NHS RACE & HEALTH OBSERVATORY

THE POWER OF LANGUAGE

A CONSULTATION REPORT ON THE USE OF COLLECTIVE TERMINOLOGY AT THE NHS RACE & HEALTH OBSERVATORY

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INTRODUCTION

The NHS Race & Health Observatory was formally established in April 2021, with a remit to examine ethnic health inequalities in England and beyond. Its primary objective is to commission new research and synthesise existing evidence to support the NHS and other national bodies to reduce these inequalities through evidence-based policy recommendations. In pursuing this objective, it is important not just to consider what our priorities should be, but also how we talk about them.

In recent years, there has been much discussion about terminology and race. In public policy in the UK, it has long been the norm to use initialisms such as BME and BAME to refer collectively to a hugely diverse group of people. Recently, spurred on by a resurgent Black Lives Matter movement, there has been renewed scrutiny of these terms, including by the UK government's own Commission on Race and Ethnic Disparities.

As an organisation working in the field of race equality, we recognise the profound power of language. Terminology that crudely conflates different groups of people does not just erase identities; it can also lead to broad brush policy decisions that fail to appreciate the nuance of ethnic inequality in the UK.

The Observatory is a new organisation, and from the very beginning we have been committed to genuine community engagement, and to amplifying the voices of underserved communities. In making a decision on the language that we adopt as an organisation, we wanted first to speak to the people for whom we exist – the patients, service users, workers and members of the public who, as a consequence of their ethnicity, are less well served by the health and care system in this country.

This report details the findings of a stakeholder engagement exercise held over the Summer of 2021. We engaged with thousands of people to better understand how our stakeholders feel about collective terminology, and about terminology around race in general. We learned not only people's views about language, but also found that conversations about language are a gateway to reflections about so much more – power, belonging, identity, collectivism – and that it is impossible to divorce what we do from the language we use.

We began this process intending to settle on terminology that we, as an organisation, would use to speak collectively about groups who experience ethnic health inequalities. Perhaps unsurprisingly, it was not as simple as that. The diversity in this country – cultural diversity, ethnic diversity, diversity of thought – is such that no one term could ever suit all of our stakeholders. We are a nation of complex individuals, each person a rich intersection of characteristics, values, and backgrounds.

Our outcome then, much like the issues we are grappling with, is nuanced. We have not settled on a term, but on a set of principles, drawn from the enriching and enlightening conversations we've had on this topic over the past months. This report was designed primarily to look inward, and we will not be recommending that other organisations follow our path. Instead, we recommend that others take their own time to listen to and learn from the people they work with and for.

OUR APPROACH TO LANGUAGE

As a result of this consultation process, we have developed five principles that we will follow when writing and talking about race and ethnicity.

Be specific

We will always be as specific as possible about who we're talking about. Collective terminology should never be used for convenience or to save time. We are a research-led organisation, and we will deal primarily in specific conclusions about specific ethnic and racial groups. We will be clear in our conclusions and our recommendations about who we are really talking about, and we will require all organisations we commission to disaggregate findings by ethnic group.

No acronyms or initialisms

We will never use acronyms, initialisms or other contractions to refer to groups of human beings. Contractions like 'BME' and 'BAME' create a further level of needless abstraction from the communities and individuals we are talking and writing about.

Context

We will only use collective terminology where we absolutely must. And even where collective terminology is required, we will always be guided by context, and will not adopt a single blanket term. We will always challenge ourselves to think specifically about what we are trying to say. In practice, this means that you will see the terms 'Black and Asian', 'Black and minority ethnic', 'ethnic minority', 'Black, Asian and ethnic minority' and 'people who experience ethnic health inequalities' depending on the context and the content of the work reported on. Where the context is not decisive, we will use the above collective terms interchangeably. This is to reflect the fact that no one term suits everyone and to pursue our objective of respecting individual and community dignity. As above, even where we do use these terms, we will not use acronyms or initialisms.

Transparency

We will always be up front and open about the approach we have taken to language. This report will remain on our website at all times, and we will include explanatory text in all of our documents and reports to explain our approach to language.

Adaptability

We accept that language develops and that a term that is acceptable today may not be in a few months' time. We will not draw a line under these considerations, and we will always welcome productive challenge around our approach to language and the rest of the work we do. We will change and adapt our language, over time, to ensure that our work remains relevant to our stakeholders.

The following sections outline the consultation process that led to the development of these principles.

CONTEXT

We cannot remove a discussion of terminology from its historical and political context. Collective terminology has never been static, evolving with political and social movements over decades. The term 'BME', an initialism of 'Black and minority ethnic', originally gained traction in the early 1980s, and is thought to have evolved out of the social concept of political blackness.[1] Political blackness, closely aligned with trades union movements of the 1970s, saw the term 'Black' adopted widely by diverse communities who experienced racism in the UK, including Black African, Black Caribbean, Asian and other communities.[2] As was frequently the case, the term changed with the times, becoming first 'BME', and, in the 1990s, 'BAME' (or Black, Asian and minority ethnic) to more explicitly recognise the existence of, and inequalities experienced by, British Asians.

