

Editorial

Globalising care

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As we compile this edition, the British General Election is in full swing, and the parties and pundits are exercised by two issues in particular: the health service, and immigration or (in some forms) national identity. Clearly, we cannot be unmoved by these debates, nor can we respond to them all. Nonetheless, we were pleased to note that a study by the Institute for Public Policy Research (Sriskandarajah, Cooley and Reed, 2005) makes it very clear both that migrants are very heterogeneous, and that they make a substantial financial contribution to the exchequer through the taxes they pay. As the authors reported:

> ... even low paid migrant workers work relatively long hours and pay not insignificant amounts of tax ... and may have only restricted access to, or do not make full use of the (health and social care) benefits they are legitimately entitled to. Further, while immigrants' share of expenditure on health care ... and other public services is an inherent part of the analysis ... this argument ... fails to recognise the contribution immigrants make to the provision of public services. (Sriskandarajah, Cooley and Reed, 2005)

As they observe, well over a quarter (29.4%) of NHS doctors in 2003 were foreign-born, and since 1999, nearly half (43.5%) of nurses recruited came from outside the UK. Meanwhile, Dr Beverly Malone, leader of the Royal College of Nurses, noted at their annual conference that there was a current shortfall of home-grown nurses of about 15 000 per year, which was barely being filled by finding between 12 000 and 14 000 internationally recruited, overseas trained nurses each year – a figure which is beginning to fall. We explore some of the reasons for that in this issue, along with a host of other concerns about providing health and social care in a globalised, multi-cultural society.

As we have seen, the recruitment of NHS staff from overseas is a topical issue. Matiti and Taylor conducted a small-scale but in-depth evaluation of the perceptions of culture relating to nurses recruited from overseas. They note that we all have, and operate within, at least two cultures: that of our own personal background, and that of the environment where we work and live, which are rarely identical. For migrants, personal culture is closely linked to notions of self and home, and self-identity (or self-confidence), which is critical in determining their effectiveness at work. This is, therefore, a critical issue which may be aided by the preparation and induction processes. Clearly, even such 'universal' professional cultures as nursing are differently developed and practised in diverse settings, in ways which may not always be transparent to those training, or providing induction programmes for, migrant staff. This paper provides an interesting and provocative insight into some of these issues and suggests how we could do better all round. Oh yes, and it will not surprise readers that once again, communication – the use of languages and the effects of accents and dialects – was an issue.

In a complementary paper, Bridget Taylor also looks through another qualitative small-scale study at the experiences of overseas nurses, using a slightly different approach including participant observation. Her key findings include not only revealing communication issues and differences in the nurses' role, but also the experience of being deskilled, and the recipient of racialised discrimination and abuse. It is clear that they are not treated 'with due regard', despite shed-loads of recommendations and guidance in this matter. Amazingly, and perhaps tellingly, none of 50 UK-trained nurses working alongside the overseas nurses reviewed responded to an invitation to take part in focus-group discussions, suggesting a distinct lack of collegiality and solidarity, and maybe underlining the complaints of those interviewed about their isolation and marginalisation. It is also significant that the UK staff did not describe white nurses from New Zealand and South Africa as 'overseas' nurses, although these individuals themselves clearly identified with, and shared experiences of exclusionary treatment with, nurses who were apparently non-white. All commented on issues around the levels of skill, and questions of permission to practice, and the scope of nursing roles. There were

evidently learning experiences, some of them more positive than others, but there are also clear policy implications.

Both studies do reveal some positive outcomes and factors, such as the relatively healthier status relationship between doctors and nurses, and the dramatic impact of being given active support by mentors or peers when facing racist comments from patients. Humour was also a key resource that could be used in both directions. However, one feels very strongly for the isolated internationally recruited nurse (IRN); perhaps it is as well that so many are 'over here', to give each other the support they clearly need.

Despite the importance of international recruitment, and the fact that it is an ongoing issue, we should like to note that we have now selected four good papers on the experiences of those so recruited out of those submitted to us in the past 6 months (see also Allen *et al*, 2004; Alexis and Vydelingum, 2004). We believe that our readers will wish to think about other matters, and we shall not be selecting any more papers on this topic for inclusion in print in the next few months, at least until some time and development have elapsed, or maybe something new is found to say on the subject.

