ummm sometimes you get frustrated …'* [Black African, Middle, P35]. Another doctor put it as '*…we are very much living in a now now now now now society! Ummm treat me now, do it for me now, I don't care if somebody else is dying, I want it now, that is getting worse*' [Indian British, Senior, P58]. In general, doctors felt that the easily available information on the internet is exacerbating this change in the society, which has led patients coming to the hospital with expectations that are sometimes difficult to deal with [Indian, Middle, P50]. Resultantly the doctor-patient relationship seems to have changed. For example, one participant explained,

> *medical practice has gone from very paternalistic… whereas now it's much more patient focused, umm and along with that, comes a patient's demands, so ummmm patients will come in and say I want this and that … and patients come in ummm sometimes complaining very angry, umm saying I have paid my taxes and things like that and kind of taking as a given, or what they must receive, when actually, I don't know, it's kind of a cycle.. a vicious cycle, and that affects the way you see the patients and the way the patients treat you* [Asian Indian, Junior, P18]

Evidently, patients are becoming more active consumers, potentially leading to increased expectations which could be partly intensified by health-related information becoming easily available. This might not only cause a dissonance in the doctor-

patient relationships but could also damage the authority of the medical profession, with patients challenging the authority of doctors and debating the treatments being offered. Moreover, there seems to be a perception that patients' awareness of new developments in the field of medicine has resulted in their expectations from doctors to create miracles, which need managing [Indian, Senior, P16]. It was found that the NHS has not managed to keep up with the changing interactions between patients and doctors where people are told how to better their health without actual negotiation or partnership [White, Junior, P53]. These frustrations are found not to be limited to interactions with the patients alone, but also include relatives and friends who sometimes get involved. For example, a doctor said,

> *…so ummm patients that, well sometimes it's not the patient, it is like patient relative so umm they just kind of expect a lot more ummm than what you are able to provide for them given kind of time constraints and time like …. so, some difficult patients would be patients that you don't actually find anything wrong with them but they also kind of complain about 101 things...*[Libyan British, Junior, P30]

Similarly, another doctor highlighted, *'sometimes dealing with the relatives makes me unhappy because they often have more to complain about and have more questions than the patient themselves'* [Asian Indian, Junior, P18]. Arguably, the impact of all of these factors is not fully in control of the Trust. However, the Trust can work towards implementing policies and practices that ensure patients are satisfied with waiting times and with the processes required in accessing the doctor. One doctor highlighted, *'... maybe they want to have this appointment, in 2 weeks, but they have to wait for 2 months...'* [British Hong Kong Chinese, Junior, P32]. So, arguably although there doesn't seem to be a 'quick fix' for the waiting times due to the lack of resources, as discussed above in section 7.3, any efforts by the Trust to reduce waiting times and increase patient satisfaction, could impact the patient appreciating their doctors' work, which in turn can contribute in creating a conducive environment for EE.

7.5.2. Lack of resources

Lack of resources emerged as another factor that affects doctors on a daily basis impacting EE. The main underlying cause for the lack of resources was found to be the funding that the NHS receives. Chapter four discusses how the NHS is funded

through general taxation. Analysis of the responses reveals that although each Trust has different levels of funding, all the Trusts are currently facing issues where doctors' day to day work is impacted. One doctor clarified that different types of Trusts have different levels of funding depending on certain aspects such as the size of the Trust and services provided [Indian British, Middle, P31]. Another doctor explained, '*...in general none of the Trusts that I work with have enough money to do the job that they need to do properly (hmm), and that affects the way they work umm we are constantly waiting, trying to push the barriers...*' [Indian, Senior, P16]. Funding has been found to dictate not only the treatments that doctors can use but also equipment and medications prescribed [British Indian, Middle, P19].

It was also found that lack of resources resulted in '*…stress, being overworked'* [White, Junior, P53], '*overstretched'* [Indian British, Senior, P58]. This stress was believed to be partly due to the fact that many Trusts do not have enough doctors. For example, a doctor explained,

> the government, they are regulating the, you know inflow of immigrants to the UK, so I think that will affect on you know like international umm medical graduates to be able to work in NHS, but I don't know how they will manage without you know overseas doctors uuuu because uuu they are always short of doctors… [Burmese, Middle, P38]

Evidently, there seems to be a shortage of doctors to meet demands, which doesn't seem to be appreciated. The analysis of the responses also reveals that there is a belief among doctors that there is a lack of appropriate candidates that could fulfil the vacant posts or required levels of staffing for the NHS. For example, one participant highlighted, '*...lack of staff is not so much money, (yes) they would employ more people if they had more employable people... so that's not lack of money, that's just lack of staff...*' [Israeli Argentinian, Middle, P55]. Another doctor pointed out that the NHS is short of senior doctors [White British, Junior, P48]. A consultant stipulated that the NHS needs good quality doctors who are committed, responsible and can be relied upon [Indian, Senior, P1]. Arguably, the reason for certain Trusts not having all the required specialities on site can be this lack of availability of appropriate staff. For example, a participant revealed that when they receive a patient that requires neurosurgical procedures, they have to call another hospital, wait for the consultant

there to accept the patient and in this process, not only is the life of the patient in danger, but it is also a burden on the system [White Asian, Middle, P44]. The lack of staff in the NHS was found not to be limited to doctors, but spread across nurses as well [Korean, Middle, P11; Indian British, Middle, P31]. Such an environment that is characterised by shortages would arguably not be conducive for EE. For example, a doctor explained how this is affecting their work,

> *...I mean we are kind of physically, mentally pushed...you are pushed to your limit and then you, you in your mind weigh up, do I go to work or if I do go to work, by being not well I am gonna satisfy patient care? It's actually better that I stay home; there's a lot of unplanned leave... there have been times when … there aren't people working, you have to cover for them (hmm), you have to do hours on one night shift, and you have to cover for 2 people, and it was just me covering...* [Asian Indian, Junior, P18]

It is perceived that this high-pressure environment is increasing absenteeism, consequently adding pressure to the already overworked staff. It was found that on a day to day basis, doctors are juggling between serving individual patients to the best of their ability and keeping up with the number of patients they must get through in the day. For example, one doctor said, *'…frustrated because actually you don't feel then you have given good quality care to each of the patients and to each of the families because actually you are rushing through…'* [British Indian, Middle, P19]. In particular, it was found that not being able to complete all their work for the day frustrates them [White mix background, Middle, P52; Black African, Middle, P57; Hungarian Caucasian, Junior, P36]. One doctor said,

> *…do this do this, you are not doing this, you know you are putting in your 100%, but someone wanted to make it 200%. But I am like everyone has a pace to go at, and you can only go at a pace because if you go [at] other person's pace, you can get your patients into trouble. You can make big mistakes. Ya so like when you are being pushed to do something when you are already doing something, you are stressed out ya so that basically bothers you...* [Black African, Middle, P14]

Such unmanageable workloads might hinder doctors in enacting their professional roles and responsibilities, negatively impacting EE. In particular, as seen in section 7.3 and evident in the above quotes, the quality of care provided to patients can suffer and doctors' core professional duty of looking after the patients' health and wellbeing is put at risk. Whereas, appropriate workload, that does not create undue pressure [Muslim Asian, Middle, P7] allowing enough time with the patients [Asian Indian, Senior, P2] can potentially contribute to make doctors happy.

In addition to lack of funds and staff, it was found that the NHS is witnessing a stretch in physical space and lack of beds. Participants exclaimed, '...*like physical space in A&E it's not enough, like the place, you know, if you have ten patients waiting, it looks like a refugee camp, it's just, it's so!*' [Israeli Argentinian, Middle, P55], there are '…*lack of beds, lack of space…*' [Indian British, Senior, P58]. This arguably affects patients and frustrates the doctors as well. For example, one doctor explained,

> *...sometimes there are limited bed space, or limited resources (hmm) and... a bit frustrating because we want to see the patients but... you need to wait for space in order to be able to see them and umm giving them treatments that might be needed, and that's frustrating because it upsets the patients because they are waiting, it upsets your day because it means you are waiting...* [French British, Junior, P34]

It was found that the impact of the lack of beds is more acute in ED. Doctors revealed,'*… sometimes it is just not having the right service, finding out that you can't send a patient to this place because they are full*' [Tamil Sri Lankan, Middle, P51] '*... there's bed pressure as well... all the beds would be full, and so we really struggle trying to keep the patients*' [British Asian, Junior, P24]. Findings revealed that there are also situations where patients need to be discharged, but it is not possible because of issues with care in the community. For example, a doctor clarified, '...*they are not physically unwell, but because ummm again… the social care in the community, it is sometimes just difficult from the social aspect to discharge the elderly patient...*' [British Asian, Junior, P24]. This reveals how the pressure created due to a lack of space and availability of beds can push doctors to make decisions that are not necessarily the best for the patient but pose to be the only option in that given scenario. Again, such

decisions can clash with their professional duties and resultantly can negatively impact EE.

In essence, it was found that the lack of resources restrains doctors in being able to perform their duties to their fullest adding to the frustration. A few doctors insisted, '…*there are resources problems, uuu if they don't have the resources whether they are people, money or equipment then this will cause an obstacle*' [Greek Palestinian, Senior, P39]. When the appropriate equipment is not available, doctors feel anguished, for example, one doctor said, '*...can't buy the right equipment, how can we do our jobs...*' [White, Junior, P53]. In section 7.7, the importance of being able to contribute to patients' health and wellbeing is discussed, and these experiences provide empirical evidence for factors that are important for creating a conducive environment for EE. Adding to the burden of already insufficient resources are certain protocols and systems that also hinder the creation of a conducive environment for EE, as discussed below.

7.5.3. Protocols and Systems

Analysis of the responses revealed that protocols and systems that support doctors appropriately can contribute in creating a conducive environment for EE. It was found that doctors get frustrated with little administrative things not getting resolved. This includes swipe cards, log in and passwords not being provided to locum doctors. For example, a participant pointed out, '*they are hiring doctors, you know they are spending 500 pounds (hmm) on a doctor, and then they don't give, provide him with the stuff he needs, so basically, those doctors were useless!*' [Pakistani British, Middle, P33]. Additionally, the slow IT systems, constraints due to protocols, not-well-thought-out layouts of wards resulting in wastage of time for doctors, again was found to make them feel disengaged and frustrated. This can also put patients at risk. For example one doctor pointed out, '*...quite dangerous for the patients … cause I can think of a million things – laughs – where the system just fails, and it just frustrates everyone...*' [Malay, Junior, P37]. In particular, they sometimes feel that the systems lead them to do tasks which distracts them from their core profession. One participant disclosed, '*it takes me 20 minutes to print, to do a discharge letter, and by the way not just time, but it's a very mundane task. This is not what I am trained for!*' [Ugandan African, Middle, P56]. Other doctors specified;

…so bureaucracy makes me really unhappy, ummm and frustrated … so having to follow a protocol, although I agree with protocols or the way things should be done because it makes the safe patient care, but that's not why I personally went to medical school, I didn't go to medical school to follow a protocol, I went to medical school to use my brain [British Indian, Middle, P15]

...I think sometimes when they write protocols... like you see protocols are just wrong, or they use like scoring systems that are not appropriate or they are in ummm not validated... they have pathways for everything, there is a protocol for everything... like doctors sometimes they know what they are doing or they know sorry they know what they should be doing, but they end up sort of messing up the use of guidelines and protocols and ummm under investigating it, over investigating... [Israeli Argentinian, Middle, P55]

The responses above support the argument already made in section 7.3 i.e. doctors feel that the protocols and systems created by managers who lack knowledge of ground realities are inappropriate. In particular, it was found that top-down decisions make doctors feel undermined. Participants revealed that the government sets targets [British, Junior, P42] and dictates working patterns [British Sri Lankan, Junior, P47]. One participant put it as '*...I think there is this umm top level umm top, this government endeavour to undermine everything that the NHS or the medics and doctors do...*' [Ugandan African, Middle, P56]. So, in essence, there is evidence here to support the argument that there is an opportunity for policy makers in NHS Trusts to understand the frustrations of the doctors and attempt to take remedial action, which in some cases might only mean some small changes. Such modifications to protocols and systems could potentially contribute in creating a conducive environment for EE.

Associated with protocols and systems, there is also evidence for scope for improvement in infrastructure allocation. For example, one doctor explained,

…is the equipment available when you need it, yes or no, you know things like that can make me frustrated (hmm) if the equipment is available, umm and you are opening the packaging to open the needles or open the medicines, like so I need a bin to throw this packaging away,

> *and if the bin is in another room, that will frustrate me…* [British Indian, Middle, P19]

Doctors feel that facilities and space dedicated to them to use, need enhancing [White Asian, Middle, P44]. One doctor clarified,

> *...the rooms are big, airy, spacious, each room has got its own bit of an equipment, so I am never having to go from room to room looking for things … things that just make things more efficient, each room has got it's own printer with its own sort of prescriptions and like label printer, ummmm ya so just things that make you save time umm I guess will make it more work conducive...* [Asian Indian, Junior, P18]

Hence, it is evident that sufficient allocation of infrastructure would result in doctors potentially being content and happy in the work environment which positively impacts EE. Additionally, doctors find the appointment time slots inadequate [Asian Indian, Senior, P2]. For example, one participant complained about the 4-hour target for ED waiting times, she said,

> *We are all running around like a headless chicken trying to provide this world-class service. It is not world class if you can't provide it! So, you need to change your goal post, ha, you need to be realistic about it and provide what you can. You can still provide a good service; you can still provide a good service without everybody feeling stressed, depressed and like we are running around aimlessly!* [Ugandan African, Middle, P56]

It was found that such time pressures can not only frustrate doctors but can also hinder their ability in maintaining good relationships with the patients which is an aspect of 'professionalism in action' as stipulated by the General Medical Council (GMC) in the good medical practice guidelines. Overall, an environment in which doctors do not feel empowered enough to be able to carry out their professional duties to the best of their abilities is unlikely to be conducive for EE. Participants expressed their frustration that arises due to failings of protocols and systems which prevent or restrict them from enacting their core duty of patient care. For example, participants said, '…*obstacles in what I believe is right care*' [Tamil Sri Lankan, Middle, P51], '…*there is, unfortunately, things that we are unable to do as either a health care system or on a smaller basis*

within the hospital or ward. It is frustrating when your hands are tied' [British, Junior, P42]; '*…either I cannot do what I want, or I am not allowed to do what I want'* [Greek, Middle, P17]. A doctor emphatically revealed that they are '*…trained to become a doctor, a clinical agent, but now…we are treated more [as] financial agents…'* [British Hong Kong Chinese, Junior, P32]. As mentioned in section 7.2 such an environment means doctors sometimes have to make decisions based on resource availability in contrast to what is 'best for the patient'. This can cause internal conflict where, doctors feel that they are not upholding their professional roles and responsibilities. Resultantly, this can negatively impact EE as the policies and practices might not be in alignment with the doctors' sense of professionalism.

The issue of overstretched resources discussed in section 7.5.2, could be aggravated by the inappropriate use of ED. For example, one doctor put it as, '*…abuse of the system by the people who could umm who don't understand or are misdirected by primary service, by the GPs, 111 to A&E, or just they don't understand what A&E is there for…'* [Italian, Middle, P49]. Another participant pointed out that some Trusts implement the policy of 'divert' which costs them, but it keeps patients safe and relieves some pressure on doctors [White British, Junior, P46]. Such protocols and policies that tackle the issue of misuse arguably could be further implemented contributing positively to EE.

Intertwined with issues of limited resources and protocols and systems, is the issue of rotas and shift swaps. Doctors find not having flexibility in leave protocols frustrating, for example, '*I follow their rules, but sometimes it is just without any clue, they just say it's not allowed to take a holiday... there is always less staff available, so they might not give you holidays, or you know that it is affecting the working of the Trust...'* [Korean, Middle, P11]. Moreover, over 25% of the participants expressed that work pressure frustrates them. For example, one participant pointed out with anguish,

> *…we [are] working to full capacity and even then we have got waiting times, about 12-13 weeks which understandably patients don't want to wait that long but there is constantly this pressure, constant from managerial staff to do more, to see more, to discharge more because obviously, they get, they get more money for seeing new patients than they do for follow ups, and they don't understand that you can't just*

> *discharge patients umm you know it's sometimes just not medically safe*
>
> *to do so...* [Chinese, Senior, P20]

So, in essence, in addition to the high-pressure work environment discussed in section 7.3, the number of unsociable hours that doctors work for a long time leads to a perception of unsustainable working lives [Italian, Middle, P49] and is arguably an obstacle in EE. This factor is also intertwined with remuneration.

Despite the pressures at work and the fact that doctors are working more than their contracted hours as discussed in previous sections, there is still a perception of a threat of a pay cut. A doctor explained in detail,

> *…my hours were meant to be 8 till 4, and I was working 7:30 till about 6:30*
>
> *every single day and that's goodwill, you are not getting paid for it, … it's*
>
> *just expected of you. Whereas if you get a significant pay cut that is not just*
>
> *that you are getting less money, but your pay is getting cut, so people are*
>
> *saying we value you less! You are going to go home on time, you know you*
>
> *are more likely to say I am not staying 2 hours extra every single night extra*
>
> *because you don't appreciate me and I don't think it's a conscious decision*
>
> *I think people are getting burnt out and frustrated and drawing a line … and*
>
> *it's affecting morale a lot... that will affect how people work, people will*
>
> *disengage when they feel they are not valued…* [White British, Junior, P46]

Another doctor clarified,

> *…You aren't allowed to become a doctor for the money… but then I think*
>
> *that to neglect the money is basically to neglect yourself – laughs – I mean*
>
> *you have to think about it. You can't really pay your mortgage with goodwill*
>
> *or altruistic.* [British Hong Kong Chinese, Junior, P32]

It is evident from such statements that the risk of a cut in remuneration can negatively impact doctors. It was found that the main driving motivational factor for a doctor is their ability to contribute to patients' health and wellbeing (altruism). Nonetheless, the services doctors provide to the NHS are done so on a 'work basis' in contrast to 'charity basis', and remuneration was found to be important to them. This could mean that although the absence of what a doctor would consider appropriate remuneration is a

factor negatively impacting EE, it's presence would not alone automatically ensure a conducive environment for EE.

7.5.4. Teamwork

In addition to the aforementioned factors, which are mostly external to the doctor community, internal collegiality, good team working, support from seniors, being able to contribute to junior colleagues' development, praise by colleagues and a discrimination-free environment were all found to be valued by the participants. Nurturing these factors through appropriate policies and practices arguably would aid in creating a conducive work environment for EE. Each factor is discussed further below.

Working in a team appears to give doctors a sense of unity, for example, one participant said, '*feeling like you are working towards a common aim*' [White, Junior, P53]. Another insisted '*team is working well, that makes me happy*' [Indian, Senior, P25]. The working team is not limited to just doctors, one of the participants explained,

> *…so not specifically work colleagues because in hospital you have to work with different teams, different ummm different locations, so you work with nurses, and you work with health care assistants, you work with radiologist…in the different teams you have to sort of speak to radiologists, you have to speak to other members of the team to refer certain patients and things like that, so I think it's very important umm to have these things functioning well!* [British Iraqi, Junior, P41]

As seen in sections 7.2 and 7.3 and from the quote above, it is evident that teamwork is a significant part of doctors' daily working lives and could impact EE. Good team working can potentially contribute in creating a conducive environment for EE, and it is also part of the two-way relationship as seen in the working definition, where doctors are expected to participate in improving the performance of the Trust. However, in the current working environment, some doctors highlighted how not having good relations with colleagues can get frustrating [Pakistani British, Middle, P33]. For example, a doctor said, '*…I work in departments where people there, you know, find it difficult to communicate with them, difficult to form a bond with them, difficult to you know… have some kind of not just working relationship but have a relationship like properly talk to them…*' [British Indian, Middle, P19]. Here, it can be said that communication

difficulties could cause problems in team dynamics, and this is discussed further in the context of ethnicity in chapter eight. It is important to note here that in line with the discussion in section 7.3, team working skills can be integral to doctors' 'success' at work. Hence, the evidence discussed above reveals that policies and practices that support good team working could also contribute positively in creating a conducive environment for EE.

As seen in section 7.2, the roles and responsibilities of doctors can be hierarchical, which means that as a part of team working there is an element of seniors supporting juniors. It was found that 'l*ack of senior support*' [Israeli Argentinian, Middle, P55] frustrates doctors, particularly when they come across a situation which makes them feel incompetent or lacking in authority. For example, a participant highlighted, '…*you just want a question answered cause you can't answer it yourself, you know if you could do it yourself, you would do it*…' [White, Junior, P53]. Sometimes, senior doctors can present themselves as being inaccessible, one doctor said, '…*if they are scary and kind of unapproachable, then you are more likely to kind of try and struggle rather than go and talk to them*…' [White British, Junior, P48]. In other situations, one doctor pointed out, '…*there are no senior cover so in that case, we don't know, at least for me, I don't know who to ask, and I sometimes feel helpless and you know bit and quite scared ummmm also on during my on calls…*' [Burmese, Middle, P38].

It was also found that support from seniors is integral to participants' happiness at work. For example, participants said, '*…actually* [it] *depend*[s] *upon good seniors, good registrars and good consultant…*' [Asian, Middle, P13], '…*the seniors they help us at every time (hmm), so I am very, uu very very happy working with them*' [Muslim Asian, Middle, P7], '*…if you are not sure of your diagnosis, or you are not sure uu what you are dealing with, you do have someone that you can speak to*' [Chinese, Middle, P9]. The support appears to give junior doctors a sense of 'safety'. However, support is not limited to just medical advice, the responses revealed that even a general 'checking up' is valued by juniors. For example, one participant explained, '*…consultant asked me, how are you feeling? you ok? can you cope? Well, that kind of questions just make me better, feel better*' [Korean, Middle, P11].

Senior support was found to be integral to a junior doctor's daily work, not only because, as discussed in section 7.2, certain treatment decisions are only in the

jurisdiction of seniors, but also because their learning is deemed to be a continuous process, with senior staff potentially playing an integral supportive role. Hence, the lack of senior support could impact a junior doctor's work, hinder good patient care and EE. There is arguably an additional benefit in encouraging senior doctors to support their juniors. Analysis of the responses revealed that senior doctors also found contributing to a junior doctor's development very satisfying. For example, a doctor was emphatic, '*my juniors and my juniors, when you teach them something… when they do well…*' [Indian British, Senior, P58]. Hence, there is potential for the Trust to possibly implement specific policies and practices that nurture this culture of supporting juniors in line with creating a conducive environment for EE. In a similar context, a culture where praising colleagues is encouraged could be beneficial. One doctor said praise from '*other team members or umm other workers, your boss*' [White, Junior, P53] makes them happy.

Unfortunately, it was found that teamwork is sometimes negatively impacted due to discrimination. For example, one participant was anguished, she said,

> *…on reflection and comparing the level of support that I got and the level of support that I feel my colleagues are getting and I know that now, I see it, when you are in it, it's not so obvious, but when you come out and reflect, and even just observing my younger colleagues' interactions, umm it's different ... I truly feel that based on who I am, what I look like, and my, perhaps even gender, that I did NOT get the support that my male blonde, blue-eyed colleagues got…* [Ugandan African, Middle, P56]

Similarly, another doctor shared her feelings and revealed,

> ...*patients or the relatives of the patient umm if you are not uummm if you are Asian doctor, they don't want to, you know, they don't want to believe, or they don't want to trust … I can see from their ummm words, from their face, so in that case, you know that's depressing for me, uuuu so these are the frustrations…* [Burmese, Middle, P38]

A participant clarified, '...*the behaviour of that nursing staff was very good with that doctor, and with the other doctors, it was not the same as with Asian doctors that's what we had experienced*' [Indian, Middle, P54]. Evidently, discriminatory behaviour

has been experienced from not only patients but also colleagues. Moreover, there also seems to be a presence of discriminatory systems as further discussed in chapter eight and although the following chapter discusses it in the context of ethnicity at length, it is important to note that discrimination in any form is not considered conducive to EE. Having deliberated on the experiences of participants there is evidence to support the argument that there is potential to implement specific policies and practices to create a conducive environment for EE. All the above themes also contribute in addressing the second research objective. The following section is concerned with the response from doctors to the conducive environment for EE.

7.6. Doctors' response to EE

As per the working definition of EE for doctors, presented in chapter three, there is a two-way relationship where the conducive environment for EE encourages doctors to advocate for their Trusts as a place of work and treatment and participate in improving its performance, as an individual, as part of a team and as or with management. The findings pertinent to these components are discussed here with an aim to address the second research objective and to contribute to contextual understanding, which aids analysis for the third research objective.

7.6.1. Advocating for the Trust as a place of work

Section 7.3 presented the differences in work environments in different Trusts. Building from this, this section specifically presents the themes that emerged as important factors considered by doctors in advocating for their Trust. It was found that good senior support encouraged doctors to advocate for their Trust as a place of work. For example, doctors revealed

> *…there's obvious connect between the higher management and the staff working at ground level* [Indian, Senior, P25]

> *…I feel I can talk to my consultants if I have issues, if I have concerns, if I am not sure, I can approach to them, talk to them, uuu I think it's a lot more of a horizontal structure to work in* [British Indian, Middle, P19]

So, senior support can be considered to be an important component that encourages doctors to advocate for their Trusts as a place of work, as well as being an important component in creating a conducive environment for EE, as seen in section 7.5.4.

Hence, potentially there could be a dual benefit for Trusts that can provide good senior support.

Other reasons for doctors to advocate for their Trusts include having well organised and smooth functioning systems [Pakistani British, Middle, P33; Malay, Junior, P37; Hungarian Caucasian, Junior, P36; Chinese, Senior, P20; Black African, Middle, P57], good resources [White Asian, Middle, P44; French British, Junior, P34], being well-staffed [Pakistani British, Middle, P33; White, Junior, P53] and having flexible contracts [Burmese, Middle, P38]. These factors are similar to some of the themes, as deliberated on in section 7.4, that emerged as integral in creating a conducive work environment for EE. Not only does this mean that Trusts with said characteristics are likely to have doctors that advocate for it as a place of work, but it also supports the working definition that incorporates advocating for the Trust as a response to a conducive environment.

It was found that good learning opportunities also encouraged doctors to advocate for their Trust as a place of work. For example, participants said,

> *…. In terms of its location and geographic, demographic of it, is very different from other parts of the UK, you get to see diseases umm that you won't be able to see in other parts of the UK, umm like you know TB, malaria and all these weird and wonderful stuff and you get excellent learning opportunities* [Malay, Junior, P37]

> *…they trying to change, they have different types of educational uuu classes or educational sessions for doctors, training doctors, non-training doctors like us, trust grade doctors, so obviously, I definitely would recommend this Trust to anybody, to any doctor, in particular to international doctors* [White Asian, Middle, P44]

> *…I recommend my Trust, if you want to learn emergency medicine experience, this is the best place for that – both laughs – you will learn or you will learn, no way out (ok right ok) because in this place you have the opportunity (hmm) some people see that like a problem (hmm) well I see that like an opportunity (hmm). We have so many patients (hmm) every day that we have a chance to learn a lot of things every day* [White mix background, Middle, P52]

It became evident that doctors value learning, and Trusts that have a varied patient base and/or high patient volume facilitate this learning. Trusts that support and provide opportunities for training could also give doctors reasons to advocate for it as a place of work.

It was also found that ethnic diversity of staff made participants want to advocate for their Trusts. In particular, one participant clarified,

> *… because it's a place where you come, and you don't feel like you are out of the ocean or out of the sea. There are different ethnic groups, different people that can be related to that have just started working there that are new to the system as well. They understand your fears and worries, you know. You have friends, people that are ready to put in, people are really friendly, people are ready to help you and teach you stuff. So, I will I would recommend it as a place of work for someone that is just starting in the NHS, 100%* [Black African, Middle, P14]

Another participant stated,

> *…the Trust that I am currently working is a very uu good Trust in particular for, for international doctors, because there are lots of international doctors and they can umm give you because they... all of them umm progress through the same career path that you need to progress! And they can tell you exactly what do you need to do to progress in your career. Umm and you can see different types of people, and you don't feel like oh you are alone, or nobody knows, or sometimes you feel that you talk differently because even we know English, English is our second language!* [White Asian, Middle, P44]

The impact of ethnicity on doctors' responses to EE is the concern of chapter eight however, there is evidence to support that immigrant doctors of ethnic minority and International Medical Graduates (IMGs), in particular, value ethnic diversity in Trusts. It can be seen from the quotes above that doctors feel more comfortable when there are 'others' in a similar situation to theirs; be it their English-speaking ability, experience in the NHS or even just the fact that they are from an ethnic minority background. Hence, there is arguably an opportunity for Trusts to not only 'market' the

ethnic diversity of the working environment but also to support and encourage its growth.

In addition to the reasons above, that were found to be encouraging advocacy for the Trust as a place of work, it was found that poor infrastructure or 'struggling hospitals' were significant factors for doctors not to advocate for it as a place of work. For example, participants said,

> *…you know one of the hospitals I work there, is … an old building, it was built in the 1970s, obviously hospitals have changed since then, and it could do a little bit more investment and make it much more ummmm easier to work in that organisation* [Indian, Senior, P16]

> *…it's a really hard place to work. Umm* [X] *is in special measures with the CQC, is a struggling hospital and it is a really difficult place to work. It's quite behind on how it run, there are a lot of things that are done in a much slower way then I was used to do in my previous hospital! (hmm), umm … it is an incredibly stressful place to work, and it is really tiring, and it is, it is a big toll on you as a person trying to kind of work in that system* [White British, Junior, P48]

These factors have also appeared in previous sections, and this supports the notion that where a conducive environment could encourage doctors to advocate for their Trusts, the inverse can be true as well, where the lack of a conducive environment could discourage doctors to advocate for their Trusts as a place of work.