Historically speaking, these collective terms have at times been considered a force of empowerment, representing a recognition of shared experiences of discrimination, and embracing the power of collectivism and coalition-building to bring about social change. But they have also increasingly been adopted by politicians and public servants to speak in general terms about people who are not White, leading not just to generic conclusions about the state of racial inequalities in the country, but also to a policy approach that fails to recognise the nuanced circumstances of different ethnic groups in Britain.[3] By the time the COVID-19 pandemic came to the UK in 2020, the term 'BAME' was being widely used in government and NHS documentation, with limited critical engagement around the use and meaning of the term.[4]

The disproportionate impact of COVID-19 on Black and Asian communities in the UK, and the murder of George Floyd in the USA, prompted a mass reappraisal of racial and ethnic inequalities around the world. This included a proliferation of articles and blogs examining the use and impact of the terms 'BME' and 'BAME' in public and health policy (Milner and Jumbe, 2021; Aspinall, 2020; Aspinall, 2021; Khunti et al, 2021; Routen et al 2021). These conversations were carried out not just in national publications, but in organisations across the country. For some, the time was right to adopt new terminology, with terms such as 'racialised minority' or 'racially minoritised' being promoted as a way of acknowledging the processes by which a person becomes a minority, as opposed to accepting it as a matter of fact (Milner and Jumbe, 2021).

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[1] Aspinall, Peter J. "'Black African' identification and the COVID-19 pandemic in Britain: A site for sociological, ethical and policy debate." Sociology of Health & Illness (2021).

[2] Modood, Tariq. "Political blackness and british asians." Sociology 28.4 (1994): 859-876.

[3] Milner, Adrienne, and Sandra Jumbe. "Using the right words to address racial disparities in COVID-19." The Lancet. Public Health 5.8 (2020): e419.

[4] Aspinall, Peter J. "BAME (black, Asian and minority ethnic): the 'new normal' in collective terminology." J Epidemiol Community Health 75.2 (2021): 107-107.

Perhaps in recognition of the above, a 2021 government commission into race and ethnic disparities in the UK recommended that the government "move away from the use of the term 'BAME', to better focus on understanding disparities and outcomes for specific ethnic groups'.[5] Although the government is yet to respond to or accept this recommendation at the time of writing, some will likely see this as a positive intervention. For others, as we found during our stakeholder engagement, there is concern that removing explicit reference to Black and Asian communities could be seen as a means of diminishing the focus on specific inequalities experienced by those people.

[5] https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities/foreword-introduction-and-full-recommendations

METHODOLOGY

The consultation utilised a mixed methods approach, consisting of the following:

- A public survey, co-designed with our stakeholder engagement group, seeking the views of the public on the use of collective terminology to describe multiple ethnic groups, and on their preference relating to specific terms. **5,104 people took part in the survey, though exact response numbers vary by question.**
- A series of focus groups held with members of the public and/or health and care workers, designed to flesh out the findings of the survey. **80 people were invited to take part.**
- A more targeted stakeholder roundtable aimed at reaching those with an expert or professional interest in the matter. **15 people took part.**

Survey

The survey primarily sought the views of respondents on the following:

- Their general level of comfort with the use of collective terminology.
- Their level of comfort with the following specific terms:
  - Black and minority ethnic (BME)
  - Black, Asian, and minority ethnic (BAME)
  - Ethnic minority
  - Minority ethnic
  - People of colour
  - Racialised minority
  - Racially minoritised
  - Global ethnic majority
- Whether they identified with additional terms not included in the above list.
- What their reasoning was for the above opinions.

To add nuance to our understanding, respondents were also asked for information about their own ethnicity (according to Census 2021 categories) and to indicate whether or not they worked in the health and care sector.

Focus groups and roundtable

All focus groups (including our stakeholder roundtable) were carried out virtually. Each was a facilitated and semi-structured session lasting 90 minutes, aiming to understand the nuance behind the outcomes of our survey. The sessions were carried out between September and October 2021.

Caveats

This consultation process was carried out primarily as a form of stakeholder engagement to inform the approach of the Observatory to collective terminology. As such, the findings below should not be read as a research output, but as a report of the outcome of those exercises. The survey was made available on our organisational Twitter account and circulated via various health-related networks. As such, the respondents are primarily (86.8%) people who work in the health and care sector. We also acknowledge that, as with any survey of this kind, there is a selection bias in that those with stronger feelings about a subject are more likely to express an interest in having their say.

