Cultural Awareness in Nursing and Health Care

An Introductory Text

Karen Holland
CULTURAL AWARENESS IN NURSING AND HEALTH CARE

This introductory textbook relates theory to practice and enhances students’ learning and understanding of cultural issues that impact on patient care and their own practice as nurses, while considering wider social and political issues.

Now in its third edition, *Cultural Awareness in Nursing and Health Care* has been updated to include new research, evidence and a completely new chapter focusing on the healthcare workforce itself and the issues it’s facing. Other topics include:

- Health, illness and religious beliefs;
- Mental health and culture;
- Women’s and men’s health in a multicultural society;
- Caring for the elderly;
- Death and bereavement.

Key features:

- Includes international perspectives and issues relating to overseas nurses studying and working in the UK;
- Case studies, reflective exercises, summary boxes and website links designed to stimulate discussion and shared practice;
- Fully updated with guidelines for practice and education.
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This preface begins with sadness because my co-author, friend and colleague died on 6th January 2014. She was just 53 years old. As soon as she knew she was going to die we sat down together in a nice restaurant and considered our options with writing the third edition of this book, and who should now write her chapters. This was accompanied by some tears but also humour as Christine and I worked diligently over our lunch, turning from work to reflection on where we began with the ideas for a book of this kind, along with Christine’s recollections during her doctorate study of what hairdressers and others believe mental health to be. Some interesting perceptions.

The history of the book as seen in the first edition stems from developing and teaching a transcultural nursing and healthcare module but without enough resources that focused on United Kingdom health and social care. We used ideas from our lecture notes (based on personal experience, and mainly US textbooks) together with personal narratives of our students from different cultures to help us on that first book. We were so grateful to ARNOLD, the first publisher we had, for taking a risk on what was then a relatively unknown area in UK books. Four of us were also fortunate to receive an award from the university’s teaching and learning scheme to support us in developing additional material for students undertaking a Cultural Awareness Module using problem-based learning. This was an incredible leap forward for all of us in learning about different cultures, in particular from our own students. It was a wonderful development opportunity.

It was the beginning of our journey to support students and practitioners, mainly in nursing at the time, but we know from collaborative work we have both undertaken that the book has been used by others working within multicultural environments. I have special memories, for example, of working with the senior chaplain at a large teaching hospital supporting the development of their standards for cultural care. The book was their main resource at the time.

We built the contents of the book in various ways into our curriculum and we were especially pleased to be able to offer Cultural Awareness in Health Care as an option module in the 2010 curriculum following the Nursing and Midwifery Council review of the NMC standards for preregistration nursing (NMC, 2010). The book became a core text for us as well, and the university was able to offer the book as an e-book for students in any programme.

So to the book, how did we agree on a way forward? We both met with colleagues of Christine and I who had each volunteered to write a chapter on their own or together. It was a very difficult time for us and also for Christine but she and I worked on all the chapters and highlighted new things we now needed to add to them. The time after her death was very sad indeed but we had signed a contract to write the book and I slowly started the next stage of the journey on my own in terms of editing the book, but with fantastic and committed individuals who believed as we did in the importance of enhancing the knowledge base around cultural issues in their broadest sense.

Some of our book reviewers wanted more of a focus on race and ethnicity as a book but we have remained true to our original premise and ideas while ensuring that there is more integration
of these important issues throughout the chapters. I did, however, rewrite Chapter 13 based on reviewer feedback and I am very grateful for their insight and comments that have influenced the content.

The book, however, remains true to our belief that to support students and practitioners to care for patients and work with colleagues from different cultures, we begin by raising awareness of the overarching issues that we encounter in our daily practice and professional lives. The title therefore remains *Cultural Awareness in Nursing and Health Care*.

**Chapter 1** remains as before where we explore the concepts of culture, race and ethnicity as they apply to health care and nursing. We have added new evidence throughout and especially from Australia and New Zealand.

The New Zealand Cultural Safety Standards are important and especially the definition of what is meant by cultural safety. Their definition of culture encompasses such areas as ‘age or generation; gender; sexual orientation, occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief’ (Nursing Council of New Zealand, 2011). It needs to be read in its entirety to fully appreciate its meaning for Maori health in nursing education and practice and resonates well with the chapters in this book.