7.6.2. Advocating for the Trust as a place of treatment

The empirical evidence reveals that the 'standard of care' was the most significant factor that impacted advocacy for the Trust as a place of treatment. For example, one participant explained in detail,

> *…so both the fact that there's very good facilities at* [X]*, so whether it's that you have been an accident or whether you are unwell for a medical reason, and you need to come in, I think the facilities available at* [X] *whether that's the surgical expertise, theatres, whether that's umm getting your scans done, I think all of that is really umm very good and I think in terms of the consultants that I know from having worked at the*

Trust, I think the calibre, the quality of the doctors is really very high. Ummm and also, even though like it's a tertiary centre, so we get lots of the more complicated cases and patients, it might not be reflected in figures because sometimes you are dealing with the more complicated cases and the patient outcomes aren't necessarily as good, I think the consultant manage that really well and I, you know I would trust them myself [British Asian, Junior, P24]

So, in essence, from the quote above, it can be identified that a good standard of patient care is a combination of good staff and facilities. In particular, the availability of facilities for various ethnicities was found to impact recommending the Trust as a place of treatment. For example, one doctor said,

…I suppose that does play a role because this place is so ethnically diverse that the staff is very ethnically diverse and aware or they do like lots of services, special services for lots of you know other ethnicities, umm they do advocates and you know for people who don't speak English, umm they may have great chaplaincy as well, so you know when people are dying umm they do like the, they do like you can call for a priest or an imam or something to talk to you umm so they are quite, they are very aware of the ethnical diver…ethnic diversity of it, of the area [Malay, Junior, P37]

So, although NHS Trusts do try and meet most of the societal demands of patients in the area, the Trusts that do it better seem to be easier to advocate for. Doctors value the support their patients get from their Trust, and this was found to impact them advocating for their Trust as a place of treatment. The availability of ethnically diverse doctors, and how this impacts patient care, is discussed further in chapter eight. In reference to staff being the pivotal factor in the patient receiving a good standard of care, for example, participants said,

…the people on the ground are really dedicated staff. They really care about the patients, and they think of the patients before anything else. So, they put the patients first and yes, the patients get the treatment that they deserve to get, I think ya, I would [Black African, Middle, P14]

> *…I have been there as a patient, and my patient experience has been positive. Ummm so I can only go on my personal experience, I had very fantastic nurses who were looking after me after surgery umm and they didn't know that I was the consultant … because it was a different department altogether* [Chinese, Senior, P20]

> *…I want to be safe and in safe hands (hmm) umm if I am sick or anything, I want to be in safe hands! (right) so I think that Trust A is a better place, I don't trust the doctors here in Trust B!* [Pakistani British, Middle, P33]

Evidently, a good standard of patient care is subject to the experience patients have with doctors, nurses and other staff. This supports the theme identified in section 7.5.1 where it was argued that patient satisfaction is subject to their experience with a range of staff, and not only limited to the treatment they receive from the doctors. This means that some of the remedial action for creating a conducive environment for EE, discussed in section 7.5.1 could also encourage doctors to advocate for their Trust as a place of treatment. In reference to the facilities being important in recommending the Trust as a place of treatment, a participant stated,

> *…I think it's just in terms of wait times and space sometimes, there isn't space to …… while you are waiting to be seen, there is not enough space sometimes and sometimes it takes quite a long time to get seen* [Indian, Middle, P50]

The lack of space as stated by the participant above, was unfortunately found to be an ongoing issue faced by many Trusts, as discussed in section 7.3. The underlying issue of a lack of resources was also found to be an obstacle in creating a conducive environment for EE, as deliberated upon in section 7.5.2. Hence, Trusts that have good facilities are not only more likely to find that this can contribute in creating a conducive environment for EE, but it was also found that doctors consider it in advocating for their Trust as a place for treatment. It is also evident from the quote above that waiting times can contribute to the consideration of assessing 'good standard of patient care'. Other participants stated,

> *… So, it's quite you know quick and effective, and efficient clinical care, so I would recommend* [Burmese, Middle, P38]

> *I don't recommend as a place of treatment, sadly because it is too busy, there's not enough staff, uuuu everybody's over pressured overrun, you know, I don't recommend it* [British Indian, Middle, P15]

> *…the fact that many and many and many a times I have seen people waiting 5 hours to be even seen in A&E. so I wouldn't want, you know if there is something, if my dad had chest pain, I wouldn't want him to be waiting for 5 hours to be seen* [White British, Junior, P46]

Evidently, long waiting times is a deterrent for doctors in recommending a Trust as a place of treatment. Lack of appropriate staffing emerged as a factor in section 7.5.2, and here it is one of the factors that is found to be causing a delay in patients being seen, resulting in a work environment that can be classified as 'too busy', with staff who are believed to be chronically under pressure. Overall, there is evidence to show that the efforts in creating a conducive environment for EE, as deliberated upon in section 7.5, also could positively impact doctors in recommending their Trust as a place of work and treatment. The following section is concerned with the findings pertinent to doctors participating in improving the performance of their Trust.

7.6.3. Participation in improving the performance of the Trust

It was found that participating in the performance of the Trust, either as an individual or as a team, was mainly due to intrinsic altruism, work pressure, targets or mandated participation in audits and other quality improvement projects and collegiality. As discussed in the roles and responsibilities section (7.2), a majority of doctors' work involves teamwork. So, in essence, participation in improving the performance of the Trust cannot be completely segregated into individual and team participation. For example, one participant put it as,

> *…I am a part of a big machine, I do my little part, but my little part pushed forward (hmm) could put the valve forward (hmm) so I do my best effort. I am hoping that everyone is doing their best efforts so we [are] moving forward to our goals* [White mix background, Middle, P52]

This supports the argument that participation, although on an individual basis, is the team's effort that will yield results. For example, a participant said,

> *…So I would call that all what I am doing is improving what the Trust is doing and working quite hard and significant … to get people seen in a good level, to give the best treatment available, and the kind of the care that we give in the neurology department very good, which reflects into the Trust and so there is a direct relationship between how much I perform and this reflects on the Trust's performance* [Greek Palestinian, Senior, P39]

Although the participant in the quote above is referring to his own contribution, the impact analysed is at a 'department level', which includes efforts of others. It is also perceivable that performance is identified as 'best quality treatment' and 'speed at which patients are seen', and there seems to be no significant external drive apart from a suggestion that the efforts will result in good patient care. Nonetheless, in the ED, the external pressure of efficient working seems more evident. For example, a participant explained,

> *… in A&E, its question of making sure that you are being efficient, so you try and work as quickly as possible …if you start to slack off, and you are not working as hard as you can, then it makes umm work difficult for the rest of the department or the other doctors or the nursing in the department and obviously the patients are kept waiting longer … there is constantly the 4-hour pressure, …so that's something that you do need to be very keenly aware of and so having to constantly work hard* [British Asian, Junior, P24]

So, in essence, it can be argued that efficiency is associated with working quickly, which could help the Trust meet the stipulated targets and also ensure that the patients are not kept waiting too long. It was found that Trusts also mandate involvement in audit projects. For example, participants clarified,

> *…I mean I suppose one thing is that we all have to get involved with audit project, which is where you look at how are we performing against the national standards…* [White British, Junior, P48]

> *...I think the audits will be umm good in that respect and we each have to do at least umm one per rotation, so that will be three for me, in umm the year, so every junior doctor does that, then potentially you are*

> *identifying lots of different issues in the hospital and hopefully coming up*
>
> *with an implementation to improve those* [French British, Junior, P34]

Evidently, participating in audits appears to be a process through which Trusts engage doctors in improving processes, which in turn can impact Trusts' performance. It was also found that doctors are intrinsically motivated to learn and stay up to date, which can also improve the quality of patient care. For example, participants said,

> *…got to work, I see the patients – laughs – and then I engage myself in*
> *personal reading and development, make myself a better doctor which*
> *will eventually help the Trust (hmm) and then go, try to attend*
> *educational meetings, which would also help me overall…* [Black
> African, Middle, P57]

> *…if I stay dedicated, umm I do my own job, I think the Trust is made up*
> *of I mean I will just be one individual, but I think the Trust is made many*
> *individuals and ummm if everybody stands on their duty post and does*
> *what they should do, … strives to become better ummm like we talked*
> *about continuing medical education, ummmmm maintaining*
> *competencies, developing skills, if we all strive to do that, then the Trust*
> *would be a better place to work with so I think definitely if I keep my skills*
> *up to date, continue to work with honesty and integrity, (hmm) and*
> *encourage others to do so, then I think that will ultimately improve the*
> *performance of the Trust.* [Black African, Middle, P35]

It was found that the motivation to keep knowledge and skills up to date and to learn is an intrinsic characteristic, which is not only part of 'professionalism in action', as stated by the GMC in good medical practice, but it also emerged as a theme innate to the medical profession and is discussed further in section 7.7. Nonetheless, it became evident through the quotes such as the one above that doctors attribute their professionalism to be a contribution to improving the performance of their Trust. Moreover, the quote above reveals an element of collegiality in improving the performance of the Trust. Other participants mentioned,

> *…its personal and also you know patient care, because if you are not*
> *communicating with your colleagues, if you are, you know if you are not*
> *effective as a good team, if you don't have good relations with your team,*

> *so as a team you fail to deliver the level of care to the patient* [Pakistani British, Middle, P33]

> *…discharge is a team work, like discharging patients on time, is a teamwork between physios, doctors, nurses, social care workers* [Hungarian Caucasian, Junior, P36]

> *…a team that functions well, you know team that communicates well, if a team communicates well, then you understand each person, their role… that means as a team, they provide good quality care to the patient* [British Indian, Middle, P19]

The quotes above reiterate the importance of collegiality in achieving a good standard of patient care. It appears that the core motivation for most members of teams participating in improving the performance of their Trust is altruism, where each member is trying to assist in providing good quality of care.

It was found that participation in improving the performance of the Trust as a part of or with management increases with seniority (grades). So, in essence, registrars generally work with management and consultants generally work as a part of management. For example, a participant explained,

> *…because I am often the most senior person on at night, I am a manager, you know I am responsible for the flow into the department, who comes in, who goes out, I report to the managers in the morning, I go to governance meetings, … I am mostly a clinician for sure, but I do engage in management. I am expected to, at this level* [Ugandan African, Middle, P56]

Evidently, increased seniority results in added responsibility to work with management and being accountable for supervision. As discussed in section 7.2, consultants have a responsibility for all the doctors in their team. For example, one consultant highlighted that she tries to make her team feel involved in decision making and '*connect, not as a leader to them, but as a human being where issues like sickness can be addressed locally*' [Indian, Senior, P25].

The contribution of such efforts in improving the performance of the Trust is arguably indirect. Moreover, here, the motivation appears to be collegiality. Other participants

explained how decisions and systems and processes developed by management impact their Trust. They said,

> *…when you make decisions either as a lead consultant or part of the organisational team and we say want to do that, we want to employ this person, because he is good or employ this staff as it will help and then these things are positive (hmm) momentum, and influences in a good way the care for the patient.* [Greek Palestinian, Senior, P39]

> *So, management has to have a role because management develops structures and develop pathways (hmm), if the pathways are smooth and the structure is smooth, then the patient gets a smooth experience which reflect on the quality of the Trust* [British Indian, Middle, P19]

Again, here, it is evident that the participation in improving the performance of the Trust as or with management is motivated by the drive to provide patients with a smooth experience. Hence, overall, irrespective of participating as an individual, as part of a team or as part of or with management, the primary motivation seems to be the altruistic intention of wanting to improve the quality of care for patients, and collegiality, the secondary motivation. Efforts in supporting good teamwork as discussed in section 7.5.4 could potentially encourage collegiality, but the impact on participation is arguably weak.

Analysing the evidence discussed above, it can be contended that participation is not a direct response in the two-way relationship where a conducive environment for EE is the main motivating factor for participating in improving the performance of the Trust. It was found that the main factors influencing participation in improving the performance of the Trust either as an individual or as part of a team or as part of or with management was mainly due to intrinsic altruism, work pressure, targets or mandated participation in audits or other quality improvement projects or collegiality. This argument is further supported by the factors innate to the medical profession that emerged as significant for EE and is the concern of the following section. The themes discussed above provide insights into the participants' experiences in relation to different components of the working definition of EE. These discussions aid addressing the second research objective and also provide a contextual foundation for addressing the third research objective. The conclusion section brings together all

the themes deliberated on in this chapter with an aim to address the second research objective.

7.7. Factors innate to the profession

The reason for discussing the factors that are innate to the medical profession is that the changing role of doctors working in the NHS is restricting the satisfaction gained from the patient contribution, in turn, impacting EE. All the factors discussed above require the Trust to implement appropriate policies and practices to ensure that a conducive work environment for EE is maintained. However, certain factors emerged which are innate to the role of a doctor. Analysis from the participants' responses revealed that the ability to contribute to patients' health and wellbeing, exposure to varied conditions and learning as a result, meeting and working with a variety of people and experiencing the worthiness of the profession are all factors that can positively impact EE.

Although a doctor's primary duty is to maintain the health and well-being of patients, this aspect of the profession emerged as by far the most significant factor, where 61% of participants expressed this feature of their day to day work, makes them happy. For example, one doctor put it as,

> *…when you save lives when you know people come, they are just poorly; they are not very well, and you know we with our efforts we treat them and when they recover, so that gives us a lot of happiness.* [Pakistani British, Middle, P33]

It was found that this satisfaction is not limited to treatment, but also extends to being able to renew hope or support the patient morally. For example, participants said '*psychologically if they are happy*' [Indian British, Middle, P31], '*if I can educate, if I can restore hope*' [Ugandan African, Middle, P56], '*and sometimes that can be with a patient who actually doesn't really have much going on, I find actually I get quite a lot of satisfaction from dealing with patients who have anxiety problems!*' [White British, Junior, P48]. Even assisting in the processes peripheral to the treatment was found to give participants a feeling of job fulfilment. For example, a doctor expressed,

> *I managed to push her, and you know the incision was done, and she could get in time for the Burberry modelling casting in the afternoon, so that was a good feeling you know giving someone the opportunity to*

> *participate in modelling interview for Burberry…* [Hungarian Caucasian, Junior, P36]

Other nuances that emerged include not only '*providing good quality clinical care*' [British Indian, Middle, P19] but also doing this as part of a team [Israeli Argentinian, Middle, P55; Indian, Senior, P1] as well as doing it with the support of patients who '*has an attitude that or actually got a personality that you can get along with, then you can try and make the best of the situation I think, umm that can make me feel a lot better*' [British Asian, Junior, P24]. Additionally, a doctor stated that he is '*happy when I do the diagnosis right*' [Nigerian, Middle, P26]. Considering the discussions in all the previous sections, due to the lack of resources and time pressures, doctors may sometimes leave work without the satisfaction and pride of having done a good job. This reiterates the importance of addressing the shortcomings in the efforts in creating a conducive environment for EE. Another factor that was found to be innate to the medical profession that contributes to EE is learning something new. For example, a doctor said

> *…and also that I can develop myself that I know that I am better now than I was a few months ago … I want to grow (hmm, right) so personal developmental is so important in being happy…* [Caucasian, Middle, P43]

There is evidence to show that doctors value coming across varied conditions and other learning opportunities and as discussed above in section 7.6.1. This learning opportunity was also found to be a factor that encourages advocating for the Trust as a place of work. The responses below suggest that factors pertinent to social satisfaction are twofold. Firstly, meeting and working with a vast variety of people. For example, one doctor explained,

> *…I think happy in terms of umm I meet different people... (Hmmm...) in terms of patients… meet different colleagues ...I think we have got different locum doctors where those who come around into your departments…I think you meet different doctors...you socialise sometimes, and you meet different people in teachings … (Hmmm...). You work with different kind of people in audits, quality improvement projects ... (Hmmm...).so I think it's variety of people you meet...I think,*

> *basically, personally, I think I enjoy talking to different people...* [Indian British, Middle, P31]

Secondly, it was found that experiencing the worthiness of the profession was a factor that can be considered conducive for EE. For example, participants said, *'…I am happy of the respect that still doctors have*' [Italian, Middle, P49]; *'…I am happy as well when I see how umm special this job is actually…'* [British Hong Kong Chinese, Junior, P32]; *'you are happy, and you are like oh! I did something good today'* [Black African, Middle, P14]. This includes being able to follow the footsteps of parents who are also doctors [Muslim Asian, Middle, P7].

All these factors innate to the medical profession emerged as conducive to EE, and although they are not entirely in the jurisdiction of the Trusts, it could be important for policymakers to consider these factors as supporting conditions for EE. In particular, using the findings in other sections to juxtapose the findings in this section, the themes identified for creating a conducive environment for EE are further supported. For example, 'patient appreciation' is linked with 'experiencing the worthiness of the profession'. So, in essence, arguably efforts by Trusts as discussed in section 7.5.1 in creating an environment where the chance of patients appreciating their doctors' work increases, can also be indirectly contributing to doctors experiencing the worthiness of the profession. Similarly, the remedial action required by Trusts suggested in sections 7.5.2 and 7.5.3 could support doctors in 'satisfactorily' contributing to a patient's health and wellbeing. The other two factors that emerged as conducive to EE and innate to the profession, viz, coming across varied conditions and learning as a result and working with a variety of people are linked to section 7.6.1, advocating for the Trust as a place for work and section 7.5.4, teamwork, respectively. Additionally, chapter eight deliberates on themes related to advantages of ethnic diversity which can indirectly support 'working with a variety of people'. Hence, potentially Trusts could investigate and develop opportunities for supporting these innate factors. However, this is not within the scope of this research.

7.8. Conclusion

The insights from the experiences of doctors indicate that they are working in a challenging environment. The evidence suggests that although doctors have an innate desire to do the best for their patients, they are at times in a situation where they might

have to make decisions based on limited resource availability, in contrast to purely clinical judgement. In line with the literature discussed in chapter four, there is evidence to support the argument that medical autonomy and decision-making power of doctors is being challenged both by managers and patients. In particular, it was found that certain protocols and systems and lack of resources can restrict doctors in providing the best possible care for the individual patient, and they may need to make decisions considering the patient population at large. Such decisions were found to negatively impact the satisfaction doctors get from treating patients. Also, patients' increasing expectations due to readily available information emerged as contributing to the dissonance in doctor-patient relationships. There is evidence to support the themes from chapter four, that highlight how the contemporary work environment of a doctor working in English NHS hospital Trusts is characterised by high levels of stress, due to the workloads that are increasing as a result of the lack of resources. These findings suggest that the work environment of doctors is arguably not conducive for EE.

Building from these contextual insights, the working definition of EE, as presented in chapter three, has been used to explore the experiences of the participants in each component. In the pursuit of developing policies and practices to create a conducive environment for EE, it has been found that Trusts could benefit from encouraging patients to appreciate their doctors' work, remedying certain protocols and systems that frustrate doctors, supporting teamwork and addressing wherever possible the lack of resources that hinder good standard of patient care. Additionally, training or better communication concerning all factors of the business context of the Trust could prove beneficial, particularly as the awareness of the impact of economic factors is found to be currently limited.

In line with the two-way relationship of EE conceptualised in chapter three, there is evidence to show that doctors consider factors pertinent to the work environment in advocating for their Trust as a place of work and they assess the standard of patient care in advocating for their Trust as a place of treatment. Hence, this supports the argument that advocating for the Trust is a response to a conducive environment for EE. In contrast, it was found that the main motivation for participating in improving the performance of the Trust either individually, as part of a team or with or as management is altruism and collegiality with a desire to improve the quality of care for

patients. Hence, participating in improving the performance of the Trust is arguably not a direct response to a conducive environment for EE. The findings from this chapter contribute in addressing the second research objective and chapter nine explores the themes emerging here further using the literature reviewed in chapters three and four. Using the discussions in this chapter as a foundation for contextual understanding, the following chapter investigates the impact of ethnicity on EE.

8. Impact of ethnicity on doctors' responses to EE

8.1. Introduction

Having deliberated on the findings of self-perceived ethnicity in chapter six, and Employee Engagement (EE) in chapter seven, this chapter presents the empirical evidence that explores the impact of the dual nature of ethnicity on doctors' responses to EE practices with an aim to address the third research objective. As discussed in chapter two, the social experience of living with an identity, even if it is entirely internally defined involves the external attribution of characterisation, which can vary subject to the constitution of the audience. The consolidation of all such internal and external processes are collectively referred to as the dual nature of ethnicity. Ethnicity is conceptualised as an identity that is self-perceived, subjective, contextual and fluid as presented in chapter two. EE is conceptualised as a two-way relationship as discussed in chapter three. In this chapter, responses of the participants that specifically examined the impact of ethnicity, drawing on the components of the working definition, are discussed in conjunction with themes that emerged from the analysis.

It has been found that the decisions and interactions which are constantly taking place can be influenced by a person's deep-rooted beliefs and values. For example, one doctor said, '*well that I think that comes down to ethnicity and culture and the way you are brought up. You know they feed into that a lot (hmm). So that's how they would influence it'* [White, Junior, P53]. It emerged that variations among doctors of different ethnicities and its impact can be exemplified due to the arguably high-pressure work environment, as discussed in chapter seven. For example, one participant said,

> *…if you are stretched, and you don't have time to think over what you are going to do (hmm), then you are going to go back on how your, you were brought up to uu react, so yes ethnicity is influencing* [Greek, Middle, P17]

This quote is an example of doctors not having enough time to hold back and give a fully contemplated reaction. In such situations, sometimes, ethnicity-specific pre-conditions can impact the way in which doctors respond. As discussed in chapters two and six, ethnicity was found to be synchronous with a person's beliefs and values, and hence the impact is incorporated in the analysis. For example, a participant said,

'…e*thnicity shouldn't play a role, but we are all conditioned, aren't we…? I think I come with my own prejudices, umm consciously or subconsciously'* [Ugandan African, Middle, P56]. Another doctor put it as, '*… even though we don't think our ethnic umm backgrounds influence or so, I think they do more than we realise'* [Black African, Middle, P35]. Evidently, although the impact of ethnicity in a work environment is not always clear, some participants acknowledged the possible link on reflection. So, in essence, this supports the argument that ethnicity can impact doctors' responses. The sections below discuss each theme in detail and in particular how ethnicity impacts specific components of EE. In some situations, the variations, due to ethnicity, on the responses to EE practices were found to be reduced because of the role of professionalism, and this is the concern of section 8.7.

Throughout this chapter, the variations in doctors' responses to the components of the working definition of EE due to ethnicity are investigated. The notion of professionalism adopted is as per the Good Medical Practice (GMP) guidelines, provided by the General Medical Council (GMC), against which the professional standards of all doctors are ascertained (Dearman et al., 2017). These include the responsibility of doctors in keeping knowledge and skills up-to-date, maintaining good relationships with patients and colleagues, remaining honest and trustworthy, acting with integrity and within the law, respecting the rights to privacy and dignity of patients (GMC, 2013).

Section 8.2 is concerned with the impact of ethnicity on EE as a result of the exposure outside of the UK, which has been found to be consistent among doctors of non-British ethnicities. Section 8.3 discusses the burden of reputation that doctors of an ethnic minority can have, which emerges as impacting EE. It has also been found that values among doctors of different ethnicities impacted their responses to components of EE and this is the concern of section 8.4. Section 8.5 deliberates on the findings that suggest how ethnic cohesion and discrimination can impact EE. In addition to the themes above, personality emerges as possibly playing a role in responses to EE practices. Section 8.6 highlights why this would need further investigation. Professionalism has been found to render the responses to certain components to be the same irrespective of ethnicity as discussed in section 8.7. The final section, 8.8 draws on all the findings discussed in this chapter and presents the conclusions which draw on the findings of chapters six and seven and the working definition of EE as presented in chapter three.

8.2. Exposure outside the UK

Adopting the approach taken by Healy and Oikelome (2011), the ascriptions 'migrant worker' and 'ethnic minority' are not conflated, but the overlapping nature is embraced. In line with the discussions in chapter six that document the importance of exposure and the country that an individual is brought up in for identifying self-perceived ethnicity, it was found that doctors who identified themselves as either British Indian, British Chinese or British African etc., have had enough exposure to the British ways of working to include it in their identification of self-perceived ethnicity. Some doctors who have trained abroad, i.e. International Medical Graduates (IMGs) were found to have different working styles compared to those of the same ethnicity who would have had substantial exposure in the UK. For example, one participant explained,

> *…I have seen Afro-Caribbean people who are umm maybe brought up in Africa, studied in Africa, did their medical degree in Africa, probably worked a few years in Africa as a doctor or maybe as a paediatrician and have now moved across to the UK, ummm their style, their behaviours, is different, I am not saying better, I am not saying worse, I am saying different (hmm) to the Afro-Caribbean people who have born and brought up in the UK, studied in the UK, they probably both see themselves as Afro-Caribbean heritage (hmm) ummmm but their behaviours and value systems are slightly different (right) only because they have had different experiences in life…* [British Indian, Middle, P19]

The impact of such differences on EE are discussed further in this section. The terms 'non-British ethnicities' and IMGs are used here to identify those doctors who are probably immigrants and/or have had significant exposure outside of the UK and consequently the NHS.

This exposure as well as the lack of experience in the NHS, positively and negatively, impact their responses to EE. Specifically, two doctors maintained that their non-British backgrounds made them feel less aware of the business context [Greek, Middle, P17; Black African, Middle, P57] and one doctor insisted that the political climate in her home country, made her disinterested in politics, leading her to not being aware of political issues of the UK [Hungarian Caucasian, Junior, P36]. Only one doctor insisted that politics does not influence the NHS Trusts [White mix background,

Middle, P52]. In contrast, as evident from the findings presented in chapter seven, there is heightened awareness of the business context among doctors who have had significant exposure in the UK, either because they have been born or brought up here, graduated from a UK university or have lived in the UK, and worked in the NHS for a long period.

Participants who felt ethnicity only has a minor impact on their awareness of the business context proposed alternate factors that could affect their awareness. These include an individual's interest [Israeli Argentinian, Middle, P55; Nigerian, Middle, P26], grade/level of the doctor in the Trust [Indian, Senior, P25], it was their duty to stay aware [Indian British, Middle, P31], the working environment creating the need [White British, Junior, P48], or it was important as part of their job [Chinese, Senior, P20]. Although these arguments suggest reduced impact of ethnicity, overall analysis pointed to the impact possibly being relevant, even if it might be indirect and in varying intensity. As it will be discussed later in this chapter, the interests of individuals who identify as being part of the same ethnicity can sometimes be similar. Hence, it can be argued that the impact on awareness of the business context due to the interest of an individual may not be completely independent of ethnicity. The other reasons that emerged, are interlinked with professionalism and the duties of a doctor, which could impact the awareness of the business context. However, ethnicity could also have a role to play, albeit indirect, that could have an impact, as discussed in section 8.4.

On a positive note, exposure out of the UK provided doctors with the ability to compare and contrast the NHS with other public health care systems around the world. Such comparisons can allow doctors to embrace the shortcomings of the NHS. For example, one doctor explained in detail,

> *Well, all the difference between our health care systems, … a lot of things, I have more opportunities here, to develop myself, I have better salary, the quality of life is better, the quality of the health care is better, the environment in the hospital is better, uu working hours, I would say they are better, so there are plenty of things that are better in the UK which will drag me back to the UK…. the equipment is quite good, there is enough money in the system, not like you know the Hungarian one, uuu this is one thing that affects me in a, in a positive way, I think it*

prevents burnout, that you have your opportunity to use those equipment that you want, and you can have your help, for example, there is always one consultant … who you can ask if you need help and there is also a senior fellow who you can ask for a help. Ummmm and I think what is good in the, in the Trust, in compare [comparison] *to Hungarian system is that we, in the UK, there is a totally different attitude dealing with, with the incidents, in Hungary, there is an incident we try to ignore it, we don't really want to uuuuuummmmm face it, we don't really want to work with it, and by we, I mean the whole system not, I don't want to include myself, but umm you know that is the system. But in the NHS, I think it's really good; there is a incident reporting system which helps to identify the causes of the incidents and try to prevent them* [Caucasian, Middle, P43]

In particular, such comparisons with healthcare systems outside the UK seem to make individuals appreciate what they have in the NHS, because they compare what they would have had in their home country and in some situations, those scenarios could be far worse. In such situations, the frustration due to the lack of resources and remuneration issues discussed in chapter seven were found to be less impactful on EE for such doctors. Another doctor explained how the patient dynamics also vary,

…so, there are so many things that make patient not to have umm adequate care which they desire. While in the UK, it's different. Everyone comes in; everyone gets treated, even the ones that don't want to be treated, we practically beg them oh! could you just stay back, please! You know you need these, it's good for you, you know, basically, that's it, so ya I think that's the difference… [Black African, Middle, P14].

Again, in chapter seven, how the patients and doctors interact and the importance of these interactions, in reference to EE has been discussed at length. It was found that an alternative perspective held by doctors of non-British ethnicity can change the way in which they respond to such interactions. The responses can arguably be multifaceted in the sense that the behaviour and expectations of the NHS patients can sometimes be, as evident from the above quote, unfathomable. The partnership approach expected of a doctor working in the NHS, as discussed in chapter seven,

can be frustrating for those who have not had significant exposure to British values and beliefs.

In addition to variations due to ethnicity in patient interactions, differences were also found in levels of expectations about remuneration. For example, one doctor explained how she feels content with the conditions and proposed salaries because she compares them with what she would have received in her home country. She said,

> *…you know in Hungary, we are in a totally different pay scale and Hungary, we have a totally different attitude as well and to be honest umm I have been thinking about these junior doctor contracts but even with these conditions these are like very favourable to me at the moment, because I can you know, with my salary I can support my family, I can put aside my money , I can, I have enrolled in 3 very good courses… and you know I didn't have any trouble for you know paying them... so I didn't really feel hampered by these junior doctors contract fears….*
> [Hungarian Caucasian, Junior, P36]

This supports the conclusion that doctors of non-British ethnicity consciously and sometimes subconsciously could compare their personal and/or patients' situations in their home country and arguably can become more tolerant to the issues regarding remuneration and lack of resources in the NHS. This, in turn, means that their perception of what a conducive environment for EE is, could be slightly less demanding.

The ability to scrutinise situations in light of their experiences outside the UK was found to result in International Medical Graduates (IMGs) sometimes having a comparative perspective on day to day events. The benefit of cultural sensitivity and complementary experiences outside the NHS is discussed in section 8.5. Here, the argument is more on a policies and practices level, where having worked in a different system can aid recommending or identifying areas that could potentially benefit from changing. For example, a doctor of Pakistani origin who has graduated and worked in Pakistan insisted that the exposure and health system problems in Pakistan allowed him to not only cope better but also to identify problems within the NHS [Pakistani British, Middle, P33].