The survey was open to respondents of all ethnicities and a significant proportion of respondents are from the White British group. While we welcome the views of all, for the sake of this exercise we are primarily interested in the views of Black, Asian and other minority ethnic groups, especially where the question deals with issues of self-identification. As such, some of the analyses and charts below exclude White British respondents.

QUANTITATIVE FINDINGS

The following findings were drawn from our survey. Although the sample size is considerable (5104), readers should be cautious about generalising from the figures below. This was a targeted consultation exercise designed to encourage engagement from our key stakeholders – those with a personal or professional interest in ethnic health inequalities in the UK.

Profile of respondents

Respondents to the survey were from a diverse range of backgrounds (Fig 1). White British respondents made up the largest ethnic group of respondents at 1949 (38.2%). This was followed by Asian Indian with 574 (11.2%) and Black African with 451 (8.8%) respondents. For respondents who chose Other (Asian, Black, Mixed and White), the highest proportion were people from a Filipino or mixed background. For the purpose of analysis, the White British group has been excluded from some of the charts below.

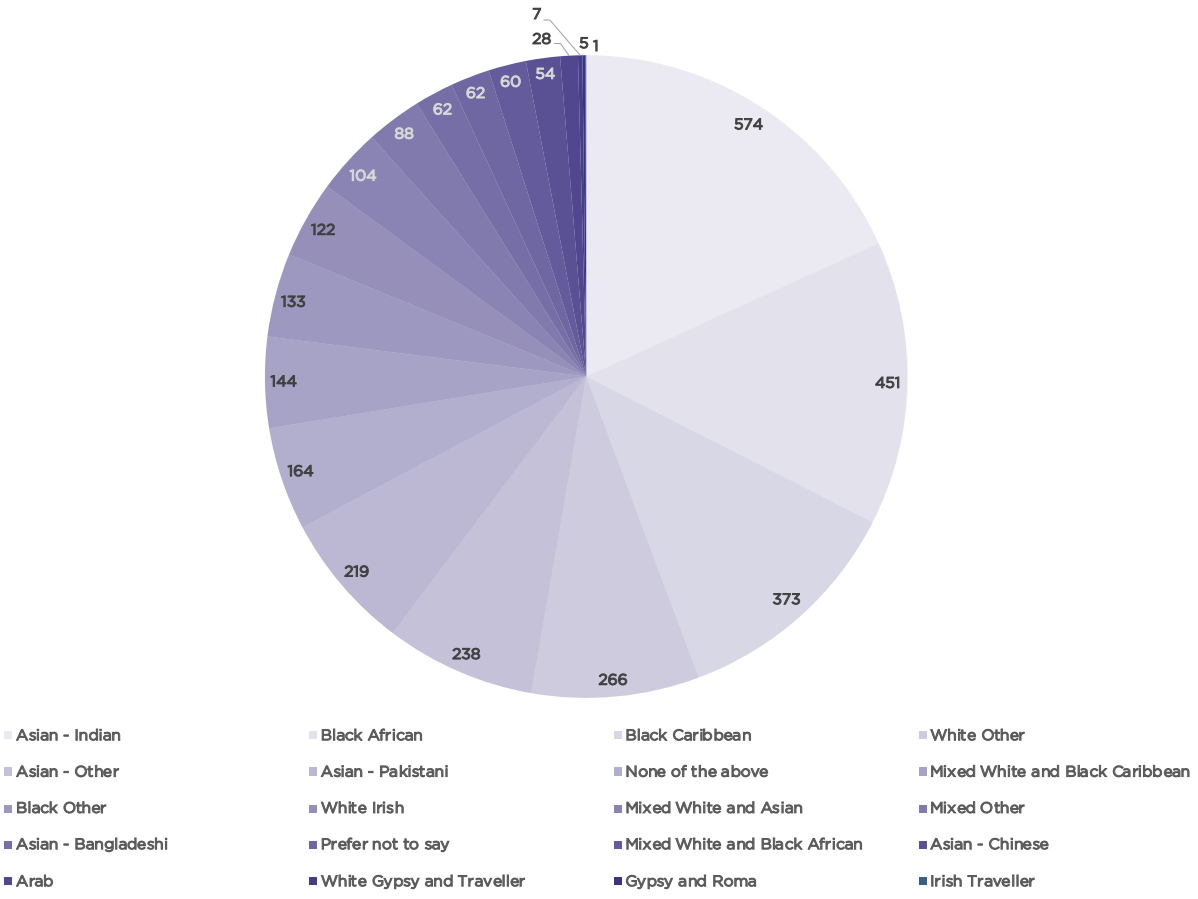

Figure 1: Ethnicity of respondents

Collective terms

The survey asked respondents whether they were comfortable to be identified 'as part of a collective term that includes all people who are not White British?' Overall, just more than half of respondents indicated they were comfortable with collective terms. However, this hides a broad range of differing opinions that is especially apparent when the responses are disaggregated by ethnicity. As can be seen in the table below, there is a significant difference in opinion, with Arab and Chinese respondents most comfortable with collective terms and Black Other, Black African and Black Caribbean respondents, as well as those who did not identify with any of the census categories, least comfortable.