**Chapter 2** is now the chapter about cultural care: knowledge and skills for implementing in practice. This is a chapter where again we refer to the Cultural Safety in New Zealand and have added further evidence on nursing models and frameworks that can support patient and family care. There are seven in all and we have updated the evidence as appropriate as well as adding a new Model of Cultural Competence in this edition, namely the Campinha–Bacote Model of Cultural Competence. We have added a number of websites that have been tested as appropriate to obtain additional information on topics in this chapter. This can also be seen throughout the other chapters as an additional resource for the reader.

**Chapter 3** focuses on the way care is affected by the religious beliefs and practices of patients and both their professional and lay carers. This chapter focuses mainly on religious beliefs but the importance of considering the spiritual beliefs of patients is also considered.

**Chapter 4** focuses on the health and illness beliefs of people and how they impact on the way care is planned and delivered. It is linked directly to the content of **Chapter 5**, which then focuses on actual healthcare systems working together in practice, whilst taking into account the challenges health professionals face when trying to attain the best care for the person with different health beliefs. In both chapters there are case studies to explore care delivery issues and exercises for the reader to explore his or her own beliefs about health and illness.

As noted in the second edition, **Chapter 6** examines how nurses can ensure that the care they give to women from different cultures takes into account their personal needs and beliefs as well as being responsive to their role within those cultures. The addition of new website links to support the case studies and exercises in this chapter brings added value to the chapter due to their international range.

**Chapter 7** focuses on men’s health and has an added value through the inclusion of findings from a doctoral study by Muwafaq Al-Momani from Jordan. The study focuses on men’s health problems related to erectile dysfunction and the way in which men seek help from health professionals. The chapter also considers the issue of men in nursing and a study by O’Connor (2015, p. 194) determines that we need to ‘examine the relationship of nursing to gendered
concepts’. Other reported studies also look at this important issue of gender and vocationalism in the rationale for men choosing nursing as a career.

**Chapter 8** has been revised and now takes a more detailed look at various health problems that may occur due to either genetic or cultural practices with regard to diet. There is an enhanced focus on the child and the young person, especially on issues such as menstruation and the wearing of different clothes and adornments.

**Chapter 9** focuses on the older person and has also been revised but retains many of the exercises and a major case study that explores the nurses’ actions when caring for an elderly Polish woman living in a warden-controlled home who has been admitted to the hospital. A personal narrative by one of the authors adds to our understanding of migration back to one’s home country after living in the United Kingdom. A term ‘cultural bereavement’ is introduced for those groups of people ‘who have experienced a permanent and traumatic loss of their familiar land and culture’. The issues around health and illness of older people from different cultures are managed by health and social care services.

**Chapter 10** explores mental illness and its impact on the lives of people from different cultures. Issues such as ‘culture-bound’ syndromes and transcultural psychiatry are discussed as is the importance of communication across a variety of scenarios, including working with interpreters. Intercultural communication and discrimination of people from different cultures who have mental illness are also addressed.

**Chapter 11** discusses many issues we are facing across the world in relation to migrants, refugees and asylum seekers. The different definitions attached to these terms will determine the kind of care that people are given, not just in health but in their new life and country, in general. The narratives and case studies throughout the chapter provide some insight into the issues impacting people’s health and there are strong links to Chapter 10 concerning mental health issues facing these three groups of people as well as additional content regarding women’s health and children and young people.

**Chapter 12** address the issues facing those who face death, are dying and those experiencing grief because of their loss and how they manage it. This chapter links with Chapter 3 on religious beliefs and spirituality. There are examples from three main cultures which explore nursing practice and caring for the dying and bereaved.

**Chapter 13** is a completely new chapter, although there are certain issues discussed from the second edition. The chapter focuses now on the workforce itself and the issues facing ‘nursing and healthcare colleagues making every attempt to deliver culturally appropriate care in a constantly changing society’.

The main focus is on the health and social care services in the United Kingdom to illustrate the key issues facing multicultural teams caring for multicultural and diverse communities. The addition of new websites and YouTube examples on intercultural communication offers added value to ensuring the understanding of the importance of the different cultural beliefs and practices in the delivery of patient care.

In the appendices, we have retained the summary of religious beliefs and practices as they impact on individual care. They are not intended to be viewed as a ‘recipe book’ but as drawing together many of the issues identified throughout this text. We have also received positive feedback from people on how useful they were as brief guides to use in practice.
We also decided to retain the overview we had in the second edition which recognised that, in still taking a broader multicultural and not multiracial standpoint, we could be accused of not reflecting the importance of race in any meaningful way. However, this book makes reference to race as an important concept within care, as we recognise its importance as a key component of the nurse–patient relationship, patient–patient relationship and nurse–nurse relationship.