The aforementioned ability to compare and contrast was also found to impact the component of the working definition of EE, 'recommending the Trust as a place of work and/or treatment'. For example, comparing the quality of care a person receives in the doctor's native country, few participants insisted they are very comfortable in recommending their Trust as a place of treatment [Hungarian Caucasian, Junior, P36, Libyan British, Junior, P30]. One doctor put it as,

> …because you know uuuu we don't have very good health care (hmm) in Burma, so you know I will be very happy to recommend that oh this hospital is very good one, so that's to do with my ethnicity and my background, I, I think you know ummmm I think because I know that ummm back home I wouldn't get that umm good quality of care (hmm) so I think my ethnicity would play a centre role [Burmese, Middle, P38]

It was found that the basis of recommending the Trust as a place of treatment and, in some cases, for work as well varies between ethnicities. Section 8.4 discusses the basis for the variations further. Empirical evidence suggests that doctors who have worked in or seen patients suffer in other health care systems worse than the NHS can be less dependent on the merits of the individual Trust. For example, participants said,

> …you are poor… you get a poor service … And [in the NHS] … you know its equal access for everybody. They are equal services for everybody… [Ugandan African, Middle, P56]

> …I think it influences because you know, I come from a different country and I am quite appreciative of what all things are available here… maybe because it's like, for me it's like nice, compared to Hungary for example. Umm maybe it plays a role in giving positive feedback [Hungarian Caucasian, Junior, P36]

Evidently, doctors' exposure to healthcare systems that have more negatives than the NHS seems to result in them being more appreciative of the standard of patient care being offered here, which could positively impact their advocacy for their Trust as a place of treatment.

In addition to the above positive impact of exposure in a healthcare system other than the NHS, it was found that IMGs had to sometimes unlearn processes or habits picked up while working outside of the UK and put in extra efforts to adopt working styles as required for the NHS. For example, one participant said that '*…ethnicity does play a role in the sense that we need to learn this thing to get used to the system because we are totally from a different environment*' [Indian, Middle, P27]. Another doctor explained that she kept forgetting to close curtains and log out of computers, as this was not something, she was used to doing in her home country [Hungarian Caucasian, Junior, P36]. A doctor who had trained and practiced in India, pointed out that she has to put in extra efforts to remember not to disclose patients' information to the relatives before explicit permission from the patient [Indian, Middle, P54]. Similarly, it was found that maintaining privacy is sometimes not a part of some cultures. For example, a doctor revealed, '*…in Iraqi culture we work, you know privacy isn't a big deal, umm if you tell someone else about someone else's illness, that's not seen as a big problem…*' [British Iraqi, Junior, P41]. Such professional habits were found to lead to doctors struggling with maintaining privacy and dignity of a patient at times, which is a core component of 'professionalism in action' guidance. Similarly, the approach that is taken by doctors of an ethnic minority was found to be different, which can impact the relationship between them and the patient. For example, one doctor explained,

> *… so, I felt that* [in the NHS] *it is really patient centred like you know in, Hungary has a good health care, but we behave in a more paternalistic way, you know, you take that medicine, I don't explain why you have to take it, just take it …. I am busy, I am running around … but here you know you need to explain things, you need to get the patients in the loop…* [Hungarian Caucasian, Junior, P36]

Such variations among IMGs, can arguably diminish with experience and exposure in the UK. Nonetheless, the differences in values and working styles were found to have impacted their participation in teamworking. For example, a participant highlighted that doctors with the same ethnic background as hers would normally try and resolve any issues among themselves whereas British doctors involve managers straightaway [White Asian, Middle, P44]. It was also found that some doctors of ethnic minorities can be more tolerant when working in teams. For example, one participant was emphatic,

> *…I have never complained about anybody before (hmm), but I have seen my counterpart colleagues who umm Caucasian colleagues here, they are willing to complain about anyone, even themselves, anybody who they think is pulling down the Trust (hmm) in anyway… even though we don't think our ethnic umm backgrounds influence or so, I think they do more than we realise* [Black African, Middle, P35]

The discussions above support the argument that tolerance to embrace and accept minor irregularities can, in some situations, come not only due to the beliefs but also sometimes due to the experiences of worse situations outside the NHS.

Overall, the findings suggest that non-British ethnic doctors can have the ability to compare and contrast the NHS with other health care systems. This ability was found to be a result of exposure, but in the context of EE, it can be associated with some benefits and disadvantages. The disadvantage can be that the exposure abroad is in lieu of the exposure in the UK and experience in the NHS which could result in a reduced level of awareness of the business context and could require IMGs to unlearn habits that are inappropriate as per the standards required in the UK. The advantages can be that the exposure may enable doctors to embrace the lack of availability of resources and issues with remuneration that could upset some colleagues who have not had similar experiences. This comparison was found to impact the responses of some doctors who identify as a non-British ethnicity in advocating for their Trust as a place of treatment, and the perception of what is and what is not a conducive environment. Empirical evidence also suggests that there appears to be an intrinsic burden of reputation on some ethnic minority doctors which is discussed further below.

8.3. The burden of reputation on ethnic minorities

Responses during the semi-structured interviews suggested that sometimes doctors of non-British ethnicity were conscious that they may need to behave with exemplary integrity and probity, in order to avoid alienating themselves and risking tarnishing the reputation of their ethnic minority peers. For example, a participant said,

> *…I think that when you are in a different country, you just try to fit in and I think it has to do with being not British but Hungarian like ya, so I am not British, and I am Hungarian, and I think that's why I would like to you know, do as the British want me to do, (laughs). So that they won't tell*

> *that oh! that Eastern European, she lives according to her own*
> *principles.* [Hungarian Caucasian, Junior, P36]

Here, the participant is evidently adjusting the expression of her ethnicity and is trying to protect the reputation of 'Eastern Europeans'. In such situations, arguably, it is not only the identity of the doctor but the identity that others attribute to him/her that could alter the response. In particular, in this quote, it is evident that the doctor is aware that others are judging or identifying her as an Eastern European, and hence attempts to behave in a manner which she perceives as expected from the audience.

Similarly, another participant explained how she works harder to make sure that her patients and colleagues do not conclude that '*Korean doctors* [are] *crap*' [Korean, Middle, P11]. Such efforts were found to be sometimes directed towards eliminating prejudices and stereotypes. For example, one doctor clarified,

> *… I think when especially when there is not many other people of a*
> *different ethnicity ummm other than umm English white, then I think*
> *being of a different ethnicity, I feel like umm it is important to make sure*
> *that I work as hard as I can, because even though ummm Asians in*
> *England isn't a very rare thing to see, I think sometimes you do come*
> *across umm prejudices and stereotypes, where some people just think*
> *that you are just not gonna work as hard, or you are not gonna be as*
> *good, … there is that, that thing that you know you need to prove yourself*
> *in a way; I think a lot of people probably feel like that but think perhaps*
> *the fact that I am from a different ethnicity might play a bit more into*
> *that…* [British Asian, Junior, P24]

Evidently, the participant feels obliged to prove her competence, just because she fears others might judge her. The empirical evidence suggests that doctors consciously feel that the potential external attribution of their ethnicity and resultant stereotyping can impact the reputation of others who share a similar ethnic identity in a multi-ethnic work environment. Additionally, there can be a risk of prejudice and stereotyping which could impact their behaviour.

The data collected during the semi-structured interviews suggests that doctors of British ethnicity do not experience this conscious notion of being judged. However, this might need further investigation in the future with a focus on this theme. The impact of

the number of years spent in the UK and the position (level) on this burden was non-conclusive, out of the scope of this research and would require further investigation. Nevertheless, the findings contribute to understanding why doctors of an ethnic minority may decide to put in extra efforts which may be in the form of keeping their knowledge and skills up to date, maintaining good relationships with patients and colleagues and participating in teamwork, potentially impacting their responses to EE policies and practices. The following section discusses the findings related to the values of the participants that were found to have role in them responding to EE policies and practices.

8.4. Values

It was found that values consistent with certain ethnicities can impact the responses to EE. The notion of professionalism that is used to contextualise the working definition of EE as discussed in chapter four documents the importance of keeping knowledge and skills up to date. The empirical evidence from this research suggests that doctors of certain ethnicities potentially have a greater emphasis on education. In particular, some Asian participants explained that within their ethnicity, it was considered normal for parents to insist on higher education. For example, doctors pointed out,

> *… Asian parents tend to be quite umm forceful when it comes to academic umm achievements, and I think that's still continued … I think part of that ambition has probably come down in, through my upbringing...* [British Asian, Junior, P24]

> *…but I think by virtue of umm sort of growing up and being brought up as a Chinese person, a lot of emphasis was placed on education and doing well in school. That is the basically the only thing I can – laughs – it's either that or abject failure (ya) when you are growing up… probably being brought up knowing education is important* [British Hong Kong Chinese, Junior, P32]

Evidently, the socially inherited values through ancestry could become an integral part of values and beliefs of participants. In particular, the value of higher education emerged as a characteristic of participants who identified as having an ethnicity associated with Asia. The analysis of the responses of the semi-structured interviews only found this particular group of ethnicities as having this characteristic. However,

this is not to say that other participants who identified with a non-Asian ethnicity would not share this characteristic but the limited data that emerged only pointed to Asian ethnicities as having this characteristic. These findings are further explored along with the literature in chapter nine. Nevertheless, doctors who identify with ethnicities that put a greater emphasis on education could arguably respond differently to the policies and practices aimed at supporting keeping knowledge and skills up to date and hence EE.

Similarly, advocating for the Trust was also found to be impacted by values. For example, one doctor insisted that Hungarians are pessimistic and would refrain from recommending anything to anyone [Caucasian, Middle, P43] whereas another doctor insisted that it is common for people of her ethnicity to advocate for the employer they are working for, because, '*namak khaya uski thaali me ched nahi karte*' [Indian, Middle, P54] meaning that we should remain loyal to the workplace from where we earn our living. Such differences appear to contribute to the doctors' responses to EE practices. In particular, the analysis suggests that the ethnicities that have beliefs about remaining loyal could lead doctors of such ethnicities to be less inclined to not advocate for their Trusts as they could perceive this as a breach of loyalty. The following section is concerned with the empirical evidence that reveals the impact of ethnic cohesion and discrimination on participants' responses to EE.

8.5. Ethnic cohesion and discrimination

It was found that there was an impact of ethnicity in the way in which doctors maintain relationships with patients and/or colleagues, respect the rights to privacy and dignity of patients, advocate for their Trusts as a place of work and/or treatment and participate in improving its performance. The variations as discussed below appeared to stem from the values consistent with the participants' ethnicities.

In the context of maintaining good relationships with colleagues and patients, a participant highlighted that the cultural differences among doctors of different ethnicities resulted in them having varied approaches. He observed that doctors of Indian ethnicity are '*…a bit more caring and family orientated than would be the case otherwise …as an Indian I would approach relationships with colleagues in a slightly different way uuuummm I would say warmer way*' [Indian, Senior, P16]. Another doctor explicitly mentioned that his ethnicity leads him to be more respectful towards female

and older team members impacting his relationship with them [Pakistani British, Middle, P33]. Such variations could lead to approaching relationships differently, where, not only outwardly expressed behaviours but internal expectations from others can also be different. This can arguably both help and hinder maintaining good relationships in the working environment. For example, the warmer or more respectful approach might be appreciated by the recipient but if it is not reciprocated, then unless the doctor is culturally conscious, it might be perceived as insensitive. On the other side of the spectrum, in some situations, the overtly personal approach that is intended as a warm gesture might not be appreciated by the recipient and perceived as intrusive. For example, one doctor said,

> …*you have different expectations, on how you behave, and these expectations may lead to some miscommunication or differences in the way you communicate, so you could have seen a conflict rising because people coming from different places, talking through different languages or means, are used to different things* [Greek Palestinian, Senior, P39]

Such empirical evidence supports the argument that varying values and expectations among different ethnicities are relevant in the day to day working lives of the doctors working in the NHS Trusts.

It was found that conflict due to lack of cultural awareness can be detrimental in the efforts in creating a conducive environment for EE in particular not only for maintaining good relationships with colleagues and patients but also for teamwork. Training about cultural differences could aid increasing awareness and potentially avoiding situations of conflict. Ideally, it can be argued that doctors should be able to provide a culturally sensitive service where the patients' expectations based on culture are met. Likewise, interpersonal relationships could also benefit. It also became evident that varying professional values can impact interpersonal relationships and sometimes lead to miscommunication. For example, participants highlighted,

> …*some people thought I was rude … if I say I need this, I need that, we need this, I need that, there is no 'would you mind', 'please', do you know like, that's a very Israeli typical and also if I had a problem with something or with somebody I will just go and say I have problem with you. Not like that but I will say… I think this is wrong or I think this is completely –*

laughs – completely irrational and unreasonable… like if you have a problem in England, you have to go behind their backs, to the manager, tell them that something's wrong and maybe they will talk to the person, and it's like… we are little kids in kindergarten you know you go to the teacher and tell him he did this to me he did that to me! So Israeli society is no bull shit (hmm) you know, straight to the point. [Israeli Argentinian, Middle, P55]

…a German that tells you exactly what you do could sound rude … in the eyes of a Greek because he is not letting him have any uu initiative. Uuu on the other side, a Greek that gives a lot of initiatives to German people might seems to be less organised or so ya ethnicity has to do, plays part in a group thing. [Greek, Middle, P17]

The varying approaches seen in the quotes above suggest how such varying communication approaches can sometimes be misunderstood and perceived as rude or intrusive. Hence, it can be argued that what is considered normal and/or professional to a doctor of a certain ethnicity or is perceived as rude to another can jeopardise teamwork.

In addition to the varying approaches and the issue of being perceived as inappropriate if behaving in a way which is not the perceived norm, there is also empirical evidence to show that varying social values can also hinder team working. For example, one participant shared her feelings and said,

…they will think I am useless and ummm you know I don't know anything, and I am always shy and ummm uuu the British people they want some, they want people very you know cheerful, sociable, initiative, interactive, so I think umm ethnicity plays a very uuu important role. [Burmese, Middle, P38]

Along the same lines, another doctor explained how she struggles with participating in teamwork. She said,

… teamwork was really hard for me, cause I just feel like ummm we are not on the same page, we don't speak the same language, even if I speak English… if you know what I mean… there are lots of differences

> *between ethnicities…* [also in] *Malaysian culture, girls are meant to be shy… I don't think it helps, as long as you don't do with things like you know you don't curse or talk like on a very high volume, uuu you… being shy is quite impeding in doing what you need to do* [Malay, Junior, P37]

Here, the value believed to be consistent with this participant's ethnicity of not being too outspoken, in particular for females, is considered as good etiquette. However, this can prove to be a disadvantage in the NHS work environment, particularly because as seen in chapter seven, teamwork was found to be a significant component of doctors' day to day activities. So, in essence, teamwork, that is considered important for a conducive environment for EE can arguably be hampered by stereotyping or contextual expression of ethnicity. This understanding could potentially benefit Trusts that look to support good teamwork in an effort to create a conducive environment for EE.

Although the differences between ethnicities can sometimes hinder teamwork, ethnic cohesion was found to be beneficial for doctors in maintaining good relationships with their patients and colleagues. The findings suggest that doctors from the same ethnicity tend to understand each other better and can also have common topics that could aid collegiality. For example, a doctor explained,

> *… I am from India… it takes time for us to get mixed with the people who are from here (hmm) because of the culture and this thing because you don't have the common topics which can be then shared with them. Apart from, the medicine side, (hmm) if you want to be friendly with your colleague, and everything, it's not always the medicine you discuss … because you are not from here, you don't know, suppose as for example, people over here, the common topic football, I am not at all interested in that, I don't know the name of the footballer, so I can't participate in them, ummm (conversation) ya conversations, even with the film hero, film actress, one of the day one of the consultant was asking oh you know that he is… do you know him? For me it was no one because I hadn't heard the name of that, so I cannot oh ya! Like that, that, but if it is like Amitabh Bachchan, like that, you say that from India, you can easily participate, Sachin Tendulkar, this (hmm) that is the difference I found*

when you want to mix up with them (sure)… so when there are colleagues, doctors who are from the Asian backgrounds, we can easily talk to them (hmm right) because of the same culture, same family value … [Indian, Middle, P54]

The quote above indicates that doctors can appreciate conversations about something other than just medicine and colleagues who share similar ethnicities tend to have shared culture, family values and interests that facilitate such conversations. The family and social dynamics are usually also very similar arguably allowing for a greater bond to develop, hence, potentially facilitating the component of 'professionalism in action', maintaining good relationships with colleagues. This, in turn, can also be positive for teamworking and hence EE. Additionally, as already seen in chapter seven, the presence of ethnically diverse staff can also positively impact advocating for the Trust as a place of work. For example, one participant said,

…here ethnicity, when I join here what I see is that, a lot of people from my own ethnicity or may be from multicultural people around, so you do not feel like you are lost somewhere. You have got some sort of support around, people telling you what to do, usually when it come to a different Trust, when people had an experience of, as a doctor like… from different background they came in and join here and they give their experience, which is really helpful to me, so that sort of way, I found good. [Indian, Junior, P28]

From the quote above it is evident that doctors can perceive an environment with other ethnic diverse staff as more supportive as they potentially have colleagues who might have been through similar journey as theirs. Homogeneity of social dynamics was found to be beneficial with colleagues as well as patients. For example, a participant revealed that when there is a patient from the same ethnic group as the doctor, there is sometimes, a greater level of comfort due to the feeling of having a connection [Black African, Middle, P14]. Such a connection and knowledge of cultural norms can help in maintaining good relationships with patients. Another doctor said,

…they [patients] *are first generation here and they came here long back, and they understand Hindi and bits and bits of English. So, communication with them has been helpful for me because sometimes*

> *British consultant or British colleagues do not understand, they do not know how they will react, they do not know what their interests are but because I am from India and I know the language that helps me a lot…*
> [Indian, Middle, P27]

Additionally, patients from different ethnicities can arguably have varying social requirements, and some doctors from similar ethnicities were found to have a deeper understanding of such requirements. For example, one participant revealed how she regularly gets sent patients who do not wish to be seen by her male colleagues. She said,

> *… the perception that patients have will vary according to the ethnicity and the sex of their doctor particularly in a field like obstetrics and gynaecology, umm so for example, many a time, I have got a male colleague who is an excellent clinician and these are colleagues that are senior to me as well as those that are junior to me, are not able to look after some groups of pregnant women and I get called in to say you know I am sorry I have to ring you, this patient will not let me examine her, because I am a male doctor, and she, her religion doesn't allow her to be examined by a male doctor* [British Indian, Middle, P15]

Such differences can hinder doctor-patient relationships, or in situations where the doctor and patient share similar cultural values, it can be beneficial in supporting maintaining a good relationship with the patient. For example, one doctor said,

> *…you have people that are of the same, similar background to you then you can understand, like especially when it comes to things like privacy and dignity and there are a lot of like Asian women sometimes, are quite particular about seeing females and making sure that they are covered and that no one can see what's going on (hmm) so I think sometimes you are a bit more sensitive with people that has similar backgrounds to you because you know they are particular about certain things…* [Indian, Middle, P50]

Similarly, other participants pointed out,

…while approaching people and understanding ummm, I am thinking about umm, for example, some problems when I was umm, there was a Muslim lady umm who had a problem, and I need to take some help but she had basically in 'burkha' and so in the end while I was starting to discuss about that, I realised that actually umm this was probably, despite the husband being there, umm I understand it, she felt really uncomfortable and umm so I offered a possibility of a female doctor to examine her. Umm I mean after this experience, this is an error which probably if I had come from a British culture or multicultural environment, probably I wouldn't have done…ya, so there are some very specific things about approaching different cultures. Also, sometimes it is very funny because the description of pain, there are studies about the description of chest pain or the intensity of pain, some people come in from different cultures with a completely different and odd ways to think, to describe the same thing and also the some of them tend to exaggerate! Umm as a cultural thing because they think like they need to have more attention! (hmm) so and you risk is to underestimate because whether exaggerating or panic, panic because you think it's much more serious than what it is … [Italian, Middle, P49]

… you would assume that medicine is medicine, ha, that that the medicine I provide to my Indian lady with diabetes, should be the same medicine I provide to my white British lady with diabetes. I think the difference is a social one. The difference is the complex social issues that these people come with… [Ugandan African, Middle, P56]

These participants are evidently aware of varying needs of patients based on their ethnicities. This awareness can positively contribute to them maintaining a good relationship with patients and in respecting the rights to dignity and privacy of patients. The variations among patients due to their ethnicities is not in the scope of this research. Nonetheless, it was found that doctors through their experience can learn to respect the needs of patients. For example, one doctor explained

…you know for, to manage their treatment and umm probably help us in being better doctors to them, it's not just the same ethnicity but also

> *having meeting patients of different ethnicity, you get to learn about the other cultures and other backgrounds of patients when, what sort of care they require and treating patients according to that, so.*[Indian, Junior, P12]

However, the cultural sensitivity evident in the quotes above was found to be higher among ethnic minority doctors and those with a significant amount of experience. So, although the impact of ethnicity appears not to be independent of experience, arguably there is potential for Trusts to incorporate cultural awareness training in an effort to create a conducive environment for EE.

The findings are consistent with the analysis in the previous chapter that discussed the perception of doctors who feel that managers do not understand the ground realities. In particular, ethnic minority doctors feel that the ethnic diversity of staff and patients is not reflected in the management of the Trusts. For example, one doctor was emphatic,

> *…you know if ethnic minorities aren't given managerial positions, then nothing is going to change, yes, if we are not heard, if there is no voice, no avenue, then nothing is going to change… if your management team is all Caucasian, and the people you have coming through East London doors, are Indian, African, Greek, you know Italian, Turkish, then really, I don't see, how you are going to provide a balanced service … because the NHS presents this white face, white managerial process, you come in, you are spoken to like an idiot, you are looked at you know as if you are dangerous, you know this, socially, I think this is it, ha, that actually is a very good point that the managerial team is all white British and the people who are actually using the service aren't, so of course it's going to be a mismatch* [Ugandan African, Middle, P56]

The empirical evidence here suggests that there is a gap in representation of ethnic minority doctors. Arguably, this gap can contribute to distributive injustice through discrimination in opportunities for progress and the absence of 'representatives' can render the procedures for justice lacking transparency and unfair. This is discussed further in chapter nine where the literature is used to compare the findings.

In contrast to the negative impact of discrimination, one of the benefits of diversity that emerged was that working in multicultural teams can positively impact teamwork. For example, a participant said,

> *…I enjoy working as part of team that is built up with various cultures and backgrounds (hmm) umm the team that I am quite closed to at the moment, my surgical team, for example, umm we have got one of white boy, he is British, then there is a girl who is Nigerian and another girl who is from Singapore, and so we are all very very mixed and its very interesting to see that actually obviously we are all from different parts of the country, different parts of the world* [French British, Junior, P34]

In addition to this positive impact, the analysis also revealed a potential negative impact. For example, a participant said,

> *…I was asking questions as in you know the most basic like you know what's a BM, I didn't know BM means your blood sugar but in Israel we call it blood sugar, not BM, so I think in all the last couple of years, ummm even though the job title is the same, I am you know I am more aware, more ummm fluent in not just the jargon, the referral procedures, the clerking, all the language they use…* [Israeli Argentinian, Middle, P55]

Such responses suggest that when doctors of non-British ethnicity have a reduced ability to speak and communicate fluently in English, then this can sometimes hinder teamwork and maintaining good relationships with patients and colleagues. It was also found that this communication problem includes the use of certain jargons, abbreviations and culture-specific phrases that are unknown to the doctor.

Another factor that emerged as impacting EE was stereotyping, and discrimination based on ethnicity. For example, a participant said, '[I] *looked after an old man when I worked in Norwich who was really surprised that I could speak English because here I am, brown, talking to this very white man*' [British Indian, Middle, P15]. Here, it is evident that the patient judged the doctor based on his/her ethnicity. Such derogatory behaviour sometimes shown to doctors of non-British ethnicity can be detrimental in creating an environment conducive for EE. This was found to be particularly relevant for teamwork. For example, one doctor emotionally explained her experience of discrimination and stereotyping.

> *…because of my ethnicity, and because I am a foreigner here, I really, feel powerless to change anything, I do… and then that leads you into thoughts of so why am I bothering. Ya so you come to work, you keep your head down, you do a good job and go home and get paid I think that is the attitude one starts to adopt, doctor after a while… if you feel powerless to change anything, you won't engage… I feel that whenever I ask somebody to do something, it takes them half an hour or they give me this funny look, or they go away, and chit chat with somebody else, … because* [xxx]*, the black female registrar gave the order, you know if those are the things that I am coming against every day, then I will not engage. I will come to work very despondent, very broken and uninterested …I do think when, if I observe umm people's response if the same orders came from my blonde colleague, then you know I think sometimes the response is different …* [also] *I truly feel that based on who I am, what I look like, and my, perhaps even gender, that I did NOT get the support that my male blonde, blue-eyed colleagues got… I think because umm I am, I come from this culture where I am a black woman, I am supposed to be quiet and do as I am told, sometimes, umm for myself, that is the mould that I appear to conform to. So, so sometimes, and especially in this culture, silence is very much mistaken for she doesn't know, she doesn't care, she is stupid, ha, so that is detrimental sometimes...The other thing is people stereotype you, ha, … because you are a black woman, you MUST be angry.* [Ugandan African, Middle, P56]

In chapter seven, in the context of teamwork, the importance of senior support and the detrimental impact of discrimination was presented. Building from this, the above quote evidences how the dual nature of a doctor's ethnicity has perhaps resulted in her appearing to be disengaged. The work environment described by her is arguably not conducive for EE for multiple reasons. Firstly, the doctor feels she is unable to voice her opinions or contribute to improving the service, particularly, because of her non-British identity. This could initiate a chain reaction where she might end up feeling disengaged and resultantly might not contribute to her full potential that could lead to missed opportunities for progression. This, in turn, could further frustrate her because

there can be a feeling that she is being left behind in comparison to other colleagues. Secondly, the discrimination experienced on the basis of ethnicity can sometimes be in the form of lack of senior support, and as already presented in chapter seven, this can hinder good team working and hence EE.

It also became evident that there can also be discrimination from some other members of staff in the form of not respecting the doctor at times due to her ethnicity. The same participant went on to explain at length (the full transcript is in appendix 11), how medical decisions or diagnosis and prognosis made by her were frequently disregarded by patients and even nurses because of her ethnicity. She further went on to explain how she felt discriminated against, due to certain policies and practices. She said,

> *…if I have trained in a developing country where really my role is clinical, and you are now asking me to award it, to do an international presentation, without really giving me the tools, by the way… and by tools, I mean, 10 years ago, we only just got the internet… I am now expected having trained and umm born and brought up in a developing country to have advanced excel spreadsheets, you know what I mean, … if I am expected to come up with wonderful poster presentations, and you haven't told me how to do that, then how am I going to achieve?...* [ibid]

Such sentiments were shared by other participants as well, however this participant particularly explained it well. Overall, there is evidence that suggests that the issue of discrimination is present at three levels; the policies and practices (organisational level), colleagues (service providers) and patients (service users). Discrimination at policy level was found to relate to the lack of sensitivity where ethnic minority doctors' varying abilities are argubaly not taken into account at the time of policy creation. For example, policies like having to be good at poster presentations and Excel skills to prove clinical acumen could disadvantage doctors from ethnic minorities, especially the ones coming from developing countries. Furthermore, discrimination from some colleagues and other staff where sometimes people stereotype doctors from ethnic minority was found to potentially lead to difficulties in team working and maintaining

good relationships with patients and colleagues. Personality emerged as a theme related to impact of ethnicity on EE and is the concern of the following section.

8.6. Impact of personality

As discussed in chapter two, not only is ethnicity considered to be instrumental in the construction of personality of an individual, but personality was also found to play a role between an individual and the environment. So, in essence, the personality can arguably impact the dual nature of ethnicity. For example, in line with the literature, a participant said, '*I guess ethnicity kind of shapes your personality and your character and your way of thinking'* [Asian Indian, Junior, P18]*.* Hence, this could be the reason why some respondents seemed to be confused between the impact of personality and ethnicity. Participants, at times, insisted that their responses to EE were more of a product of their personality rather than ethnicity. For example, one participant said,

> *…I honestly, I would be guessing to say what role it* [ethnicity] *did have! Because you know I have not been raised in a different culture so I don't have an idea of what I would like otherwise (hmm) umm and I have got friends of all different ethnicities that their personalities don't correlate you know with their ethnicity…* [White British, Junior, P46]

The impact of personality is not to be dismissed but would need an investigation that is focused on the impact of personality on workers' responses to EE practices. For example, one participant said, *'…have played role in their grooming in the personality that is how ethnicity plays a role…'* [Pakistani British, Middle, P23]. In this research, although it is evident that the impact on workers' responses to EE practices is multifaceted, the focus remains on the impact of ethnicity. In particular, where participants have insisted that the differentiator in responses to EE practices is personality and not ethnicity, they have been found to be focusing on interpersonal dynamics. A conversation with one of the participants summarises the interplay.

> *…I think relationship with colleagues mostly comes down to personalities. Umm and whether they get on well, whether they are very neutral or whether they in fact clash. Umm and that's a function of your personality and their personality'* [British Hong Kong Chinese, Junior, P32]

The same participant then goes on to accept that ethnicity also has a role to play. He said,

> *… I saw a consultant, who works in my speciality, umm at the same time treating a patient, umm with another doctor and it just so happened that they both were from Italy. Umm and so then after seeing their name badges or hearing their each other accents or something, they somehow kind of worked out that they were both from Italy, and so then afterwards they said oh are you from Italy? Yes, I am! You know hello! – laughs – so that sort of thing. Umm I mean I guess maybe like going on in the future, they might have a better working relationship knowing that they both come from the same country and going by their accents, they probably umm they have immigrated to this country from Italy, so maybe they have some sort of bond there…* [ibid]

Here, both ethnicity and personality of the doctor are arguably guiding the interaction. The ethnic cohesion can contribute in multiple ways like creating a deeper experience during mentoring, improving relationship due to a better understanding of each other's social values and possibly also language as discussed in detail in the above sections. The interactions of doctors in the work environment are also found to be impacted by the 'professionalism in action' guidance by the GMC, which is discussed further in the section below.