Ethnicity (2021 census classification)	No, I don't like collective terms (%)	Yes, I am comfortable with collective terms (%)
Arab	22.7%	77.3%
Asian - Chinese	31.1%	68.9%
Mixed White and Black African	33.3%	66.7%
White Gypsy and Traveller	33.3%	66.7%
Asian - Pakistani	36.5%	63.5%
Asian - Other	40.0%	60.0%
Asian - Bangladeshi	40.4%	59.6%
Mixed White and Asian	42.2%	57.8%
Asian - Indian	43.5%	56.5%
White Other	43.8%	56.3%
Mixed White and Black Caribbean	45.6%	54.4%
White Irish	48.8%	51.2%
Gypsy and Roma	50.0%	50.0%
Mixed Other	53.9%	46.1%
Black African	57.7%	42.3%
Black Caribbean	60.1%	39.9%
Prefer not to say	65.8%	34.2%
Black Other	69.3%	30.7%
None of the above	70.4%	29.6%
Grand Total	**49.5%**	**50.5%**

Table 1: Are you comfortable being identified as part of a collective group that includes all people who are not White British?

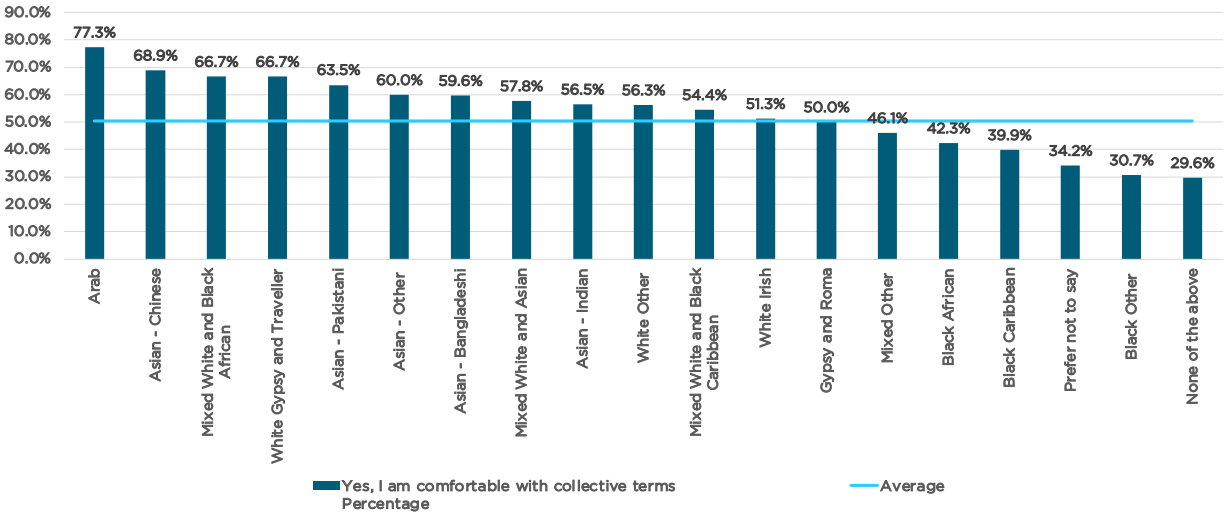

Figure 2: Are you comfortable being identified as part of a collective group that includes all people who are not White British?

Specific collective terminology

Respondents were asked to rate the following terms on a scale from 'very happy' to 'very unhappy':

- Black and minority ethnic (BME)
- Black, Asian, and minority ethnic (BAME)
- Ethnic minority
- Minority ethnic
- People of colour
- Racialised minority
- Racially minoritised
- Global ethnic majority

Respondents could also indicate that they have no strong feelings, or that they had never heard of a term. Out of all the above, 'ethnic minority' was the term with the largest number and proportion of people indicating they are 'happy' with it. It was also well known, with only 0.6% of respondents saying they had never heard of it. The terminology with second highest proportion and number of people being 'happy' with it, was Black, Asian, and minority ethnic (BAME).

Although it is the least unpopular term, the term 'ethnic minority' was also very divisive. An equal proportion of people (37.9%) were 'happy' and 'unhappy' with this term. It is notable that for no term were there more people happy than unhappy (Fig 3). The terms 'racialised minority', 'racially minoritised' and 'global ethnic majority' were the least well known of all terms.

