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Editorial

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Seasons' greetings and happy New Year to all our readers. We are very pleased with the response to the first issue of *Diversity in Health and Social Care*. The journal has attracted a lot of interest from around the world and we are now receiving articles from many different places including the UK, Europe, the US and elsewhere. Our feedback statistics indicate a healthy number of requests for electronic download of articles and a steady increase in sales. We feel very encouraged by your support and enthusiastic about continuing to develop the journal in 2005.

This second issue presents an international collection of papers on various aspects of diversity in health, many of which have been under-addressed. We begin with an unusual research study by Kemppainen *et al* comparing the use of alcohol among adolescents of school age in two different countries, namely the Russian Republic of Karelia and Finland. There is increasing global concern about the use of alcohol among young people and the effect this may have on their development. Alcohol use may cause physical and psychological damage resulting in long-term physical and mental health problems. Even if these do not arise, persistent or binge drinking will impact negatively on educational attainment and subsequent career prospects (World Health Organization (WHO), 2001). Moreover, early initiation into alcohol use carries an increased risk of injury, unprotected sexual activity and, in adult life, alcohol dependence. The manufacturers of alcoholic drinks have targeted young people, producing drinks that are intended to appeal to what is regarded as a new market, and despite the fact that they may not be allowed by law actually to purchase them (WHO, 2004). In both Karelia and Finland, alcohol may not be sold to young people under the age of 18 years. As the study reported here indicates, much younger adolescents clearly know about and have access to alcoholic drinks. Some may drink because they think it is the smart thing to do. However, coping with the increased complexity of social relationships or depression brought on by difficulties in relating to others may lead teenagers into experimenting with substances that appear to give them some relief from emotional pain, or which initially make them feel a little more confident in social situations. If this is the case then, as the study reported here suggests, educational initiatives about the harmful effects of drinking alcohol are unlikely to be effective especially if they do not take account of subtle cultural differences. Rather, professionals working with young people need to be alert to the reasons for drinking alcohol and to find ways of providing support.

Helping people cope with the problems of daily living, including social relationships, maturation processes and changes in physical or mental health leads us to consider the nature of suffering and the different ways in which this can be addressed. Health and social care professions have tended to conceptualise their roles in terms of specific physical, psychological or social interventions, but there is an increasing recognition of the importance of spiritual factors particularly when individuals are faced with serious illness or the possibility of death. Care given in the spiritual domain provides support in coping with suffering, bereavement and loss for patients, clients, relatives and professionals alike. In hospital settings responsibility for the provision of spiritual care is the remit of the chaplaincy department. Chaplains represent, and are knowledgeable about, specific faiths. Their role is to 'nurture wellbeing, foster hope and support people through the transitions that accompany a period of ill-health' and in doing so become resources for patients and staff (www.nhs-chaplaincy-spiritualcare.org.uk). In the UK, hospital chaplaincy has a strong Christian focus, led by the Church of England as the established church. Traditionally, it has tended to function using models of ministry based on visiting patients at their bedside. Other Christian churches, Roman Catholic and Free Churches, seem to have accepted this model in working with their Church of England colleagues in ministering to the sick in hospital. However, as Sheikh *et al* argue in our second research paper, in a society

that is now racially and culturally diverse, this Christian-based model can no longer meet the spiritual needs of many hospital patients. This paper presents a survey of hospital chaplaincy departments that shows some slight progress in introducing change. A small number of hospitals have created multifaith or non-denominational spaces for prayer, worship or reflection. One example is The Sanctuary, at the Edinburgh Royal Infirmary, which has been developed through collaboration between the chaplaincy team, local faith communities and other organisations, the hospital arts committees and artists. The outcome is a space that can be used by members of any religion or by those who profess no religious belief (Urquhart, 2004). In addition to such developments, a small number of chaplaincy departments now have staff drawn from faiths other than Christianity. This is consistent with the changing direction of the hospital chaplaincy service at national level, which, with the support of members of nine major world religions, has developed a multifaith working group to incorporate other faiths. However, change takes a long time, and while it is encouraging to see some signs of progress, there is still much to be done in providing spiritual care for patients from diverse faiths in the context of a health service that is undergoing major reforms.

Developing services within and for a diverse society requires a high level of cultural competence. This is a contested term that seeks to describe the ability of an individual or organisation to work effectively within the cultural context of a single service user or community. Becoming culturally competent is a gradual process dependent first on developing awareness of the self, either as an individual or organisation, and one's own culturally determined values, beliefs and traditions. Following on from this, insight into one's own cultural mores provides a basis for understanding how these may interface with the values, beliefs and traditions of others. A willingness to learn and engage with members of diverse communities is an essential component of developing a knowledge base about the relationships between culture and health. Inherent in this knowledge base is an appreciation of the ways in which culture influences individuals' and organisations' conceptualisations and experiences of health, illness, treatment and care (Campinha-Bacote, 2003). Cultural competence enables the professional to examine practice, in the light of new culturally based understanding, and 'strive towards a culturally liberated interacting style' in which differences are regarded positively as part of a 'shared learning experience' with the patient (Campinha-Bacote, 1994, p. 9). The object is to become culturally responsive by 'incorporating the individual's beliefs, lifeways and practices into a mutually acceptable treatment plan' (Campinha-Bacote, 1994, p. 11).

