

Editorial

Sticks and stones may break my bones but words may also kill me: how culturally competent is political correctness?

Mark RD Johnson MA PhD Dip HE (Warwick)

Editor, *Diversity in Health and Care*; Professor of Diversity in Health and Social Care, Mary Seacole Research Centre, De Montfort University, Leicester, UK

Paula McGee PhD RN RNT MA BA Cert Ed

Editor, *Diversity in Health and Care*; Professor of Nursing, Faculty of Health, Birmingham City University, Perry Barr, Birmingham, UK

At the start of 2009 Carol Thatcher, journalist and daughter of a former Prime Minister, caused considerable offence by using the term ‘*golliwog*’ in connection with a French-Congolese tennis player and, as a result, she lost her post as a BBC presenter. Predictably, there was a great deal of media coverage, and a storm of protest and counter-protest over the use of a word first used in a children’s story and later associated with a brand of jam, but which in our modern world has come to be regarded as a term of racist abuse. The storm was revived shortly afterwards, when the younger son of the heir to the British Crown described a colleague in the army with another pair of offensive soubriquets. A number of well-known figures testified to the pain they had felt as children when subjected to such taunts. Words can do as much and possibly even more damage as sticks and stones. The pain of words lingers on, affecting people’s lives for years afterwards. Consequently, it is easy to see why so many argue that such words should never be used, and that there are certain words which have such painful associations and devastating effects that their use should be banned.

Although we accept the terrible power of words to wreak havoc, we take issue over whether it is possible or appropriate to ban them. Words are, after all, just words. It is the meanings we ascribe to them and the context in which we use them that make the difference. It is certain that the tabloid media tendency to go berserk over such stories as the alleged change of nursery rhyme words to ‘Baa Baa Green Sheep’ is antithetical to good relationships between ethnic and racialised groups and efforts to encourage more sensitive service delivery in health and social care as well as education. Some older readers may remember when, in the 1980s, public libraries recalled and destroyed copies of the

children’s book *Little Black Sambo*, which was written in India by Helen Bannerman at the end of the 19th century. At that time, some black academics and leaders warned that there was a danger that this would sanitise the past. Interestingly, Wikipedia reports that the controversy was even more marked in Japan, and that the character has recently been rehabilitated and has re-found his Indian roots. Holocaust deniers, who we learn still exist even at senior levels of the priesthood, are a menace if they can persuade us – or even argue – that such things could not or did not happen. It remains important that we do not try to deny our past and claim that there were never racist bones in our body. Only by remembering can we explain some of the inequalities that persist. At the same time, we can resist efforts to find new epithets or categories to conceal prejudice and discrimination. Moreover, in banning the use of certain words we effectively remove the language for understanding the past. The past becomes a sanitised domain in which no one ever said anything we might now consider incorrect, particularly if, in the modern world, they are picking up the pieces after centuries of oppression. The fact is that our ancestors used these words. Their world, their views and their experiences were not the same as ours, but they are a part of what we have become. It is therefore to their credit that certain groups have come to recognise this and have seen fit to appropriate, or even rehabilitate, words that were previously associated with their denigration (sic!). Thus the LGBT communities have taken up the word ‘gay’, meaning ‘good as you’, and, in the USA some black groups regard, and use, the ‘N word’ as a part of their heritage.

These debates and denials, of course, are not confined to racialised groups and sexual orientation. More recently there was a furore over the appearance

of a one-armed person as a children's television presenter on CBeebies (<http://news.sky.com/skynews/Home/UK-news/Article/200902415227818?f=rss>). The expressions of disgust were not attractive. It would appear that appearance is all, and that diversity – looking different – is unacceptable to some people, and may even be labelled as 'disfigurement.' As the opening speaker at a recent workshop in Coventry supported by the Appearance Research Consortium and Healing Foundation observed, she did not see herself in that way – other people might be different, but she was not inferior. Posters from the charity 'Changing Faces' (www.changingfaces.org.uk) make this point very clearly. We look forward to carrying papers from research into this strand of diversity, which may reveal more subtle forms of discrimination and inequality. In conclusion, then, we must recognise that although 'political correctness' may not be a substitute for, or equate to, cultural competence, at the same time cultural competence does require us to think carefully about the way we use language and labels. Political correctness may be more a way of concealing racist thought through avoidance of plain speaking than a way of understanding the complexity of diversity.

