Editorial

Is anyone really listening?

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There is in English a phrase which might now be thought pejorative, but which seems well to describe the stately dance of policy development in relation to ‘race’ and health: a ‘dialogue of the deaf’. As the year 2007 opened, David Nicholson, the NHS Chief Executive, found it necessary to write to the Chief Executives of all NHS trusts to advise them that each trust was individually responsible for compliance with the requirements of the ‘equality agenda’, and might face legal notices requiring compliance with the Race Relations Acts of 1976 and 2000 (Department of Health, 2007). These require evidence that action has been taken to tackle racial disadvantage and organisational barriers to access (‘indirect discrimination’). The new Operating Framework Equality and Human Rights in the NHS: a guide for NHS boards, was published on 11 December 2006 and gives details not only about the expectation for race equality schemes, but also of the upcoming Disability Equality duty, Gender Equality from April 2007, and the need to take account of age, sexual orientation, religion and belief in the provision of services. To this we, and our guest editorial contributors from Scotland (Irshad, Worth and Sheikh), would certainly add language. It was therefore perhaps not so surprising that on 7 February, the Commission for Racial Equality announced a formal investigation into the extent to which the Department of Health and NHS had failed to meet their duties under the Race Relations Act 1976, as amended in 2000. There is much in the way of auguries – and no excuse for ‘not knowing’, since all the relevant documentation and guidance can easily be found on the NHS Knowledge Service’s Specialist Library for Ethnicity and Health, in the section labelled ‘Management and Policy’ (www.library.nhs.uk/ethnicity).

In our last issue, we referred to the anniversary of the abolition of the Atlantic Slave Trade (at least in British law). Social justice is a global issue, and language is a tool through which it may be attained or denied. The US Office of Minority Ethnic Health acknowledges the relationship between social justice and language and has sponsored the development of a patient-centred guide intended to assist organisations to provide services for patients who lack proficiency in English (Office of Minority Health (OMHRC), 2005). At least formally, language competency is a legal obligation in the United States (Fontes, 2005). Indeed, President Clinton even once signed an Executive Order stating that all agencies supported by Federal funds must provide services that are accessible to users with limited English proficiency – including health care. While the rights of European citizens to a ‘fair trial’ and understanding of legal charges in ‘language they understand’ are now well protected, we wonder what it will take to bring such an initiative into UK health and social care policy. Maybe we need another Wilberforce as well as the Equianos, Merediths and sundry other less well-sung heroes of the struggle against slavery.

After all, health and social care practice depends heavily on interpersonal skills and the ability to establish constructive and compassionate relationships with service users as the basis for therapeutic interventions. Numerous reports have emphasised the importance of good communication with service users, closely followed by strategies to bring about improvement. However, rather less attention has been paid to the languages spoken by service users, whether they truly understand what professionals are saying to them and the consequences of inadequate communication in this context. Experience in other fields such as law and criminal justice is not encouraging. In the past, non-English speakers have risked conviction and imprisonment for crimes they did not commit, a situation that the police and criminal evidence regulations and the Office for Criminal Justice Reform (OJCIR) have sought to address (OCJR, 2006). We would not wish to imply that events of this kind are in any way peculiar to the UK. In 2001 a deaf charity worker in India received a 10 year prison sentence for possessing cannabis. His trial was in Hindi, a language he did
interpreting the world – a fact that is more likely a consequence of our way of being in and out of language. The substitution of one set of words for another speaks another language requires far more than the effort required to take account of the functional, cultural and conceptual differences between Polish and English. Concepts such as the time of day, but they also have distinct conversational styles. To illustrate this point she draws 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 regarded as confrontational or even rude. Thus in moving between the two languages, the speaker must make a series of decisions about how best to convey thoughts and ideas and what to omit. Similarly, Hellman (1989), whose first language is English, describes 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 creates high levels of intrapersonal conflict. Finally, lack of investment in the provision of interpreting services staffed by suitably qualified people places an added burden on bilingual staff who have received no preparation for this responsibility and who may lack the vocabulary necessary to adequately explain health and social care matters. Bilingual staff are often happy to do what they can to help service users and colleagues, but they can also feel overwhelmed by the responsibility and experience high levels of stress from trying to fulﬁl roles for which they are not qualiﬁed (McGee, 2000).