This sounds very straightforward but, as Wilson points out in the debate paper in this issue, we take our own culture for granted and trying to see the world from the perspective of another can be threatening. The process of becoming culturally competent is one of evolution requiring a mixture of motivation, informal and formal education as the learning moves from unconscious incompetence to unconscious competence. Two research papers in this issue address ways in which this may be achieved. In the first of these, Koskinen *et al* present a critical examination of the experiences of students undertaking international exchanges as part of their studies. Such exchanges have become a common feature of professional education in healthcare and are intended to enable students to develop towards cultural competence through the experience of living and working in another country. In anthropological terms, being the one who is different, the outsider, provides insight into what it feels like to be a member of a minority. The student is then expected to reflect and draw on this experience in caring for patients of other cultural backgrounds. A previous study by the lead author of the paper presented in this issue showed that the educational success of international student exchanges depended on sound organisation by the university and host placement staff, as well as student resilience in the face of what could be frightening experiences. For example students might arrive, at night, to find they could not access their accommodation and that no one was on hand to meet them. Others found that members of the host placement staff were unaware of their learning needs (Koskinen, 2003). In the research reported in this issue, the importance of good preparation of the students is evident. The individual's level of maturity and ability to cope with the challenges of an alien environment are also important but need to be bolstered by supportive relationships with key people in the host locality who can assist in solving difficulties. Many of these difficulties are related to the business of daily living or coping with an unfamiliar language. The provision of good-quality support, especially early in the placement, emerges as essential. Such findings indicate that tutorial and host staff must ensure students receive adequate and appropriate preparation before an exchange begins, as well as ongoing support that will help to reduce the effects of culture shock and facilitate progress towards cultural competence.

In the second research paper on cultural competence, Papadopoulos *et al* are also concerned with education and, in particular, ways of assessing whether students have made any progress in developing the self-awareness, knowledge and skills. The impact of the Race Relations Amendment Act (2000) places responsibilities on employers to tackle instances of inequality or discrimination that may in part be fulfilled through the provision of staff development and training. The result is a growth industry in workshops, seminars and other events that purport to enable participants to

develop cultural competence skills and, in some instances, an understanding of related topics in health policy, race relations, ethnic monitoring, religious beliefs and health issues in relation to specific minority ethnic groups (see for example Training for Change Associates (may be contacted at s.chirico@ntlworld.com). Associated with these developments is a range of models that are intended to facilitate cultural competence (see for example McGee, 2000; Campinha-Bacote, 2003; Purnell and Paulanka, 2003; and others). However, there have been few attempts to evaluate the effectiveness of training programmes. Papadopoulos *et al* have attempted to do this by using a classic pre- and post-test method with their course participants. While this is a small-scale study, it highlights a number of issues for educators to address about the conduct, content and outcomes of cultural competence training.

Inherent in this training must be elements that enable individuals to recognise their own prejudices and the ways in which these can act as barriers to the provision of treatment, care or services. Culture is not a value-free concept, but one linked to the ways in which people perceive others and the judgments they make about those who differ from themselves. In the UK the report of the inquiry into the death of Stephen Lawrence, a black teenager, introduced new understanding of racism and the subtle ways in which this operates, at both individual and institutional levels, to disempower, disadvantage or discriminate against members of society who are regarded as different by reason of their colour, race, ethnicity, physical characteristics, gender, religion or other distinguishing characteristic (Home Office, 1999). Power, as Wilson argues in this issue, is an important factor associated with some enactments of prejudice. Individuals and organisations behave in particular ways simply because they have the power to do so and can justify their actions, at least to themselves, on the grounds of preserving the dominant culture from perceived threat by people whom they regard as inferior (Schutte, 1995).

