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Editorial

I never needed to know the word for diabetes till I took this job

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Consider the following sentences: my name is Paula; je m'appelle Paula, *I am called Paula*; mera nam Paula hai, *my name Paula is*. Each conveys the same information but in slightly different ways. As in all language, each example reflects specific rules about where to place verbs, the order in which words should be placed, how they should be pronounced, which syllables should be emphasised, how meaning should be delivered politely. Every language reflects an underlying system of cultural values, a mental software that is used to structure and organise thinking and thus the development of knowledge. The language in which we think is an essential part of who we are; it is what we dream in and what we use to express ourselves to others (Trudgen, 2000). Each language is unique in reflecting a particular view and experience of the world. Thus, when language dies or is suppressed, a particular world view and means of expression is also lost along with a major conduit for the transmission of culture to the next generation (Crystal, 2000).

Learning a language is not difficult; children do it every day. However, moving between languages requires a switch from one view of the world to another and back again. The speaker must bring together the sounds, grammar, concepts, expressions, conventions and way of thinking in one language and try to convey them in a meaningful way through the medium of another; thus switching between languages is a process that involves far more than substituting one set of words for another. There are a number of bilingual writers who provide insight into the degree of complexity that speaking two languages requires. For example, Wierzbicka (1997), a linguist, described her experiences as a speaker of both Polish and English and the constant changes required as she moved, within herself, between one language and the other. She argued that not only do the two languages have different conventions about expressing concepts such as the time of day but they also have distinct conversational styles. To illustrate this point she drew attention to the Polish style of conversation in which there is frequent use of the imperative forms of verbs. In English, this conversational style is construed as confrontational or even rude. Thus, the bilingual person must concentrate not only on how best to convey thoughts and ideas but must also take into account what should be omitted. In another example, Hellman (1989), whose first language was also Polish, described her difficulties in learning English patterns of voice control and modulation. For both these writers the sheer effort required to take account of the functional, cultural and conceptual differences between Polish and English created high levels of intrapersonal conflict. Wierzbicka (1997) and Hellman (1989) demonstrated that transferring between two languages can be both complex and stressful. In their experience Polish and English reflected such entirely different views of the world and ways of living in it that, in moving from one to the other, it became necessary to construct a different version of the self, a process they described as painful, laborious and exhausting (Wierzbicka 1997, Hellman 1989).

These difficulties and the resulting stress are rarely acknowledged by mono-linguistic individuals who have limited understanding of what is involved yet everyday practice in health and social care requires that bilingual staff move rapidly between two languages in order to facilitate treatment or care. In this context, they are exposed to pressures from which their monolinguistic colleagues are protected. For example, McGee (2000) found that bilingual nurses in training were expected to take responsibility for explaining operations to patients. Several years later some of these nurses could still vividly recall their fears of making mistakes, particularly when they had not been formally educated in one of their languages, and they recalled that refusals to act as interpreters or expressions of concern were likely to lead to their being labelled as

awkward or *uncooperative*, factors that might adversely affect their placement reports. Moreover, patients too were a source of pressure because, even if they could speak English, some would save up their problems and concerns for when the bilingual nurses were on duty in the belief that a shared language made the nurses responsible for every event; refusal to accept this role could bring complaints.

These findings suggest that, whilst practitioners may want to do their best for patients, being bilingual is not enough. The placing of inexperienced, unconfident people in positions in which they are required to take on responsibilities for which they have received no formal preparation must be taken seriously as a form of unsafe practice. Bilingual staff should not be pressurised into taking on interpreting roles without specific preparation that takes account of the differences between the languages concerned and which enables them to establish appropriate equivalents between the two. For example, it may not be possible to explain diabetes in exactly the same way in each language and so it is necessary to determine the best, most meaningful and accurate equivalents.

Readers will argue, with some justification, that things have moved on since McGee's research. In the UK health and social care organisations are now required under the terms of the Race Relations (Amendment Act) 2000, the Disability Discrimination Act 1995 and other legislation to provide language support to service users who would otherwise be unable to communicate effectively with those responsible for helping them. Consequently, organisations do employ interpreters whose role it is to facilitate communication between service users and professionals. However, the employment of these interpreters has not lessened the burden on bilingual staff because the everyday realities of practice mean that staff do continue to rely on colleagues. *I just want to find out a few things for the admission form; I'm sure I'll manage without an interpreter. It's too expensive to book an interpreter. It's 2am; I'll not get an interpreter at this hour. They're (interpreters) not here but you are so can you just ...* All of these statements form part of the armoury of excuses for the perpetuation of both inequitable service provision and pressure on bilingual staff. Employers still have to face up to the fact that interpreting is a proper job that requires training and not something that can be tacked onto an existing workload without preparation or recompense. Formally offering bilingual staff the choice about whether they wish to act as interpreters and then providing those who chose to do so with appropriate training would go some way to redressing the current situation.

Bilingual practitioners have the professional expertise required in the field in which they work and training would help them to become more confident in handling the differences between the languages concerned. Some form of remuneration should be given for the extra responsibility incurred and this might well prove cheaper than the real or imagined costs of booking interpreters.