8.7. 'Professionalism in action' and impact of ethnicity

As discussed above ethnicity was found to impact doctors' responses to EE practices. However, there is also evidence to suggest that the professionalism of a doctor can render the response to certain components to be the same irrespective of ethnicity. As discussed in chapter four and presented in section 8.1, the notion of professionalism adopted for this research is as per the GMC guidelines. In particular, there was evidence suggesting no impact of ethnicity on two components of 'professionalism in action' guidance, viz, acting with integrity and within the law and remaining honest and trustworthy. It was found that doctors strive to uphold certain standards of professional duties within NHS Trusts and can actively suppress, where possible or appropriate, any personal trait that is deemed to be inappropriate. For example, doctors explained,

…I guess the same goes with the profession that you choose, so I don't know, I think for me it… its integral part of somebody who wants to be a doctor and care for the people to have this kind of trustworthiness and honesty and things cause otherwise you will just, I mean its contradictory, to what you choose as a profession. [Asian Indian, Junior, P18]

…you just... that is not an option to not be honest, is not an option… I am a doctor so again you just don't lie…that's the way you should be, you should be honest, you should be truthful… [Indian British, Senior, P58]

I do not think my ethnicity plays a massive role, because you see doctors who are not for example from Pakistan uphold the same values, so the White British doctors uphold the same values for being a doctor and the black African, Arabians they uphold the same values. Pakistani Doctors or any doctors basically any doctor upholds same values… [Pakistani, Junior, P29]

…I expect a Greek-German to have the same attitude and British Indian to have a same attitude and a British British to have a same attitude sort of, these are things which are standard, particularly, in the British culture, so there is a level you expect to have and a standard where you function as a medical profession regardless of your background and ethnicity… as a doctor, you, there are certain standards and proficiencies you keep to… because there is a role you play here, and you can't say this is how I do, as a standard you are expected. It may change from country to country, you may go to another country, and you may speak with a doctor who is smoking in front of you! So, there are influences there, and you may have somebody coming from that culture which used to smoke in front of the patient, but the moment you are in the NHS, you will have to accept the standards which are here, so you have to adapt to that because of your ethnicity to make a standard which is expected from the population you treat [Greek Palestinian, Senior, P39]

So, in essence, the above quotes support the argument that there are certain standards that are usually maintained by all doctors irrespective of ethnicity and certain habits or traits are normally kept under control. In addition, participants also pointed out that their expression of ethnicity is different in a work setting. For example, one participant said, *'…in the sense that you know if I go to the mandir* [temple]*, and I mean that type of environment, my outlook, behaviour slightly changes than if I am at work…'* [British Indian, Middle, P19]. Particularly, in the NHS, the risk of losing the license to practice as a result of not acting with integrity and within the law and remaining honest and trustworthy was found to be so high, that irrespective of ethnicity, doctors would ensure that they behave as per the expected standards of the role. For example, one participant clarified,

> *… they call it probity so anything where, if you are ever found to be umm concealing something or sort of acting in dishonest way, whether that be cheating on exams or umm if you get in any trouble with the police, I remember we got a speech in the beginning of medical school about umm if you skip fares on the bus, that could be the end of your medical career because that counts as a dishonesty issue… I suppose the only time it can be difficult is umm when there are mistakes made with a patient! So, it's really difficult to then go and be really honest with that patient and explain that something's been done that shouldn't have been done and its affected your care and with apologising for it and that can really be difficult because obviously, people get angry. But it's, it's a much better way of dealing with it than try and conceal it obviously… again that's a massive GMC issue, so anything outside of the law would be end of your career pretty much... so, you just if you want to carry on working, then you don't have a choice – giggles – you have to you can't be doing anything that's illegal. Even if it's a minor thing like, like a speeding ticket or something like that, that can be something that can affect your career so, I think because it's the way medicine is, the profession, they have this umm big thing about umm representing the profession, representing the NHS, so your personal life is kind of up for scrutiny as much just as your professional life, so you don't really have*

> *a choice. Umm so it's about kind of being in professional mode 99% of*
> *the time* [White British, Junior, P48]

Evidently, the law itself or GMC guidelines play the greatest role in acting with integrity and within the law and remaining honest and trustworthy. One participant pointed out that, every doctor has to sign a probity agreement when they join the NHS [Tamil Sri Lankan, Middle, P51]. This leads to a legal duty to act with integrity and within the law and remain honest and trustworthy. Another doctor put it as *'…it's a duty you have, as part of GMC guidance and that's part of duties of a doctor to stay honest and trustworthy, so this is a duty you have to have as part of your profession'* [Greek Palestinian, Senior, P39]. Similarly, in reference to acting with integrity and within the law, one doctor said, *'…so the law itself will, is what will keep me acting within the law'* [British Hong Kong Chinese, Junior, P32]. Nevertheless, some Muslim participants insisted that their upbringing and religion influence them remaining honest and trustworthy. For example, one doctor emphasised, '*my ethnicity is quite conservative and umm stresses a lot on umm like being honest and not tell lies and ummmm you know to abide by your religion, and things like that, so it's ya, I guess that's how it influences it*' [Malay, Junior, P37]. However, this impact seems to be more focused on religion and as discussed in chapters two and six, the role of religion in ethnicity would need further investigation. The conclusion section below aims to synthesise all the findings discussed above to address the third research objective.

8.8. Conclusion

This chapter discussed the findings of the impact of the dual nature of ethnicity on EE and revealed the reasons for and variations among doctors of different ethnicities in responding to EE policies and practices. The findings here draw on not only the working definition of EE and two-way relationship conceptualised in chapter three but also the findings from chapters six and seven with an aim to address the third research objective. It has been found that there can be an impact of ethnicity on doctors' responses to EE practices and policies, particularly due to the high-pressure work environment. However, there was evidence to suggest that there is no impact of ethnicity on acting with integrity and within the law and remaining honest and trustworthy.

Doctors of non-British ethnicities have been found to be less aware of the business context of NHS Trusts, however, arguably with time the disparity may gradually diminish. Drawing from the findings from chapter seven, the exposure that these doctors have outside of the NHS can reduce the negative impact of lack of resources, irregularities in protocols and systems and remuneration issues which have been found to hinder the creation of a conducive environment for EE. It has been found that the dual nature of ethnicity, can negatively and positively impact good team working, maintaining good relationships with colleagues and patients. Negatively, because it can jeopardise good team working due to misunderstandings caused by varying communication styles and approaches, along with difficulties in communicating fluently in English. Also, discriminatory policies and behaviour faced by doctors of non-British ethnicities, from staff and patients, were found to negatively impact these components. In contrast, shared values and beliefs and cultural awareness can positively impact these components due to ethnic cohesion.

Values related to education particularly among Asian ethnicities were found to positively impact the component of 'professionalism in action' guidance, keeping knowledge and skills up to date. It was found that the perception of being judged can result in doctors of ethnic minority putting in extra efforts in keeping their knowledge and skills up to date, maintaining good relationships with patients and colleagues and participating in team working. There was evidence to suggest that some professional habits of IMGs can negatively impact respecting the rights to privacy and dignity of patients and may have to be unlearnt. In relation to advocating for the Trust as a place of work and treatment, it was found that values and beliefs consistent with the doctor's ethnicity can have a positive and negative impact. Where the Trusts that have more ethnically diverse staff, it can positively impact advocacy particularly by doctors of an ethnic minority and lack of facilities for ethnic minority patients was found to negatively impact advocacy.

The following and final chapter compares these findings with the relevant literature and is concerned with conclusions addressing the research objectives along with documenting the contributions to knowledge, practical implications, research limitations and recommendations for future research.

9. Discussions and Conclusions

9.1. Introduction

This research contributes to understanding the experiences of doctors working in English NHS hospital Trusts in context of their ethnicity and Employee Engagement (EE). Specifically, this research investigates factors influencing self-perceived ethnicity and responses to EE policies and practices. The core contribution of this research to the body of knowledge around EE is the study of the impact of ethnicity on doctors' responses to EE. The findings within this research aim to fill gaps in the literature and address the call for EE to be examined in relation to ethnicity.

The purpose of this chapter is to discuss and combine the empirical findings presented in chapters six, seven and eight with the literature reviewed in chapters two, three and four. Furthermore, this chapter brings together the overall thesis by addressing the research objectives along with documenting the contributions to our knowledge and practical implications related to ethnicity and EE. The intention of this study was not to investigate in-depth current HR practices but in contrast it considers doctors' experiences of EE. Analysis of the findings is then used to suggest changes to policies and practices that may compliment ongoing efforts of NHS Trusts. The final two sections of this chapter reflect on the limitations of the research undertaken and suggest avenues for further research.

This study is grounded in my personal interest in investigating why individuals at work and in particular, doctors, working in the NHS exhibit varying working styles. My earlier knowledge from MSc in Business Psychology and its subsequent dissertation led me to the investigations around ethnicity and EE as outlined in this dissertation. My thesis is that the dual nature of ethnicity can impact doctors' responses to EE practices in English NHS hospital Trusts. In this thesis, ethnicity is conceptualised as a self-perceived identity which is subjective, fluid and contextual. EE is conceptualised as a two-way relationship where Trusts have the potential to create a conducive environment for EE through policies and practices that are in alignment with the 'professionalism in action' guidance provided by the GMC. The conducive environment in turn can encourage doctors to advocate for their Trusts as a place of work and treatment and indirectly supports their participation in improving its performance.

Sections 9.2, 9.3 and 9.4 each review components of this thesis while addressing objectives one, two and three respectively. Sections 9.5, 9.6 and 9.7 are concerned with the contribution to knowledge, practical implications and limitations of this research respectively. Section 9.8 suggests avenues for further research while section 9.9 provides an overall conclusion to the dissertation.

9.2. The dual nature of, and factors implicated in, self-perceived ethnicity

The literature reviewed in chapter two revealed how the contemporary workforce is already multi-ethnic due to political and technological advancements (cf. United Nations Statistics Division, 2009; Giddens, 2009; Bisin et al., 2010). The proportion of such employees is growing continuously (Coleman, 2013; NHS Employers, 2017b). In the UK, in order to combat shortages in the local labour market, significant inflows of migrants (Hussein et al., 2014) have resulted in the current 'super-diverse' state of the country (Finney & Simpson, 2009; Vertovec, 2007) and the NHS (NHS careers, 2011; Healy & Oikelome, 2011). This supports the relevance and significance of the research focus.

Although official instruments such as the NHS and the UK national census ethnicity code lists accept the use of self-perceived ethnicity (Aspinall, 2001; Stronks et al., 2009), they are believed to lag behind social change due to the pressure of retaining comparability with previous measures (Ratcliffe, 2014). The findings presented in chapter six detail how the identification of self-perceived ethnicity without using a predefined ethnicity list can allow for a richer context to be revealed by respondents. This is in line with literature (cf. Woolf et al., 2011) that points out how predefined ethnic categories cannot cover all the finest disparities. The empirical evidence reveals that predefined ethnicity lists tend to camouflage varying identities and restrict nuances to emerge. Identification of self-perceived ethnicity without using a predefined list allowed respondents to identify themselves freely, enabling the subjective and context-specific nature of ethnicity to be expressed.

The subjectivity at the core of the concept of ethnicity discloses its fluid and situationally constructed nature which has been incorporated in the proposed definition of ethnicity. The external attribution of characterisation is arguably seen with all identities where even if the identity is entirely internally defined, the social experience of living with that identity can vary depending on the context and constitution of the

audience (Ville & Guerin- Pace, 2005). The expression of ethnicity is believed to be a result of the individuals' perceptions of its meaning to the audience along with its relevance and purpose of its expression (Nagel, 1994). As discussed in chapters two and six, the consolidation of these internal and external processes are referred to as the dual nature of ethnicity (Jenkins, 1997, 1994) in the research.

The findings presented in chapter six address the first objective, which was to explore the factors being frequently considered by social actors in the self-attribution of ethnicity. These findings were used to modify the working definition and present a definition of ethnicity based on insights from the experiences of social actors. This definition that contributes to the current body of literature reads as,

> *The identity that individuals give themselves subject to the context and considering selectively their country of birth, ancestry and the culture and language they adopt based on their exposure.*

This definition describes ethnicity as an identity which begins developing from late childhood (Umana-Taylor et al., 2014) as discussed in chapter two. During adolescence, an individual consciously identifies their own cultural values, beliefs and traditions (Chavez & Guido-Dibrito, 1999) and contrasts them with 'others' that they are exposed to (Weber, 1978 in Roth & Wittich, 1978) laying the foundation for ethnicity (Laursen & Williams, 2002 in Pulkkinen & Caspi, 2002). The empirical evidence supports the argument that this identity is not static and the socially inherited traits such as language and culture can be shaped, reshaped and expressed subject to the audience and setting. This shaping and reshaping was found to be a result of ethnic integration where the socialisation, and in some cases, migration, leads to exposure to differing values, norms and possibly even languages resulting in the subjective adoption of these.

Two components of the definition, however, did not appear to be fluid; 'country of birth' and 'ancestry'. Additionally, the exposure due to the country in which an individual is brought up in is considered 'not fluid' after the individual reaches adulthood. Country of birth was found to be one of the most frequently relied upon factors by participants in self-attribution of ethnicity. Research (cf. Bhopal, 2004) also documents the importance of country of birth in the identification of ethnicity. However, no other definition of ethnicity explicitly incorporates it. Using it as a proxy for ethnicity is also

no longer appropriate (The Scottish Public Health Observatory, 2016). The findings of this research support this by recognising that it is not necessary that all individuals consider their country of birth in identifying their ethnicity. Nonetheless, it was found that country of birth can be a pivotal factor in self-identification for second and third generation migrants in justifying a different ethnicity or mix of ethnicities to their parents. While there is evidence to suggest that the country of birth contributes to a sense of belonging to more than one country, it is not necessarily an indicator of the degree of integration. The degree of integration is rather subject to the duration of exposure. Based on the findings of this research, it is argued that inclusion of country of birth in the definition of ethnicity is integral and its omission from other definitions currently documented in the literature is believed to be a drawback. This emphasises the contribution to our knowledge.

As already stated, and discussed in detail in chapter two, ethnicity is considered to be grounded during childhood and adolescence. The importance of exposure due to the country in which an individual is brought up in, also emerged as significant in the identification of self-perceived ethnicity from the analysis of responses by participants in chapter six. However, the country in which the participants were brought up in, characterised the exposure received during a crucial phase of ethnic identity formation. For example, an individual who is born in the USA, and adopted by parents who identify as Indian, but brought up in the UK, might not adopt the same primary language, dressing preferences or food habits as his/her parents due to his or her exposure in school and socialisation thereafter resulting in him/her identifying as either British or British Indian.

The 'ancestry' to this individual is his foster parents and grandparents and including it in the definition concurs with literature (cf. Fenton, 1999, 2010; Hutchinson & Smith, 1996). Additionally, the findings revealed that participants consider those ancestors that they have had exposure to, in their identification of self-perceived ethnicity. Hence, ancestry is accepted here as socially constructed because the individual will not necessarily consider his/her birth, parents or grandparents, but will consider the ethnicity of his/her foster parents and grandparents in defining his/her own ethnicity. In the example above, country of birth, the exposure (in the UK) during childhood and his/her ancestry is non-fluid, but this individual may move on to live in Australia, and with time and exposure there, may decide to identify as Australian or Australian Indian.

This supports the argument that all components of the definition, including the ones that are considered non-fluid, are subjective and suggests the more significant factor in self-attribution of ethnicity is exposure. The inclusion of exposure in the definition supports the originality and its contribution to knowledge.

The empirical evidence also revealed that exposure was a significant indicator of the culture and language adopted. Subjective elements of culture such as social norms, values, beliefs, food habits, dressing and festivals were found to be adopted based on exposure both from 'within' and 'outside' of the ethnic group. Similarly, the adopted language of participants was subject to exposure. In contrast to culture, language was found to play a less pivotal role in 'exclusion' from identifying to a particular ethnicity. So, for example, not sharing cultural elements with an ethnic group was found to be a greater reason for not identifying with that group. In contrast, where even if the 'normal' language of the ethnic group was not known, other components of the definition were compelling enough for the participant to identify with that group. Both these components, language and culture, are subject to change over time, usually as a result of a change of exposure.

In addition to the fluidity of language and culture over time, ethnicity was also found to be subject to the audience or context and the actual or expected reaction of the audience. For example, an individual might feel completely comfortable in expressing his or her Indian culture and language at a community event, they might choose to hide these elements in a work setting. This is so because, at a community event, they might find that their ethnicity allows them to support their similarities with the others present, whereas, in a work setting the individuals might fear prejudice, discrimination and exploitation. As a result, these aforementioned social actors may decide to camouflage their ethnic identity. So, although the UK government through policy implementation is believed to encourage cultural pluralism, the findings suggest that this is yet to be truly reflected in the work environment of English NHS hospital Trusts. The following section is concerned with the conclusions and discussions addressing the second research objective.

9.3. An environment conducive to EE?

This section synthesises the literature reviewed of EE in chapter three, the NHS in chapter four and the findings discussed in chapter seven, in order to address the

second objective of this research, i.e. to explore the experiences of EE of doctors in relation to the EE practices. The HRM approach that conceptualises EE as a two-way relationship has shown to yield positive organisational outcomes (cf. Purcell, 2014; Truss et al., 2013; Valentin, 2014; Sparrow, 2013; Wollard & Shuck, 2011). Such outcomes are possibly the main reason for EE to remain one of the most popular and important contemporary management topics, despite the criticism due to the lack of agreement on the definition (cf. Briner, 2014; Guest, 2014 in Truss et al., 2014). In the NHS in particular, EE is considered pivotal for success in achieving overall organisational and financial effectiveness and desired quality of care for patients (NHS employers, 2013b; Ham, 2014; Jones, 2016). The investigations support the already well-documented fact as discussed in detail in chapter four, that English NHS hospital Trusts are currently facing a chronic crisis with a shortage of resources resulting in a diminished level of staff morale (Evans et al., 2015) which is in turn impacting patient care (NHS England, 2017a; Ham, 2017).

Having adopted the HRM approach, on the basis of the literature reviewed in chapter three, which conceptualises EE as a two-way relationship, the definition of EE that is subjective and contextual is presented as

> *Creating a conducive environment through policies and practices which are in alignment with doctors' professionalism. The doctor would be aware of the business context and would advocate for his/her Trust, as a place of work and treatment, ensuring that he/she participates in improving the performance of his/her Trust by working individually and as part of a team (including working with or as management).*

The working definition of EE is contextualised using 'professionalism in action' guidance for doctors as stipulated in the Good Medical Practice (GMP) by the General Medical Council (GMC). The findings revealed that Trusts do support doctors in keeping their knowledge and skills up to date by having certain allocations for paid learning and organising training sessions, especially if it is classified as mandatory by the GMC. However, engaging in this training and finding time for it was found to be the responsibility of the doctor. Building from the literature, the findings support that the positive benefits for EE are sometimes diminished due to the stressful work

environment where doctors struggle to find the time (cf. West, 2016; Royal College of Physicians, 2016; Ross et al., 2013) to attend these training sessions.

Similarly, it was found that doctors can be frustrated with the limited time they have in seeing patients and other infrastructure issues like lack of space and outdated systems, discussed later in this section, which can strain the doctor-patient relationship. The analysis shows that this can also negatively impact the doctors' ability to maintain good relationships with patients. Concurring with the literature, it was found that the majority of the work of doctors is teamwork, and maintaining good relationships with colleagues, is not only arguably integral to 'professionalism in action', but also to the smooth functioning of the Trust. The high levels of stress and pressure of targets and timekeeping were found to potentially hinder teamworking and can negatively influence the ability of doctors to maintain good relationships with their colleagues. This is in line with the literature (cf. McCartney, 2016) that suggests doctors are no longer able to leave work with satisfaction and pride of having done a good job. Hence, there is potential for Trusts to understand the issues faced on the frontline and develop policies and practices accordingly which in turn could aid in creating an environment conducive for EE.

Remaining honest and trustworthy and acting with integrity and within the law was found to be integral to 'professionalism in action' and the findings reveal that the GMC guidelines have the greatest role to play in ensuring doctors adhere to the required standards. Trusts were found to create the necessary rules, checks and balances to ensure doctors work within their boundaries. However, the role of the Trust is arguably limited. Similarly, it was found that respecting the rights to privacy and dignity of patients is a GMC enforced principle. The processes and protocols of the Trust were found to support and ensure that the principle is upheld by doctors on a day to day basis. Participants revealed that posters are used as reminders to not discuss patient information in public areas. However, in the Emergency Department (ED) in particular, it was found that the overstretched infrastructure and poorly planned departments sometimes can make it difficult for doctors to maintain privacy. Such day to day issues were found to be important for doctors in adhering to the 'professionalism in action' guidance which means Trusts would need to focus on all these issues in pursuit of creating a conducive environment for EE.

The working definition for EE incorporates the need for employees to be aware of the business context. This awareness not only assists in them appreciating and understanding how their role impacts the organisation's outcomes (Robinson et al., 2004), but it is also believed that an environment that is conducive for EE involves employees in decision making (Alfes et al., 2010).The findings revealed that the awareness of funding and budgets was the highest, closely followed by resources, mainly because these were the most prominent factors impacting doctors' day to day work. The impact of societal demands and political factors were either well-known or unknown to the participants and awareness of the impact of economic factors was the least. There was no evidence of any training or information being provided by Trusts to increase the awareness of the business context and efforts in this direction could prove beneficial for EE.

Investigating the two-way relationship of EE as conceptualised in chapter three, the findings reveal that in recommending their Trusts as a place of work, doctors consider factors pertinent to the work environment. Whereas, in recommending the Trust as a place of treatment, they tend to consider the standard of patient care. The reasons that emerged for not advocating their Trust as a place of treatment are in line with the factors discussed below in pursuit of creating a conducive environment for EE. This supports the argument that creating a conducive environment for EE could encourage doctors to advocate for their Trusts as a place of work and treatment. In contrast, participating in improving the performance of their Trusts either individually, as part of a team or with or as part of management was found not to be significantly impacted by the presence of a conducive environment for EE. Altruism and collegiality were found to be the key motivating factors for doctors to participate in improving the performance of their Trusts. So, in essence, although this component is included in the working definition of EE, it would need further investigation to ascertain how altruism and collegiality are impacted by the lack of a conducive environment for EE.

Literature (cf. Harris, 2017; Edwards et al., 2002; Iacobucci, 2017; Godlee, 2017) documents that the doctor-patient relationship is sometimes strained due to a shift away from the paternalistic approach of medicine and readily available information for patients. The findings suggest that a negative impact on team working and maintaining good relationships with colleagues could affect collegiality. Hence, indirectly, a conducive environment for EE can encourage doctors in participating in improving the

performance of the Trust, but this could be due to the impact on altruism and collegiality. Literature (cf. Dromey, 2014; Purcell, 2012, 2014) supports the argument that participating in improving the performance of the organisation is considered as an indicator of EE. Hence, the working definition is not modified as this would need further investigation.

In line with the literature, the empirical evidence shows an extremely hierarchical work environment, with interdependency and team working (cf. Lewis & Tully, 2009; Sexton et al., 2000; Jones, 2017). In this work environment, ethnicity was found to sometimes impact team working as discussed in section 9.4. The findings suggest that participating with or as part of management, is only limited to certain consultant level doctors. It was found that they can have both clinical and managerial responsibilities. The GMC stipulate four domains expected from all registered medical practitioners (GMC, 2017). However, the focus is patient or clinically oriented duties, and arguably the lived managerial responsibilities mentioned by participants is not accounted for. Empirical evidence is in line with the literature (cf. Oxtoby, 2016) which shows that having to juggle the demands between management and clinical duties can make the senior doctors feel their wealth of experience gained over the years is less employed. So, in essence, the push of the NHS to involve doctors more in management could hinder creating a conducive environment for EE. In contrast, the analysis supports that by enhancing systems that enable doctors to contribute or voice their opinions for managing the Trusts, it could aid in creating a conducive environment for EE.

The doctors working in the contemporary environment in the NHS were found to be witnessing their professional autonomy and power being challenged by both management and patients. The literature reviewed reveals how the organisational level changes have left doctors feeling pressurised for financial targets set by managers (Harris, 2017), who in the eyes of doctors, cannot understand the day to day and hands-on issues of patient care (Moberly, 2015). On the one hand, the GMC insists on doctors' responsibilities that equates to doing the best for individual patients.Yet, on the other hand, doctors are pushed to consider the health and well-being of the patient community at large in contrast to the individual patient in front of them (Aronson, 2016). Arguably this can negatively impact the efforts in creating a conducive environment for EE.

Analysis of the responses revealed that factors innate to the role of a doctor like, the ability to contribute to patients' health and wellbeing, coming across varied conditions and learning as a result, meeting and working with a variety of people and experiencing the worthiness of the profession are all factors that doctors value and hence need consideration in creating a conducive environment for EE. These innate factors are arguably not in direct control of the Trust. Nonetheless, efforts in creating a conducive environment as per the findings could positively impact these factors.

The empirical evidence discussed in chapter seven suggests that doctors depend on appreciation of their work from patients and relatives. However, in line with the literature (cf. Harris, 2017; Edwards et al., 2002) it was found that tacit knowledge which provides medical professionals authority is being challenged by patients, due to the readily available information that has a purview of enlightening the laymen, impacting the satisfaction with the treatment they receive (cf. Iacobucci, 2017; Godlee, 2017). This was found to negatively impact patients in expressing their appreciation. Additionally, the patient or their relatives expressing appreciation to a doctor was found to be dependent on multiple factors like, patient expectations, overall experience with gaining access to the medical services which includes waiting times, the infrastructure and processes. Hence, in pursuit of a conducive environment for EE, the NHS could benefit from encouraging patients to express their appreciation to doctors, work with government and media to manage expectations, and communicate the limitations of healthcare to patients.

Another arena that emerged from the analysis of the findings that impacted EE and could be improved by the NHS Trusts was protocols and systems. Currently, the findings suggest that there are administrative issues, outdated systems and not well thought out allocation of infrastructure that can frustrate doctors. The increasing dependency on protocols and reducing autonomy is heavily debated in the literature (cf. Griffiths et al., 1983; Leverment, 2002; Chambers, 2017) and there is evidence to show that this may result in some doctors feeling undermined as they feel unable to make judgements purely based on clinical outcomes. It was found that the targets and time slots allocated to doctors for seeing patients can result in them feeling they have 'obstacles' in right care. If such issues are remedied, then it could contribute to creating a conducive environment for EE.

One underlying factor that is arguably not easily remedied but emerged as integral for a conducive environment for EE is resolving the lack of resources. As discussed in chapter four, the NHS is funded through general taxation (Tweddell, 2008; McKenna & Dunn, 2015) and the current austerity has led to a decrease in funding (The King's Fund, 2017). So, although funding is not considered to be directly in control of NHS Trusts in England, the findings suggest that this is hindering the creation of a conducive environment for EE. In this cash-squeezed environment, participants felt that the NHS is being systematically destroyed with a stressed and overworked labour force that is continuously getting more and more stretched. Additionally, it is irrefutable that there is a connection between inappropriate staffing and reduced service quality (Hurst & Kelley- Patterson, 2014). Hence, addressing the lack of resources is arguably integral for creating a conducive environment for EE.

Although the findings support the argument that the doctors' main motivation for going to work is the ability to contribute to patients' health and wellbeing, remuneration also emerged as a factor that impacts EE. The recent disputes with junior doctor contracts were found to affect the morale of doctors making them feel undervalued. Research has also shown that pay and workload impact morale, however, increased pay with lower workload on their own, does not guarantee high morale (cf. Edwards et al., 2002). It was found that the high-pressure environment has caused chronic levels of stress and reduced health and wellbeing of doctors resulting in absenteeism which can further aggravate the problem. Along with the workforce, the infrastructure was also found to be overstretched with a constant pressure to discharge patients in order to ensure beds are available for new admissions. This environment was found to restrain doctors in being able to perform their duties to their fullest and can negatively impact EE.

In addition to the above factors, insights from the experiences of doctors revealed that internal collegiality, good team working, support from seniors, being able to contribute to junior colleagues' development and praise by co-workers were all found to be valued by participants. Hence, Trusts should aim to support these factors through appropriate policies and practices which could, in turn, contribute to creating a conducive work environment for EE. In concurrence with the literature (cf. Stevenson & Rao, 2014; Naqvi et al., 2016; Bécares, 2008; West et al., 2015), it was found that

discrimination, lack of support and guidance negatively impacted some of the above factors. The impact this can have on EE is discussed in detail in the section below.

9.4. The impact of ethnicity on doctors' responses to EE practices

Chapter eight documents the empirical evidence that contributes in addressing the research aim, i.e. understanding the impact of ethnicity in the variations in doctors' responses to EE, in English NHS hospital Trusts. These findings are used along with the literature about 'ethnicity at work' and in particular, 'ethnicity in the NHS' to address the third objective of this research, i.e. to explore the influence of doctors' ethnicity on their responses to the EE practices. As stated above in section 9.2, it is evident that ethnicity is a topic of significant importance. In particular the NHS spends 70% of its annual budget on staff (Charlesworth and Lafond, 2017). Moreover, 41% of doctors identify themselves as of non-white ethnicity (according to the NHS ethnicity code list) (NHS Digital, 2017). This supports the argument that the findings here are of paramount importance to EE practices within English NHS hospital Trusts.

The current body of literature acknowledges that when the ethnically diverse workforce feels valued, it results in good patient care (West et al., 2012; Dawson, 2009) and the NHS benefits from doctors who have trained abroad (GMC, 2014). However, there is evidence that staff belonging to ethnic minorities face discriminatory, bullying and harassing behaviour from managers, team leaders, colleagues, patients and relatives (Stevenson & Rao, 2014; Bécares, 2008; Naqvi et al., 2016; West at al., 2015). There is also a lack of representation in management and senior positions (Kline, 2014; Stevenson & Rao, 2014; Kalra et al., 2009; Kline, 2017). Acknowledging failures in the past, mandatory reporting of equality standards (WRES) has been put into force since 2015. Despite these efforts, the findings concur with the literature in revealing that ethnic minorities do still feel discriminated against, especially due to the lack of representation in leadership positions leading to a sense of inequality in being able to put forward a credible and collective 'voice'. Such an environment is not believed to be conducive for EE. In particular, the absence of procedural and distributive justice significantly hinders EE (Purcell, 2014 in Truss et al., 2014) and it was found that ethnic minorities can face an absence of both, in some English NHS hospital Trusts.