We also acknowledge that the way in which literature uses the phrases ‘black and minority ethnic’ and ‘white’ to define cultural groups could in fact indirectly exclude individuals in society who normally consider themselves to be ‘white’ but who are also members of a minority ethnic group (e.g. members of the Polish or Gypsy Traveller communities).

To ensure continuity and clarity of terminology, the word patient is used in the majority of the text. However, the word client is used in relation to mental health care, consistent with the literature in this area. For convenience, where the pronoun is necessary we have used ‘she’ to refer to the nurse, but this is not to disregard the fact that many nurses are men, as discussed in Chapter 7.

Each chapter concludes with a list of further reading which will enhance the reader’s understanding of the issues discussed, as well as a list of relevant websites for additional resources. Throughout the book we have endeavoured to ensure that the text is referenced to supporting literature, reflecting our recognition and belief that practice needs to be evidence-based. However, this has not always been possible due to the dearth of material in nursing literature that reflects the issues we have chosen to discuss, in particular, research studies related to nursing practice and cultural issues. The whole text is a reflection of our own ideas, values and interpretations of events, and not those of the publishers. We have made every attempt to ensure that these have been represented and dealt with sensitively.

Karen Holland and
Christine Hogg
Acknowledgements

As with the first and second editions, we wish to offer our thanks to a number of people who have given us their support throughout the writing of this book.

I begin, however, by thanking all those who have both read and purchased copies of our first two editions and for all the helpful feedback we have received over the past 15 years since its publication. This has been gratefully received and used to update the book as much as possible. We are aware that many of those who have read chapters applicable to their work have been enabled to change their practice as a result. This has made us believe that another edition was necessary in order to enhance, whenever possible, the evidence-base for their practice.

My personal thanks first go to Debbie, Elizabeth, Shelly, Naomi, Moira and Angela who agreed with Christine to continue the work she began on her chapters. They have been brilliant and have really engaged with the task of updating and rewriting chapters to bring them up to date. I cannot thank them enough for stepping in and helping us both at such a distressful time. Thanks also to Muwafaq and Prem for their personal experience contributions and sharing with our readers.

At Hodder Arnold we wish to thank Naomi Wilkinson (Commissioning Editor) for commissioning this third edition and for her support for the new chapters, and Grace McInnes (Senior Editor, Health & Social Care) at Routledge for her ongoing patience and caring approach when all of us as authors of this book were grieving for a dear friend and colleague but who were committed to ensure that the work Christine and I began would be continued. Latterly, we have had the support of Carolina Antunes (Editorial Assistant) to whom I am very grateful for being kept to strict deadlines in order to get this book to final publication. Additional thanks go to Linda Leggio (Production Editor) and her team for the overall support with this stage of the book, and finally to Arun from NovaTechset for his amazing patience and management of the editing and proof-checking process for this book.

My other acknowledgements must go to Christine’s family, all of whom were supportive of us writing this book initially and continued to support our endeavor in pursuing her special area of interest and beliefs. My personal acknowledgement goes to my husband, Terry, who knows how much this book meant to both Christine and I and when she died gave me both emotional and practical support in dealing with my own grief initially and then focusing me on editing this book.
Foreword

Cultural awareness is about connecting with people. This book opens doors as to how we as nurses and health care providers work with people in multicultural environments – who have religious beliefs, languages and backgrounds different to those of the health care provider.

As nurses, we meet and engage with people from all walks of life and cultures in our practice. Health care can be compromised if the health care provider is not able to appreciate and respect the patient’s background, language, religious beliefs and culture. Nursing is a complex ever-changing profession and there are numerous influences on the quality of care that the nurses provide. High-quality patient care has been the aim of nursing curricula since the time of Florence Nightingale. It was her belief that the practice of nursing should not be limited by gender, spiritual beliefs or values, and I have no doubt that in today’s world she would also have added culture.

The authors are passionate about creating bridges between nurses and health care professionals and persons of different cultures for whom they care. They have explored cultural traditions from across the world and contextualised these for local health care; the book will, however, also be a good resource for international readers. The theoretical basis of the book is clearly articulated and the evidenced-based approach enables the student to further explore aspects of particular interest.

This new edition of the book takes into account our rapidly changing, multicultural society. Challenges of culturally sensitive and competent health care, in a society in which our patients come from many different ethnic, language, cultural and religious backgrounds, require that nurses have not only the knowledge, but the skills and attitudes to competently care for their patients. The information in this book has been carefully chosen, and is enhanced by the practical examples and references to updated policy and legislation. Each chapter sets the scene for the content, identifies key learning points and includes case studies and reflective exercises which encourage the reader to reflect on his/her own experiences and translate the concepts into practice.