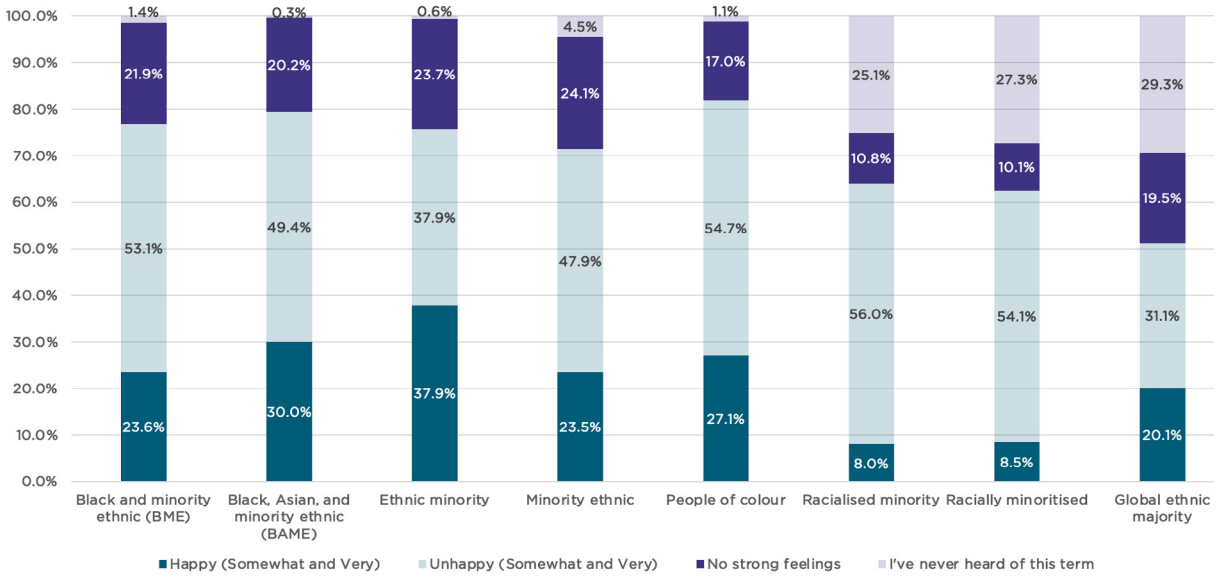

Figure 3: To what extent are you happy with the following terminology? (Exlcudes White British respondents)

These headline findings, however, conceal a degree of complexity and nuance in the findings. Even though 'ethnic minority' emerged as the least unpopular term, there were still significant differences between ethnic groups. For example, 51.9% of White Other respondents were comfortable with the term 'ethnic minority' compared to 20.9% of Black Other respondents. In general, Black and Arab respondents tended to be less comfortable with the term 'ethnic minority'.

Tables 2-4 below show how feelings towards the three most popular terms vary by ethnic group. The three terms explored here are 'ethnic minority', 'Black and minority ethnic', and 'Black, Asian and minority ethnic'.

Ethnicity (2021 census classification)	Happy (Somewhat and Very) (%)	Unhappy (Somewhat and Very) (%)	No strong feelings (%)	I've never heard of this term (%)	Gap between Happy and Unhappy (%)
Gypsy and Roma	75.0%	25.0%	0.0%	0.0%	50.0%
White Gypsy and Traveller	66.7%	33.3%	0.0%	0.0%	33.3%
Asian - Chinese	62.2%	13.3%	24.4%	0.0%	48.9%
White Other	51.9%	22.1%	25.5%	0.5%	29.8%
Mixed White and Asian	50.0%	27.3%	21.6%	1.1%	22.7%
Asian - Other	47.7%	26.7%	24.6%	1.0%	21.0%
Asian - Bangladeshi	45.8%	35.4%	18.8%	0.0%	10.4%
White Irish	43.8%	31.3%	25.0%	0.0%	12.5%
Asian - Indian	41.1%	32.2%	25.7%	0.9%	9.0%
Asian - Pakistani	38.4%	33.1%	27.9%	0.6%	5.2%
Mixed White and Black Caribbean	37.8%	36.2%	26.0%	0.0%	1.6%
Prefer not to say	36.4%	48.5%	15.2%	0.0%	-12.1%
Mixed Other	35.1%	45.5%	18.2%	1.3%	-10.4%
None of the above	32.0%	49.6%	17.6%	0.8%	-17.6%
Black Caribbean	29.5%	51.8%	18.4%	0.3%	-22.3%
Mixed White and Black African	29.4%	47.1%	23.5%	0.0%	-17.6%
Black African	27.7%	43.7%	27.7%	0.9%	-15.9%
Black Other	20.9%	61.8%	17.3%	0.0%	-40.9%
Arab	18.2%	36.4%	45.5%	0.0%	-18.2%
Grand Total	**37.9%**	**37.9%**	**23.7%**	**0.6%**	**0.0%**

Table 2: To what extent are you happy with the following terminology - 'Ethnic Minority'?

