Editorial

Hold the front page: culture matters in healthcare – are we making progress?

Mark RD Johnson MA PhD Cert HE (Warwick)
Editor, *Diversity in Health and Social Care*; Professor of Diversity in Health and Social Care, Mary Seacole Research Centre, De Montfort University, Leicester, UK

Paula McGee RN RNT MA BA Cert Ed PhD
Editor, *Diversity in Health and Social Care*; Professor of Nursing, Faculty of Health and Community Care, University of Central England, Perry Barr, Birmingham, UK

A recent article in the well-respected and widely read *British Medical Journal* is reported to have come to the startling conclusion that 'healthcare professionals involved in the care of people with type 2 diabetes should consider cultural factors when educating individuals to manage their condition' (Lawton *et al*, 2005). The *Journal of Diabetes Nursing* (9(8): 316) in reporting this finding 'despite the study's limitations' has perhaps done us a service in drawing this fact to their readers' attention, as the original researchers have performed a useful service in adding to the sparse literature on South Asian people's perceptions of their medication. Nevertheless, as editors of *Diversity in Health and Social Care*, we may perhaps be pardoned for feeling that the wheel has already been discovered: the conclusion at least is all too well rehearsed. Why is this not a truism for all trained health professionals? And we as researchers encounter mounting frustration in communities because they are aware that we have shed-loads of research, yet they feel that little has changed. There is a lot of understandable and perhaps justifiable resentment and downright anger.

One small example: the Department of Health has recently launched yet another programme – the 'Pacesetters Programme' – to deliver equality and diversity improvements and innovations resulting in reduced health inequalities for patients and service users, and working environments that are fair and free of discrimination. As usual it is a fixed-term 'project' with a promised funding of £200 000 over 2.5 years. There is (as far as can be seen) no link with previous 'projects', and as usual the key workers are all from minority groups, thus continuing the ghettoisation of black and South Asian people in the Health Service while letting their white colleagues off the hook yet again. Diversity? Equality? 'Well it's for them isn't it? Nothing to do with us.' If people are angry, it is hardly a surprise. Time and again we see ambiguity in the way

in which the health and social care services, and indeed society in general, respond to issues of diversity. Those in power set about meeting the demands placed on them in a carefully limited way. On the one hand they set up schemes, but in ways that place intolerable demands on post holders because of inadequate investment – money is promised but not delivered. As McGee's study (2000) made clear, senior personnel prioritised cost-effectiveness and control. They allowed only those initiatives that did not pose a threat to the *status quo* or which enhanced the public image. Alongside this is Husband's argument that:

> Successive governments have sought to diffuse and defocus the formulation of policy *by* minority ethnic communities through promoting ever-changing, but ambiguous policies *for* minority ethnic communities. (Husband, 1996, p. 37)

Thus, British governments have sought to control ethnic minorities and impose policies on them while not appearing to do so. In Husband's (1996) view, government strategy has been characterised by 'inexplicitness' that has, ultimately, hampered progress.

Some better news, however, can also be found. We welcome in this issue three new siblings to the family of diversity-oriented journals. The evidence base is growing, and more people are interested to access it and indeed to generate it. Our own pile of submitted papers is growing, and we would encourage anyone who wants to get their results published in time for the Research Assessment Exercise to hurry! For those of you seeking more reading, in the meanwhile, the *Journal of Muslim Mental Health* is now available, the product of a collaboration between the New York University Center for Global Health and Muslim Mental Health Incorporated, an American group committed to provide a broad spectrum of multicultural healthcare services, promote research and educational activities, introduce Muslim mental health concepts and advance

culturally sensitive therapeutic approaches – sensitive to the Islamic tradition and culture. The first issue deals with such contentious topics as perceived religious discrimination and paranoia, schizophrenia and concepts of good and evil, counselling and alternative support among Muslims in Ohio, and arranged marriage. The second issue will be a thematic issue dedicated to Iraqi mental health. The publisher's website is at www.tandf.co.uk/journals/titles/15564908.asp.