What is particularly unique about this book is the journey that the reader travels as he/she explores each of the chapters. We journey through the developmental stages of life, consider the particular cultural communication and care needs of vulnerable groups, and are encouraged to reflect on our own values, cultures and beliefs, and practice as we do so.

Whether a nursing student, experienced nurse or from another health discipline, this book will be a resource for promoting culturally sensitive communication between health care provider and patient, and facilitate decisions regarding planning and implementation of quality care.

The ability to ‘cross the bridge’ of cultural and other differences in communicating with and caring for our patients, and in so doing making a real connection is surely one of the great privileges of being a nurse. This book provides the resource for nurses to be able to do just that.

On a personal note, it has been a special privilege to be asked to write this foreword. I met both authors some years ago at a NET (Networking in Healthcare Education) conference, have valued them as colleagues, and visited and stayed with Christine and her family. The commitment of the
co-author and her colleagues to complete this project is an acknowledgement of the significance of her work. Her passion and work lives on in this new edition.

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CHAPTER 1
Culture, race and ethnicity: Exploring the concepts
Karen Holland

INTRODUCTION

This chapter aims to explore and discuss the concepts of culture, race and ethnicity. These three concepts are found being discussed in various ways in the media, government and health policies and in the literature generally. Consideration of their individual meaning as well as their application and interpretation within nursing and healthcare practice will then enable the reader to understand some of the underpinning issues throughout the book.

This chapter will focus on the following issues:

- Cultural care in context
- The meaning of culture
- The meaning of race
- The meaning of ethnicity
- Culture, race and ethnicity in nursing and health care

CULTURAL CARE IN CONTEXT

Nurses have been advised in the past that the needs of different cultural groups were not being catered to (Chevannes, 1997; La Var, 1998), and that there was a need to ensure that healthcare practitioners are suitably prepared to cater to these needs (Gerrish et al., 1996). However, as noted in the first edition of this book in 2000, there remains very little specific guidance offered by the statutory and professional bodies on how to make these recommendations a reality within healthcare practice and nurse education. The publication of the English National Board research report (Iganski et al., 1998) on the recruitment of minority ethnic groups into nursing, midwifery, and health visiting was an example of the evidence clearly indicating a need for a national policy. The Department of Health in the United Kingdom began this cultural change in health care by ensuring that National Health Service (NHS) Trusts adhered to Patients’ Charter standards with regard to privacy, dignity, and religious and cultural beliefs (Department of Health, 1992), and in 2009 published guidance for NHS organizations on how to manage the issue of belief and
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religion in order ‘to implement and comply with the requirements of legislation on religion or belief enacted recently’, and also provided general practical guidance around the issues that fall out of that for the NHS (Department of Health, 2009).

However, despite the increase in information and research concerned with ensuring that the culture and religious beliefs of patients and clients are considered in health care and nursing, there remains a distinct lack of evidence on what is available to help us to achieve this. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 1992 Code of Professional Practice set out for nurses, midwives and health visitors how they were expected to relate to the general public in the course of their work. It stated the need to:

Recognize and respect the uniqueness and dignity of each patient and client and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor.

(UKCC, 1992)

The updated Nursing and Midwifery Council (NMC) professional code (The Code – Standards of Conduct, Performance and Ethics for Nurses and Midwives, 2008), however, no longer made this an explicit issue as in 1992 but an implied one, where ensuring that the specific needs of individuals is met is an accepted part of ensuring that nurses ‘make the care of people your first concern, treating them as individuals and respecting their dignity’. For example, it states that as nurses we ‘must not discriminate in any way against those in your care’.