To understand ourselves we must first understand where we have come from. Those who ignore history, or who seek to sanitise it, do so at their peril. The past is not and never was an idyllic place – a great deal of it was brutish and vile, and it is no use pretending otherwise. If any of our readers has an hour or so to spare, and finds themselves on the south side of the river Thames, let them spend it in the Imperial War Museum, near Waterloo station, where the exhibition on crimes against humanity demonstrates what we are all still capable of – as observed by Fergal Keane:

'The idea that the Germans were uniquely able to conduct a genocide against the Jews, that the Cambodians had some sort of germ inside them under Pol Pot, or that the Rwandans were different, is wrong. We are all capable of that.'

The museum's exhibits also demonstrate how the Holocaust was concealed by the use of prettified terms and camouflaged language. Moreover, we cannot ignore the fact that we ourselves have created words for our own era that our descendants will doubtless find worrying or offensive. We have no way of knowing what these might be. Maybe our descendants will simply stare in amazement at what we have wrought in order to avoid what we consider to be *giving offence*, and to conceal prejudice, discrimination and anything else we find it uncomfortable to acknowledge. The problem with words is that they will not remain still. They continue to grow and develop without any consideration for our sensibilities. This is our strength as conscious, intelligent beings. Words enable us to communicate with one another, to express ourselves and share our thoughts in ways that no other

species on this planet can do. Words make us capable of much that is good and more that isn't. The words themselves are neutral – it is what we do with them that matters, and what we feel about them is our problem, not theirs.

Two words with which readers will be familiar form the basis of this issue, in which writers examine the topic of cultural competence from a variety of perspectives and approaches. Cultural competence requires us to think about the words we use and how we use them in working with our clients. If used appropriately, words enable us to form therapeutic relationships that benefit not only our clients but ourselves. It is through words that we learn from our clients how we may best help them and those we encounter later. Cultural competence therefore places great emphasis on interpersonal skills that can be learned.

In this context, we start with the paper by Kelly and Papadopoulos on the use of online courses to train healthcare professionals. All healthcare workers are accustomed to the concept of continuing professional development and the need for lifelong learning. The potential for short online courses that are accredited to attract and educate healthcare staff in cultural competence is therefore considerable. Such courses can also alert them to the risks of lacking such skills, and provide evidence of the benefits to the healthcare professional as well as to the patient. We also recognise that cultural competence is itself an ongoing and evolving process that needs to be continuously updated, so online learning can facilitate updating of both materials and learners. The authors also suggest that online anonymity may have benefits in terms of the ability to deal with sensitive issues (or indeed political correctness), although we may offset this against the risk of non-disclosure or the ability to enter PC answers, guessing at the expected preferred response, with no opportunity to challenge real beliefs and behaviours. The authors attempted to mitigate this risk by including real-time online tutorial inputs and chat-room discussions, but these were the least successful elements of the course. We are also, it has to be admitted, still far from having research that can demonstrate unequivocally that better patient outcomes arise from giving staff culturally competent training. However, their pilot students appear to have enjoyed the experience and to have been provoked into reflective learning, so at least we have a starting point or 'proof of concept' on which to build.

Abrahamsson, Andersson and Springett, in a collaboration between Sweden and the UK, take a different approach to mediating the interface between healthcare professionals and culturally different service users – in this case, an especially sensitive issue when that difference arises from unwanted (forced) migration. The intervention in this case was to train migrants from the minority community to use their own cultural

competence in their co-ethnics' traditions alongside some acquired skills in the 'host' community's culture, arising from experience of life in Sweden (in this case defined as a minimum of five years). The role of bridge-builder is not a simple one, and the study reminds us that cultural competence can work both ways. It also shows the importance and value of bringing forced migrants into the processes of service development and avoiding the traditional paternalistic approaches of former transcultural care models. Training had to be provided by 'gate-openers' to these 'bridge-builders', and they clearly gained from this as well as the validation of their own knowledge – and of course gained a paid role within the health service, as well as a new and more secure identity to help with the processes of settling into a new country.

The paper also reveals some interesting insights into different cultural expectations of medical expertise, noting for example that one client was concerned because the doctor looked something up in a book. At home, doctors were assumed to know everything, and therefore checking details was perceived as an admission of ignorance. Interestingly, this point was raised in a thesis that one of us examined recently concerning Pakistani perceptions of appropriate consulting behaviour and evidence-based practice, and it may have wider relevance.

Similarly, the use of terms to describe roles as 'gate-openers' and 'bridge-builders' moves us usefully on from concentrating on Ray Pahl's 'gate-keepers' (Pahl, 1975) to see a more proactive possibility, while the authors' references to 'othering' – which can work both ways – opens up the possibility that this model can have wider application to other 'diversity excluded' groups. Finally, however, we need to note their observation that empowerment may also marginalise the bridge-builders from their own communities and put them in jeopardy if they are not given continuing support and value. In this, the Swedes have encountered the familiar British dilemma of 'projectitis', whereby not doing nothing raises expectations, only to dash them again!