On this side of the Atlantic, our colleagues in Italy have launched the *International Journal of Migration and Transcultural Medicine*, associated with the International Institute of Medical Anthropological Social Sciences (IISMAS, www.iismas.it). The sample issue we have seen carries papers on HIV/AIDs and anti-retroviral treatment, and an epidemiological study of giving birth comparing gypsy and non-gypsy women in Italy. The Institute has strong links to Africa and especially Ethiopia, and one of its editors (Aldo Morrone) has also produced a useful illustrated *Dermatology of Human Mobile Populations* which we hope to review in due course. The journal is innovative not only in its attention to 'mobile' and transcultural populations but, like *Diversity in Health and Social Care*, it also explicitly encourages interdisciplinary research: unlike us, however, it is also bilingual, all papers appearing in both English and Italian. More information is available from its publishers, www.mnlpublimed.com or IISMAS.

On the other side of the globe, we are advised by the indefatigable Ruth de Souza in New Zealand that she and her husband have just launched a new free online journal about ethnic issues in New Zealand. The journal features articles written by key thinkers in the ethnicity sector in New Zealand and overseas. This open-access online publication offers a refreshing and challenging new perspective on what's going on in minority ethnic communities – noting that in New Zealand (or *Aotearoa*) , the rights of the Maori people are protected by the Treaty of Waitangi, and European 'whiteness' is just another ethnicity, albeit a powerful and large one! Issue 1 of the *AEN Journal* is available online at http://journal.aen.org.nz and includes a guest editorial by the Race Relations Commissioner and articles by Maori Party Co-leader Tariana Turia and Mervin Singham, Director of the Office of Ethnic Affairs. It features a viewpoint on the Palestine–Israel problem from a New Zealand Jew and a New Zealand Muslim. They characterise 'international' 'down there' as including a contribution from UK-based psychiatrist Suman Fernando, discussing racism in the mental health system, and the US-based human rights writer Amy West who challenges New Zealand's immigration controls, noting that 'changes made to protect borders from perceived terror threats come at a high cost to the safety and future of refugees'. This sounds rather topical for us too.

In our own journal, in an issue that focuses on different ways of seeing, and the resources inherent in our diverse cultures, we open with a guest editorial by Mary Dawood. She provides a practitioner's eye view of the essentials in supporting survivors of torture. It is a long-term undertaking by the UK, and hence a long-standing obligation on professionals, to support victims of torture, of whom there are a surprisingly large number among the asylum seekers and refugees who arrive in Britain. Regrettably (and as educators, we must share some of the blame) few doctors or nurses are adequately trained to recognise and deal with these issues. Mary's editorial spells out some of the key points with clarity and well-chosen advice. We hope that this, and the article by Sutton *et al*, will help remedy some of the deficiency.

In their paper (p. 77), Vicky Sutton and colleagues spell out their learning from working with young refugees, and highlight the positive change processes described by these children. Most demonstrate considerable resilience – an under-recognised resource – but there are ways of enhancing and building on it, as much as there are ways of undermining a person's capacity to cope or thrive. However, more of the literature so far published has concentrated on post-traumatic stress disorder (PTSD) and counselling or spotting damage, while refugees who present with strengths and resilience still have sub-clinical emotional and behavioural needs and cultural resources. Social support, activity and religious belief (and practice) are key factors in moving forward, getting over dislocation and loss. The worst thing, it seems, is having nothing to do, and in time the worst experiences may come to be seen as a form of learning or growth. Professionals can play a key role in assisting these processes.

Martha Chinouya and Eileen O'Keefe return us to a Zimbabwean perspective and another way of looking at human rights (p. 89). We stress (several times in this issue of the journal alone) the importance of diverse cultures as resources. Elsewhere we have heard the anti-political correctness lobby bemoan the restrictive effects of 'human rights' legislation. But human rights are not viewed universally as homogenous, even if they are all founded on some common notions of respect, humanity and connectedness. Cultural formulations such as *Ubuntu* (or *Hunhu*) assist us to understand and *use* these different models, such as the weight and nature of 'confidentiality', to support and help clients without compromising the wider commitment. Further, such sensitivity can help prevent accusations that the way 'we' deal with public health issues such as HIV/AIDS is all about protecting 'our' society from 'them' and not meeting the needs of others. There are few societies that lack the concept of solidarity, but too many who define it as 'for us against them'. Here's one alternative!