The new Code (NMC, 2015) can be downloaded at (https://www.nmc.org.uk/globalassets/site documents/nmc-publications/nmc-code.pdf). Here is an example from the revised Code, which can be seen to reflect the need for understanding cultural diversity and equality of care:

Section: Practice effectively

7 Communicate clearly

To achieve this, you must:

7.1 Use terms that people in your care, colleagues and the public can understand
7.2 Take reasonable steps to meet people’s language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people’s needs
7.3 Use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people’s personal and health needs
7.4 Check people’s understanding from time to time to keep misunderstanding or mistakes to a minimum, and
7.5 Be able to communicate clearly and effectively in English. (p. 8)

This remains a holistic approach that ensures that nurses care for people as individuals irrespective of their culture, which is essential in today’s multicultural UK society. However, to ensure that student nurses become not only culturally aware but demonstrate knowledge about different cultural groups so as not to discriminate requires a much more focused Standard as per the UKCC (1992) one.
The new NMC (2010) Standards for Pre-Registration Nursing also offer a broad approach for student nurses to achieve in practice:

**Generic Standard for Competence: Domain 3: Nursing practice and decision-making**

All nurses must also understand how behaviour, culture, socioeconomic and other factors, in the care environment and its location, can affect health, illness, health outcomes and public health priorities and take this into account in planning and delivering care.

(NMC, 2010, p. 44)

It is left up to curriculum development teams including practitioners, students and service users to interpret this competence statement, which as can be seen includes understanding culture and how it impacts on health and illness.

**Reflective exercise**

Consider the NMC (2010) statement above and plan at least two Learning Outcomes or Goals for your next practice placement on how you are going to ensure that you can identify how culture (as well as the other concepts defined) impacts on health and illness and how you intend to demonstrate this for your mentor in clinical practice.

The Australian Code of Professional Conduct (2008), unlike its UK counterpart, has retained a more explicit Conduct statement: ‘Nurses respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues’ (4) and offers four explanatory statements as to how this is visualized (see Box 1.1).

**Box 1.1 Conduct statement 4: Nurses respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues**

**Explanation**

1. In planning and providing effective nursing care, nurses uphold the standards of culturally informed and competent care. This includes according due respect and consideration to the cultural knowledge, values, beliefs, personal wishes and decisions of the persons being cared for as well as those of their partners, family members and other members of their nominated social network. Nurses acknowledge the changing nature of families and recognize families can be constituted in a variety of ways.

2. Nurses promote and protect the interests of people receiving treatment and care. This includes taking appropriate action to ensure that the safety and quality of their care is not compromised because of harmful prejudicial attitudes about race, culture, ethnicity, gender, sexuality, age, religion, spirituality, political, social or health status, lifestyle or other human factors.

continued
From this we can see very clearly what those involved in the education of student nurses would be able to promote in the undergraduate curricula and this incorporates a clear statement in Point 4 around the vulnerable group that we have now included in Chapter 11.

A major report published in New South Wales, Australia, was a National Review of Nursing Education, with one element focusing specifically on multicultural nursing education (Eisenbruch, 2001). The conclusion from the review was that, at least in Australia, ‘nursing has embedded within it a notion of multiculturalism which is both new and old’. Omeri and Raymond (2009) discuss how some of the population changes since 2001, however, have created new challenges for nurses and healthcare services generally so that new ways of supporting culturally diverse populations have to be developed. Cultural competency frameworks for care delivery (see Chapter 2) is one such development.

The Australian government also worked with the health professions (National Health and Medical Research Council, 2006) to produce a guide to ensuring cultural competence: Cultural competency in health: A guide for policy, partnerships and participation (access this at: http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/hp19.pdf).

In the United Kingdom this approach to multiprofessional cultural competency is not as clear, and Lauder et al. (2008) in their report on the evaluation of pre-registration nursing and midwifery programmes in Scotland found that there was generally an exposure to cultural issues rather than any development of competency and, again, this was variable across the education providers. This raised the issue of how students were both prepared for, and experienced, meeting the needs of a multicultural community in any one of the four UK countries, namely England, Scotland, Wales and Northern Ireland.

New Zealand nurses, however, have a very different experience to these countries because multicultural nursing care is not only part of general health care of the community but there is also a specific set of standards called the Cultural Safety competencies which they have to achieve and then adhere to as qualified nurses. These can be accessed at the Nursing Council of New Zealand website, along with other linked policies: http://nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses.

<table>
<thead>
<tr>
<th>Box 1.1 Conduct statement 4: Nurses respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues (continued)</th>
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<tr>
<td>3. Nurses refrain from expressing racist, sexist, homophobic, ageist and other prejudicial and discriminatory attitudes and behaviours toward colleagues, co-workers, persons in their care and their partners, family and friends. Nurses take appropriate action when observing any such prejudicial and discriminatory attitudes and behaviours, whether by staff, people receiving treatment and care or visitors, in nursing and related areas of health and aged care.</td>
</tr>
<tr>
<td>4. In making professional judgements in relation to a person's interests and rights, nurses do not contravene the law or breach the human rights of any person, including those deemed stateless such as refugees, asylum seekers and detainees.</td>
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From Code of Professional Conduct for Nurses in Australia (Australian Nursing & Midwifery Council 2008: Rebranded in 2013 but Code is unchanged)
EXERCISE

Consider your own learning experiences either as a student nurse or a healthcare professional and, focusing on one encounter with someone from a different culture to yours, decide what you would have liked to know about their culture which would have helped you to manage their care differently. Use the definition of cultural safety in Box 1.2 for an overarching topic; for example, an issue relating to gender or sexual orientation. When you have undertaken that task, read one of the chapters or appendices that can offer an insight into that specific culture.

