Accepting differences

In this second article, Mike George examines how managers, educators, and nurses themselves all have a part to play in preventing patients from black and minority ethnic groups being seen as 'problems' in the system.

Nurses must 'recognise and respect the uniqueness and dignity of each patient and client and respond to their need for care, irrespective of their ethnic origin or religious beliefs,' says the UKCC Code of Conduct.

A fine sentiment and a noble aim, but in practice how does this translate into nursing care for the almost three million members of the black or minority ethnic communities — particularly care given by a predominantly white nursing staff?

In 1992 the Department of Health admitted publicly that it was not doing enough to provide equal standards of care for those from black and ethnic backgrounds. And the RCN's recent literature search confirms that 'wide gaps exist between the health care experiences of the majority whites and patients/clients of black and minority ethnic origin' (1).

Research into race, ethnicity and health care, much of it quite recent, has tended to identify a number of specific problem areas. Differences in disease patterns, for example, have become widely recognised, such as the higher rates of heart disease among people from the Indian subcontinent, or the increased risk of stroke for those born in Africa or the Caribbean. No-one is confident about understanding the reasons, though Dr Kenneth Caiman, the government's Chief Medical Officer, has suggested that inadequate health education may be a cause.

The relatively high incidence of compulsory admissions under the Mental Health Act of Afro-Caribbean people has posed questions about the assumptions of the dominant white culture, so bridging the divide between the causes of illness, and diagnosis and treatment. And many recent studies have focused more on how health professionals can fail patients from black and minority ethnic communities.

One type of response has been the production by health authorities of checklists, or ethnic fact files for nursing staff, which can include dietary issues, religious or cultural practices, and clinical matters. Jennette Golding, RCN North East Thames senior officer, says that while they may be useful in some circumstances they can also be a form of oppression 'by saying that these people are different'. She is also concerned that ethnic categorisation could encourage nurses to avoid dealing with the whole person.

'How patients see themselves, and what their ethnicity means to them and their condition in terms of health care is central to the concept of dealing with the whole person,' she says. 'Instead, you could see a black person in a hospital bed and assume, possibly mistakenly, that he or she was African, and look up a book or guide to see what's to be done, rather than approaching the individual like any other patient.'

Dealing with different cultures

She does not deny that nurses can feel stress and anxiety when dealing with a person from another culture. Nasrin Khadim and James Marr recently highlighted some difficult issues like toileting arrangements, provision for prayers, and dietary needs among older Asian people (2). Kathy Murphy and Jill Macleod Clark identify several key problem areas: basic communication difficulties, problems in building an adequate nurse-client relationship, problematic behaviour of the client's relatives, stress caused by not being able to understand clients' assumptions about health care, and feeling that as a result they are giving below-standard care (3).

So it may be understandable for nurses facing these difficulties to protect themselves from anxiety by withdrawing into a basic clinical approach — which might involve going to a reference book and looking up the 'category' of person in order to use this as a way of dealing with the patient. But Jennette Golding maintains that nursing staff should try to relax a bit and talk about their problems. We need to ask ourselves 'what is it that I bring culturally to a person who is different from me?' — we all have prejudices and individual backgrounds, as well as our nursing culture. We need to find ways of accepting difference, and respecting it, in order to be able to give good quality care,' she says.

A common complaint is that managers seldom take time to allow for honest discussion, so unnecessary myths can too easily arise, or specific difficulties can develop into apparently enormous problems.

For instance, although Ramadan is important, it does not have to be a major problem as long as nurses have an appreciation of the general norms, says Jennette Golding. 'You could, for instance, tailor someone's medication in the knowledge that they may be taking it at night rather than through the day.' One of her male colleagues was unable to see female patients in a particular community because of its religious and cultural norms. Instead, he regularly saw the men and they had talks 'about women and childcare', and through this indirect route his objectives, for instance for vaccinations and immunisation, were achieved. Ms Golding cites this example to support her view that there are many models for delivering care, that there may not always be a textbook-like right way, and that the prime requirement is honesty — even when it means admitting failure.

Some blame may be attached to purchasers, particularly in areas where there is a substantial black or minority ethnic community. Many nurse specialists have to struggle to get particular conditions or care issues taken seriously when they are associated with race or ethnicity.
One obvious example is sickle-cell anaemia. Comfort Acheamong is a nurse specialist in the sickle-cell and thalassaemia centre at London's Central Middlesex Hospital, and she points out that blood testing of new-born children to screen for sickle-cell is still very patchy. There is also a shortage of specialist nurses, and the subject is not integrated into the nursing curriculum, she says. She and her colleagues spend much of their time putting on short training courses for nurses, GPs, and the public – even so, they lack many basic resources.

While sickle-cell may be considered by purchasers to be a minority concern, the consequences, for example for A&E departments, may be profound – for both patients and staff. For instance, past neglect means that there are many people undiagnosed, who present themselves to A&E during a crisis.

**Inadequate pain management**

Comfort and others also cite instances in hospitals where the very severe pain which can accompany sickle-cell is regarded by staff as some kind of hysterical behaviour, leading to inadequate pain management.

Lack of training is also one of the complaints aired by Pat Black, clinical nurse specialist in stoma care, who works for Hillingdon Health Authority. Many patients with whom she works are from black or minority ethnic backgrounds, and there are many important cultural issues with which she has to grapple. ‘You learn a lot on the job, especially about how to be flexible, and I’ve found that you can adapt most things on a ward including the positioning of beds to allow patients to pray.’

For Janice Beer, a clinical nurse specialist in diabetes, working with a large Bengali community in Tower Hamlets, effective outreach work is a priority. As there is no written language, she says, it has been crucial to employ a Bengali-speaking linkworker (a community dietician is in post), and her unit has had to commission its own videotapes for diabetes education, as no existing material was adequate.

She and her colleagues also have to provide a great deal of local training for community and hospital nursing staff.

Neslyn Watson-Druee, who chairs the RCN’s Race and Ethnicity Committee, also identifies management failure to use the skills and knowledge of nurses with specific cultural knowledge and information, which is particularly important given the inadequate numbers of nurses with black and minority ethnic origins.

A mixture of training needs and changes both in management and nursing practice are suggested by Sally Gooch, Clinical Leader of the Stepney Nursing Development Unit. ‘How many of us realise that sticking plaster is usually pink. Why? Because it is assumed that skin is pink,’ she says. ‘How many of us were taught the signs and symptoms of cyanosis, jaundice, cardiac arrest and pressure sores in people with hyper-pigmented skin? How many of us know how to care for the skin or hair of an African or West Indian person? How many of us have thought, when struggling to remove sutures from a black person, the sutures are usually dark because of an implicit assumption that a patient’s skin is white?’

It is now accepted that nurse educators must examine how well courses reflect the reality of our multicultural society, and the RCN has produced a curriculum audit tool to explore selection and recruitment, and also course content.

But will managers in purchaser and provider units be similarly challenged and/or educated to encourage change? If not, then everyday nursing practice is far less likely to change.

Not only does patient care suffer, but the continuation of practices which assume that people who are ‘different’ are therefore ‘a problem’ causes extra stress and anxiety among staff and patients alike. And changes in staff attitudes are surely a necessary part of any real effort to increase nurse recruitment and promotion among black and minority ethnic people.

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References

Plasters are pink and sutures black because of an assumption that skin is white.