Gina Higginbottom and Nigel Mathers (p. 99) open up a world of Caribbean alternative and herbal medicine, and the hidden world of self-medication in communities of Caribbean origin (not all of whom, be it noted, are 'African' in their history and orientation). These groups are not unique in their self-care, but they do have an epidemiologically unique profile of hypertension, and a better understanding of self-care and belief systems can only be helpful in tackling this epidemic of heart disease, which is all too often symptomless. In the process, Gina and Nigel also demonstrate the usefulness of the phenomenological approach, and the value of vignettes to elicit responses, not to mention a strong 'user/survivor/carer' input to the research advisory group. Since we are increasingly aware of the pharmaco-effectiveness of many 'traditional medicines', it behoves us all to consider what alternatives our clients may be using, and to seek to understand them.

Warfa and colleagues (p. 111) consider the effects of life events and substance misuse on mental health among black men from the Caribbean and Africa, and white men of British origin. All their informants were 'dual diagnosis' referees, with both mental health and substance use problems. Such service users are characteristically 'high-maintenance' cases causing considerable difficulty to the NHS and social care system. The problem seems to be at least in part due to the culture of mental health services, which are less good at addressing the issues of substance abuse. One crucial aspect of this is to recognise that different cultural groups may well have differing patterns of addiction or use of drugs, and differing awareness of and readiness to address these issues. A more sympathetic or insightful approach may pay dividends in outcomes. It is also interesting to note that migration, whether as refugee, accompanying child, or simply from Essex to London, may be a crucial stress factor. Some hope, however, arises from the observation that a few respondents reported having professional care from someone who did understand. We hope that the students of these authors are learning from all this!

Alvina Palese and colleagues from Udine in Italy examine the adaptation of service providers – nurses in this case – to Italian practices (p. 123). This makes a change from looking at the experiences of overseas-trained nurses in Britain, although some similarities can be noted. Not least among these are problems of language, technology and hospital organisation – but the differences in professional cultures and roles are perhaps the most critical in the long run. Should any of our readers be contemplating emigration, they could also consider what they might learn before such a step! We also commend this paper to those organising acclimatisation courses for nurses and others coming to fill the UK's never-ending skills gap. Overall, we all need the awareness, and perhaps

some of the external gaze of newcomers, to make us more conscious of our own 'taken for granted' assumptions and beliefs (or 'culture'). Technology and labour do not, as is often assumed, transfer between settings in a seamless fashion: we all have something to learn and something to offer in such exchanges.

Mullen and colleagues present a perspective on diet and oral health from Scotland (p. 131), which may well be (in)famous as the home of the deep-fried Mars bar, but has also a lot to teach its neighbours about multiculturalism. Those familiar with Scottish epidemiology may well wonder what are the implications of cultural assimilation (especially in diet) and the concept of the 'healthy diet', but our authors show how many of the constraints on the latter arise from the pressures of poverty and keeping employed in often demanding work roles. These, as much as 'acculturation', are salient features in lifestyle choice. The insight provided by this study into the life and diet of 'second-generation' migrants is very helpful. From the point of view of a wider health research community, we may ask why so much of this sort of work has been done by dentists – could we have more research into food and drink by general physicians? Or are dentists better at asking, or in a better position to ask, questions? At least it is clear that their respondents had a clear and fairly accurate understanding of a healthy diet, and that most tried to stick to the best elements of their traditional cultures, despite exhortations, no doubt by politicians, to integrate more!

Returning to the southern hemisphere but considering the role of mentoring in the support of children with disabilities, we learn of the value of such approaches for the welfare of families as well as the person mentored, and the fact that providing such support is itself a learning experience (p. 141). Actually, it is not really clear who, in the end, was mentoring whom. Mackey and Goddard are to be complimented on achieving such a dual result with their nursing students. Like other papers in this issue, they have decided to work from strengths, rather than a deficit model, and to build on family resources. Action research, further, means not being afraid to bring about change and to recognise that all research and scrutiny causes change – so why not do it deliberately? Maybe we should try to make more of research as a health improvement strategy, as well as a way of providing a voice for unheard communities and learning for people with hidden skills. But, as in nearly all the papers featured in this issue, evaluation and reflection are also critical, as is checking back and feedback from research participants.

And, as ever, we conclude with a selection of reviews, news and the sharing of good practice in our Knowledgeshare section. We hope that our readers do find this of value, and would welcome responses, comments and criticisms – or letters suggesting

alternative views – on the contents of all sections of the journal including the Knowledgeshare and the editorials. Diversity means letting a thousand voices speak!

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