In this context, we are pleased to introduce our recent wave of Polish and other Eastern European migrants provide essential services in cities and rural areas alike. Wierzbicka argues 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 draws 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 regarded as confrontational or even rude. Thus in moving between the two languages, the speaker must make a series of decisions about how best to convey thoughts and ideas and what to omit. Similarly, Hellman (1989), whose first language is English, describes 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 creates high levels of intrapersonal conflict. Finally, lack of investment in the provision of interpreting services staffed by suitably qualiﬁed people places an added burden on bilingual staff who have received no preparation for this responsibility and who may lack the vocabulary necessary to adequately explain health and social care matters. Bilingual staff are often happy to do what they can to help service users and colleagues, but they can also feel overwhelmed by the responsibility and experience high levels of stress from trying to fulﬁl roles for which they are not qualiﬁed (McGee, 2000).

In this context, we are pleased to introduce our guest editorial which also takes up some of the arguments aired in a recent British Medical Journal debate (Adams and Jones, 2007). There clearly is a cost in working across languages, in terms both of time and expertise, but this pales into insigniﬁcance in the light of the human rights implications, and the potential risks of misinterpretation and failure to follow or agree a treatment plan. Irshad, Worth and Sheikh present many arguments that are familiar, but it may be worth underscoring the fact that the UK population is in a constant state of ﬂux. They, like many of our authors, refer to ‘BME’ populations: this term (the acronym for black and minority ethnic) includes many ‘new’ minority groups originating in Africa, east and central Europe and other parts of the world.
as any casual observation of both inner London and remote parts of rural Britain will show. Nor should we forget that, as earlier European migrants have also demonstrated, when people get older they may lose what fluency they have acquired in the majority language. Irshad and colleagues make a convincing case for the value of investment in services for ITALS – interpreting, translation and language support – and they present an effective demolition of the traditional ‘use a family member’ alternative. It is not only the poor we have with us always: there is also the stranger and the person who cannot speak our language – or perhaps whose language we cannot speak.

Also from north of the border, Mullen and colleagues in Glasgow bite into the question of factors affecting ‘going to the dentist’ across a range of ethnic groups including the white Scots. They present a sound summary of the considerable published evidence base on ethnicity and dentistry. It will not surprise many that a visit to the dentist was not seen as a pleasurable or popular pastime, but younger people do seem more likely to take active steps to preserve oral hygiene or appearance, so things may be changing. Interestingly, while Chinese people prefer Chinese dentists, some South Asian women would prefer a white male to a Pakistani male if they cannot have a gender-matched, female professional. And while there is some acculturation, younger people from migrant backgrounds still have to accompany their older family members on their appointments, and hence would prefer dentists who could speak the parental language. The dentist’s chair is no place for an interpreter!

Ryan and an international cast of colleagues report on a multinational study in Scandinavia, Poland and the UK of the stresses of working for mental health services. This is, as ever, topical, and while more statistically challenging than most of the reports we carry, the paper merits close reading. Burnout is an international phenomenon, and while it has many components it can be combated if properly understood. The paper also shows some interesting sex and national differences in needs, and has relevance both to the care of one’s staff and also to service delivery. It is clear that prior training (not post hoc) and increased experience can be helpful, as is a feeling of being able to make a difference – but (as UK colleagues at least will aver) reorganisation is a hazard. It might also be worth trying to spot signs of low self-confidence, lack of assertiveness and inability to set limits, in new recruits – since although it might be nice to have meek and hard-working staff, who thrive on their managers’ approval, they are the most likely to become burned out and create problems later on. Unpaid overtime and excessive work-related travelling are also false economies. It would be nice to think that this research will improve the work conditions of some healthcare staff.

Public understanding of science is at best a mystery, and if it becomes misunderstanding, can be at worst a potential hazard to those who miss out on access to the potential benefits of ‘progress’. There is no benefit in scientists developing ‘new reproductive technologies’ if no one understands or knows of their existence to make use of them. Culley and colleagues, however, challenge the familiar ‘deficit model’, while not denying inequality in access to information, by showing the subtleties and complexity of knowledge about infertility among South Asian populations in Britain. On the other hand, it is far from clear that healthcare professionals are as well informed or as sensitive to the diversity of needs and expectations in those South Asian communities. Without that better understanding, they are poorly placed to offer support, care or even access to the range of treatments that exists, especially when information is not made available in languages and formats appropriate to potential users. This is perhaps ironic when those of us with long memories recall the plethora of targeted ‘health promotion’ materials from the 1970s and 1980s aimed at limiting fertility among South Asian migrants (Bhopal and Donaldson, 1988). While it is true that South Asian communities do value children highly, and that childlessness is a highly stigmatised state, the team note increasing acceptance of at least a delay in childbearing and perhaps a fall in expected total family sizes. Asian women were not ignorant of the causes of infertility, but may have been more constrained in their ability to express or discuss this publicly. Neither were they unwilling to seek help – the stereotype of the fatalistic Orient is quite clearly fallacious, but religion remains a reassurance and comforting to those who weretheyunwillingtoseekhelp–thestereotypeofthe