Box 1.2 Cultural safety definition from Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice (Nursing Council of New Zealand, 2011)

Cultural safety

Cultural safety relates to the experience of the recipient of nursing service and extends beyond cultural awareness and cultural sensitivity. It provides consumers of nursing services with the power to comment on practices and contribute to the achievement of positive health outcomes and experiences. It also enables them to participate in changing any negatively perceived or experienced service. The Council’s definition of cultural safety is:

The effective nursing practice of a person or family from another culture, is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual.

The outcomes of research studies (Iganski et al., 1998; Beavan, 2006) and initiatives from health and social care services focusing on meeting the needs of diverse communities in the United Kingdom and other countries is essential to supporting the implementation of professional recommendations, but first there is a need for a common understanding and appreciation of the issues to be addressed.

One of the important factors influencing decisions about the needs of multicultural groups is that there is a shared understanding of different cultural backgrounds. This involves understanding the use of language and terminology related to care. In the literature, three terms are frequently used in discussion about cultural care practices, namely culture, race and ethnicity. An understanding of the meaning of these terms in relation to health care is the focus of this chapter.

However, Baxter (1997) cautions us about using the terms ‘culture’ and ‘multicultural’, in that such usage ignores issues of race and ‘does not provide an adequate explanation of how racial discrimination arises or how it can be addressed’. While this is acknowledged, we have
observed when teaching that if the broad cultural issues are explored first and students are clear about the background of different cultural groups (e.g. in terms of lifestyle and beliefs), then the subsequent teaching and discussion of issues related to race and racism become easier and less confrontational because the student has a clear and safe framework within which to explore his or her own views and experiences. This view is unchanged since the first edition of this book. Giving students and practitioners a good foundation of understanding the needs and practices of different cultural groups can enable situations which could be considered discriminatory to be managed differently. One of the most important aspects of ensuring the needs of all patients is effective communication underpinned by an understanding of potential differences which could impact the nurse–patient relationship (Jirwe et al., 2010; Durey et al., 2011; Taylor et al., 2013; NMC, 2015).

Each chapter in this book will give both student and teacher the opportunity to begin a reflective learning process in order to bring about change in their own beliefs and practice, and in addition to begin to influence that change in others. To enable them to begin this reflection and learning, it is essential to understand the meaning of the major terms and concepts we shall be exploring and using throughout this book.

THE MEANING OF CULTURE

The terms culture, race and ethnicity are often confused in their interpretation by healthcare professionals and the public in general. In order to determine what is meant by culture, let us examine the following definitions:

Culture is ... a complex whole, which includes knowledge, beliefs, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.

(Tylor, 1871, cited in Leininger, 1978b, p. 491)

Culture is the learned and transmitted knowledge about a particular culture with its values, beliefs, rules of behaviour and lifestyle practices that guides a designated group in their thinking and actions in patterned ways.

(Leininger, 1978b, p. 491)

Culture is ... a set of guidelines (both explicit and implicit) ... that an individual inherits as a member of a particular society and that tell them how to view the world and learn how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces and gods and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation – by the use of symbols, language, art and ritual. To some extent, culture can be seen as an inherited ‘lens’ through which the individual perceives and understands the world that he inhabits and learns how to live within it.

(Helman, 2007, p. 2)

There appears to be agreement in these definitions that culture is an inherited or learned set of guidelines through which we come to know how to live in our own social group or within society.
Henley and Schott (1999, p. 3) point out that culture is ‘not genetically inherited’, nor is it ‘fixed or static’, but in fact ‘changes in response to new situations and pressures’ (Jirwe et al., 2010).

