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Editorial

Where have all the flowers gone? When will they ever learn?

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The last few months have seen a succession of memorials and funerals for some icons of our age, from Madiba Mandela to Pete Seeger, who gave the earlier years of struggle for equality and diversity their songs, catchphrases, cheerleaders and recognisable faces, and much of their energy. We also mark the passing of Professor Stuart Hall, the West-Indian-born sociologist who did much to establish antiracism in social science, and who was very clear about the distinction between positive factors such as *differences, differentiation* and *diversity* and the negativity of *discrimination.*

The struggle continues. Regular readers will be aware that one of our major concerns is violence and discrimination aimed at women, particularly when bound up in and accentuated by 'ethnic' or 'cultural' considerations that militate against criticism. It was therefore good to see how communities and activists came together to support international End FGM day (Tuesday 6 February 2014). This was a highly successful campaign that at one stage garnered two signatures a second on a petition to urge British schools to tackle this issue through education and vigilance. The Twitter hashtag #EndFGM rapidly became a trending address, and is worth a visit to find what is still ongoing with regard to this issue. It now seems that the UK Secretary of State for Education has in fact bowed to pressure and will be writing to all schools to alert them to this issue. Only by constant organisation and pressure, often through such websites as www.change.org, can we bring about improvement and challenge the process that Stuart Hall termed 'othering' by making the 'other' part of 'us.'

The papers in this issue have a lot to say about 'othering' and exclusion. The 'other' is useful to and may thus be tolerated by the 'norm' but never become a part of it. The 'other' is and continues to be different. No matter how well acculturated, there will always be that moment when a curtain passes between the 'other' and the majority group, an indefinable something that separates and excludes and which neither side can remove. This may be most acute for first-generation migrants. There is the expectation that the second generation will be more acculturated, find it easier to fit in, and speak the language like 'one of us', but in time they too may find, often because of visible differences, the subtle ways in which discrimination functions, below the radar. One can feel like an insider with an 'access all areas' pass at a pop concert, but still find that there are dual worlds and rooms that one cannot access without extra privilege. Even when one has the privilege accorded to fame or position, discrimination can continue. Indeed, it can hurt even by association when one feels that others of one's own group are being discriminated against, which may lead the famous to show their solidarity with the struggle. Few of us can write songs like Pete Seeger or speeches like Madiba Mandela, who gave a voice to the voiceless and dispossessed, but this journal uses such academic privilege and power as it can to ensure that at least the scientific evidence for equality is there for those who need and seek to use it. We also comment on and expose those situations where evidence exists and action is not taken, as some of the papers in this issue seem to demonstrate an institutional slowness to learn from previous experience, research and campaigning.

In this issue

In a paper from Sweden, where many of our readers are likely to find themselves unable to communicate in the local languages, Olt *et al* (2014) describe the experiences of migrant care workers and how the second generation may differ from the first. In Sweden, as in much of Europe and the USA, the

growing proportion of older people in the population is putting increased demands on care services, requiring the recruitment of more staff. Increasingly these are found from among migrant workers and their descendants, who may still be more willing to accept such challenging and frequently poorly paid positions (Hatzidimitriadou and Psoinos, 2014). The question is whether a diverse workforce is really a solution to the provision of care and services for older members of migrant populations. Olt and colleagues suggest that it is not in fact such a simple equation. There remain problems of intra-workforce communication, and it cannot be assumed that the children of migrants are fluent in their parental languages. Acculturation is associated with the loss of important skills, such as the ability to speak the languages of first-generation migrants. Adopting the values of the new society can alienate first- and second-generation migrants from one another. The allocation of second-generation staff to care for first-generation migrants creates either healthcare ghettos or oases, depending on one's point of view. In these contexts, the 'other' is tolerated as a means of looking after 'ethnic patients/clients' so long as that 'other' relieves the majority population of having to do anything about them.

The mechanisms that maintain these ghettos are discriminatory, but often too subtle to be overtly illegal. In our second paper, Likupe *et al* (2014) demonstrate how some of these mechanisms work in a UK setting. Healthcare, and indeed other public services in the UK, have long relied on migrant labour. Recruitment tends to be cyclical, and is currently in an upward phase as many healthcare organisations attempt to fill nursing vacancies. Eligible candidates are expected to have post-qualifying experience, and frequently hold senior positions in their home countries, but once they are in the UK they frequently find that they are assigned to junior posts in which they cannot use all of their skills. If this were for a designated period, just to help them to adapt before taking on more responsibility, few would quibble about it, but the reality is that opportunities to progress are very limited. The research of Likupe and colleagues examined the role of managers in blocking opportunities for their black African staff. Some managers colluded, or preferentially discriminated in favour of other white staff; others meanwhile simply did little if anything. This paper shows yet again that health services in the UK continue to use migrant labour as a short-term measure to plug holes in service provision whenever there is a shortage of home-grown professionals. Universities respond by stepping up production, there is then an abundance, and overseas recruitment stops until the numbers fall away and then the cycle starts again. Migrant labour is simply used as a means to an end, and no consideration is given to the fact that the people who are recruited are highly skilled human beings, who deserve the same chances as everyone else in return for the same work, and who frequently have a great deal to teach the host population. It really is time that a developed country such as the UK moved on from post-World-War-Two modes of functioning aimed at rebuilding. Black African people now form a significant and expanding part of the population and deserve better. In this spirit we endorse the NHS Employers Personal, Fair and Diverse campaign (Twitter @PFDChamps) and their sponsorship of NHS Equality, Diversity and Human Rights Week (12–16 May 2014).