That said, we are unlikely ever to run out of things to say that are connected with migration. The coming of migrants from overseas brings a constant flow of new clients with different needs and understandings which need consideration in the provision of health and social care and the development of culturally competent practice. Does one size really fit all? The paper by Patricia d'Ardenne and colleagues encapsulates the debate about providing a non-discriminatory, inclusive and accessible service. We do not really best meet people's needs by simply ignoring difference and 'treating everyone the same' (clearly impossible, even in clinical terms), or at least as individuals ignoring differences of culture, belief, appearance and civil status. However, culturally specific services run the risk of buttressing apartheid, being separate but not equal. Nevertheless, questions remain about the ability of a generic mainstream service, or even a specialist one, to deal with diversity. On the evidence presented here, a pragmatic approach underpinned by a good level of insight into the layers and types of diversity can work. Indeed, their paper, based on an audit of the first few months of their practice, indicates that this approach delivers better than expected results, helps all, and refutes some long-standing stereotypes such as the did-not-attend (DNA) rates of service users whose first language is not English. It also appears to reassure those of us who have concerns about the value of cognitive behavioural therapy (CBT) among people who suffer from very real pressing financial, legal and personal material needs as well as psychological trauma. We look forward to the end of the story when some more outcome measures can be critically examined.

Gatrad and colleagues provide some useful materials, which could easily be fed into medical or surgical training or used as a case study for awareness raising. Male circumcision which is legal, unlike female genital mutilation, is widely practised for health reasons and by members of minority faiths and cultures for whom it has a specific meaning that is poorly understood by outsiders. However, for those 'cultural' groups, it has a very specific meaning, and this may be poorly understood. What is more, it is one of the things that unites Jews and Muslims, and is known to Christians. As a result, we here present our readers a not inconsiderable amount of biblical or scriptural citation and exegesis, which may be unusual in a journal oriented to health and social care. We do not apologise for this, any more than we would expect a patient or practitioner to apologise for their faith and beliefs. Hopefully, this combination of approaches, bringing in epidemiology and bio-science, will stimulate, inform and, in a real sense, educate all.

As Gatrad and colleagues' paper shows, users from diverse backgrounds may have different views about what health is, and how to treat or maintain it. Earlier research (see Bhopal, 1986) has tended to assume high levels of reliance on the use of folk or traditional medicine among black and minority ethnic groups, especially those of Asian origin – where of course 'traditional' meant relating to the traditions of those communities, such as the use of ayurvedic or unani medicine, and reliance on Hakims and Vaids (see for example Aslam, 1979). This naturally meant that they were alternative to the dominant western European medical tradition. As these approaches, along with Chinese medicines and acupuncture, have become increasingly popular across the whole population, and have been relabelled 'complementary' therapies (with the support of Prince Charles, amongst others), it is perhaps time to revisit this ground and to consider the power dynamics inherent in the debate. In the process, we may find ourselves considering what we mean by 'traditional' and how new (or very old) ideas can find acceptance and even join the armamentarium of the established practitioner and the regulatory apparatus of the state!

Ali and Hussain-Gambles present a powerful discussion about the identity of what is often termed 'the west', recognising the effects of globalisation and the issue of relativisation that bedevils our relationship with other cultures. They remind us that European (including British) medicine has very similar roots to what we now label 'traditional exotic' medicine and that western adoption of 'scientific' (allopathic) medicine required the input of Muslim/Arabic traditions preserved by Galen and others. Further, it is also clear that many South Asians are seeking, and using,

the same 'complementary' therapies (homeopathy, etc.) as are in vogue among the majority white population. These therapies have been poorly served by evaluation research, and the pharmacist's eye of the author is evident in detecting the potential dangers for the user. The paper lays out a thoughtful agenda for further research, which we shall hope to play our part in publishing in the future.

From a North American and service provider perspective, Voyer and colleagues examine the question of compliance – or as we now term it, concordance (also known as adherence – Christensen, 2004): how older women from four cultural groups living in Canada view medical advice on their medication. While based on small numbers of people interviewed, it gives deep insights into motivation and behaviour, eliciting feelings which seem to be commonly held within, and differ significantly between, the selected ethnic groups. Understanding these differences in beliefs, values and attitudes is essential for health and social care professionals in formulating and supporting care plans that take account of the diverse sources of help and opinion that patients/clients may rely on. Amazingly, the authors report that they could not find any research studies that examined the role of culture in medication adherence among older women, despite the well-established literature on health belief and behavioural models, and metres of print on cultural competence and transcultural nursing and health promotion. Clearly, there is a long way to go in developing research and training, let alone good (or best) practice, improving the full range of health care support to users from black and minority ethnic or cultural backgrounds. This may yet require a raft of small-scale or highly focused studies dealing with particular groups or processes. However, it does not surely need much research or thought to recognise that there are some key general principles at work, and being expressed here, which should already be informing policy, education and training, and practice.