The empirical evidence discussed in chapter eight details the positive and negative impact on doctors' responses to EE practices. In particular, non-British doctors were found to be less aware of the business context and to some extent struggled to uphold the standard of 'professionalism in action' stipulated by the GMC in contrast to their British counterparts. This can negatively impact the efforts of NHS Trusts in creating a conducive environment for EE. Nonetheless, the empirical evidence suggests that some ethnic minority doctors can intrinsically feel the need to put in extra efforts in order to make a good impression and ensure that the reputation of the ethnic group, they identify as being a part of, does not get tarnished. This contributes to the understanding of why non-British doctors put in extra efforts in contrast to their British counterparts in participating in improving the performance of their Trusts, in keeping their knowledge and skills up to date and maintaining good relationships with patients and colleagues, all of which can positively alter their responses to EE. Additionally, the findings are coherent with the literature (cf. Stokes et al., 2015) which suggests that certain ethnicities have a greater emphasis on education leading them to respond positively to policies and practices aimed at keeping knowledge and skills up to date. Similarly, certain values such as, respect for elderly and women, being family oriented, were found to be consistent among certain ethnicities, again positively impacting the ways in which doctors of these ethnicities could respond to maintaining relationships with patients and/or colleagues, respecting the rights to privacy and dignity of patients, advocating for their Trusts as a place of work and/or treatment and participating in improving its performance.

As discussed in chapter eight, the exposure that non-British doctors have outside of the NHS means that they are potentially able to embrace the stretch in resources and issues with remuneration better than their British colleagues which can positively impact their perception of a conducive environment for EE. The findings also suggest that ethnic minority doctors can have a greater understanding of cultural sensitivities of patients, which can help them in maintaining a good relationship with patients. A greater ethnic diversity among doctors was also found to positively impact them advocating for their Trusts as a place for work and treatment.

Nonetheless, miscommunication due to varying approaches and lack of awareness of professional etiquettes, seen among doctors of different ethnicities has been found to

lead to conflict which can be detrimental in the pursuit of creating a conducive environment for EE, particularly in the context of maintaining good relationships with patients, colleagues and team working. These findings add to the current body of literature (cf. Batnitzky & McDowell, 2011; Likupe, 2006; Magnusdottir, 2005) that acknowledges cultural differences and language barriers as challenges to social integration in the workplace. It was found that when doctors of non-British ethnicity had a reduced ability to speak and communicate in English, it hindered them in maintaining a good relationship with patients and impacted their teamwork.

The literature discussed in chapter two reveals how the models of ethnic integration prevalent in society might also be reflected in the work environment, and hence the NHS could benefit from encouraging and supporting cultural pluralism which is in line with the literature discussing benefits of ethnic diversity. The frequent interpersonal contact as seen in the work environment of doctors is known to be pivotal in increasing trust and cohesion between ethnically diverse members (Sturgis et al., 2014). As stated above in this section, research is unequivocal in highlighting the benefits of ethnic diversity and the contribution of the immigrant workforce to the NHS. Hence, providing a safe environment for them to work in, free of discrimination and prejudice, where they can uphold their ethnic values can be fundamental in creating a conducive environment for EE.

Another way in which ethnicity was found to impact doctors' responses to EE were their professional habits. Although the 'professionalism in action' guidance by the GMC was found to restrict the variations due to ethnicity, in certain situations which are discussed later in this section, professional habits such as; remaining loyal to employers, not being accustomed to data protection practices, and approaches to conflict resolution were found to impact doctors' responses to maintaining privacy and dignity of patients, teamwork and advocating for their Trusts both as a place of work and/or treatment. Using the notion of professionalism of a doctor, discussed in chapter four, the investigations found that acting with integrity and within the law and remaining honest and trustworthy had no evident impact of ethnicity. The GMC guidelines emerged as the greatest factor in pushing doctors to adhere to these two factors irrespective of their ethnicity.

Overall, the investigations reveal that ethnicity can impact doctors' responses to some components of EE. Considering the high number of ethnic minority doctors, remedial action could also help to improve the working environment, making it conducive for EE and simultaneously helping the NHS reap the benefits of ethnic diversity. The findings can also contribute in the ongoing endeavour of the NHS, in attempting to create an environment for ethnic minorities where they feel involved, supported, empowered and valued. It is believed that the NHS is currently finding creating this environment challenging (NHS England, 2017b). The contribution to our knowledge is discussed below.

9.5. Contributions to knowledge

This chapter has so far presented the findings for all three research objectives set out at the outset in chapter one. In doing so, both practical and theoretical contributions have been made for ethnicity, EE and the NHS. Without repeating the points already made, this section discusses not only the contributions to knowledge and originality of the thesis but also demonstrates how the various calls within the literature have been addressed.

Overall, there is scope for the findings to be used in publications in peer-reviewed journals that deliberate on HRM such as Human Resource Management Journal and the international journal of Human Resource Management along with other journals such as; Journal of Ethnic and Migration Studies, Ethnicities, Health services Management Research and the British Medical Journal. It is intended that the findings from chapters six and eight respectively will be used to inform two articles initially suitable for publishing. In particular, the resultant definition of ethnicity from this research and the use of self-perceived ethnicity without a predefined ethnicity list not only fills a gap in the literature but would also be suitable for publishing in Ethnicities journal and Journal of Ethnic and Migration Studies. Similarly, the impact of ethnicity on doctors' responses to EE practices in English NHS hospital Trusts, fills the gap in the literature and is suitable for publishing in Health Services Management Research and the British Medical Journal.

Objective one was to explore the factors influencing the self-perceived ethnicity of doctors. In order to achieve this objective, a working definition, presented in chapter two, was required as research (cf. Aspinall, 2001; Bhopal, 2004) highlighted the need

for researchers to stipulate their own definition. In doing so, there is a contribution to knowledge as 'exposure' is incorporated, and the findings discussed in chapter six and summarised in section 9.2 result in a proposed definition of ethnicity. This addresses the call within the literature (McKenzie & Crowcroft, 1996; Bhopal et al., 1991; Ahdieh & Hahn, 1996) in defining ethnicity through experiences of social actors. This definition supports the achievement of objective one and also has implication for practice which is discussed further in section 9.6.

The second objective was to explore the experiences of EE of doctors working in English NHS hospital Trusts, that is presented in chapter three. Using the 'professionalism in action' guidance for doctors by the GMC, discussed in chapter four, to contextualise the working definition, it addresses the call within the literature by Truss et al., (2013); Jenkins & Delbridge, (2013); Valentin, (2014) and Purcell, (2014). The findings presented in chapter seven and discussed in section 9.3 reveal the experiences of doctors in relation to the EE components from the working definition addressing this second objective. The insights from the experiences of doctors highlight what a conducive environment for EE that is in alignment with the 'professionalism in action' guidance would look like. The literature reviewed in chapter four and the findings presented in chapter seven are used to discuss how the work environment and the contemporary role of doctors impact each component of the working definition of EE. The methodology employed and discussed in chapter five highlights the call within the literature (Choudrie et al., 2016; Schwandt, 1998, in Denzin & Lincoln, 1998) to understand phenomena through meanings, and insights from complex experiences of social actors by taking their point of view.

The third objective was to explore the influence of doctors' ethnicity on their responses to the EE practices. There was also a call for research from NHS Employers (2013b), Truss et al. (2013) and Bailey et al. (2015) to explore EE in relation to different ethnic groups. There is a wealth of literature examining EE and gender (cf. Lockwood, 2007; Robinson, 2007; Kular, et al.,2008; Denton et al., 2008; Crush, 2008; Alfes, et al., 2010; Lowe, 2012; Dromey, 2014), age (cf. Robinson, 2007; Lowe, 2012; Schaufeli et al., 2006; James et al., 2011), and length of service (cf. Robinson, 2007; Lowe, 2012). However, there was a gap in the literature with no research on the impact of ethnicity in relation to EE. The findings of this objective are presented in detail in chapter eight and discussed using the literature reviewed in chapters two, three and four in section

9.4. The discussions highlight where ethnicity does and does not impact the doctors' responses to EE. The thesis presented in the introduction section (9.1) of this chapter, supports the achievement of this objective in addition to demonstrating an original contribution to our knowledge. In addressing this objective, working definitions for both ethnicity and EE were created, and this is discussed above as components of objectives one and two respectively. The contribution to knowledge also has practical implications which are discussed further in the section below.

9.6. Practical Implications

The working definition of EE presented in chapter three addresses the criticism from Purcell (2014) who concludes that the current definition of EE from NHS Employers (2013d) lacks direction for policy and practice development. The working definition presented in chapter three not only aids policy and practice development in encouraging a conducive environment for EE, but the findings presented in chapter seven and discussed in section 9.3 also reveal the insights from the experiences of EE of doctors working in English NHS hospital Trusts. It was found that in pursuit of creating a conducive environment for EE, Trusts could benefit from encouraging patients to appreciate their doctors' work, remedying protocols and systems that frustrate doctors, supporting teamwork and addressing lack of resources that can hinder good standard of patient care. These insights are arguably important because it was found that currently the NHS is facing a financial crisis and the EE of doctors is considered pivotal in maintaining patient safety, good standards of care and financial efficacy through work efficiency. Remedial action and policy or practice modification can be inspired by these findings.

The findings discussed in section 9.4, pertaining to the impact of ethnicity on EE, can have direct practical implications for policy and practice of EE for the large number (more than 40%) of ethnically diverse doctors working in English NHS hospital Trusts. Although the findings are specifically for doctors, they could contribute to the currently ongoing endeavour of the NHS (Jones, 2016) in understanding how to make ethnic minority staff in general, feel valued, supported and empowered, which it is finding challenging (NHS England, 2017b). The literature discussed in chapter four highlights the positive organisational outcomes that ethnic diversity is believed to bring, along

with the challenges of integration, removing discrimination and prejudice. The findings contribute to resolving these challenges while revealing the interplay with EE.

The proposed definition of self-perceived ethnicity supports the subjective, fluid and contextual nature of the term. There is potential for not only the NHS but also for others to consider using the identification of self-perceived ethnicity without a predefined ethnicity list to allow for the nuances and impact of exposure to be reflected. This could allow for a better understanding of variances between ethnicities; however, understandably, it would also need further research as discussed in section 9.8. The next section is concerned with the limitations of this research.

9.7. Research limitations

Conceptually, the terms ethnicity and EE have contested meanings and validity. Although working definitions for both terms have been documented, testing these definitions was not in the scope of this research due to time restraints. Having contextualised the working definition for EE, direct generalisability of the findings of EE are limited to the current period and for the doctors working in English NHS hospital Trusts. Nonetheless, the relevance of the findings are still significant due to the prevailing scenario of the NHS.

Methodologically, the issues discussed in chapter five, for gaining ethics approval from the NHS Trusts, resulted in me having to conduct the interviews outside of the participants' working hours. I heavily relied on snowball technique to recruit participants. This resulted in possibly a less broad variety of participants in the sense of having a greater spread of levels, departments, NHS hospital Trusts and ethnicities. The scheduling difficulties meant I had to conduct some interviews over Skype. Moreover, doctors' time in participating in the research could not be documented in their Continuous Professional Development (CPD) portfolios, which resulted in some of them refusing to participate and potentially there could have been greater engagement in the interview if the participation was not only a favour. Although the semi-structured interviews were in-depth and yielded significantly rich data, the length of interviews could have potentially been longer if there were no time restrictions from the doctors. Also, the snowball technique meant that the participants would know me

personally and any biases that arose due to this would remain a limitation of this research.

9.8. Recommendations for Future Research

Considering the significance and relevance of this thesis, where the focus was on doctors, their ethnicity and EE in English NHS hospital Trusts, future research can explore ethnicity and EE in various other professions and industry sectors. Also, a longitudinal study of the impact of ethnicity on workers' responses to EE, particularly investigating variations with career progression and duration of stay in the host country for immigrants would be a valuable avenue for future research. This research used 'professionalism in action' guidance by the GMC for doctors to contextualise the working definition for EE and found that senior doctors find the burden of managerial duties as a task which distracts them from the core duties and doesn't allow them to fully employ the tacit knowledge gained through experience over the years. Further investigations into such considerations in other professions has the possibility of making valuable and actionable contribution to the literature of EE.

This research also paid considerable attention to the work environment of the doctors working in English NHS hospital Trusts. It found a significant impact of this context on EE. Future research could benefit from investigating the impact of different work environments on EE. For ethnicity, there is much to be gained from studies investigating the use of open-ended, self-perceived ethnicity. The data collected during the semi-structured interviews suggests that doctors of British ethnicity do not experience this conscious notion of being judged, however, this might need further investigation in the future with a focus on this theme. The impact of the number of years spent in the UK and the position (level) on this burden was non-conclusive and out of the scope of this research. However, there is some evidence and logically, it is likely to impact this burden but would need further dedicated investigation. The impact of personality is not to be dismissed but would need an investigation that is focused on the impact of personality on workers' responses to EE practices.

In particular, it was not within the scope of this research to examine ethnicity as an identity in pre-adolescence, and the focus remained on investigations using adults in a work setting. Hence, investigations of self-perceived ethnicity outside of work

settings and the factors impacting ethnicity as an identity pre-adolescence would be beneficial.

9.9. Conclusion

The thesis has concluded that the dual nature of ethnicity can impact a doctor's response to EE practices and policies in English NHS hospital Trusts. The research found evidence to conceptualise ethnicity as an identity which is not only self-perceived but also subjective, fluid and contextual. The factors considered in the identification of ethnicity have been found to be significantly influenced by exposure.

EE, in general, is considered a pivotal component for the NHS in achieving organisational and financial effectiveness along with the desired quality of care for patients. The findings from this research highlight that the resource-starved, high-pressure work environment of doctors can hinder creating a conducive environment for EE. An investigation into professionalism and the changing role of a doctor revealed that English NHS hospital Trusts could benefit from not only encouraging patients to appreciate their doctors' work but also to understand the limitations of medicine. Also, doctors value the opportunities in keeping their knowledge and skills up to date, but the stressful work environment sometimes doesn't allow them to pursue the necessary training freely and time pressures can also hinder the doctor-patient relationship as well as the ability to maintain a good relationship with colleagues. Remedial policies and practices, information and training about the business context by the Trusts could positively contribute in creating a conducive environment for EE. The findings suggest that administrative and infrastructure related issues along with doctors' diminishing authority and increased dependency on targets for financial efficiency can leave them frustrated which is arguably not conducive for EE.

It was found that some ethnic minority doctors can feel the need to perform well intrinsically, while the exposure outside the NHS can allow them to embrace lack of resources better. Asian ethnic groups in particular, were found to have a greater emphasis on education as well as respecting the elderly and women. Such variations can result in a positive impact on their responses to EE. However, there was evidence of discrimination and prejudice which negatively impacts EE. Hence, English NHS hospital Trusts can benefit from remedial action not only due to a large number of doctors from the ethnic minority but also because ethnic diversity has shown to yield

positive organisational outcomes. The findings from this research have practical implications with the potential to inspire policy and practice of EE in English NHS hospital Trusts. In addressing the research objectives, there is a substantial contribution to our knowledge and calls within the literature have been addressed.

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Appendices

1. **Email conversation with NHS policy manager**

From: **Steven Weeks** <Steven.Weeks@nhsemployers.org>
Date: Wed, Aug 14, 2013 at 7:03 PM
Subject: Staff survey and engagement scores ethnicity
To: Tejal Chandarana Nathadwarawala

Please apologise for my delay in responding to you. NHS Employers is not responsible for the organisation and running of the staff survey

The issue of staff engagement and ethnicity is not one that has been researched in any great depth so far as I am aware so I think there is scope for some useful research here

The results of the NHS Staff Survey are available broken down by ethnic origin and so each Trust will have access to results for its own organisation by ethnic and occupational group. It would have to make a special analysis to cross check within each occupation by ethnic group

On national basis results are published by occupation and ethnic group and are available for the 2012 survey. It could be requested by ethnic group and occupation i.e. engagement scores for medical staff of different ethnicity but this is not currently published.

On ethnicity overall there were some lower levels of engagement identified for some ethnic groups although doctors as a group had amongst the highest levels of engagement overall. Other reports e.g. from the BMA would indicate that there may be issues of disengagement amongst some groups of ethnic minority doctors and therefore it would be a useful issue to look into

The staff survey is overseen by NHS England and run by Picker Europe

survey organisation. I think they would be happy to look at investigating this data on the basis you identified

The 2012 results and how to contact the staff survey team can be found here www.nhsstaffsurveys.com I suggest contact via NHS England richard.ashworth@nhs.net or Jenny.King@pickerEurope.ac.uk Best wishes with approach and please come back to me if you have any queries

Steven Weeks
Policy Manager

2. NHS ethnicity code list

National Codes:

White

A   British

B   Irish

C   Any other White background

 Mixed

D   White and Black Caribbean

E   White and Black African

F   White and Asian

G   Any other mixed background

 Asian or Asian British

H   Indian

J   Pakistani

K   Bangladeshi

L   Any other Asian background

 Black or Black British

M   Caribbean

N   African

P   Any other Black background

 Other Ethnic Groups

R   Chinese

S   Any other ethnic group

 Z   Not stated

3. Staff Engagement Star Policy

4. Participant Information Sheet

FORM EC6: PARTICIPANT INFORMATION SHEET

Title of Research

The impact of ethnicity on workers' responses to employee engagement practices – a case study of doctors in the NHS, Trusts, England

Introduction

You are being invited to take part in a research study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask me anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of this study?

The research project aims to investigate the impact of ethnicity on registered medical practitioners (hereafter 'doctors') employed in any capacity in NHS Trusts in England, responses to employee engagement practices in the NHS, England. The research will also attempt to examine which employee engagement practices work well and which do not work well amongst doctors of different ethnicities.

Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason.

How long will my part in the study take?

If you decide to take part in this study, you will be involved in a semi structured interview lasting up to one hour. The interview will be conducted at your place of work at a time and in a place convenient to both yourself and the researcher. The

questions will relate to the impacts of ethnicity on worker responses to employee engagement practices.

What are the possible disadvantages, risks or side effects of taking part?

None

What are the possible benefits of taking part?

It is not anticipated that there will be any direct benefits for you personally, but it is hoped that recommendations may arise from the study which will improve employee engagement practices in the NHS.

How will my taking part in this study be kept confidential?

All data collected will be stored on a password protected hard drive as will all copies of transcript material, research notes etc.

What will happen to the results of the research study?

The initial results will be presented as a doctoral thesis. Academic publications may also arise in the future. Anonymised quotes from your interview may be used in the thesis and any publications which may arise from the study. The data from the study may also be used in future ethically approved studies. The data will be stored for 5 years after completion of the doctoral study.

Who has reviewed this study?

This research has been reviewed by the researcher's academic supervisors and the University of Hertfordshire Ethics Committee. The study has also been reviewed by the relevant R&D office of your NHS Trust.

Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me, in writing, by phone or by email: Email id: t.nathadwarawala@herts.ac.uk, Ph no.: 0044 (1) 707281263

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this

study, please write to the University Secretary and Registrar. Thank you very much for reading this information and giving consideration to taking part in this study

5. Standard introductory email

Hello,

I have recently given an interview (my interview lasted for __ minutes) to Tejal, who is a PhD student researching 'the impact of ethnicity on worker responses to employee engagement practices - a case study of doctors in the NHS, England'.

The data that she collects is not only confidential, but the interpretation and analysis is anonymous. Please see the attached information sheet that gives more details about her research.

I have copied her in to this email and it would be great if you can reply to us both confirming that you are happy for her to contact you directly to arrange a possible interview at a mutually convenient time and place.

In case you want to contact her for further information or clarification, her details are as below:

Tejal Nathadwarawala,

PhD Student

Visiting Lecturer, Business School
BPS accredited Psychometric Tester (level A and level B)
MSc Business Psychology,
University of Hertfordshire.
PG Dip. Clinical and Community Psychology,
Bachelors of Business Administration,
The Maharaja Sayajirao University of Baroda.
(M):+44(0)7429490199

Thanking you in advance for your help in this research,

With warm regards

6. Old interview schedule

Semi- structured interviews with doctors in the NHS: Face to face interviews will be conducted with doctors working in the NHS Trusts in England.

Aim: The aim of the study is to see how ethnicity influences the worker's responses to the EE practices in the NHS Trusts, England.

Pre – interview steps:

- Introduce myself
- Give my business card
- Explain (verbally) about the research study and interview and the procedures involved, for example, anonymity of the data, voice recording of interviews, confidentiality of data, time required for interview etc.
- Hand over the Consent form and the Participant Information sheet (for the participant to read the information provided and sign it)

The questions will be in relation to the following themes:

1. The participant's self-perceived ethnicity
2. The work environment in the NHS Trusts
3. The EE policy and practice in the NHS Trusts
4. Concept of EE in the minds of the participants
5. Drivers, antecedents and consequences of employee engagement
6. Experience of participants (at the present level and in the past when they started)
7. Perception of differences in opinions about ethnicity and EE practices amongst the colleagues, managers and organisation.

The impact of ethnicity on doctors' responses to Employee Engagement practices in English NHS hospital Trusts

Qs. no.	Questions	Prompt	Reason for question
1.	Please tell me little bit about your background.	Tell me about your nationality, age and self -perceived gender, etc.	Rapport building and understanding their background
2.	What is your self-perceived ethnicity?	Why do you think your ethnicity as 'that'?	Self-perceived ethnicity and reason for that
3.	Can you please tell me something/more about your career and career history?	For eg. professional and educational status; How long have you been working in the NHS? Current post and the history of past posts; When / where did you get your training?	Career history
4.	What is your current role/position in the Trust?	Roles and responsibilities; Are you satisfied with it?; Are you coping with your role, are you finding it challenging?; Where do you see yourself 5 years down the line?	Perceived clarity of job/role, work load and job satisfaction
5.	What are the factors that encourage you to	When do you enjoy / love your work the most?;	Individual EE needs,

N.B. Q2 and Q3 can be used in a floating order as per the answer provided by the respondent. It will be ordered in order to keep the story flowing.

	work or make you happy / committed at work?;	What makes you feel unhappy / stressed? ; What do you understand by the term staff engagement?	feeling of enjoyment / stress, drivers and consequences of employee engagement	
6.	Have you heard about the NHS staff engagement star policy?	If yes – what do you know about it and how was it communicated to you? ; When were you exposed to this?; Was there anything similar to this in the past; If yes – what was it? If no – what managers / organisational policies contribute to you enjoying your current role? ; What more do you think the manager / organisation can do?	EE policies and practices in the Trust; drivers and consequences of employee engagement; organisational environment	
7.	Do you think the implementation of the staff engagement policies have changed in the years that you	Present scenario and development; To what extent is the implementation actually taking place in the real situation?	Experience of participants in the context of staff engagement policies in the Trust	*N.B.* If Q6 is answered as no, then Q7 will have to be omitted. Q8 and Q9 will then be discussed in relation to the practices and policies that the participants discuss

	have been working in the NHS?	What do you think should ideally be happening?	
8.	How do you personally respond to these staff engagement practices?	What impacts your responses to these practices?	Relation between ethnicity and employee engagement
9.	Do you think your colleagues respond to staff engagement policies differently?	How and what, in your opinion, is different?; Why do you think the responses are different?	Relation between ethnicity and

7. New interview schedule

Component no.1:   Agreement of policies and practices with doctor's professionalism

Component no.2:   Awareness of business context

Component no.3:   Advocating for the Trust as a place of work and place for treatment

Component no.4:   Participating in improving the performance of the Trust not only individually but also as part of a team that includes working with or as management

Q. No.	Questions	Prompts	Reason for question
1	Please tell me about your professional and educational background	• When and where: -under-graduation -post-graduation • Roles and responsibilities -past -present	- Professional context/ Background information - Rapport building - To identify experience levels
2	Please tell me about your career aspirations.	• Where do you see yourself 5 years down the line? •Same or different role? -why •Same or different Trust? -why	- To ascertain career aspirations and/or if there are any dissatisfactions with the current role and/or Trust - Rapport building
3	Please tell me about where you come from and where your forefathers lived?	• What is the native - culture - language	- To understand their background in the sense of their ancestral culture and language to contextualise ethnicity

4	So, in comparison to your forefathers, considering where you have lived, what language and culture have you been exposed to and what have you adopted from this?	• Have you been exposed to? - Immediate family - Diaspora that share your ancestral culture and language? • What languages do you speak? • What culture have you adopted?	- To identify the components of ethnicity that they have been exposed to and/or adopted
5	What ethnicity would you identify yourself as and why?	• What components do you consider important in identifying your ethnicity	- To ascertain their self-perceived ethnicity and why they identify themselves with this ethnicity
6	From the ethnicity listed here, what ethnicity would you select?	• Show the NHS ethnicity list	- To compare the response to the self-perceived ethnicity - To bring uniformity in the context of the NHS

7	Please tell me how do you think the Trust as an organisation, affects your day to day work?	•Please give me an example
		•Is there anything that influences:
		    ○ keeping knowledge and skills up-to-date
		    ○ maintaining good relationships with patients
		    ○ maintaining good relationships with colleagues
			- To gauge how the values, goals and policies of the Trust influence the doctor's professionalism
			
			- This response will be mapped back to component 1 of the EE framework
			
			- To gauge the influence of ethnicity on

		- remaining honest and trustworthy - acting with integrity and within the law - respecting the rights to privacy and dignity of patients •How do you think your ethnicity plays a role in your response just provided? •And why?	component 1 of the EE framework
8	What makes you feel happy or frustrated at work?	•Can you give me an example? • And why?	- To gauge how the values, goals and policies of the Trust influence the doctor. This response will be mapped back to possibly all the components of the EE framework
9	Can you please tell me about the factors that influence the Trust that you work in?	•What about: - Political factors, - Economic factors, - societal demands, - resources (internal and external), - funding and budgets •How do you think your ethnicity influences your awareness of these factors? •And why?	- To gauge the awareness of the doctor of the business context - This response will be mapped back to component 2 of the EE framework -To gauge the influence of ethnicity on component 2 of the EE framework

10	Do you or would you recommend your Trust as a place of work and/or treatment?	•And why? •Please give an example (if he/she has recommended the trust) •How do you think your ethnicity influences your inclination for recommending: - working at your Trust? - getting treatment at your Trust? • And why?	- This response is mapped back to component 3 of the EE framework - To understand the reasons why participants either do or don't advocate their Trust as a place of work and or treatment? - To gauge the influence of ethnicity on component 3 of the EE framework
11	Tell me about your activities that you feel is or will improve the performance of the Trust	• Please give an example of these activities that are -individual -team work - as part of management •How do you think your ethnicity influences your participation in these activities as -an individual? -part of a team? -management? • And why?	- To gauge the participation of the participant in improving performance of the Trust, individually and as a team - This response is mapped back to component 4 of the EE framework - To gauge the influence of ethnicity on component 4 of the EE framework

8. Consent form

FORM EC3: CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here*, *in BLOCK CAPITALS]*

………………………………………………………………………………………………

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..……………………………………………………………………………………………

hereby freely agree to take part in the study entitled

'The impact of ethnicity on worker responses to employee engagement practices – a case study of doctors in the NHS, England'

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed and asked to renew my consent to participate in it.	*Initial*

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.	*Initial*
3 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.	*Initial*
4 I agree to having the anonymised data kept for a period of 5 years following completion of the doctoral study and that it may be used in future for ethically approved studies.	*Initial*
5 I agree to having my interview audio recorded	*Initial*

Signature of participant: Date

Signature of Principal Investigator: Date

Name of Principal Investigator: TEJAL NATHADWARAWALA

Ver.3 – 03.03.14

9. Coding using Nvivo

Nodes

Name
Ethnicity
Socialisation and subjectivity
Religion
Native culture and language
Impact on personality
Forefathers
Factors affecting self percieved ethnicity
Upbringing
Skin colour
Nationality
Language
Exposure
Culture
Country of birth
Country in which thye have been brought up
Ancestry
Exposure
Effects of migration
Adopted culture and language
Employee Engagement
what makes you Happy and frustrated at work
Impact of Ethnicty
Happy
Work Environment
Treatment by staff
Praise
Team working
support from seniors
Smooth functioning
Seniority and Control
Contribution to junior doctors' development
Social Stimulus
Patient Care
Patient appreciation
Learning and development

- Contribution to patient health and wellbeing
- Frustrated
  - Work pressure
  - Protocols and Systems
    - Patients
  - Pay
  - Lack of support or guidance from seniors
  - Lack of resources
  - Lack of choice of hospital
  - Feeling incompetent or lack of knowledge
- Participating in improving the performance of the Trust not only individually but also as part of a team that includes working with or as management
  - Participating as part of the team
  - Participating as or with management
  - Participating as an individual
  - Influence of ethnicity
- Impact of ethnicity
- Awareness of business context
  - Societal demands
  - Resources
    - Manpower
    - Equipments
  - Political factors
    - Junior doctor contract
    - Brexit
  - Internal work systems
    - Leadership and Management
    - Communication of policies and practices
  - Influence of ethnicity
  - Funding and Budget
  - Economic factors
- Agreement of policies and practices with doctor's professionalism
  - Respecting the rights to privacy and dignity of patients
  - Remaining honest and trustworthy
  - Maintaining good relationships with patients

- Maintaining good relationships with colleagues
- Keeping knowledge and skills up to date
- Influence of ethnicity
- Acting with integrity and within the law
- Advocating for the Trust
  - Trust as a place of work
  - Trust as a place of treatment
    - Longer waiting hours
  - Influence of ethnicity
  - Attachment to the Trust
- Context
  - Work environment
    - Team work
      - Heirarchical structure
    - Predictibility
    - Doctor – Manager relationship
  - Roles and Responsibilities
  - Professionalism of doctors
  - Impact of Ethnicity
  - Consideration for jobs or roles or progression
    - Work life balance
    - Reputation of Trust
    - Pressure at work
    - Power and Authority
    - Patient contact
    - Cost of Living
  - Comparing NHS with other health care services around the world

10. Memos

doctors seemed to be aware of the various factors of the business context in varying frequencies **without probing**. For example:

- Political factors[i,ii]
- Economic factors[iii]
- Societal Demands[iv,v]
- Resources (internal and external)[vi,vii,viii]
     - equipments[ix,x]
     -financial[xi,xii]
     -manpower[xiii,xiv,xv,xvi,xvii,xviii]
- Funding and budgets[xix,xx]
-Internal work systems[xxi,xxii,xxiii,xxiv,xxv]
     -communication of policies and practices[xxvi]
     - Leadership and Management[xxvii,xxviii]

Also the **length of service**[xxix,xxx,xxxi,xxxiii,xxxiv] **/ postion**[xxxii,xxxv] impacts the awareness of the business context.