Our third paper continues the theme of black African experiences of healthcare in the UK. Rabiee and Smith (2014) explore the perceptions of a range of black African people about mental health services in Birmingham, the second largest city in the UK. Although many of their themes, such as the role of spirituality and the community third sector, are familiar, this paper looks particularly at the specific needs and views of Somali and Congolese communities. It also highlights the traumas that are additional burdens on some people whose migration paths lead to asylum applications. This study has some strong messages for improving practice.

As readers of this journal are only too aware, mental health is just one field in which members of black African and other minority ethnic groups are underserved. In a useful addition to the rather sparse literature on black and minority ethnic (BME) groups and cancer, Patel *et al* (2014) present their findings about black and South Asian women's experiences of breast cancer. In the light of many reports about the silence and stigma associated with cancer, it is encouraging that their respondents spoke of 'unlimited support' being offered by family and friends. Nevertheless, there are clearly still some communities where more public education about the condition is required to develop appropriate support networks and challenge ignorance. As previous papers in this journal have emphasised, clinicians really do need to understand and work with their patients' spiritual understandings and networks to help them to improve their coping skills and resilience. Factors such as body image and lifestyle are as important to BME women as to any others, and are poorly managed in practice. A recent report from BME Cancer Voice, a small third-sector grassroots organisation, reported in February 2014 that an alarming 58% of BME patients who required prostheses were not offered one that matched their skin tone. It is good to learn that this organisation has been taken into the sponsorship of the Black Health Initiative (www.blackhealthinitiative.org or @BHILeeds). Clearly research and campaigning can go together, and need to do so.

In our final research paper, Burchill and Pevalin (2014) explore the hypothesis that one barrier to

accessing healthcare in the UK is the lack of cultural competency among gatekeepers, such as community-based nurses and health visitors. It is also pleasing to see a model of practice originally proposed in our first ever issue (Quickfall, 2004) being used to good effect here. Perhaps it is not surprising that the nurses' capacity to extend their services was constrained by external factors such as national legislation and NHS policy, despite in many cases their own personal commitment and abilities. On the 25th anniversary of the Stephen Lawrence Inquiry (Macpherson, 1999) which named and exposed the extent of institutional racism, it is appropriate to highlight the structural issues facing migrants and minority ethnic groups. Some health visitors in this study showed a lot of initiative in using the alternative options available, such as calling on their duty to safeguard mothers and children, emphasising the role of the individual gatekeeper as a 'policy entrepreneur' (Connelly, 1989) or 'street-level bureaucrat' (Lipsky, 1980) to reinterpret and affect such structural injustices. What makes a difference is not just knowing about culture, medicine and nursing, or about culture-linked issues such as FGM, or learned skills such as the use of interpreters. What makes 'effective practice' is being prepared to do something. If you are not part of the solution, you are part of the problem.

The remainder of this volume contains our usual selection of good practice reports, educational materials and reviews. The Practitioner's Blog deals with a very common issue, the need to spell names correctly and the consequences of failing to do so. As far back as either of us can recall, there have been reports drawing attention to the need to ensure that records are kept up to date and culturally competent, to ensure that 'medical mistakes' or other accidents do not happen. In a diverse society, the accuracy of spelling presents a greater challenge to patient safety than ever before. Our Did You See? article comes from contributors in the Netherlands and presents a critique on in-service education about diversity awareness. We have 'rested' our regular CPD slot, as there is more than enough to be learned by reflecting on this and also the case described in the Practitioner's Blog by Dawood and Matthews (2014). Finally, Knowledgeshare features an interesting collection of reports, including one about shamanistic practices.

As we emphasise the role of the individual in bringing about change, we close with a note of pride and an acknowledgement of the contribution of one of the founding members of our Editorial Board, Professor Rashid Gatrad OBE. Rashid has been a great friend to the journal, as well as a prolific publisher on the subjects that concern us (see, for example, Gatrad *et al*, 2005, 2006, 2011). What is more, he has been an indefatigable advocate and activist in his home community in the West Midlands. We are delighted to report that he was awarded the Freedom of the Borough of Walsall earlier in 2014 for his contributions to the welfare of people in the area. The citation states that the Freedom of the Borough was awarded in recognition of his work at Manor Hospital in reducing the number of infant deaths. We congratulate Professor Gatrad, pictured here with Councillor Mohammed Nazir, Mayor of Walsall.

Twitter: Please use our Twitter identity (@DiversityJnl) as an alternative to contacting us using our email address (dhc@radcliffepublishing.com). We use the Twitter feed to ensure the widest possible coverage of the journal, and will be using it to highlight other issues of concern to our readership. We welcome feedback, and hope that this might make it easier for some of our readers to respond to what they have read in the journal, as well as to retweet and spread the word about us. Do follow us!

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