The paper by Lin and colleagues, from Taiwan, which is a study of health beliefs, continues the theme of cultural competence but tackles the role of culturally distinctive views among *patients* in the way that they approach healthcare and coping strategies. Since common diseases occur commonly, it is important not to focus on rare and obscure culture-bound syndromes in minority groups, interesting though they may be. Instead, we need to understand how minority cultures may affect behaviour in 'majority' conditions, and if they are no different, we have still learned something. It is rather alarming that the authors can argue that this is the first such study in Taiwanese patients facing coronary heart disease, since we may presume that its findings will have some relevance to

the much larger, wider Chinese diaspora. However, it has to be accepted that many of their findings – for example, that symptoms like chest pain were not immediately recognised as precursors of myocardial infarct – are not peculiar to Chinese patients. One of the main risks of relying on peer-reviewed publications is that papers which report 'no significant difference' are rarely published. We feel that it is important to report when diversity does *not* divide as well as when it does make a difference. On the other hand, the reaction to symptoms or even to diagnosis was so significantly inappropriate in terms of physician-recommended behaviours that it is important not to stop reading at this point. One particular issue is that while heart attack patients are advised to modify their lifestyle, avoidance of 'stress' by stopping work and social life, or only changing one's diet until the symptoms stop recurring, is inappropriate and potentially risky. Again it is probable that these issues are not confined to Chinese patients, but cultural competence requires us to recognise that maladaptive behaviours and misbeliefs are also commonly held and need to be combated regularly.

Palmer and her Australian colleagues draw our attention to the fastest-growing African minority group in that country and alert us to the fact that 1% of the current population of Australia were born in Africa. As this group is particularly at risk of HIV-related conditions, there is a clear need for cultural competence in health promotion, which includes a shift to more visual forms of information as well as gender-specific targeting. The community was very supportive of a strategy that used selected opinion leaders, despite the stigma or sensitivity associated with this condition. A key finding was that community members assumed that they were unlikely to acquire the disease after migration ('once they're here they're safe'), although there is no real evidence to support this. There was also, among migrants, a feeling that acculturation (which was perceived as desirable by members of the 'host' community) placed members of the community at higher risk of disease, and indeed there is some evidence that this is true. Another key point was the reporting of a very active process of community formation and the emergence of networks and associations that could play a significant role in future health promotion – much more so than the often proposed use of community radio, which in this case was rarely listened to. Cultural competence requires organisations and healthcare professionals to be aware of and make links to such bodies.

Mitchell H Rubin's contribution is a reflective journey – from a plush suburban practice to directing a culturally competent community-oriented clinic centre in East Harlem, which serves families of Mexican origin in New York. This group is, incidentally, a novelty or cultural minority among the Latinos of

Harlem. His journey to full cultural competence included visits to other centres and also to Mexico, the source of the migrants, where his education was enlarged and enabled the creation of this unique resource. This very personal history is also evidence of the possibilities of change, and ripe with ideas for potential good practice. We note, in passing, that a key element was the sensitivity and reflexivity of the individual clinician. (This is also a first in this journal, in its use of poetry, and maybe we should do this more often.) The core of his professional approach is encapsulated in one sentence:

‘All communities respond well to caring medical providers in friendly, well-organised, efficient and aesthetically pleasing facilities: this simple formula only works if you know where your clientele come from and what they expect.’

Wise words – and the antithesis of political correctness.

Finally, in this issue, we present another sideways look in the ‘Did you see?’ section, and a selection of good things in the ‘Knowledgeshare’ section. The former, which considers wider aspects of stigma and

public attitudes to mental illness, carries some parallels to the issues of disfigurement. The latter begins with two reviews of practical handbooks on race, ethnicity and mental health, bringing the whole debate up to date with very practical recommendations and conclusions as well as examples of good practice. It also contains a lengthy report of a study of forced marriage, which provides support and conclusions that build on an earlier debate piece in *Diversity in Health and Social Care* (Uddin, 2006). It is good to feel part of an ongoing stream of debate and development.

And, as ever, we invite our readers to share their contributions or to join us in debate. Details of the journal’s submission criteria can be found at www.radcliffe-oxford.com/journals/J26_Diversity_in_Health_and_Care/M10_Contributing.htm

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