See Also Links

[i] Internals\\P32
so probably like macro and micro politics. At a micro level I think just seeing different personalities clash, people undermining other people, umm personality clashes I think more than anything and on a more, on a larger level, on a wider level, I think it's a lot to do with money, who pays for what, how much are we prepared to give for this patient and umm sort of I guess, ya.

[ii] Internals\\P32
he threat of litigation, so nobody wants to get into trouble with the lawyer or the court. Umm the threat of getting bad press in the media.

[iii] Internals\\P42
Interviewer: hmmm, and you have obviously, you have already talked about increasing public demands, societal demands (ya ya) and resources internal and external and obviously funding and budgets that play into the role (ya). Right, so you are obviously quite aware of lot of factors that are playing or influencing the way the Trust is working.

[iv] Internals\\P48
with the Trust themselves, they have to look at the local demographics, the kind of plan, what they are doing so I know that they in terms of things like umm the kind of umm treatments that they will invest in , the kind of programs that they will kind of set up and the kind of local antibiotics guidelines is all based demographically! So they do look at things like ethnicity and age and the general kind of makeup of the population to decide what kind of umm health care issues is it going to be more predominant in that area and then they kind of tailor services to see that. Umm so like Luton, when I was working there, had a really large obesity research centre because there were quite a large obese population in that area and the surrounding area and they had got a diabetes program as well, umm and I think I am not sure of what sort of specialities Watford has, but there is sort of, different areas will have different things that they umm prioritise and it will be either be based on kind of geographical accessibilities so things like major cardiology centres tend to be in London or places that can be got to quickly by ambulance. Umm where other sort of more niche things will be based on what the kind of population demographics surrounding the area are!

[v] Internals\\P53
I think we spend a lot of time designing things for people, we don't actually understand how people interact with our service. Umm you know, I think the biggest example may be something like diabetes which we have created a very medical model for and actually its more about how someone takes that model and adapts it to their life and how do they cope with that and I think we fail miserably because, you know and that's clear from how many people are developing and getting the complications and all the rest of it. We you know we are just dictating to people how they should uplift their lives (hmmm)

and not actually negotiating with them. (right) there's no, you know the health service is full of buzz words like partnerships, but they are meaningless if there is no partnership.

vi Internals\\P46
there is just no capacity

vii Internals\\P47
I think its quite important I mean so at watford now we have the stroke unit which at the royal free we didn't have. So somebody I mean usually you know ambulances are quite good at you know whether they, when they triage if they think it's a stroke, they will take it straight to some you know somewhere that has a stroke unit so they can get sort of immediate urgent care. Umm but you know strokes can happen while you are in hospital and people can come in you know of the street you know that might had a stroke or they you know the ambulances the paramedics may not realise that it could be a stroke. Umm so I think its obviously good to have you know specialist centres but ummmmm ….. I do think I mean the fact that A&Es have closed down and like there is more you know stress and pressure like around Watford you know st albans used to have an A&E I think hemal used to have an A&E and these have closed down so they put a lot more pressure on umm Watford but also you know the time to ummm you know being able to access the correct medical treatment is also you know longer I guess but that I guess again its down to money to be honest.

viii Internals\\P51
The assets that are actually required to provide good care! (hmm). Umm its really funny but even if you for example, you catheterise someone, you want to it for just a short period, and you want the community to organise, the person not to have his, for his catheter to be removed (hmm)… some Trusts don't even have that service! And or you know some Trusts don't have any stroke care, so you just send them up to another place (hmm). Its all very, its difficult, umm but you ??? I mean I worked in wales, which was I don't really sorry for the welsh! – laughs – its so sad, you know for cancer care for example, (hmm) if you request a referral, we are supposed to be seeing within 2 weeks (hmm). They don't get seen in 2 weeks, they get seen in 5 weeks or 10 weeks (hmm) over the place I was in wales, I mean its horrific! (hmm).

ix Internals\\P46
theres not enough beds

x Internals\\P53
 they cant buy the right equipment,

xi Internals\\P32
money and I think that's significant. that's the first thing, I thought of because I think that's probably an indication I think of how much I believe this - giggles – cant enforce it enough, money is

xii Internals\\P46
theres not enough money

xiii Internals\\P14
well for the number of patients that are seen in the nhs, I don't think that the manpower is enough because sometimes, you see sooo many patients and you are like so tired, you are like oh my god am I even thinking, I am so tired, so I think the manpower for the amount of patients, because the nhs is free, everyone comes in here, even visitors on visiting visa come here to use nhs. So they need more hands because they have more patients in an outflow, they need more hands.

xiv Internals\\P14
ya but the equipment and all that technology, we are still behind in that aspect because no money to get equipments and then the power back home, electricity back home, we need power to maintain it. Then umm, because the equipments are so scarce, they get over used and they get bad. So I would say manpower in the uk is not adequate, we need more hands. Yes definitely.

xv Internals\\P25
I think what happens in the Trust lately is…ummm…bit of… the sickness rate were high..so the second factor was..ummm..I think medical and ummm..there was umm problem with maybe retaining the staff..so..I think I can only think of these two..things

[xvi] Internals\\P46

theres not enough doctors

[xvii] Internals\\P48

I think to be honest, its not really a question of whether you want the more responsibilities, you kind of don't really have a choice, they way the system is set up, umm you kind of you progress through the training, its very kind if umm one directional, you can I mean no way the rounded, but the way that the system is set up for you to progress through the training and get to a level of seniority as quickly as possible because I think the NHS is short of senior clinicians and so they are trying to follow you through to that as quickly as possible!

[xviii] Internals\\P53

if they cant hire enough staff

[xix] Internals\\P51

t has a huge impact and for example, a Trust that is struggling for money, etc. ummm or didn't have the amount of ....

[xx] Internals\\P56

so you know earlier you said one of the factors that is affecting the Trust (yes) is the budget (yes), finance (yes, yes yes)

[xxi] Internals\\P48

I suppose they make all the kind of the decisions. So they will be the ones who decide what the local policies are, what umm which will be things like what antibiotics be used to how we run things, so we.. so Watford has a slightly different way of running A&E to a lot of places because they don't split people up into what areas they are going to be working in the day, everybody covers everything, umm which is the Trust decision I think and its also regarding local protocols, so we have specific forms for specific things that is specific to Watford hospital that other hospitals wont use, we have certain protocols you have to go through to get certain tests ordered. For example if you want CT scans overnight you have to ring a specific company who arrange that for you which is different to other hospitals where you have a onsite radiographer who would sort out for you. So everything like that, umm the kind of policies and protocols that each hospital has is Trust specific!

[xxii] Internals\\P46

as an organisation how would it affect your work?

Participant: ummmm so.. in terms of they are the people who decide the staffing levels

[xxiii] Internals\\P46

in terms of they are the people who decide the staffing levels, they are the, you know if the Trust is a poorly managed Trust, my life would be much harder, if its umm and all sort of ways really, if its poorly managed they wont fill staffing holes umm and unfilled areas, so there will be more stress on umm each team working there. Umm in the same way, even stuff like the contract, umm it's the Trust that is to decide if they want to implement the contract because its not enforced at the moment so that's them. umm they are the people who choose, its top down isn't it, so they will choose who is the most senior in each department and whose running the department and has a direct effect on me. Umm because that's who is directly incharge of say my rota, or umm you know the teaching that we get stuff like that (hmm) that's all (ok), I mean huge a amount

[xxiv] Internals\\P51

The assets that are actually required to provide good care! (hmm). Umm its really funny but even if you for example, you catheterise someone, you want to it for just a short period, and you want the community to organise, the person not to have his, for his catheter to be removed (hmm)... some Trusts don't even have that service! And or you know some Trusts don't have any stroke care, so you just send them up to another place (hmm). Its all very, its difficult, umm but you ??? I mean I worked in wales, which was I don't really sorry for the welsh! – laughs – its so sad, you know for cancer care for example, (hmm) if you request a referral, we are supposed to be seeing within 2 weeks (hmm). They don't get seen in 2 weeks, they get seen in 5 weeks or 10 weeks (hmm) over the place I was in wales, I mean its horrific! (hmm).

[xxv] Internals\\P53

so not all the General Practitioners are self employed (hmm). There are what are known as salaried GPs who work for umm a group of partners who themselves may be self employed (OK) but they are an employee of that group and they agree to

do a certain number of hours, sessions, however, they want divide it. So, but I think as a GP, you are right in saying that you are a bit more self reliant. Umm and you are not as tied to a big body as a junior doctor might be.

xxvi Internals\\P48
Everybody knows about confidentiality and that sort of has to be kept as a number one priority sort of in everything that you do. So you have it really kind of hammered into you from the beginning that you cant discuss patients, you cant discuss anything that could be potentially umm identifiable by anyone who might know the patient. It is, its easy to slip up because you are sometimes more be discussing someone in a way you think is not recognisable and then someone might think, you know someone knew that person they might recognise that story, so you have to be really careful about what you talk about and where you talk about things. Umm and we get reminded about it a lot, there is always sort of posters around about discussing things in bathrooms or in lifts where you think you cant be heard, umm and also like in A&E we sort of get reminded quite often that when we are sitting at the desks umm discussing the patients, even with the consultants where you have to discuss them and so this is what I think is going on, umm there's quite an often the patient in the cubical can hear you because they are not very far away. So you to kind of bear in mind that you cant sort of say things in a way that you wouldn't want the patients to hear you saying them. So you cant, if you have someone who think making all assumptions like you cant say I think they are making it all up because they might be able to hear you, so you have to kind of think about it – giggles – in a kind of more careful way about how you putting things

xxvii Internals\\P53
who they have got leading them, (ummhmm) then how well they empower the people below that to do the jobs that they are meant to do and lead the smaller and smaller and smaller teams below that. Umm whether they, whether their objectives are measurable, you know, some of their objectives are so vague (hmm) you know we want to be, we want to deliver compasioante care, well that's a nice word to say but what does that mean (hmm) on the floor or how does that work.

xxviii Internals\\P53
you said that who have they got leading them. When you say that can you explain a bit more about it.

Participant: ya well I think that they are very they are in a very difficult position that they have got you know lots of it, they have got such a huge remit to deliver and that person has to be stoking all the different fires, moving the right people around, getting the, you know getting it done and doing it in a way that you know I have worked as an admin in a different hospital that was failing may be 10 years ago and through leadership and through effort they have turned that into a very very successful place that's got a very good reputation and that takes a lot of time, umm and a vision to see it through and I think you know may be it wasn't just one person that lead that but you know carrying that seems to be that the executive stays for a very short period of time so you gotta be able to hand over to the next person, to the next person, I don't really, I feel a lot of stuff that we get sent here, it doesn't, it seems to change every week and it doesn't seem to make any sense to average person on the floor.

xxix Internals\\P12
umm not really no (no?) no I have very limited knowledge about that – laughs – I wouldn't be able to answer this question.

xxx Internals\\P14
I will not know much about the because I just started working like 5- 6 months ago so I am, it's a bit still greeny when it comes to the admin parts of things or I really cant say.

xxxi Internals\\P25
My awareness of all these factors? I don't think it effects at all..I mean..because I am in a position of leadership so I need to be aware of all these factors..

xxxii Internals\\P39
hmm right so obviously you have almost, you know, you know about everything, obviously I am assuming over here, correct me if I am wrong, that I think it also comes due to the level that you are working at. You are at a consultant level, you know you have sort of experienced since these many years, you have been through these situations and I think that is the reason, you sort of know the ins and outs of the Trust, how the Trust is working and what are the factors that might be affecting the Trust, is that correct? (ya, I presume so)

xxxiii Internals\\P48

I think I have only become more aware of these kind of things since I have started working.

[xxxiv] Internals\\P25

o..for example, if we're about..there's a training is set for a .it's next time..some training that'll last you for a year...then we have to re book. so we get reminders and like if we are out-of-date for some training activities so we get reminders from the medical education so..ummm..we need to keep up-to-date with all the training..that is set...by the trust as well by the..umm..General Medical Council

[xxxv] Internals\\P25

Maybe If I had..I..yaa..yaa..if I had someone like Medical junior doctor of ethnic background like hmm.. you wouldn't have to know all these factors because it is not important for them so..

Interviewer: Ok..so it..it is the position that matters..

Participant: Well..yaa..I suppose it is position that matters there

Doctors who are from the ethnic minority seem to not only be less aware[i,ii] about the business context, but they also seem to be less confortable with the norms, regulations, systems and basic etiquettes of the NHS. This could be impacting their EE. For some participants, it is also a less of a priority and there is a lack of interest.[iii] Some ethinc minorites feel lack of support[iv]

Some doctors face discrimation[v] and that leads to disengagement[vi,vii,viii]

Lack of representation of ethnic minority in management leeds to disengagement.[ix]

Work ethics can differ significantly.[x]

See Also Links

[i] Internals\\P14
I will not know much about the because I just started working like 5- 6 months ago so I am, it's a bit still greeny when it comes to the admin parts of things or I really cant say.

[ii] Internals\\P14
ok do do you like, would you know something like some political factors or economic factors

Participant: ya

Interviewer: or societal demands or internal or external resources or funding and budgeting that might be influencing

Participant: na na na na I dont

Interviewer: the trust?

Participant: I am cluless when it comes to that. I really don't know.

[iii] Internals\\P14
so because of that it makes me you know ya I am aware of things ya because I am sent letters and I have to be aware but it doesn't make me so interested because right from the time I started working, we have not been informed. So its just like do I really need to know that? You know. So it makes me a kind of unaware of things happening around you.

[iv] Internals\\P56
I truly feel that based on who I am, what I look like, and my, perhaps even gender, that I did NOT get the support that my male blonde blue eyed colleagues got. And I understand it, its not ok, yes but I understand that I am just a one person working in a system that's not mine, yes, so I am a foreigner for all intent and purposes, ha. I am an immigrant who is here to train, to learn, and do better. So I also appreciate the psychology that comes with that. The system is a system and the system is not made for new, so I get it, I get it. But the system should not sell this fair objective type thing when its not that. But that's my honest, ya.

[v] Internals\\P56
there is also the team working points, I think if as a registrar I feel that whenever I ask somebody to do something, it takes them half an hour or they give me this funny look, or they go away and chit chat with somebody else, and it takes a patient who isn't well, who should have fluids I in 10 minutes on arrival, gets it in an hour because xxx, the black female registrar gave the order, you know if those are the things that I am coming against every day, then I will not engage. I will come to work very despondent, very broken and uninterested and if I have trained in a developing country where really my role is clinical and you are now asking me to award it, to do an international presentation, without really giving me the tools, by the way, I am, and by tools I mean, 10 years ago, we only just got the internet. The internet started 2000 yes, so 7 years into this, I am now expected having trained and umm born and brought up in a developing country to have advanced excel spreadsheets, you know what I mean, by the way I have never ever really even thought about this before, but if you, if this is, if I am expected to come up with wonderful poster presentations, and you haven't told me how to do that, then how am I going to achieve

^{vi} Internals\\P56
yes, I think because umm I am, I come from this culture where I am a black women, I am supposed to be quiet and do as I am told, sometimes, umm for Myself, that is the mould that I appear to conform To. So so sometimes, and especially in this culture, silence is very much mistaken for she doesn't know, she doesn't care, she is stupid, ha, so that is detrimental sometimes and I have many friends or few black friends are being told that they are too quiet or they need to speak up more. Umm and so I think that plays a part in not only your engagement but also your progression to system. If people don't think this person is going to come in speak up and being heard Or make any contribution, then you wont get the job and I think that is very much a cultural thing. Ummm and also because of my ethnicity, and because I am a foreigner here, I really, feel powerless to change anything, I do, a lot of the time I feel powerless to change anything. And then that leads you into thoughts of so why am I bothering. Ya so you come to work, you keep your head down, you do a good job and go home and get paid I think that is the attitude one starts to adopt doctor after a while.

^{vii} Internals\\P56
Interviewer: ya I mean I guess, ya, I mean its just because you said this scenario to me right now, I think that's what I straight away thought that it might be becuase of that, that you are receiving, umm not hostile is not the right word (no), but kind of hostile behaviour (yes, yes, ya)

^{viii} Internals\\P56
So yes, I think those are 3 very good areas where I get frustrated. And therefore could affect the degree to which I engage.

^{ix} Internals\\P56
well, its because of my ethnicity that I am aware of it. If I was a, if I was a cocasian person, you know, and unfortunately, so so this is the thing, we have to appreciate the populations has changed, the population has changed. If we were still this monochrome, white umm predominantly white country, then its fine, yes but its because I am different that I know these things. Yes, but the problem is and you are talking about engagement, the problem is if there are so many hurdles put in place, so that I make, to prevent me from making any type of progression, I will cease to engage. So you know I can have all these bright ideas, but if I am junior doctor forever, then so what? So what? You know if ethnic minorities arent given managerial positions, then nothing is going to change. Yes, if we are not heard, if there is no voice, no avenue, then nothing is going to change. (hmmmmmmmm, true), nothing is going to change.

^x Internals\\P55
ome people thought I was rude and you know too forward, and if I say I need this, I need that, we need this, I need that, there is no would you mind, please, do you know like, that's a very Israeli typical and also if I had a problem with something or with somebody I will just go and say I have problem with you. Not like that but I will say you know know I think this is wrong or I think this is completely – laughs – completely irrational and unreasonable in England , like if you have a problem in England, you have to go behind their backs, to the manager, tell them that something's wrong and maybe they will talk to the person and its like like you know we are little kids in kindergarden you know you go to the teacher and tell him he did this to me he did that to me! So Israeli society is no bull shit (hmm) you know straight to the point.

the knowledge and skills of students graduating from the UK universities[ii] seems to be different to foreign universities[vi,vii,viii] [i,iii,iv,v] . UK universities are guided by GMC[ix,x] Importantly, the professionalism of students from UK should have a significant agreement with policies and practices because the GMC overlook both the education and work environments.[xi,xii]

See Also Links

[i] Internals\\P12

so let's say for example, you are working daily in the Trust (ya) now there would be certain factors that would be affecting your work (ok) in the Trust (ok)

Participant: ummmm I mean I don't really come across particular obvious factors. Ummm communication wise it's not very difficult amongst the Trust people because everybody speaks in English (ok) and English is a universal language, so we don't find it very difficult and most people are quite, I mean, I would say almost everyone, ummm is quite professional, quite polite, so there is hardly any issue with people to work with, so I don't think I have faced any issues per say – laughs – to call it ya.

[ii] Internals\\P46

I am only in A&E because when you sign up to umm you are basically in medical school you sign up to like a 2 year course and that includes 6 different rotations and you get them as a package. You dont get to pick and choose particularly. So everyone does A&E, so the fact that I am in A&E isn't like I have decided to do it and want to change my mind, its just that I am doing it, do you know what I mean, because you, that's, its in the package I have picked. (sure) so ya!

[iii] Internals\\P46

we are really encouraged to go to that and the Trust does well in facilitating that we go and you know that's probably because they have been you know that's one of the things they have to do because our salaries arent fully paid by NHS England, but actually quite lot of it is paid by the teaching fund. Umm so they are obliged to give us some amount of teaching.

[iv] Internals\\P46

just thinking about A&E, umm compared to A&E in Whittington, say, where its just a generally umm better reputed hospital, umm you know last weekend I was working nights and we had 16 people waiting in the corridor which is not actual hospital beds, and just literally in the corridors where waiting for treatment and you know that was quite a regular weekend and if that happened nice in Whittington, it would have been put on divert umm and so when A&E is full, hospitals are full, you can get put on divert, which cost the Trust money, its like you get fined for it, but it keeps the patients safe, because it means no one can bring more people to the hospital but Watford didn't do that! It didn't put you on divert, so more people kept coming, although we had lots of people in just waiting in the corridor. So if they have got different standards, you know

[v] Internals\\P48

umm so its something that starts with medical school and its something that comes down from the GMC, so you have to do mandatory communication training as part of your medical school training. Umm and you know exams at the end of every year medical school there is always at least 1 station, that is communication skills station, where you have to demonstrate adequate communication skills and that kind of building relationship with patient in order to pass, graduate as a doctor! (ok) Umm and then within the kind of competencies we have to demonstrate to pass each year, communication skills is in that, so you have to kind of provide evidence that you have sort of had good communication skills with patients and that comes from the feedback that you have asked for from like your colleagues or stuff like that to show that you have sort of shown good communication skills throughout your working.

[vi] Internals\\P48

influences you remaining honest and trustworthy?

Participant: umm I mean that's another thing that the GMC is really strict on. So it's a strikeoffable offence is being sound to be dishonest. Umm so its one of these things that again is drilled into you from the beginning of medical school is like if its, they call it probity so anything where, if you are ever found to be umm concealing something or sort of acting in dishonest way, whether that be cheating on exams or umm if you get in any trouble with the police, I remember we got a speech in the beginning of medical school about umm if you skip fares on the bus, that could be the end of your medical career because that counts as a dishonesty issue. Umm so its something we have really hard drilled into us

^{vii} Internals\\P48
I think its something that is so drilled into you from medical school so we don't really even think about it, you just kind of are ware that you have to kind of 100% honest all the times or else that would be end of your career. So you don't really think about it.

^{viii} Internals\\P25
Right.any.anything about political factors that might be affecting the Trust?

Participant: I'm not sure of that.

Interviewer: Ok..any..any..any economic factors or societal demands?

Participant: No..I don't think our trust is doing all in terms of keeping money and things like that

Interviewer: And..and..and what about funding and budget?

Participant: No..we are not..we do not have problems at all

^{ix} Internals\\P32
In terms of the Trust, umm I mean the GMC, my professional body always talk about being trustworthy and honest and I cant imagine myself ever being untrustworthy or dishonest.

^x Internals\\P48
mean we have all kind of things that kind of manage that for us, so we have a certain number of things like GMC mandated things that we have, we have to sort of do every year and every I think every some 5 years you have to pass a revalidation. Umm but we are also as trainees, we are under a umm, we are under the umbrella of health education England (hmm) and beneath each of that is each denary. So I am under a denary which is technically north central Thames so it covers London and a few places outside of London, who decide whether or not I have completed my training to a satisfactory level to pass to the next year (hmm) so we have a certain number of assessments, we have to do, in each rotation we have online forms, we have to for them we have to get feedback things that is signed by people that we worked with and consultants and stuff like that, so, that is.. mostly organised by the denary who decides sort of what, who passes who doesn't but the actual rules of what you have to do each year in order to pass I think comes down from a combination of health education England and the GMC. Umm and the Trust is only involved in kind of minor level in that the denary will appoint someone within the Trust to be overseeing all of that, to make sure that you are actually doing what you are supposed to be doing.

^{xi} Internals\\P48
starts with medical school and its something that comes down from the GMC, so you have to do mandatory communication training as part of your medical school training. Umm and you know exams at the end of every year medical school there is always at least 1 station, that is communication skills station, where you have to demonstrate adequate communication skills and that kind of building relationship with patient in order to pass, graduate as a doctor! (ok) Umm and then within the kind of competencies we have to demonstrate to pass each year, communication skills is in that, so you have to kind of provide evidence that you have sort of had good communication skills with patients and that comes from the feedback that you have asked for from like your colleagues or stuff like that to show that you have sort of shown good communication skills throughout your working.

^{xii} Internals\\P46
is there anything that influences you to remain honest and trustworthy?

Participant: ummm well its tuff, it was very you know well discussed in the medical school, I think that the profession in itself, attracts the similar type of person mostly which are people who want to help, umm and who are probably are more trustworthy than others.

Some respondents seemed to be more aware of the difference between various hospital type[iii]s and the fact that various hospitals came under one Trust[i,ii,iv]. Also, due to the exposure to other various hospitals, some respondents are aware of their internal systems[v] too.

See Also Links

[i] Internals\\P46
Whitting hospital but the Trust is Whitting health

[ii] Internals\\P53
which Trust are you working in?

Participant: umm West Hertfordshire NHS Trust, and I am working at Watford General which is a large district general in the north west of London and Hertfordshire. Before that I did my undergraduate training at umm Barts and the London medical school which is in East London. Umm and you know I completed in a full time education before that.

[iii] Internals\\P58
I mean will I got to another district general hospital, probably not because the problems are replicated. But I go to a teaching hospital, there is always the possibility of that! But actually they come with their own stresses and strains and huge political messes there

[iv] Internals\\P50
o I am working here at Watford hospital! So its west Hertfordshire, the Trust.

[v] Internals\\P51
So, I have worked in london for such a long time, (hmm) where care is so much better, you don't realise it! You have a heart attack, its confirming having TCI, have treatment like within 2 hours (hmm). That will not happen in wales (hmm).

When doctors are allowed to decide or create a plan of action[i], they feel in control and empowered. or given a role in management[ii]

See Also Links

[i] Internals\\P48
Its now, its more about me, kind of deciding what I think the plan should be and then making it happen and then telling someone else of what I have done.

[ii] Internals\\P56
You know if ethnic minorities arent given managerial positions, then nothing is going to change. Yes, if we are not heard, if there is no voice, no avenue, then nothing is going to change. (hmmmmmmmm, true), nothing is going to change.

Stereotyping affects the doctors in various ways[i].

See Also Links

[i] Internals\\P56
The other thing is people stereotype you, ha, so they think because you are a woman, you must be angry, ha, because you are a black woman, you must be angry. So I and I must be very careful, because theres another black registrar in my department and she is the exact opposite of me – laughs – she is loud and you know she tells it like it is etc. etc. and I see some, the feedback she gets, oh! Interactions with her are just very unpleasant, ya, so are just very stressful. So therefore, when people are looking for people to give opportunities to, she is not going to be one person they pick, do you see what I mean?

11. Sample full transcript with coding

Interviewer: Right ok. So umm will you please tell me about your professional and educational background?

Participant: umm yes, so I am a oh Gosh, this sounds like a proper interview now {both laugh}. Oh sorry, we are recording so it has to, there is no loud laughter and {no you can}, ok {oh yes yes, you can cry, you can laugh, you can do whatever, you can pass a joke, I mean its absolutely fine}. Ok alright. Can I just ask may be because I have got the ethnicity, umm what is the purpose I, did you send me that in an email?

Interviewer: the what?

Participant: whats the purpose of this interview. Whats the…

Interviewer: ok, alright ok (before we start) right ok {see what happens, thank you} (had sent the participation information sheet) right so tell me about your professional and educational background.

Participant: yes so I am a currently a emergency medicine practitioner. So I am a junior doctor I guess, I having, I graduated years ago, so I am not really a junior doctor but we come under this large umbrella, of junior doctors as we are are not umm independent practitioners, consultants. So I am a year old if you like, who trained in Uganda. So I trained in a developing country {ummhmm} umm and practised in that country for a year. So I did my F1 equivalent in English terms and then moved to England, 8 years ago in really with intentions of practising surgery of training and practising surgery and over the years I have what I think really tried to strategically place myself in umm in jobs in positions where that could further that interest. So I umm worked first as a locum. I started, interestingly and I think very important, as a medical student I came here for my elective. So I as a fourth year, spent 6 weeks at St. Georges which has a very special place in my heart doing a clinical elective and I think that's what planted the seed. That was the first engagement if you like with the national health service and that was the goal ha, that was where we wanted to go, that's where xxx saw herself. So upon graduation, I came back to England and started doing my exams, my conversion plab things. Once those were passed, I needed a job but didn't have a contact. So one morning I remember it very clearly, in mile end, I woke up and thought I am going back to St. Georges to look for the guy, who had 3 years previously, given me 6 weeks in his department and I went there and he said yes. He pointed me in right direction and that's what got the ball rolling. So I went from clinical attachment to a fully registered doctor and have done F2 through now to I am about ST4-ST5. I did umm my training, I did 2.5 years as a surgical trainee. So I completed core surgical training and aon umm completion of that really felt, very, umm and this is, its a great interview this one, very disillusioned, very broken, umm feeling that may be this is not the, the way I have been trained, the practise medicine is very different from the way its practised here. Umm and also I really resented the tick box exercises that I was required to do and they were tick box exercises and I never really felt that I was gaining anything. So I was trained under the regime of you go to work, you do good job and that's where your learning happens. So its a very, umm its not a service driven umm process. You come to work, as a junior doctor you really here to learn not provide the service and I found that here I really felt that I was required to do things when nobody was training me and there is this culture of lot of umm bickering. Bickering but also nobody says, theres, you don't get any feedback, nobody gives you sort of in my opinion genuine constructive, this is for you, this is what we have observed, this is how you might do better, nobody I tell you in my 8 years have never sat me down and given me anything, any of that support. And so really at the end of course surgery I came out feeling umm this wasn't a place for me. So I went, I left and I pursued the things that I loved umm which are travel, expedition, humanitarian medicine and I was

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away, intended one year, I was out for 3. So I just returned to the training umm and in something different. So I have left surgery and I now train in emergency medicine. And that ya so my ethnic background in a nutshell is I can consider myself, I am Afro-Caribbean, umm my father is Ugandan, my mother is Jamaican . I was born in Africa, I was born in Uganda. So I am Ugandan for all intents and purpourses and purposes and I have now trained and now training as an emergency medicine practitioner.

Interviewer: ok -laughs

Participant: sorry that was at least 10 minutes.

Interviewer: no no, that's sort of absolutely interesting thing about, you know obviously it is helpful when you sort of give sort of a gist of you know what have you been doing, where are you and you know whats the goal and where you intend to go forwad you know. So ok, you said you did your training in Uganda and you practised for a year umm similar to FY1. So when did you finish your under graduation?

Participant: umm 2006. I graduated, ya 2006

Interviewer: ok and umm have you already finished your post graduation or are you yet to do your post graduation?

Participant: umm by English standards you mean?

Interviewer: ya I mean like you know we have these masters and bachelors

Participant: yes so so 2006 was MBC3 Bachelor of medicine and bachelor of surgery. In England on completion of surgical training, we become a member of the royal college of surgeons. So those are exams. So I am a member of royal college of surgeons.

Interviewer: so that is sort of a post graduation?

Participant: yes that you can call that a post graduate umm qualification.

Interviewer: ok so when was that?