Language forms one of several threads in this new volume of *Diversity in Health and Social Care*. We are pleased to begin with two guest editorials. First, Ivan Lewis reminds us that tackling inequities was one of the founding aims of the NHS and one that it has continued to uphold in remaining free at the point of delivery and in employing staff from diverse backgrounds. However, tackling inequities in health requires a great deal more. The focus is now on helping people in a very diverse society to retain their health as a part of upholding their dignity and well being irrespective of where they live or any personal characteristics. To neglect health, to fatalistically accept that ill health and suffering are inevitable, runs counter to the principle of upholding human rights; everyone is entitled to the same good standards of healthcare.

Haluk Soydan, one of our new editorial board members, discusses the need for equity in health, linking this to evidence-based medicine. In doing so he raises some pertinent questions about the ways in which inequity is institutionalised and perpetuated so that disadvantaged populations continue to receive services that are not suited to their needs. He draws attention to the international Cochrane and Campbell Collaborations, for which when conducting a systematic review, the expectation is that papers in all languages will be incorporated, and not, as is too often the case in academic studies, restricted to English language publications. The problem remains of translating the context of studies.

Older people form one of the social groups most likely to experience inequity in health. As Caldwell *et al* point out in our first paper, definitions of *older* are not precise; biological ageing is not the same as psychological or social ageing, both of which may be linked to individual circumstances and personality. Cultural values and beliefs also play a part; what is considered *older* in one society will be thought *young* in another; age-related behaviour that is the norm in one place will be unusual in another (Helman, 2000). The consequences of becoming older are, however, closer to universal: failing health, increasing dependency and loss. The increasing number of older people presents a challenge to health and social care providers worldwide. The 'quick fix' approach of the established medical model will not suit populations in which long-term conditions are the norm. Caldwell *et al* put forward some suggestions about how the care of older populations, as opposed to cure, may be organised.

Our second paper takes us back to the issue of language. Given the importance of language in every aspect of our lives it not surprising to find that it is

surrounded by a social and political morass. Which language we speak and how we do so; our fluency, accent, use of intonation and gestures; our ability to conform to a million social niceties are all carefully observed and noted particularly by those who consider themselves to be socially or culturally superior. Members of dominant groups persist, despite the lack of evidence, in making judgements about the way in which individuals speak and persist in the belief that languages, other than their own, are in some way inferior (Crystal, 1997). Johnstone and Kanitsaki's paper explores inequity in health through the medium of language prejudice and highlights the ways in which those who speak the dominant language in an approved way are privileged. Language prejudice is evident as a form of racism that has hitherto received little attention.

In our third paper we turn again to the subject of the inequities in health experienced by black people who use mental health services. Chandler Oates and Nelstrop's paper adds to the body of evidence provided by black service users and links this to the formulation of national guidelines on the management of violent behaviour. We hope that those responsible for service design and delivery will take notice.

Service user perspectives and language form the basis of our fourth paper in which Sunsoa describes a pilot study in which she developed a tool to assess learning among South-Asian people with type 2 diabetes. She demonstrates how equivalents were established between English and five South-Asian languages. The tool revealed how much or how little patients understood about their condition; how inaccuracies in translation can lead to deficiencies in understanding. Elsewhere in this issue, one of us has written about the supposed reluctance of South-Asian people to take part in research. Sunsoa's paper shows that people from this background will take part if researchers make an effort to engage with them in an appropriate way.

Our education paper in this issue focuses on the usefulness of simulation in learning about culture. Koskinen, Abdelhamid and Likitalo demonstrate the usefulness of games in enabling students to develop new insights into cultural awareness. The use of these games in promoting an understanding of the cultural dimensions of daily life is an under-researched area that we hope these authors will explore further.

Our final paper by Brown opens a debate about a new topic. When a parent dies, adult children may see the solution of care for the remaining parent in terms of inviting Mum or Dad to come and live with them. For the older person this can mean uprooting themselves from a home and way of life in which they have long been settled and where they perhaps enjoy a certain well-earned status. Relocation can be a difficult and stressful experience at any time of life but particularly so for older adults to whom the usual ways of making friends, for example, through employment or children, are not available and who may not easily adjust to new places or people. When relocation requires travel to another country, with a different language and culture, the stress and difficulty must seem very hard indeed. As Brown points out, such a move can leave older people socially and physically isolated, depressed and with too much time on their hands. She points the way towards an understanding of this experience and we look forward to hearing more about this in due course.

Finally, we introduce a new feature *Did you see?* In each issue one of our distinguished editorial panel or a guest expert will discuss a recently published article or report that readers may have missed and which it is felt will be of particular interest to our readers. Where possible we shall try to link these to our own content and discussions will be intentionally critical and polemic. In this issue Johnson discusses a recent article in the *British Medical Journal* about the recruitment of members of minority ethnic groups into clinical trials. We are pleased to announce that that Dr Nisha Dogra has kindly agreed to edit the *Did you see?* feature.

The Knowledgeshare section is, as always, filled with useful information, reports, websites, books and so on that you may have missed. Once again if you would like to contribute to this section please contact Professor Lorraine Culley at lac@dmu.ac.uk

We hope our readers will enjoy this volume of *Diversity in Health and Social Care*. We are grateful for the encouragement and support we continue to receive and which make the journal a success. We look forward to hearing from readers through our new letters page. Items for this page should be addressed to the editors and sent to dhsc@radcliffemed.com

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