Ethnicity (2021 census classification)	Happy (Somewhat and Very) (%)	Unhappy (Somewhat and Very) (%)	No strong feelings (%)	I've never heard of this term (%)	Gap between Happy and Unhappy (%)
Mixed White and Black African	41.2%	35.3%	19.6%	3.9%	5.9%
Mixed White and black Caribbean	38.3%	40.6%	20.3%	0.8%	-2.3%
Asian - Bangladeshi	29.8%	48.9%	21.3%	0.0%	-19.1%
Mixed White and Asian	28.9%	42.2%	27.8%	1.1%	-13.3%
Black Caribbean	28.3%	55.4%	15.3%	1.0%	-27.0%
Black African	25.8%	52.2%	21.4%	0.6%	-26.4%
Asian - Pakistani	24.0%	46.8%	26.9%	2.3%	-22.8%
White Irish	23.5%	48.1%	27.2%	1.2%	-24.7%
Asian - Other	22.5%	53.9%	23.0%	0.5%	-31.4%
Asian - Indian	20.6%	53.8%	24.0%	1.6%	-33.2%
Prefer not to say	20.6%	64.7%	11.8%	2.9%	-44.1%
White Other	20.6%	44.6%	31.4%	3.4%	-24.0%
Mixed Other	19.5%	64.9%	13.0%	2.6%	-45.5%
Asian - Chinese	17.8%	66.7%	15.6%	0.0%	-48.9%
White Gypsy and Traveller	16.7%	16.7%	66.7%	0.0%	0.0%
Black Other	14.3%	70.5%	14.3%	0.9%	-56.3%
Arab	13.6%	50.0%	36.4%	0.0%	-36.4%
None of the above	10.2%	73.2%	15.0%	1.6%	-63.0%
Gypsy and Roma	0.0%	50.0%	50.0%	0.0%	-50.0%
Grand Total	**23.6%**	**53.1%**	**21.9%**	**1.4%**	**0.0%**

Table 3: To what extent are you happy with the following terminology – "Black and minority ethnic (BME)"

Ethnicity (2021 census classification)	Happy (Somewhat and Very) (%)	Unhappy (Somewhat and Very) (%)	No strong feelings (%)	I've never heard of this term (%)	Gap between Happy and Unhappy (%)
Mixed White and Black Caribbean	40.0%	45.6%	14.4%	0.0%	-5.6%
Asian - Other	39.9%	34.3%	25.3%	0.5%	5.6%
Asian - Pakistani	39.2%	35.8%	24.4%	0.6%	3.4%
Asian - Bangladeshi	38.8%	44.9%	16.3%	0.0%	-6.1%
Asian - Indian	35.7%	42.7%	21.1%	0.4%	-7.0%
Asian - Chinese	35.6%	35.6%	26.7%	2.2%	0.0%
Mixed White and Asian	34.4%	41.1%	24.4%	0.0%	-6.7%
Mixed White and Black African	34.0%	46.0%	20.0%	0.0%	-12.0%
Arab	31.8%	40.9%	27.3%	0.0%	-9.1%
Mixed Other	29.9%	58.4%	10.4%	1.3%	-28.6%
White Other	29.3%	42.9%	27.3%	0.5%	-13.7%
White Irish	27.7%	53.0%	19.3%	0.0%	-25.3%
Prefer not to say	25.7%	48.6%	25.7%	0.0%	-22.9%
Gypsy and Roma	25.0%	50.0%	25.0%	0.0%	-25.0%
Black Caribbean	24.0%	63.8%	12.2%	0.0%	-39.7%
Black African	23.4%	54.9%	21.7%	0.0%	-31.5%
White Gypsy and Traveller	16.7%	16.7%	66.7%	0.0%	0.0%
None of the above	14.7%	68.2%	16.3%	0.8%	-53.5%
Black Other	12.6%	73.0%	14.4%	0.0%	-60.4%
Grand Total	**30.0%**	**49.4%**	**20.2%**	**0.3%**	**0.0%**

Table 4: To what extent are you happy with the following terminology – "Black, Asian, and minority ethnic (BAME)"

Other terms

As part of this exercise, we asked respondents to identify any terms not listed above that they felt worked better as a collective term. Below are some of those terms, presented in no particular order:

Culturally and Linguistically Diverse (CALD)	Culturally Vibrant
Black Arab Asian Latino (BAAL)	People of Minority Origins
British Ethnic Minority (BEM)	Communities who experience racism
Systematically Marginalised and Excluded (SME)	Discriminated Ethnic Minority
Culturally Diverse Minority Group	Non-indigenous
Minoritised Persons	Racialised communities or racialised individuals
Ethnically Marginalised	Traditionally Marginalised Background
Ethnic Group	Asian, Afro-Caribbean, Multiplex Ethnicity (AACME)
Diverse Ethnic Groups	Diaspora communities
Ethnically Minoritised	Multicultural
Non-white	Underserved
Minoritised Ethnic Group	People with Ethnic Heritage
Cultural Diversity Group	Black, Asian and minoritised
Global Ethnic and People of Colour (GEPoC)	Melanated
Black, Indigenous, People of Colour (BIPOC)	CAAMEL (Caribbean, African, Asian, Middle Eastern and Latin)
Marginalised ethnic groups	All Ethnic Minorities (AEM)
Historically oppressed by Europeans	Seldom heard communities
Minoritised Ethnic Communities	Asian, Black, Mixed & Other (ABMO)
Non-White British (NWB)	From a minoritised background
Afro caribbean and Asian Minority (ACAM)	

The vast range of terms suggested mean it is difficult to pick one term that appeared more popular than those included in the survey. That said, the above list is a useful illustration of what people find lacking about the more commonly used terms. Among the most common suggestions for alternative terms were ‘non-white’, ‘Black, Indigenous, and People of Colour (BIPOC)’, and several variations including the word ‘marginalised’.

QUALITATIVE FINDINGS

The findings below are drawn from a combination of free text responses in our survey and the conversations and insights we heard about in the focus groups and roundtable we held. They are organised by theme. Because all sessions were held on condition of anonymity, none of the specific insights are attributable to any individual.

Context is key

"One of the rationales for grouping people by ethnic categories is for analysis. Are people with different characteristics receiving the same services, experiencing the same outcomes etc. It is imperfect and will never reflect the diversity of the individual. Make categories as generic, neutral and transferable as possible between different contexts to enable comparison and insight that can inform conversations and actions" – consultation respondent.

Broadly speaking, the majority of respondents were negative about the use of collective terminology to refer to diverse individuals. The reasons were varied, as explored below, and the strength of feeling differed for each term. Even so, there was an overriding acceptance that, in some circumstances, it was necessary to speak in general terms about people who, on account of their ethnicity, experienced ethnic health inequalities. These contexts ranged from the scientific – for purposes of research and analysis to identify broad inequalities – to the political – where coalition-building and collectivism were seen as vital prerequisites to achieving equality.

What emerged as particularly important was the need to be explicit about the context in which we are talking or writing, and to be willing to explain and justify the use of such terminology in that context. It will never be acceptable to refer to an individual by a collective term, but if we're trying to aggregate upwards to make a point about the lives and opportunities of communities who are not White, then we should be willing to say as much.

Homogenising

"It does not feel useful to employ catch-all terms within healthcare essentially covering anyone 'not white'. Clinical risk factors, social determinants and care-seeking behaviour differ so significantly among various minoritised ethnic groups in the UK that to lump them together makes no sense. It is so important to collect data on risk factors and outcomes for people from minoritised ethnic backgrounds, but it needs to be at a granular enough level to mean something - otherwise it is a very blunt instrument" – consultation respondent.

One of the most prominent objections to using collective terminology was that doing so

falsely groups together a large number of diverse communities. Many respondents were keen to point out the crudeness, for example, of speaking as though Black and Asian communities had the same universal experiences. The same could be said of Black African and Black Caribbean communities, or Indian and Bangladeshi communities. The picture becomes yet more complex when we think in an intersectional way about how, for example, age and deprivation are considered. The risk of using terms like BME and BAME is that they prompt people, including our leaders and policymakers, to think in a one-size-fits-all model. Not only is there a political outcome, where false categories of 'us' and 'them' are formed, but the homogenising process means that interventions in healthcare become more diffuse and less targeted.

We also heard that this concern extended beyond collective terminology, to include more specific ethnic categories. Although it was not the primary focus of our group discussions, many felt poorly represented by the Census categories, where they did not recognise themselves. This was particularly expressed by Filipino respondents, who described feeling marginalised because they are grouped under the broad heading of Asian, meaning that policy interventions rarely focused on this group, despite the relatively large numbers of Filipino staff in the NHS workforce.

Minorities

"I don't like anyone being described as a minority as I think it is diminishing" - consultation respondent.

Although 'ethnic minority' was highlighted by many respondents as among the least problematic of all collective terms, there were many who disagreed with the use of the word 'minority' because of its broader implications. Even where factually correct, people took issue with being identified by their minority status, on the basis that it implies something 'inferior' or 'less than' the majority population. Some felt that a reliance on words like 'minority', 'marginalised', and 'minoritised' might actually serve to further ingrain inequality, by implicitly reinforcing a hierarchy.

Many also highlighted that the term minority was always contextual. As recognised by terms such as 'global ethnic majority', a person's ethnic minority status is entirely dependent on the population they are being placed in. For this reason, one focus group respondent suggested that, when writing, we should be mindful of this context, using the term 'ethnic minority in the UK', thereby being explicit about who we're referring to. This concern was closely related to discomfort with any words or terminology that imply a negative difference when compared to the 'norm'. Many respondents were concerned

that being described collectively in a way that set them apart from the White British group would suggest that they were somehow less British, or not British at all.