Andrews and Boyle (2012) viewed culture as having the following four main characteristics:

1. It is learned from birth through the process of language acquisition and socialization. From society’s viewpoint, socialization is the way culture is transmitted and the individual is fitted into the group’s organized way of life.
2. It is shared by all members of the same cultural group: in fact, it is the sharing of cultural beliefs and patterns that binds people together under one identity as a group (even though this is not always a conscious process).
3. It is an adaptation to specific activities related to environmental and technical factors and to the availability of natural resources.
4. It is a dynamic, ever-changing process.

(Andrews and Boyle, 2012, p. 10)

Different cultures have established values and norms that govern how individuals communicate with one another and how they behave towards each other. All societies have ‘norms’ that guide the ways in which individuals do this, and they can be either rewarded or punished as they conform to, or deviate from, the established norm. Our culture therefore determines the pattern in which we undertake both roles and responsibilities related to family, friends and the workplace.

For example, nurses have their own professional and social culture and student nurses learn through gaining experience in different types of practice placements and establishing what knowledge and skills are essential in order to ‘survive’ in that culture. So, student nurses have to know how to behave when in uniform and what is expected of them when they are working on a ward. Holland (1993) found that there were aspects of nurses’ culture, such as the order in which they carried out their work, which had remained unchanged since Florence Nightingale’s day. She also found that there were many rituals that were important in ensuring that everyone, including the patients, knew what to do in hospitals. One of the most important rituals was that of the handover report, when information was communicated by nurses about the patients and their care. Other researchers have also found rituals associated with nursing culture (Wolf, 1988; Street, 1992; Kaminski, 2006), including the handover (Strange, 1996; Philpin, 2006).

De Santis (1994) stated that when patients and nurses meet one another, there is in fact a meeting of three cultures:

1. The nurse’s own professional culture, with its beliefs, values and practices;
2. The patient’s culture, based on the patient’s life experiences of health and illness and their personal values, beliefs and practices;
3. The culture of the setting in which they meet (e.g. hospital, community or family setting).

If we can understand that these cultures exist when we are communicating with patients, this will enable us to begin to understand some of the actual and potential problems that may arise when assessing, planning and implementing care.
One other culture that De Santis (1994) did not account for, and which can have a substantial effect on the nurse–patient relationship, is that of the nurse’s. For example, if the nurse is a Muslim and is caring for a Muslim patient (male or female) there may well be an occasion for conflict where body care or personal preference is concerned. In some situations, the student nurse may be asked to interpret for the patient as he or she speaks that particular language. However, this is not always viewed positively by students, especially if they are asked frequently to undertake this role:

I didn’t mind doing this [interpreting] for patients, as it saved time and helped them straight away – and I can speak four different languages, which, of course, was even more useful. But I found I was being asked to do it on other wards as well and it was not helping me to make sure I met my learning objectives on my ward.

(Adult nurse student, Year 1)

Consider the following Case Study, which explains this meeting of cultures as explained by De Santis (1994) (Box 1.3).

**Box 1.3 Patient case study**

Mr Mohamed Kalhid Quereshi, a 68-year-old Muslim man, is admitted to a large district general hospital after having been seen by the consultant in the diabetic clinic of the outpatients department. He has been admitted with glycosuria (sugar in the urine).

The first ‘culture’ he meets is that of the hospital (organizational culture). His previous experience of hospitals will determine his behaviour and his understanding of all that is taking place. If it is his first visit, he is immediately faced (like anyone coming into hospital) with the dilemma of where he has to go. The signs on the doors and walls will not necessarily be familiar. If it is a hospital that acknowledges the needs of a multicultural society, the signs will at least be in different languages, but it would be incorrect to assume that he can actually read these.

Walking through the hospital, this patient will encounter many different individuals in different uniforms of different colours. On reaching the outpatients department, again there will be an array of signs for different departments (e.g. Orthopaedic, ENT, CT Scan, Diabetic Clinic). To those who work in the hospital, these signs will be familiar as they have been learned and they are part of the hospital culture. However, to Mr Quereshi, even in his own language their meaning may not be readily understood unless he is familiar with the cultural language of the hospital. At this stage he may begin to experience what Herberg (1995) has termed ‘culture shock’. This is similar to what happens when one travels to a different country and for the first few days everything is very strange or alien. People are also uncertain how to behave in such new environments (Burnard and Gill, 2008).

The second culture Mr Quereshi may encounter is that of the nurse (nursing culture), who may ask him for ‘his sample’ and who may, if she does not receive a response, hand
The meaning of culture

Reflective exercise

Imagine that Mr Quereshi is a patient on your ward. You are to be his named nurse and have to undertake an assessment of his needs on admission to the hospital.