Participant: umm that was 2012

Interviewer: ok and that was in London, right?

Participant: that was in Leeds

Interviewer: leeds ok right. So umm and you said as an ST4-ST5 at the moment which means you are umm registrar.

Participant: I am a registrar. I would really put it under the bracket of registrar. I think these days its so fluid and confusing. I am a registrar {ok} ya.

Interviewer: so you know and which Trust are you working in at the moment?

Participant: Barts

Interviewer: umm and obviously I am assuming that you would have worked from FY2 till registrar, you would have worked in other different umm NHS Trusts, right?

Participant: that's right.

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Interviewer: right ok, so how long have you been working in Barts now?

Participant: 3 months.

Interviewer: ok so where have you been working in before?

Participant: yes, so before barts, I did my 6 months ITU at I think that's northwest. I cant remember the name of the Trust, but its Northwick park, its whichever Trust is, its Northwick part. I think its north west London.

Interviewer: yes, ya. Ok and..

Participant: and before that I took the 3 years off and I went away and before that so I did my core surgical training with Leeds, which is Leeds university umm health care Trust and before that, I worked in Jersey. I did FY2 in Jersey general which is in the channel islands and that is Wessex dineary.

Interviewer: ok (that's Wessex, ya) ok right. Ok its not been long that you have come into barts, but obviously (no) you know sort of 3 months is not bad (yes yes). So umm you know tell me about your roles and responsibilities. What were your roles and responsibilities in the past and what have been your roles and responsibilities at present? as you as you apply you are like on a treadmill, and you sort of like, you know I applied in September, got offered the graduate course in Cambridge in October November and then you know September you start and you go rolling forward, there is no sort of looking back, they think that you will just go through it.

Participant: yes so my roles in the past have been those of a junior doctor and that includes being a good member of the team and the clinical responsibilities that come with it, so clerking patients, reviewing patients, umm prepping patients pre-operatively, engaging in the surgical procedure, looking after patients post – operatively, seeing them post operatively in clinic and their long term follow up. Umm and yes in so in that summary I have included thats medical jobs which are paediatrics, gynaecology, so that's ha normal job, clerking and examining and the surgical bits. My role now as a registrar is more senior. So I am really expected to not only see patients and provide senior advanced care and decision making, but also umm mentor younger doctors, teach younger doctors and be responsible for overall flow and organisation of a busy district general A&E department. (ok) so what I mean by that is I am frequently the senior person, I am always if I am on the night shift, the senior person on. There is no consultant physically present in the department, I work with one other registrar and 3 junior doctors, during a 10 hour night shift.

Interviewer: hmm, and you said like you know in the past you said one of your umm main job or roles and responsibility is to be a good team member and that's a very interesting point. So what do you mean when you say a good team member?

Participant: my definition of a good team member is somebody who turns upto work and reliably. So on time everyday and if present in work. So is not distracted and engages fully in the care of the patient. And not only the care of the patient but engages with colleagues in a positive manner, in a positive motivatroy umm build up tight manner, not one of doom and gloom and keeping people well when they are down, tight manner, ha, I think a good team member is also somebody who empathises and listens, I, do you know what, I honestly think thats competence is almost down at the bottom of the list. I think many times just working with people is the softer skills. It's the softer skills of communicating, of respect, of compassion, you know we all competent, to be honest, ya we are all we all have a certain minimum IQ and can do the job and lets face it, its not that complex, even though the guideline, nature of our practise given that there is a hierarchy of extensive hierarchy,
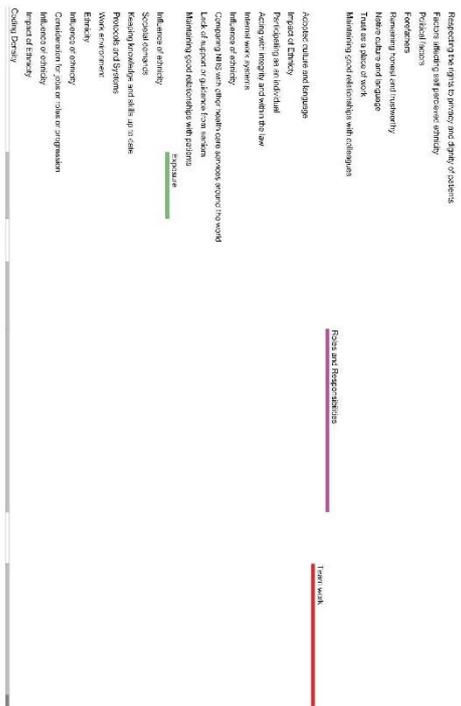
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really, in my experience, health care is complex, but theres so many people around theres so much support, umm that really I think is the other softer skills that make the work place, make or break the work place.

Interviewer: hmm. Right and you know again that's interesting when you say support {both laugh}

Participant: support - laughs

Interviewer: do you mean you get or you don't get that support - laughs

Participant: I mean you know I am very open and I consider myself somebody who umm is very self aware and but also very open and tolerant. And really I don't just say that I try very hard to be that person and I went in surgical training with the end goal I will speak from my surgical training because that's where I failed, ha, that's where I really had difficulty. My end goal was to be a surgeon and a good person, that was the end goal and I went in very open, this is who I am, this is what I can give and this is I hope what you can do for me. On reflection and comparing the level of support that I got and the level of support that I feel my colleagues are getting and I know that now, I see it, when you are in it, its not so obvious, but when you come out and reflect, and even just observing my younger colleagues interactions, umm its different, I honestly, I felt that I, I am also very, I get on with it, I am not a needy doctor – giggles. This is the end goal, xxx move on with it and I will, I will go, ha, so I don't need the constant reassurance or the constant checking in and I think if you are that kind of a doctor here, umm you will succeed despite the odds. But if I was somebody who required pushing and encouragement, and somebody who perhaps did have language skills, then I really wouldn't go anywhere and I think that's what I mean by support. I truly feel that based on who I am, what I look like, and my, perhaps even gender, that I did NOT get the support that my male blonde blue eyed colleagues got. And I understand it, its not ok, yes but I understand that I am just a one person working in a system that's not mine, yes, so I am a foreigner for all intent and purposes, ha. I am an immigrant who is here to train, to learn, and do better. So I also appreciate the psychology that comes with that. The system is a system and the system is not made for new, so I get it, I get it. But the system should not sell this fair objective type thing when its not that. But that's my honest, ya.

Interviewer: and you said that you know a good team member, when you were explaining, you said on of the important things is that he/she engages with the care of patients. Now when you say that what do you mean when you say engages?

Participant: I think frequently the way many department, there are many hurdles to providing good patient care. And that's those may include logistical things so even though just the way the ward is organised, even just the room where the blood taking kit is. So if the nurse sees patient or the ?? or the phlebotomy room is far away from the patient and I have to walk miles to find a needle and to a syringe in order to take blood and I have, it takes me 20 minutes to find anything, to set up a trolley. It takes me half an hour to find a nurse who can help me cannulate. It takes me another half an hour to get a porter to send drugs because the pod is broken, you are familiar with I am sure the setup of the hospital, ha. It takes me 20 minutes print, to do a discharge letter, and by the way not just time, but it's a very mundane task. This is not what I am trained for. So it takes me 2 hours to write a discharge letter. It takes me another 20 minutes to find a printer that works, you know those sort of logistical hurdles, if I come across that everyday, for the next 2 years, I am sorry, I would rather do I don't know, sit in microbiology – laughs. Ya so I think this is the logistical points, but there is also the team working points, I think if as a registrar I feel that whenever I ask somebody to do something, it takes them half an hour or they give me this funny look, or they go away and chit chat with

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somebody else, and it takes a patient who isn't well, who should have fluids I in 10 minutes on arrival, gets it in an hour because xxx, the black female registrar gave the order, you know if those are the things that I am coming against every day, then I will not engage. I will come to work very despondent, very broken and uninterested and if I have trained in a developing country where really my role is clinical and you are now asking me to award it, to do an international presentation, without really giving me the tools, by the way, I am, and by tools I mean, 10 years ago, we only just got the internet. The internet started 2000 yes, so 7 years into this, I am now expected having trained and umm born and brought up in a developing country to have advanced excel spreadsheets, you know what I mean, by the way I have never ever really even thought about this before, but if you, if this is, if I am expected to come up with wonderful poster presentations, and you haven't told me how to do that, then how am I going to achieve? So yes, I think those are 3 very good areas where I get frustrated. And therefore could affect the degree to which I engage.

Interviewer: hmm how often does this happen. I mean does that is it something that umm you come across very often, is it that you see your juniors coming across very often?

Participant: how often does what happen specifically?

Interviewer: so basically this sort of you know as you said, if you think that ohh xxx black women (yes yes) has given the orders and that is the reason I have to do this (yes), that (yes yes yes) sort of a feeling of I have to do rather than I want to do (yes) I mean how often does this feeling (how often does this happen)

Participant: I wouldn't say very often. I think umm but also remember that I have just come in. I am not very experienced in this role. So I and I am new in this Trust. So I am bit learning how people work, people are learning how I work umm I do feel this umm this requirement to work harder than everybody else. I think you know what it might not even be with me, ha, something to do with me, I think umm its normal, it's a new job, you are looking to prove yourself, yes, you are looking to prove that you are spending their money wisely umm and you are looking to prove that you have the skills. So you know it might even not have anything to do with race or gender and just the fact that I am new in this role. But I do think when if I observe umm people's response if the same orders came from my blonde colleague, then you know I think sometimes the response is different. So I haven't yet answered your question, but I will in 2 seconds. The , on Friday, I had a patient, we were doing the ward round, we were doing the hand over at 4 o clock and somebody died, expectedly. We were just we were waiting and the nurse came and said to me, xxx can you come and umm just certify this death. So I left the ward round, went to certify the death and returned to the ward round. So the la.. the nurse who asked me to complete the task was with me at the time and I said to her and the patient's wife, he has passed away. So what I didn't do at the time was go on computer and type, this man has died at this time. 10 minutes later, somebody another nurse came and gave me the package that is for the patient's relatives. It includes what you need to do bla bla bla and a blue form for me to fill in that I have to fill in with red ink. She handed the blue package to me as if to off load her burden on xxx. So xxx this packet is for you with no explanations or anything. You have to fill in the blue form with a red pen, ok, I will do that for you. Do you have a red pen? No. so its that sort of you know unhelpfulness. One you are dumping the work on me, two you are not even you are not helpful ha, you want me to now trace around the department looking for a red pen. Half an hour after that the ward round finished and the consultant came looking for me to say oh I have just certified that death. I said to him I did that half an hour ago. So he is gonna repeat in the same – laughs – the same process. He is gone into the side room and confirmed that this man is dead. Meanwhile the man died 45 minutes ago {both laugh}. Ya. died 45 minutes ago so he said to

me so why didn't anybody tell me you have done it? I didn't say anything, but I would umm volunteer perhaps the white blonde guy who is really the one who can confirm death. The man is dead, you don't need a doctor to tell you that. Ya, you really don't need a doctor to tell, so you know there is umm I don't know what to make of this scenario but these things happens. Sometimes you notice it, ha, you, I when I was a surgical SHO, I would go to A&E and see patients and explain what I think was going on and explain the diagnosis and say I will get back to you because I need to come back with the registrar. The registrar would be either a white female, a blonde colleague, a white male, where we do surgery, ha, there is no people who look like me. Umm would repeat verbatim the same thing and you would see people's body, you just observe people start to relax, ha, because, the same thing But again, I still question is it because they are hearing it for the second time and these are sick vulnerable people who need to keep hearing the same thing or is it more than it has come from somebody who looks a certain way. So how often does this happen? I don't know. I don't know, it depends on the scenario. I would say quite freq... I would say it happens so frequently, we stop noticing.

Interviewer: hmm well, I mean, again that's very interesting, because you know this whole incident that you told me actually you know it in itself has a lot of questions that I can ask, (good good good) but what I am thinking the main thing is that as you said you know it might be that its because may be of your ethnicity or the way you look sometimes people are just used to the white authoritative figure? (skype hanged, so recording paused and started again after establishment of contact) umm, you know the scenario that you gave me, like ya it might be because of ethnicity (yes) that you know people might be sort of umm behaving in that particular manner or at times at times (hmmmm) it questions umm in you know is it that there are any particular group of people who are sort of doing this behaviour you see?

Participant: ok!

Interviewer: umm

Participant: yaa, I don't know (sorry I am loosing your voice again) think that people behave this way

Interviewer: ya I mean have you found any such patterns?

Participant: I.. I haven't I don't think I have paid much attention. When I worked in leeds, which is predominantly white place, umm perhaps I felt it more but I don't know what the, also you know I think a lot of it might also be patient expectation and I think in general people don't expect to see a black face in surgery , ha, surgery is predominantly an old white man ummm field {hmmm}. So so I think.. and because the population is generally white, (hmm), it might seem that you know if this group of people who behave like this (hmm). So now that I work for Barts, our population, our team is much more multicultural, we are in north east London, ha, and the umm even the doctor make up is more multicultural, but also it's a different thing, its emergency medicine, so that tells a track of lots of other people. So perhaps now I don't see it. I don't, I never feel like this when talking to an Indian person or well, I don't know a black person, I obviously don't feel it, I think because ya , I could a leave it that, I don't feel it when I speak to these other ethnic groups. With lots of white people by the way, the consultation is normal, ha, and they are, we all need understanding of what's going on and ??? – giggles, yes, but ummm I never had a hostile reaction, I think the reactions have always just been those of umm perhaps of relief on hearing it from somebody else, or like I have just described, ha, needing somebody else who is totally inappropriately to confirm death, then – laughs – the people knew I had done it already, what is it, the man died, what are you achieving by getting a second person to do it? So I don't know, I don't know, that's one I will think about.

Interviewer: hmm ok, alright, lets move on and you know obviously these are some the issues that will sort of you know umm may be just go on while we are talking you know (yes, yes). So moving on umm tell me you know, let me first ask you how old are you because you are saying I am senior now, I am old, I am like you don't seem to be old!!

Participant: I don't seem to be old. I am 35

Interviewer: oh so you are not old!

Participant: no no no, I am not old

Interviewer: nooo (both laugh).

Participant: no no I am not old. Ok.

Interviewer: I am like why are you saying like this... you know (yaa) I had to ask this question to you.

Participant: I am all older, I am older, but I am not old.

Interviewer: - laughs – yes, you are older than the younger doctors but you are not old. Right ok. So tell me about your career aspirations.

Participant: my caree… so I apologise if this might sound arrogant but I mean it with humility. I have made it already as far as I am concerned. I am all that I need. You know I have achieved as far as I am concerned. What the system tells me – laughs – my career aspirations need to be and what the system tries to impose in me is this idea that you haven't made it until you have a consultant sign of. Until some other or the system, not just one person, until you have been through lots of people who can confirm that you can practise as an independent practitioner and are good enough to do that. So, my career aspirations are to continue to be a good doctor, one who is confident and compassionate. But more importantly, to find a balance in life, because I not just my career and I really feel that I have dedicated 10 years and is longer, that's just 10 years since graduation, I started 5 years before that and 5 years before that. So I am 35 but this will be going on for more than half of my life. So I think for me now, is most importantly the career aspiration is to be balanced, is to look after xxx - {myself} too. But yes, but academically I need to get a consultant sign of and to go ???

Interviewer: ok so where do you see 5 years down the line?

Participant: yes, 5 years down the line, I want to be married - laughs – with children, that's what I want, those are my career aspirations and I am not even joking. Because like I said, I have proved to myself and I hope to many others and actually proving to many other doesn't mean it. I proved to myself that I am a competent and a compassionate individual and I know this based on my patient outcomes and patient feedback. So for me that's enough (hmm). My, in 5 years time I want to be continuing to do this (hmm), continued. That's what I, but I want to incorporate in my life the other things that I call important, so family and I also like to do, I like expedition, I like to travel, I like to see far flung places on the planet, I like to do humanitarian work, so really I want balance. I don't want to be in the emergency department for 50 hours a week in 5 years time. I want to work part time – laughs – as an A&E and part time as a human being, doing the things I love (hmm).

Interviewer: hmm so you know when you say you don't want to see yourself as (yes) doing 50 hours a week or whatever (yes), umm would it be a same role or would it be a different role then?

Participant: that's a good question because you know lets not make decisions of 5 years, based on today's circumstance, ha. The role would be different in 5 years time, if all goes the plan I would

have my consultancy sign of and the role would be different. The role would be more managerial, umm more supervisory, more and I think less time. I would be at work doing clinical work, few hours a week. So you are absolutely right, yes.

Interviewer: so why would do you want a different role?

Participant: ya, thank you for that good question. Umm ya perhaps I am umm making a decision in 5 years time, based on my current umm hardship, based on my current, I am working all hours constantly but because I am working all hours constantly, I question whether I would get to the end and that is it, that is the point. The point is not that in 5 years time, the role will have changed. The point is that I don't think that I will get to 5 years time based on how I feel now.

Interviewer: so you think umm you wont sort of progress ahead? Or its gonna be too much that I am gonna leave – laughs (yes, yes)

Participant: I think, I think that this pace is not sustainable. I think I cannot continue to work 50 hours a week for the next 4 years in order to achieve this end goal that people tell me I need to be achieving. I think I have run out of patience and find other more important things to do. And that is I think a very good answer to your question. The role would have changed, but I don't think I have the energy or patience to get there. Nor do I think it's the most important thing. I don't feel that it will complete me. I don't feel that this is you know all I need to be doing with my life, you know. (ok) because I feel I have already done it, (ok), perhaps – laughs- you know I am complacent now (laughs) but as far as I am concerned, there is nothing more – laughs – this is howitsm ment to be I have a very good idea. I have a very good clear idea of what medical practise in England means (hmm hmm) and you know they they they we they try to s/tell? It as you know as its still very respectable bla bla rubbish, its absolute rubbish! Its not good (both laugh) – don't tell your father in law! Don't tell him (laughs – no I wont)

Interviewer: right ok, I mean that's a fair answer you know, yes you might not want to be in the place where you are and you know apart from all the comments to be honest, let me tell you one thing, you know after having a chat with you, looking at your expressions, looking the way you sort of you know you present yourself, I think medicine does need you, let me tell you that - laughs

Participant: thank you

Interviewer: because you sound soooo helpful, you sound so sort of empathetic that I think people need someone like you, you know so sort of thing that , ok there is someone there to sort of be there with us. (yes) so I think you should be there – laughs

Participant: thank you, thank you very much. See that means a lot to me and that means a lot to me, it really does and like I said this is the best job for me in the world and I think what frustrates me is not the medicine, it's the system, {system}, it's the geographical location and the system and the way it works (hmm). And I don't think, I haven't I have only worked in England. I am sure these problems exist everywhere. So you know I think immigrating again is not the answer - laughs

Interviewer: right, ok

Participant: so finding another system is not the answer. I think finding a balance, ya, is for me the way forward.

Interviewer: sure ok, lets assume (yes) that you are continuing as a doctor 5 years down the line, you are Dr. XXX consultant (yes). Umm would you be in the same Trust or would you be in a different Trust and why?

Participant: the idea of the job that I am in is that I remain in this Trust for 4 years and complete and get my sign of there. Because I have invested in this Trust so much or I will have invested so much in this Trust and they will have invested so much in me, the idea or the sensible thing would be to remain in the Trust. This is the purpose of these sort of calls And so will I still be in this Trust? I think its early days, I cant tell. Umm will I have got somewhere else? If I do, it will be into a different part of the country, umm where the pace of life is slower, where the setting is, will beautiful so the city setting in London especially, London is a world city is difficult. So I would hopefully be by the coast or somewhere in the Yorkshire dales - laughs umm so yes, will I still be here, hopefully, for sentimental reasons and because I have invested so much and but I move, its for the lifestyle, its for the lifestyle.

Interviewer: hmm but you still move i... inside the boundaries of England...

Participant: yes

Interviewer: right ok, right...

Participant: inside the boundaries of England, I also would very much like to continue my work as a humanitarian if I can, and to do something for the country that gave me this gift, ha, that gave me, I went to medical school for free.so I feel some sort of ownership, some sort of responsibility to umm give back (give back), yes yes

Interviewer: ok so moving please tell me, you have already said that your forefathers, specifically your father and your mother comes from carribean (yes) and your father comes from africa (uganda), Uganda (yes) and you come from Uganda (yes), so you have already told me that you are from Uganda and your forefathers particularly from Uganda, (hmm) what is the native culture and language?

Participant: umm there are 56 languages – laughs, spoken in Uganda. Ummm somewhat similar dialect. The main language is the language spoken by the largest central tribe is Luganda. Umm so in my clinical practise, I would have taken histories in Luganda. (Luganda..) Luganda, yes so Uganda with L at the front.

Interviewer: oh ok, so that's your native language.

Participant: so that is the language spoken by majority. My language is a different language, so my father comes from the western part and they speak Lutoro because they come from the kingdom of Toro. So Lu is then is the prefix before the language (ok) you if you are muganda, which is the tribe, then you speak Luganda. If you are mutoro, you speak lutoro. If you are choli you speak lucholi and so on and so forth.

Interviewer: ohh, ok that's interesting. So then is your culture mutoro?

Participant: yes

Interviewer: native culture

Participant: yes
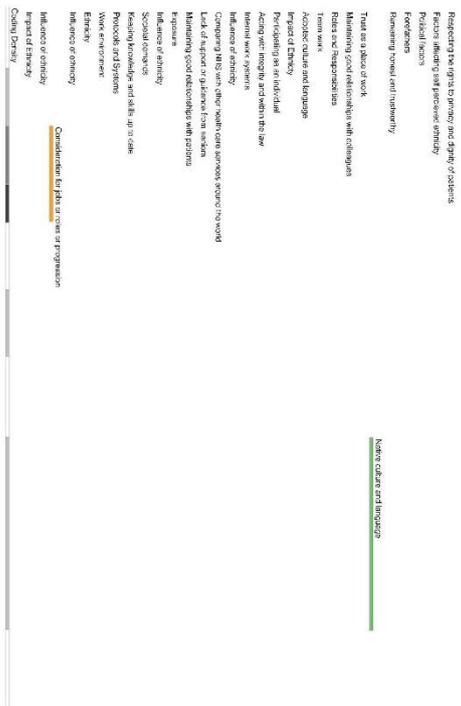
Interviewer: ok, that's really interesting, so you know tell me something about you know so what would you describe your culture as?

Participant: um ya so its funny because I grew up as you know in umm in a mixed cultural household. My mother is Jamaican but actually she was raised in England. umm and my father is Ugandan and raised me in Uganda. So in the household, we spoke English and were raised, you know the maternal umm the maternal role took over, I was raised by my mother, ha, so the culture in many parts of the developing world is that we are raised by the mothers and fathers are the providers. So I never really felt got the full benefit of experiencing my toro culture. So I feel I grew up in a household that was really quite western. Ummm because we spoke English and were raised by a mother who was born in, raised in England and kept links with England throughout my life. So we never spoke lutoro in the household. We were nuclear families which means the extended family never really came round and my father never endeavoured to speak the language or teach us or speak the language to us. But we grew up in this culture, in the setting of this African culture. So that, that also I think is a bit different, I think my outlook is a bit different. So I am not the typical umm sort of Ugandan and motoro person unfortunately or fortunately and so I cant really tell you much about the culture. Apart from to say as I got older, I appreciate it more and I am more inquisitive about what it is.

Interviewer: hmm so did you live in England or were you based in Uganda?

Participant: we were based in Uganda, I went to medical school in Uganda and we were backwards and forwards for school holidays etc.

Interviewer: so you came here for during your school holidays?

Participant: yes (ok).

Interviewer: ok so you know in comparison to your forefathers, considering where you have lived (ya) what language and culture have been exposed to and what have you adopted from this?

Participant: so I have been exposed predominantly Ugandan culture or which is you know many tribes as multi tribal (hmm). Umm what culture have I adopted? I think again I was trained there, ha, and I have lived there most of my life so I have adopted the african culture, I have adopted the Ugandan culture. But I am still very aware of, but I think what the upbringing has done has made me so flexible and so fluid and so adaptable. Umm so I identify as a black person, as a Ugandan person, as an African person. But by the same token, you know I am, I don't share a lot of the common beliefs and behave in a manner as to emulate the tradition of a Ugandan person.

Interviewer: hmm ok

Participant: if that answers your question.

Interviewer: ok right ok ya I mean umm ya you said that you have been exposed to the immediate family right?

Participant: yes, aha

Interviewer: umm have you been exposed to the diaspora that share the ancestral culture and language?

Participant: umm very minimally, so so, I and more so now in London, but when training in jersey, leeds, Bristol, no, no not really – giggles – no.
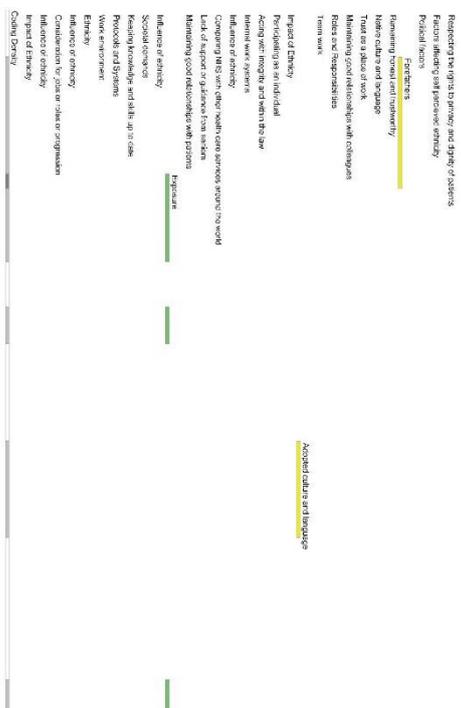
Interviewer: ok right, so what languages do you speak? You said you speak English, you..

Participant: and that's the other thing, I only speak english

Interviewer: oh ok

Participant: properly, so I can take a clinical history, in Luganda, I can ask that were you coughing, were you vomiting, did you have abdominal pain, but I cant have a fluent conversation.

Interviewer: ok, hmm, so so then would you say because you know, I am a bit confused here, because (yes) because you are saying that your mum has sort of had a what do you say, influenced your upbringing (yes) and Jamaican English upbringing, whereas you are saying you have adopted Ugandan culture (yes) umm (yes), so like, you know if you had to tell, so what culture have you adopted? if you know I am ???

Participant: ya see this is the problem with your your interviewing -giggles – this is the problem, this is the problem you are trying to create these boxes, to fit people in. The truth is, these boxes don't, well they shouldn't exist. And I don't think, I do not fix in your box and I think that is the deeper question. That is the answer. There is no box. (no I mean) I am this fluid, so so, (of course ya) what i mean by that my mother who is the primary care giver, raised me to speak English and likely with the norms, umm or the respect or the language techniques of a british person, likely, (right). But I was physically present, in an African society which means that when I came out of the home and had to engage with my fellow African people, I had to behave in a certain culturally accepted way and I learnt these culturally accepted ways. {hmm}, when I returned home, at, to a now a primary care giver with an English culture, again, I to adapt to that culture. Also my mother wasn't the the person who really tried to learn the local language and integrate with everybody, ha, so luckily, or unluckily. So she never gave me that tool either. She never gave me the local language skills, she doesn't motivated to learn it either, because she she didn't think they were of great importance either. So I am very, I am astutely aware of the Ugandan culture and the African culture and beliefs and norms in general, because I have lived there, I have practised medicine there. But equally, I am at ease with the western culture (hmm). So so you know plus or minus, to a great extent, I also we have our you know this is not right, this is too liberal, this is left wing but Im fluid , im fluid.

Interviewer: hmm, so like you know, I completely agree that you know there might not be a particular box that you fit in {hmmm}, yes I am a particular this person or I am a particular that person and yes I have had you know many such doctors who said I am a bit of this, I am a bit of that. And you know what I tend to ask next question to this {yes, yes} is that you know so like can you give me an example of where you think, well, this is particularly you know Ugandan or African in me {yes} and this is particularly british in me, you know

Participant: yes, oh wow – both laugh – oh god. Ummm I think ok, lets, yes, may be this is a good or bad example. In hospital practise, all these hierarchical titles has been rejo, you know, as far as I can, I am no longer Dr. (surname), I am XXX – laughs – ya {hmm}, and this what does XXx mean? XXX is, I am a black person called XXX and XXX is an English name, yes. In culturally, it has no real meaning to me. My surname is XXX and that tells anybody, who I am, where I come from, what tribe I belong to and who my forefathers were. That has meaning, hmm, that is a sense of belonging. The rest of my colleagues are also known by the same first names. So I call my consultant, XXX, I, you know professor XXX, I have been reduced to, he has been reduced to being called XXX and you know may be we are just all humans and we are all equally in the hospital. But these sort of umm what I am getting at maybe is disrespect for elders and umm disrespect for elder colleagues, but also for our elderly parents. Umm and these boundaries, and just perhaps the behavioural norms, regarding

marriage and regarding living with people before you get married and regarding abortion and so all those ideas and all that belief system, I think is predominantly for me an African belief system (ok, yes). I don't know if that makes things clear. What the English part is I think is this adaptability, ya. I am able to be liberal and entertain your ideas and have a conversation with you, that doesn't mean I agree. Umm so I think my belief systems are still very much conservative, you know you are an afrcian woman, you should be well behaved and be quiet. Those are still my the belief systems- laughs

Interviewer: ok

Participant: we shouldn't hear you!

Interviewer: be quiet - laughs

Participant: do as you are told..

Interviewer: ya sure, ok right ok so you know that absolutely sort of answers somewhere or the other you know its not in one particular box, but its sort of this is particularly African beliefs and these are something that I have adopted the English culture. So that's absolutely right. (ya) so what ethnicity would you identify yourself as and why?

Participant: I am, ha ha I am definitely Ugandan, I am African {ok}, um yaa.

Interviewer: ok and {clear??} ok why do you say that?

Participant: because because I was born and bread there and I spent most of my life there and ya you know ya its simple, its clear. To me its very clear, even with all these backwards and forwards and I travelled extensively, I know who I am. I know where I come from.

Interviewer: so what are the components that you consider important in identifying your ethnicity?