We note that this paper used, and incorporates, Larry Purnell's elegant diagram of his comprehensive Model for Cultural Competence, and believe that this is a useful introduction to that approach. Readers may wish to contrast it with others we have covered in previous editions, such as that of Papadopoulos *et al* (2004) or Quickfall (2004), and incorporate them all into teaching, research, and reflection.

Evidently we need to train our new clinical practitioners in diversity approaches, and many of our papers are designed to provide material for such education. While so much of the debate and practice so far has been in post-qualifying, 'catch-up' training, Dein's paper is one of a small field examining what should happen in the primary socialisation and skills acquisition phase of undergraduate medical education, by asking those who are or will be responsible for the delivery of much of their training. Perhaps most alarming for those of us who have been trying to promote, develop and deliver such learning support, is how small a move there appears to have been among such educators, even to the point that the now widely acclaimed and practised technique of reflexive learning, common currency among high-level professional educationalists, has apparently not made much impact on practice-based educators. All agreed that there was a need for medical students to understand a patient's cultural factors, and that it was impossible to learn (or teach) everything that might be required. Communication issues were seen as of great importance, including both presentation by patients and advice giving by doctors. Nonetheless, while practice-based learning and peer teaching have their merits, this seems a bit of a hit and miss, and potentially dangerous approach, risking generation of stereotypes and the exploitation of students from minority backgrounds. While a (self-reflexively) small study, the paper raises important issues which we anticipate that we shall return to in future editions.

In the Knowledgeshare section we pick up on some of the themes raised in the research and debate papers. A review of Yasmin Gunaratnam's new book tackles the issues of methods and power, and embedded constructions of 'race' within a wider social context, while Jan Cambridge reports on a conference about interpretation and communication. The resources described include a mental health helpline for Chinese speakers, a new network relating to 'ethnicity' training, and our regular web-watch slot. These features indicate the breadth of interest in 'diversity' and the need for more papers that address broad areas of concern. We have recently called for papers for future issues and look forward to receiving more contributions to this journal.

Finally, but not least nor last, we welcome in this issue a guest editorial from Julia Neuberger, the distinguished broadcaster and commentator. She highlights the links between social, health and 'criminal justice' care systems, showing how deficiencies in the early experience of the one can lead to demands being made later of others – notably through mental health care needs and problematic behaviour among those committed to incarceration by the justice system, although of course those discharged from prison can also subsequently present health and social care agencies with extra needs. Joined-up thinking, a popular theme of earlier elections, is required to overcome these problems. Indeed, Rabbi Neuberger's contribution draws our attention to the role of 'exceptional' individuals and the need for stability and a sense of real belonging, to prevent future pathology. This is not just 'emotional stuff', but a real agenda or even a curriculum for emotional literacy – which might lead to greater 'respect;' (another theme of the recent election) which

given and received on both sides, would please many and avoid much conflict and indeed, wasted resources and lives. Assertive outreach or simply reaching out to offer people love and care instead of fear and blame, might be a good investment.

REFERENCES

Alexis O and Vydelingum V (2004). The lived experience of overseas black and minority ethnic nurses in the NHS in the south of England. *Diversity in Health and Social Care* 1(1):13–20.

Allan HT, Larsen JA, Bryan K and Smith PA (2004). The social reproduction of institutional racism: internationally recruited nurses' experiences of the British health services. *Diversity in Health and Social Care* 1(2):117–26.

Aslam M (1979). *The Practice of Asian Medicine in the United Kingdom*. PhD thesis, University of Nottingham (unpublished).

Bhopal RS (1986). The inter-relationship of folk, traditional and Western medicine within an Asian community in Britain. *Social Science and Medicine* 22(1):99–105.

Christensen AJ (2004). *Patient Adherence to Medical Treatment Regimens: Bridging the Gap between Behavioural Science and Biomedicine*. New Haven, CT: Yale University Press.

Papadopoulos I, Tilki M and Lees S (2004). Promoting cultural competence in healthcare through a research-based intervention in the UK. *Diversity in Health and Social Care* 1(2):107–16.

Quickfall J (2004). Developing a model for culturally competent primary care nursing for asylum applicants and refugees in Scotland: a review of the literature. *Diversity in Health and Social Care* 1(1):53–64.

Sriskandarajah D, Cooley L and Reed H (2005). *Paying Their Way: The Fiscal Contribution of Immigrants in the UK*. London: IPPR.