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problems which may have much greater salience for
women – almost by definition from BME origins
who were at risk of one of the haemoglobinopathies.
It is also clear that even within the context of this
research there were some practitioners (and indeed a
whole maternity unit) where routine ethnic monitoring
data were not being collected, nearly 10 years after
this became a requirement for all inpatient care
episodes (Department of Health, 2005). ‘Ethnicity’ is
not the same as either ‘colour’ or nationality, and
failure to recognise this can, as Dyson and colleagues
show, have a potentially serious impact on care delivery.
At least the categories devised for the 2001 census
do seem to address this need and be reliable and
acceptable, even though Dyson and team demonstrate
a higher ‘detection rate’ for their own more complex
questions.
Judy Davison adapts another qualitative research
approach, the often neglected use of life histories, to
evaluate the effects of abuse on women’s propensity to
drink (alcohol). In this, she turns the conventional
paradigm (men drink, assault women) upside-down and
reveals alcohol use to be a coping strategy for
problems which may have much greater salience for
the subject. We should know that women may be
different from men, but we rarely explore this issue in
relation to problems behaviour in a way that enables
better interventions and support. Further, the research
method itself is shown to be an empowering and
‘feminist-appropriate’ strategy, which like many of
the papers we carry, allows and highlights the voices of
the oppressed and the service user.
Meanwhile, we can report some slight progress or at
least, an opportunity. Knowing that many of our
readers are already convinced of the merits of patient
profiling and ethnicity monitoring, and that one of the
front-runners in the French presidential race has
espoused the cause of ethnicity recording in France
(Chrisafis, 2007; against all odds, it must be said), you
may be aware that a UK Census Test will take place in
2007. The questionnaire for the 2007 Test, published
on 31 October 2006, shows the questions on ethnic
group, national identity, religion and language at the
latest stage of development. However, these questions
are by no means finalised. It may not yet be too late to
make responses to this consultation, which will in-
form further question development in 2007. The
Office for National Statistics (ONS) will then make
recommendations in 2008 on the questions for the
2009 Rehearsal and 2011 Census, which will then need
to be agreed by Parliament in early 2010. The Census
Test questionnaire is available at: www.statistics.gov.
uk/censustestquestionnaire. The 2001 questionnaire,
against which current data will need to be compared, is
at: www.statistics.gov.uk/censustestquestionnaire.
The report on the 2005 consultation is available at:
www.statistics.gov.uk/about/consultations/ and the
ONS review of ethnic group, national identity, reli-
gion and language considers issues such as: accept-
ability of terms, categories included and excluded,
collecting national identity data separately from eth-
ic group data, continuity with 2001 data on ethnic
group and religion, and allowing multiple responses
in the ethnic group question as well as the level of
information required on languages. All of these are
vital issues for discussion – and are at present being
subjected to lively debate on the Minority Ethnic
Health electronic discussion network (www.jiscmail.
ae.uk/minority-ethnic-health). Latecomers can catch
up via the archive of that list. What we do not ask
about or measure is often ignored, but is seldom
unimportant.
Our regular Knowledgeshare section in this issue
presents us with some challenges as well as access
to good practice and information. In particular we
should like to draw readers’ attention to the challenge
of facing up to feelings, fears and myths around
sexuality in providing social care – and how this might
interact with the complexity of working with learning
disability. At the same time, we can point to develop-
ments in policy and practice in mental health, and
enable readers to share what is provided as a briefing to
our legislators through the parliamentary office of
science and technology in Kaveri Harriss’s succinct
summary. Further, a report from the Genetic Inform-
ation Group about their Translation Project pro-
vides additional evidence of the importance and risks
of working across languages. And finally, maybe we
can conclude with an observation made by Chief
Rabbi Jonathan Sacks, as broadcast on BBC Radio
4’s Thought for the Day on 26 January 2007 (Holocaust
Day): ‘May we never forget that the people not like us are people, like us’.

REFERENCES