Race and colour

"People of colour... we all have 'colour', I feel this will somehow support a hegemonic 'whiteness' as the norm, against which you have the 'other', in this case, 'people of colour'. I think it may therefore have unintended negative consequences" - consultation respondent.

Some of the terms included in the survey and discussed in the focus groups were seen as especially problematic. The terms 'racialised minority' and 'racially minoritised' were either not well known or prompted largely negative reactions. For some, this was because they did not think that adopting brand new terminology was a useful step, but for others it was because there was too great a focus on colour and difference, and they were uncomfortable with race being the defining aspect of a description of their identity, as opposed to nationality or cultural background.

Relatedly, the term 'people of colour' was especially divisive. Many respondents to the survey were negative about the term, as they thought it too closely resembled the word 'coloured', which has long been an offensive and racist slur in the UK. For others, who sometimes explicitly identified themselves as of a younger generation, the term 'people of colour' was acceptable and even preferred. Many noted that the term was an Americanism and felt that it did not translate easily to a UK context.

Self-identification and collectivism

"Some of these terms seem to create divisiveness within a population and the health service. Hospitals and care settings should be the last places where anything other than collectivism should be emphasised. We work collectively to promote the health and wellbeing of all. Every person within our society is an individual" – consultation respondent.

There was a tension, throughout the consultation process, between the desire for self-identification, and the recognised benefits of collective identity. Many individuals did not associate at all with any of the collective terms and spoke in strongly negative terms about experiences of being individually referred to as an 'ethnic minority'. The majority of those asked were unhappy with the idea of being spoken about in a way that they felt erased their singular identity, and much of the negativity towards collective terminology was based on a desire to own and celebrate the nuances of a person's individual culture, heritage, nationality or ancestry. Individuals were much more likely to identify themselves

as, for example, Black, Pakistani, or mixed heritage, than they were to associate with broad terms like 'ethnic minority'.

Conversely, some participants in our face-to-face engagement spoke about the importance of collective thinking. These respondents felt that, because many ethnic groups shared some experiences of discrimination or racism, it was in their collective interest to pool power and be jointly represented. Relatedly, some respondents in our focus groups expressed real concerns about the fact that government policy seemed to favour the term 'ethnic minority'. This, they felt, was a conscious effort to remove the specific words Black and Asian from popular discourse.

This tension, between a desire for individual self-identification and the desire for collective action, was not resolved during this process and no consensus was reached.

The evolution of language

"I think that the terminology we use is not perfect but the debates about what term to use distract us from the real problem which is discrimination and inequality" – consultation respondent.

For some respondents, this consultation was a reminder of a familiar cycle. There have been frequent conversations over the past decades about the terminology we use to talk about race and ethnicity, and some feared that discussions about terminology served only to distract people from the real issues of race inequality. Many of those people take what they see as a more pragmatic approach to collective terminology – namely that it is not that important – instead choosing to direct their passion and time into work they think is more important.

Others pointed out language always evolves, and that it would be more beneficial not to get bogged down in these debates as it is likely that times and terminology will change again before long. It is more important, some people told us, to understand the political motivations of those who are promoting the change of language.

CONCLUSION

When we started this process of consultation, the aim was to find a term that the Observatory could use to refer to the broad range of people that we exist to represent and to serve – people who experience ethnic or racial health inequalities. In the end, we have found that the solution is not that simple and there is no clear consensus about whether collective terms are useful or not. For some, they are empowering. For others, they gloss over the richness of cultural identity. Even for those who do feel comfortable with collective terminology, or who at least see them as a necessary evil, there is no consensus about which terms they prefer or don't prefer.

We have found that some terms are more palatable than others, and that some terms are more well known than others, but it would be wrong to conclude this exercise by holding up one term that we felt comfortable using above all else. To do so would be unfair to those we heard from and wouldn't properly represent the range of views of our stakeholders. Even though the term 'ethnic minority' emerged as the least unpopular term in our survey, we know that it is less well liked by some ethnic groups than others. We also heard concerns in our focus groups about the risks of erasing the terms 'Black' and 'Asian' from public discourse.

That is why, instead of concluding this process with a single term, we have instead developed a set of principles that will guide our approach to language. We are not recommending that other organisations adopt the same principles, but we hope that they will help others in reflecting on their own approaches to language. If nothing else, we recommend that organisations reading this report take the time to speak to their own stakeholders and staff and do what they can to ensure their use of language is meaningful to their intended audiences.

These 5 principles can be found on page five of this report. We will adopt these principles going forward, but we will not end this conversation here, and invite our stakeholders to get in touch and share their views.

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