Two papers in this issue address prejudice and discrimination. The first presents research commissioned by the Royal College of Nursing in the UK into the experiences of nurses recruited from other countries to work in the NHS as part of a strategy to overcome staff shortages. By the late 20th century, nurses in particular were in very short supply and the nursing workforce was ageing throughout the world (Buchan, 2002). In the UK, nursing and other staff shortages constituted the biggest obstacle to the delivery of *The NHS Plan* (Department of Health, 2000). Consequently the plan included a target to increase the number of nurses by 20 000, over four years, through a combination of approaches that included recruitment from abroad (Buchan, 2002). Recruiting teams were commissioned to attract staff from other countries to help maintain the health service in a manner reminiscent of Enoch Powell's Ministry of Health in the 1960s. A code of practice was issued by the Department of Health to ensure that internationally recruited staff were appropriately qualified, that their recruitment and employment complied with UK law and that they had the same support and access to education as other NHS employees (Department of Health, 2001). Allan *et al*'s research documents the experiences of nurses recruited to work in different parts of the UK, Leeds, Cardiff and London. These practitioners were mature adults with, on average, 14 years post-qualifying experience, accustomed to the demands of nursing and well able to provide good-quality care. Moreover, at the time of this research, they had been working in the UK for almost four years, giving plenty of time to cope with cultural changes and adapt to new ways of working. Such individuals might reasonably expect to be valued as sound members of nursing teams and, in some cases, hold positions of responsibility and seniority. Allan *et al*'s research demonstrates that, for those who appeared to fit into the dominant NHS culture because they were not noticeably different, things could go fairly well. They were allocated to the wards they had chosen and could find it easier to gain acceptance, until that is, differences became apparent because of their accents or ethnic origin. Black nurses on the other hand, fared far worse. Many encountered racism for the first time, and were shocked by having to think about the significance of their colour in UK society, an experience that in some ways inverts that of the dominant white majority whose members can take almost every aspect of daily life for granted (Frankenburg, 1993). Being white is to be part of the societal norm against which others are judged. The experience of being white is so taken for granted that it is questionable whether white people realise that that they are white because discourse by whites is couched in terms of 'people'. 'People', that is whites, act in certain ways, possess certain values while 'others' do not (Dyer, 1997). Allan *et al* show that black people encountering prejudice based on their colour, experience challenges to their sense of self. Some felt angry and frustrated by this experience, leading one participant to say 'Oh in South Africa it was better', a shocking indictment of the behaviour of fellow nurses. This research challenges the health service to reassess both organisational and individual behaviour, and to take a proactive role in addressing racism. A profession that defines its primary role as providing care should be able to set a much better example of doing so in relation to its own members.

Allan *et al*'s paper also demonstrates that legislation is not enough to bring about change. Other strategies are also needed and these must be reviewed regularly to ensure that they are appropriate in a changing society. Dimond's paper outlines the work of three commissions set up in the UK: the Equal Opportunities

Commission, the Commission for Racial Equality and the Disability Rights Commission. Each of the commissions has specific powers to investigate particular forms of discrimination, run campaigns and, in certain instances instigate prosecution. However, the introduction of human rights legislation in the UK has brought a re-evaluation of the roles and functions of these commissions that has culminated in a proposal to amalgamate them into a single, new Commission for Equality and Human Rights. Dimond's paper presents the arguments for and against this single commission. Whatever decision is made, it remains essential to ensure that the dignity and human rights of vulnerable and oppressed people are upheld.

Inherent in any consideration of prejudice and discrimination is that of organisational culture that may be summed up as 'the way we do things around here'. Organisational culture affects individuals' experiences of their work and job satisfaction. Every healthcare setting has its own traditions, values, practices and procedures, some of which are evident in organisational policies and protocols, while others are more informal. One of the key features of health service cultures is that of valuing teamwork. Modern healthcare is highly complex and no single profession or practitioner can meet all the needs of an individual patient. Team working facilitates collective or group decision making and action based on the contribution of members of diverse disciplines. In certain fields of practice, team working is important for other reasons. For example, operating theatres are essentially closed environments in which staff teams work together for the benefit of patients. With the exception of the surgeon, anaesthetist and maybe the peri-operative nurse, most staff involved in an operation will not have met the patient prior to surgery. Patients are anaesthetised for most of the time they spend in theatre and consequently there is no interaction between them and the staff. The satisfaction of belonging to a team, in a highly stressed working environment and in which members depend heavily on each other to fulfil clearly specified roles replaces that of interacting with patients. The sense of belonging, of working together towards a common goal, the approbation of and interaction with other team members are extremely important in operating theatres, replacing interaction with patients as a major source as job satisfaction (McGee, 199?). Silen-Lipponen *et al*'s research paper presents an examination of the organisational cultures of operating theatres in three different countries. It highlights the main and consistent features of these cultures: professional teamwork, distracting teamwork, organised teamwork and the physical environment. Understanding these features and the subtle ways in which they influence the experience of work is crucially important for two reasons. First, it is difficult to recruit nurses to work in operating theatres, which are perceived as highly stressed, unpredictable environments that lack the satisfaction gained from interacting directly with patients. These recruitment difficulties have provided opportunities for the development of non-nursing roles such as that of operating departmental personnel. These roles do not carry the same professional responsibility and accountability for patient safety wellbeing that is the remit of the theatre nurse. If patients are to continue to benefit from the presence of nurses, then efforts must be made to ensure that operating theatres present attractive work settings with good career opportunities. An understanding of organisational culture represents a step in the right direction. Second, the UK is not the only country that is recruiting nurses from aboard. Understanding the differences and similarities in the culture of theatre work in different countries will help individuals prepare for experience abroad and enable managers to appreciate the ways in which the expectations of internationally recruited staff may differ from those of local nurses.

All the papers contained in this issue are concerned with health. We are pleased to be able to present research about such a range of under-addressed topics and promote an understanding of various aspects of education aimed at enabling health professionals to become culturally competent. We are aware that, increasingly, care is being delivered in multidisciplinary teams that include professions whose background is not in health. While there has been much good work done about diversity in social care, we feel that the overlap between the two fields has been under-explored (Williams *et al*, 1998). Consequently, knowledge and skills are confined to professional silos rather than shared, thus undermining the aim of seamless provision. We plan to include more articles that examine the interface between health and social care in a diverse society. We look forward to receiving such papers in the future.

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