Participant: ummm I think colour {laugh} what I look like, you know it's a white Zimbabwe isn't really a Zimbabwean is he – both laughs. Ummm you know by the same token we all umm there is a lot in the news these days about being black and british, ha, ya we have been here a long time but and for my forefathers, yes they are likely, they have made their contribution, but really?, so so, colour is what and just sort of general features, genetics and for me that's it really. That's it. I think, its colour and geographical location from where I came

Interviewer: ok, right, ok so you know from the NHS that provides its code of ethnicity codes, which one would you tick?

Participant: what is the. Is this british, british African, black African, black carribean, I always tick black African.

Interviewer: ok black African {yes}

Participant: there is no afro-carribean box, there isn't that box.

Interviewer: no, no,no, right ok, so you know please tell me how do you think the trust as an organisation affects your day to day work?

Participant: the Trust provides this structure, this physical structure where I go to work. Ummm and the ummm logistics, the things I need to work, the Trust pays me in a timely fashion. Ummm the Trust responds to my needs in terms of umm annual leave, study leave and also provides a nice I think nice, an environment in which I work. I am.. as you eluded too earlier, that differs from Trust

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to Trust. So I moved to London in search of a multicultural experience, and of course its London, ha, so it's the suppose to be the peak of – laughs – supposed to be the peak of learning. Umm but I moved really for this multicultural experience (ok). So that the Trust provides me too along with all the other small you know logistical things.

Interviewer: alright ok, so is there anything that influences you keeping your knowledge and skills up to date?

Participant: umm well, yes, so I will give you a good example. I am like I said I just moved to this Trust, and its my first experience as registrar in emergency medicine, umm so and I come not only that but I come from a surgical background, so there are certain things that I have not done. So the majority of my registrar colleagues have been through an acute medicine core training which has taken them through intensive care or bla bla bla. So there are certain skills that they have and I don't; ultra sound, management of the airway etc. etc. umm what was your question again?

Interviewer: so is there anything that influences you keeping your knowledge and skills up to date.

Participant: yes, so knowing this, ya ummm, so I guess what I am trying to say is that my experience so far has been people asking me, have you done your ultra sound course? No, have you done this course? No, have you done this course? No. and that's where the conversation ends. Nobody has ever said to me XXX you need to call so and so, oh you can get this course here, Oh this is running next week, oh XX take your annual leave and do this, no, I keep getting this you know, this, have you done your sedation course? No, and that's where it ends. So why have you asked me, ya! As in and these questions are asked by my consultants and other colleagues while I am in the middle of a clinical scenario. So I understand I have the responsibility to keep my skills up to date. But having knowing my background, yes, its its it would be helpful if somebody said you have not got these things because of your background, this is where you need to go for them. Yes, so, so far I am still just still blindly feeling my way around trying to keep my skills up to date. (so just).. when someone can just sit down and says to me so and so runs this, so and so runs this course, its happening here there and when.

Interviewer: so its just that you are keeping your knowledge and skills up to date yourself.

Participant: yes. Yes. I know what I need to do but the logistics of finding these things and its not just logistics, you have to take study leave, you have to pay for them. Yes, I live in London, its expensive you know and how many of these can I do? And for much longer? You have renew these ATLS, APLS or ALS every 4 years, I have to do it. Yes, I have to do exams , that's the other, theres this pressure to complete exams. Well, if you are not teaching me anything, how am I gonna pass this exam?

Interviewer: hmm so then when you keep your knowledge and skills up to date yourself, is it that you read yourself on the internet or the books or is it something like that?

Participant: yes, and I think post graduate you know we are sold this line that oh its all post graduate learning now. You are supposed to be self directed, ha. Well, actually no, actually we can help each other to keep up to date and there are so many resources out there, umm that you know we shouldn't be struggling to keep up to date. The other thing is time, the other thing is time and energy. Would I come to home at night, my goodness the last thing I want to see is a book. (both laugh). Really?

Interviewer: yes, laughs – ok so is there anything that influences maintaining good relationships with your patients?

Participant: theres lots of things that influence, when you say maintaining, you refer to I, a longer term relationship. I think the nature of emergency medicine is that I don't have long term relationships with my patients. So it's a bit of a trick question here. Umm but the things that influence having a good relationships with may patients are I think good communication skills, and I think, communication is not just speech. Communication is listening, is empathising, is umm what was I going to say very importantly, its just smiling, ha, it's a facial expression, is just an extension of I care for you, I hear you on this dark day, ha. A lot.. the majority of the patients I say this is probably the worst day of their lives to come into the emergency department. So just that listening ear. But the other, I say logistical things are quiet spaces, private spaces, umm the busyness of the department. If I have a 100 people in the department, I don't have 20 minutes to spend with you. Umm and is even worse, if you come with something I deem to be trivial, so if I think you should have gone to the GP, and I have a 100 people in the department, my god, our conversation is going to be short and sharp. So, I think of all these things, its it's a in whipps cross A&E department, we had one small area called initial assessment which is totally unfit for purpose. There are 3 cubicals divided by curtains, with patient on the opposite side of the ward. So there is no see through, patients cant see us, cant see whats going on, they cant hear whats going on outside if you waiting and inside there is this open space that is just divided by curtains. So my man in that corner can hear exactly the other guy in the other corner – laughs came in with. This is not going to be a good relationship. Yes and we are, I am trying desperately to try and seem professional but we are listening next door to my man has had 10 bouts of diarrhoea to the last 10 hours (laughs) you know, (that doesn't help), you know if you are unable to take good histories from women, these sensitive conversations we cant have. So there is a lot of, it's the layout of the department, its whats going on in the department, it's the nature of my day, you know, how many other competing interests have I got. This would be very, I am sure the answer would be very difficu.. different from somebody working in surgery or (hmm), ya.

Interviewer: ok, is there anything that influences maintaining good relationship with your colleagues?

Participant: yes. I think good relationships with colleagues are fostered when the work environment is open and honest. So when people feel free, to just have the chat about anything, and having a chat about anything doesn't necessarily have to be we go in a qutie room and, we fight it out, ha, just in the corridor for people to say, hey, I see you!, I appreciate you, I know you are working hard and you know but we see you. Those are, those foster good relationships. I think socials, umm we are all stressed, we are all tired and stressed, social activities, and I want to start a few of them are very important. But also leadership. If the leadership is poor and chaotic and disorganised and doesn't seem logical to everybody and that's where transparency comes. This is what we have decided, there was no real discussion with anybody with about what we have decided, the message is words, are spread or advertised promptly or extensively, so I am hearing about it 6 weeks later because I was on annual leave, and I got one email. You know just general organisation or courtesies and leadership is ya.

Interviewer: ok is there anything that influences you to remain honest and trustworthy?

Participant: the fear of being sacked – laughs – well so I I like to think that I am always honest and trustworthy, that's expected, you know as in it's a given. We don't discuss it, I am honest and trustworthy, end of story. Umm but I think umm in the interest of may be disclosing certain things,

then umm the general feel of the, the fear of being sacked, the anxiety that comes with promotion or demotion, the anxiety that comes from general loss of face, yes, and embarrassment. But yes, if we are all open and honest with each other, and we are all tolerant of mistakes, and they do happen very often, ha, and we all practise in this culture that is not finger pointing and doesn't blame and this, it's a culture that's not blame, then I will be open and honest. Umm if we are working in a culture where whistle blowing is accepted and allowed and people can reflect on their umm mistakes openly and honestly, then yes I will be honest with you. But if those conditions aren't there then, you wont hear from me.

Interviewer: ok is there anything that influences you acting with integrity and within the law?

Participant: umm yes, so again, I think integrity can be learned. I don't think we are born with integrity, umm so if it can be learnt, somebody has to teach me. So, umm that means you know we have to identify that problem, so umm, a leader needs to think about and intentionally, try and assist people to work and behave with integrity. Umm again I think that comes with openness and transparency and just a general feeling of support and a feeling that if I do this wrong, or what have, then somebody has my back, somebody is going to understand why I did what I did. Umm I think but even patient contact, the nature of our patient, I think patients also have a responsibility, ya, to walk through those doors and behave in a certain manner, umm and have understanding of the, not a great understanding, that's too much to ask, but be aware that, be aware of the environment in which we are practising, that is ward of continuing financial constraint, there is no infinite pot of money, ya, that is aware of me as a human being, I am just there to help, yes, I am not God and I don't perform miracles (hmm). And so also just be open and honest with me. So last week I had a lady who came in with entopic pregnancy who I had seen the previous week and you know had she told me the truth the first time, we might have gone to the bottom of what the problem was. Umm so you know during my second umm exchange with her, I tried very hard to remain act with integrity, to remain professional and non-judgemental and to do the best thing for the patient. But people lie – giggles. So I think goes on to, patients have responsibility to understand that this is the 2-way relationship (of course).

Interviewer: ya, ok is there anything that influences you to respect the rights to privacy and dignity of patients?

Participant: umm yes, the system, so as just described right now, our initial assessment unit, there is no privacy there at all. Umm but I think ya, its, ya logistics really and it's the logistics of how we store information, of how we log on, ha, if you tell me that this is the computer system and this is what you need to do, and umm I need to leave for something and I leave the screen open, then everybody can read it! And its nobody's responsibility you know to close the screen down and it remains open all day and the patients can see then again I think it's a joint effort. Its team work (hmm), its team work.

Interviewer: so how do you think you know your ethnicity plays a role in all these responses that you have just provided? (laughs) so you know talking about keeping your knowledge and skills up to date (you are supposed to tell me that, yes) – laughs; maintaining good relationships with your patients and colleagues, remaining honest and trustworthy, acting with integrity and within the law and respecting the rights to privacy and dignity of patients? You know you answered all these questions, how do you think your ethnicity plays a role here?

Participant: in good and bad ways. I will start with the good ways. I think its stereotypical. It's the stereotype but I think the stereotype has some truth to it. I think, umm black people in general,

especially in the history of this country, have, are known as the carers, are known as perhaps this happy go lucky umm people who care, ha, with a bit of compassion, I think that is our stereotype. So, umm in terms of patient care I am hoping that when I walk through the door to start the consultation, people see this caring compassionate individual. And also, yes , you know I think that is further reinforced by my personal characteristics. But I think umm, firstly, I hope People see oh she is black and she will care and she will give a damn! As supposed to – laughs – you know some other groups – laughs – umm I think umm so any other good ways... umm it's the stereotype though isn't it. I guess the answer to your question is ethnicity shouldn't play a role, but we are all conditioned, arent we. How else does ethnicity play a role. I think I come with my own prejudices, umm consciously or subconsciously. So so you ask me culturally how do I identify, ethnically how do I identify, I am come from a society that does not look well upon alcoholism and excess and taking drugs. So when I come in contact with somebody who has come with overdose who is high on alcohol, who is high on cocain, I have very little sympathy, I have very little empathy (hmm). As far as I am concerned, you are wasting my time and this is a self impulse problem (hmm). It's a same with smokers, ya (ya). So perhaps yes those ideals, those cultural ideals make me less empathetic (hmm). So if you come, if you are a smoker and you come to me with lung cancer, I am going to be less sympathetic with you (hmm hmm). So ya, may be those sort of interferences.

Interviewer: ya and I guess how I am connecting now what you are saying umm (yes) to the umm all the things that I have asked you, you know what influences bla bla bla.. (ya) I think you know it does make sense because you know if you say that you are gonna have less empathy towards people who are not good in your eyes (yes), sort of you know I mean it does in a way alter how you maintain the relationship with your patients (absolutely). You know for example, if some staff is not, if a person needs attention, and if as you said earlier, if the staff is going to be sort of chitchatting, bla bla bla (yes), you are going to feel that that you know excuse me, the patient needs care here better (yes) go do that. I think that's where your compassionate and caring nature comes in to the paly, so ya, I mean (hmm) I can connect one plus one (yes, yes). Ok umm you have already talked about what makes you feel frustrated at work (yes) you know things that sort of people not doing their work properly, umm what else do you think makes you feel happy or frustrated at work?

Participant: aaaaa, I wish there was a lesser workload – laughs – so I think what makes me frustrated at work are time constraints, are unrealistic impositions of time constraints. And I was thinking about this, this morning, the NHS, and I am just going to put my shoes on, ha, because I need to go out somewhere, we can talk, will walk and talk (ok). Umm the NHS many years ago started this 4 year wait, 4 hour wait in A&E. its great, it's a good idea. It means I need to see you, sort you, have a decision in 4 hours. Apparently, that's high quality care. It is not realistic (hmm). It is not realistic. We are all running around like a headless chicken trying to provide this world class service. It is not world class if you cant provide it. So you need to change your goal post, ha, you need to be realistic about it and provide what you can. You can still provide a good service, you can still provide a good service without everybody feeling stressed, depressed and like we are running around aimlessly. That's what frustrates me. The stress at work, the stress, the stress, the stress.

Interviewer: hmm what makes you feel happy at work?

Participant: don't know! – laughs – no I think again, for me this is the best job in the world. I feel happy when I have been able to umm solve people's problems and I think like I said, for many people, coming to A&E is like the worst day of your life. So, if I can make that process a little bit smoother, if I can educate, if I can restore hope, then for me that makes, so I think for me whats makes me happy is still that patient relationship. Its, it that is what makes me happy, I really, I can

manage these other things, you know you deal with them, there is stress of work, but ultimately, for me is the patient relationship (hmm hmm hmm).

Interviewer: ok, can you please tell me the factors that you think influence the Trust that you work in?

Participant: ohh, sorry, you have to be more specific there.

Interviewer: so you know earlier you said one of the factors that is affecting the Trust (yes) is the budget (yes), finance (yes, yes yes). So are there any other such factors that you think are affecting the Trust that you are working in?

Participant: wow, ummm..umm , I, wel... so, I I I couldn't, I am postulating here, I am assuming that the Trust its financed but it I think its also leadership and I think its government leadership and its not just this Trust. I think there is this umm top level umm top, this government endeavour to undermine everything that the NHS or the medics and doctors do and there's this this ummmm they systematically destroy any confidence that the general public has in the medical profession. It is a slow disintegration, it's an effort to slowly disintegrate what I think is the medical profession. You know I think, I I am yet to see a good NHS story in the last 4 years, 5 years. I have not seen one. All you hear are the horrors, is who killed who accidentally, its who got stroke off, there are no positive messages out there. So what effects Barts Trust, I think also perhaps government policies, government guidelines, umm but that's not just Barts, I think that's probably everybody. (hmm hmm). I think the other thing that might affect Barts Trust is the population, ha, if you have a 100% of managers, being blonde and blue eyed, I keep saying blonde and blue eyes, the british arent really blonde and blue eyed – smiggered – but if your management team is all cocasian, and the people you have coming through east London doors, are indian, African, greek, you know Italian, Turkish, then really I don't see, how you are going to provide a balanced service, yes because and its funny because you would assume that medicine is medicine, ha, that that the medicine I provide to my indian lady with diabetes, should be the same medicine I provide to my white british lady with diabetes. I think the difference is a social one. The difference is the complex social issues that these people come with. Given the context in which we live, given we are all immigrants, yes, we are all, may be I say we are all immigrants, long time ago we were all immigrants, now may be not so much. But you know we come with other complex social issues, complex prejudices already, umm mental health issues and if I am living you know if I am a black person at home living with my elderly mother who came from Jamaica, 50 years ago, who has who is already paranoid that the system doesn't work and has mental health issues, I will not engage with the NHS. Because the NHS presents this white face, white managerial process, you come in, you are spoken to like an idiot, you are looked at you know as if you are dangerous, you know this, socially , I think this is it, ha, that actually is a very good point that the managerial team is all white british and the people who are actually using the service arent, so of course its going to be a mismatch. The way you understand the mental health as a white person, who earns, who might come from a household that earns a 100,000 a year is not the same way that I understand it who comes from a household that earns 24 grand! (hmm). The constraints are different and if you are the one making the protocols, then I am not going to get the care that I need. Yesterday I went to oxford to attend a umm, it was tropical health day yesterday, so there was a lecture and we were presented this case of a 50 year old Gambian man, who was in this country, he is 50 years old, he moved to England aged 18, that's some 32 years ago and he had these ongoing neurological symptoms that he thought a neurologist was not able to help him with. So he multiple, multiple visits, back and forward to a G.P., with no, to a GP and specialist with no umm changes or improvements as far as he was concerned. He made
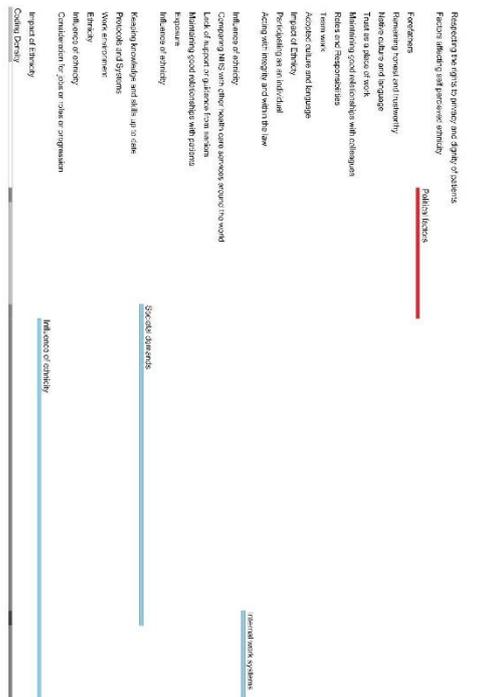
the trip back to Gambia, to access traditional healing, of course that doesn't work, ha, but that was the nature of his desperation. Having accessed the NHS multiple times, its over a period of 32 years, eventually, we made the diagnosis of HIV, so that explains it, but he had, he had been, there were so many missed opportunities, because because we don't see this problem, ha, because if my cocasian brain only sees paralyses, as some other non-infectious cause, I am not going to investigate HIV. So this man is now, has AIDS, yes, so at the very end, when we missed so many opportunities and I have come across many patients, I was on ITU 6 months ago, it's the same – man from Poland, many visits to his GP, never had an HIV test, he now comes with AIDS, the end, at the end, dying! This is in England, in 2016! It's the nature of the system, its its its you know, I don't think its just clinical equipment, I think if an ethnic minority doctor had seen that patient, that question would have been raised (hmm).

Interviewer: I completely understand what you are saying and I think its very interesting, because ya even I never thought that this might be the situation that is occurring actually. If you are not able to think from the point of the service user

Participant: ?? minority... no no so so this culture again, umm this culture is one that is a very individualistic culture. Everybody lives on their own, you know its all me me me me me.. me myself and I. nobody looks after the elderly. Nobody looks after anybody but themselves. So we are now in a crisis where everybody is at that we are aging, we are living longer, people are in hospital longer, your 90 year old grandma cannot go home with you, because well, you work. So you cant afford put them in a care home, so she is stuck in a hospital for months, and months and months, yes and again this puts strain on system, you know there are so many issues we could talk about. Umm {so I mean} and I think a lot of them are cultural. A lot of them are.

Interviewer: hmm hmm so I think you have probably mentioned the political factors, the economic factors, the supply and demand sort of kind of thing you know (yes). You have talked about the societal demands, umm and you have talked about the resources, internal and external, what is the gap and the you know (yes, sorry I have to keep moving) and what is exactly affecting (yes, yes). So you know again, I mean and again I mean and and what I see again (yes), you know according to my initial comment again coming back to that, NHS needs people like you (thank you). You know sort of because not everyone understands this. Its (no) very different to sort of and its very difficult to sort of have this understanding that you know it is the service, the users are different than the service providers. And (yes), you have exac.. I tell you I am so impressed, its, you have pin point.. you have literally hit the nail on the head, because I have never ever thought about this and now when I hear this story from you, it makes sense! You know I think that's where NHS is going wrong. So you know, how do you think your ethnicity influences your awareness of these factors?

Participant: well, its because of my ethnicity that I am aware of it. If I was a, if I was a cocasian person, you know, and unfortunately, so so this is the thing, we have to appreciate the populations has changed, the population has changed. If we were still this monochrome, white umm predominantly white country, then its fine, yes but its because I am different that I know these things. Yes, but the problem is and you are talking about engagement, the problem is if there so many hurdles put in place, so that I make, to prevent me from making any type of progression, I will cease to engage. So you know I can have all these bright ideas, but if I am junior doctor forever, then so what? So what? You know if ethnic minorities arent given managerial positions, then nothing is going to change. Yes, if we are not heard, if there is no voice, no avenue, then nothing is going to change. (hmmmmmmmm, true), nothing is going to change.

Interviewer: do you or would you recommend your Trust as a place for work?

Participant: most definitely (both laugh), most definitely, ya, ya

Interviewer: ok why?

Participant: so its interesting, actually because theres lot of people leaving and umm Barts and sorr can we, can I pause there? I am going to switch over to my phone again! I am going to walk...

Interviewer: ya, ya ..... Trust as a place of work..

Participant: oh yes yes yes. So I umm I came to Barts really because of the presumed ummm multiculturalness of it all, ya, so not only is the team multicultural, but the patients are also and I always felt this things since I practised here, every time I go to work and I feel like we are doing this wonderful job for to great british people. I have always thought but why cant people who look like me get the same service, ya and why the poor people, why are they unable to access such good health care. So for me its important that I feel rightly or wrongly that I am serving my own population, ha, because I am a good doctor and I have services to provide. So you know I think its important that I serve my people also. And my people doesn't necessarily mean black people, it means you know poor people who umm perhaps on the fringes of society, who don't have access, those sort of things and I think umm these populations exist mostly in east London, ha, geographically is east and north London. So, so yes, I would recommend my Trust to anybody who wants to work in an incredibly diverse environment. Umm having said that, I have noticed a lot of people leaving, especially nurses, theres a lot of nurses leaving and theres a lot of umm a lot of the doctors are locum doctors, so they are not permanent staff. Now that's that's my expe.. reflective of the way the management runs the place, ya, or it might be reflective of who these doctors are and I can tell you who they are, they are black people and they are indian people, who for one reason or another, have felt that they want either the flexibility of choosing when they work, they want to earn money, yes, or have failed to progress in the system. (hmm). So ya, Barts is lovely, I love it for its diversity, but I am sure it has its problems. (hmm). I haven't been there very long.

Interviewer: right, ok do you or would you recommend your Trust as a place of treatment?

Participant: umm – (both laugh) – A&E, A&E, A&E is very stressed financially, space wise, but I think even even through that we do a good job. So yes, and some people might argue to be honest I think whipps under special measure anyway. So is the royal London, ummm but yes, come to my Trust on the day that I am working.

Interviewer: (both laugh) that's a good answer!

Participant: yes

Interviewer: I will recommend but that's only when I am there!

Participant: yes yes, only when I am there – laughs!

Interviewer: right ok, so how do you think your ethnicity influences your inclination for recommending working at your Trust and getting treatment at your Trust?

Participant: ummm I am, well I recommend it because , I recommend people come into contact with people like myself, ha, who look like me. Ummm but and you know I having, if you asked me the same question about Leeds, would I recommend people working in Leeds Trust? Yes, I guess the reason is it's a nice environment to work in. umm so is it really about ethnicity? I don't know, I don't

know, I think ultimately about the work environment, or about the perceived care that we are giving to our patients, the perceived and real care that we are giving our patients. I am not sure ethnicity has a role! But ya, if you are looking for a multicultural place to work, then Barts is a good place, Barts is a good place

Interviewer: So I am also thinking that you know because you said that you know you want people who look like you, or who are like you to (yes) to be sort of in a nice environment and you know Barts having, although with its own pros and cons, but at the end of the day it still has a multicultural environment (yes). You sort of feel that people like me should have a good platform to start with isn't it. So (yes) theres somewhere or the other this sort of you know umm internal beliefs or the value system that is sort of playing role or your upbringing that you know to be good and to be caring for everyone, sort of is sort of pushing in, isn't it there?

Participant: yes, thank you, you have summarised beautifully and and and not because you are poor, ha, is it you get an poor service, yes, its this ummm we see it in the humanitarian world as well, ha, I just returned from 6 months in Jordan, on the, in the refugee camp, yes and in the middle east, refugees live, its hardship, but they live in these nice metal containers, ha, what you and I would class as umm what are these called, you know these these, metal things, shipping ,you know the shipping containers, (yes) yes so that's what the refugees in the middle east live in, yes on the refugee camp. In Africa, you are sleeping under tents, ha, loose light things that are flapping in the wind – laughs – they provide no protection against sun or rain. Yes, and somehow that's acceptable, ha (ya), somehow just because you are in Africa, that you are poor person, then this standard of living is acceptable. Do you see what I mean? (ya) I think I I ya, for me that doesn't suit well! And I think you know its equal access for everybody. They are equal services for everybody (sure).

Interviewer: yes, I understand what you are saying, (hmmm), ok so moving on to our last question, (oh yes!) – laughs – (oh no!) – laughs, ok so tell me about your activities that you feel is or will improve the performance of the Trust.

Participant: my activities that will improve performance of the Trust, (or that is at the moment improving), hmmmm well I think before I came, during my 3 years away, I have spent time, ummm, in my mind, added value to what I do. So I have travelled, I have worked on a refugee camp. I have travelled by myself as the medic who proves, so I think what I, what those sort of activities have done has umm widened my, I am able to communicate and work well with people from all over the world, yes and so, I can connect with people from all over the world, so it doesn't really matter whether you are afghani, in a burkha, yes, or , I don't know, you come from latin America and you speak Spanish. You know I think as a patient, i.. a doc... with me in a doctor patient relationship you will get a fantastic service and I think that comes from my umm exposure to all sorts of people, and that has been intentional, ha, I have gone in search of that experience. Umm I think the other, the other, well the other activities are normal, ha, I do with all humility the same job as most other people. Umm and you know I am competent, I think also this period of independence, away from a consultant from telling me what to do all the time, has given me confidence to think and act independently so that I am not always relying on other people to to for a second opinion and I think that might be to my own detriment as well ha, because we are talking of support, I had to support myself. Yes and I think when people see that, they sort of leave you to it (right). Forget that you also need once in a while, umm a kind word or just some reassurance and acknowledgement (hmm hmm). So...

Interviewer: ok, so you know you said obviously your competence, your confidence and your independence is sort of all together sort of pushing the performance of the Trust, ummm obviously

with independence comes the individuality. So how many of these activities would you say are individual, how many would you say are team work and I don't know if you are involved in as a part of management?

Participant: yes, umm the majority bit really A&E, accident and emergency is a team sport, it is not, well everybody brings their own individual attributes, but it is purely a team sport. Umm so yes I would not be who I am without the rest of the team. I cant work without the rest of the team.

Interviewer: and are you involved in or as a part of management? (what was the other part of the question?)

Participant: oh yes yes as an I mentioned earlier because I am often the most senior person on at night, I am a manager, you know I am responsible for the flow into the department, who comes in, who goes out, I report the managers in the morning, I go to governance meetings, so yes I am part of management. I am mostly a clinician for sure but I do engage in management. I am expected to at this level.

Interviewer: hmm ok, so how do you think your ethnicity influences your participation in these activities as an individual, as a part of team and as management?

Participant: yes, I think because umm I am, I come from this culture where I am a black women, I am supposed to be quiet and do as I am told, sometimes, umm for Myself, that is the mould that I appear to conform To. So so sometimes, and especially in this culture, silence is very much mistaken for she doesn't know, she doesn't care, she is stupid, ha, so that is detrimental sometimes and I have many friends or few black friends are being told that they are too quiet or they need to speak up more. Umm and so I think that plays a part in not only your engagement but also your progression to system. If people don't think this person is going to come in speak up and being heard Or make any contribution, then you wont get the job and I think that is very much a cultural thing. Ummm and also because of my ethnicity, and because I am a foreigner here, I really, feel powerless to change anything, I do, a lot of the time I feel powerless to change anything. And then that leads you into thoughts of so why am I bothering. Ya so you come to work, you keep your head down, you do a good job and go home and get paid I think that is the attitude one starts to adopt doctor after a while.

Interviewer: hmm hmm hmm and when you say you feel powerless to change anything, is that is it that it then affects in your managerial tasks or do you think that affects your team work?

Participant: well I think I am if you feel powerless to change anything, you wont engage. If you don't engage, then you don't get the opportunities. The opportunities to change come from people who engage in audit, research, go to meetings, do poster presentations, organise activities, ya, that is where you make change, you don't make change as a clinician. You don't make change seeing patients, ha, you don't do that. That's not how it works. to make change I think happens at a managerial level and you have to have proved yourself. You have to have done all these audits and research things etc. So we find, if I feel powerless to change anything, and I am not engaging, I wont get that opportunity. It's a self fulfilling proffacy isn't it?, it's a self perpetuating problem. The other thing is people stereotype you, ha, so they think because you are a woman, you must be angry, ha, because you are a black woman, you must be angry. So I and I must be very careful, because theres another black registrar in my department and she is the exact opposite of me – laughs – she is loud and you know she tells it like it is etc. etc. and I see some, the feedback she gets, oh! Interactions with her are just very unpleasant, ya, so are just very stressful. So therefore, when people are looking for people to give opportunities to, she is not going to be one person they pick, do you see

what I mean? So not only did you not engage, but you start to adopt false behaviour, yes, that assist you to go somewhere, do you see what I am mean? So we are all acting, we are all just playing the game yes and sometimes you miss out on real genuine people who know whats going on and know what they are doing.

Interviewer: hmm hmm and ya I think that in itself sort of explains that you know its sort of then sort of brings influence on everything as an individual, as a part of team and in management in that sense, isn't it? And and (yes) I think it makes sense when you were talking earlier that you know there are certain, some people who needs second authority, (yes), umm a white doctor to say this person has passed away (yes). Maybe its because of this another black lady who has been not very pleasantly received and that's the reason they might be thinking you are like kind of saying?!

Participant: wow, yes! Wow, ya and because I haven't been there very long.

Interviewer: exactly, because and you know when they would have heard that there is another registrar coming who is a black lady, (yes), they might have though oh! Not another unpleasant you know sort of a manager to report to!

Participant: yes, yes

Interviewer: ya (absolutely) it might be that (yes, yes)

Participant: and so I am recognising this because I am self aware, I am going to dumb down, ha, I am going to more quiet than usual – hehe – because I am not wanting to incite this reaction (ya) yes, so I will speak up less, ya you know I will be everything that the other person is not, rightly or wrongly.

Interviewer: ya I mean I guess, ya, I mean its just because you said this scenario to me right now, I think that's what I straight away thought that it might be because of that, that you are receiving, umm not hostile is not the right word (no), but kind of hostile behaviour (yes, yes, ya). Anyway, that brings an end to the interview

Participant: wow! - Both laugh