1. What will you need to know about his admission to the hospital from the outpatients department?
2. How will you ensure that he understands the role of the nurse and other healthcare workers who will be caring for him?
3. What knowledge of his culture will you need in order to ensure that the assessment of his needs is culturally appropriate?

Your responses may have considered the following issues with regard to the three cultures identified by De Santis (1994).

Organizational culture

Organizations such as NHS Trusts have equality and diversity policies which ensure that all patients, regardless of culture, are afforded equal care. (See Chapter 13.)

For example, any information that is given to Mr Quereshi about his admission to hospital should be provided in his own language as well as in English. We do not know if he speaks English as well as another language or if he speaks English minimally. However, whatever language he speaks mainly, we cannot assume that he is able to read. This is important to recognize for any patient regardless of their main spoken language. This could be a language such as Bengali. (An example of a site for diabetic patients to access in many different languages about their condition is that of the Diabetic Association: http://www.diabetes.org.uk/Other_languages/Bengali/)

In addition to written information, many hospitals employ the services of trained interpreters or link workers who offer a very valuable service to both health service staff and non–English-speaking clients. A study by Alexander et al. (2004) found that ‘the role and practice of interpreters has become professionalized’ (p. 60). They made the following observations:

As a crucial part of this professionalisation. There is increasing stress on codes or guidelines for standards of behavior and practice. These guidelines differ according to the various types of interpreters: linguistic interpreters, community/cultural interpreters, interpreter-advocates and so on. The linguistic model for example, is simply interpreting what is said, neither adding nor taking away, and is the primary model for work in the legal field. …In contrast the community and advocacy models are more likely to be found in the health and social care fields, for example informing a health visitor about the cultural issues involved in a client’s situation. (p. 60)

They also found that, regardless of which model was used, there ‘are standards and ethics of good practice in which the interpreter needs to be trained and accredited and which need to be followed in order to provide a professional service’ (p. 60). There still remained the untrained interpreters, mainly those from families and friends. These cause a number of problems, because of such practice as ‘bias and distortion because of lack of language competence, especially knowledge of specialist terminology, inaccurate translation and mistranslation because of poor skills and also personal unsuitability and lack of confidentiality’ (p. 61).

A study by Hadziabdic et al. (2014) exploring ‘Arabic-speaking migrants’ experiences of the use of interpreters in healthcare’ identified the following issues which relate to those above and can also be seen as applying to many other different populations and cultural groups where intercultural communication in important situations becomes problematic:

The main findings were that the use of interpreters was experienced as both a possibility and as a problem. The preferred type of interpreters depended on the interpreters’ dialect and ability to interpret correctly. Besides the professional interpreters’ qualities of good skill in language and medical terminology, translation ability, and neutrality and objectivity, Arabic speaking participants stated that professional interpreters need to share the origin, religion, dialect, gender and political views as the patient in order to facilitate the interpreter issue and avoid inappropriate treatment. (p. 49)

Mr Quereshi of course may or may not require the services of an interpreter to ensure that his admission to the hospital takes into account his cultural needs as well as his health needs. Recognizing some of the issues that could arise as stated in the above research will enable you to consider various options regarding the type of interpreter needed.
The meaning of culture

Nursing culture

As Mr Quereshi will usually be cared for by female nurses, he may find receiving care an embarrassing and uncomfortable experience. Being aware of his specific beliefs and needs as they relate to his Muslim culture will help nurses to interact with him in a sensitive manner. The way in which he relates to the nurses may also be influenced by his views about women and nursing. The role and status of nurses in some societies may be lower than those in the United Kingdom because of the links to beliefs about ‘dirt and pollution’ (Jervis, 2001). Lawler (1991) and Somjee (1991) cited the example of Indian nurses, where the touching of excreta is linked to low status and low caste in Indian society. Johnson (2011), in her study on professional identity, and nursing in India, also raises similar issues and again links nursing with evidence of a low status.

Nurses need to ensure that patients of all cultures understand their role in order to avoid misunderstanding.

Being cared for by nurses from his own culture would not necessarily help Mr Quereshi, even though communication on cultural needs would be an asset.

This is because the relationship between men and women in Muslim culture is very restrictive and to be cared for intimately by a Muslim female nurse might be more embarrassing than being cared for by a non-Muslim nurse.

Patient culture

Mr Quereshi is a Muslim man and, in order to ensure that his care is appropriate, the nurse must have an awareness of his specific cultural needs. For example, diet will be an important aspect of care, given that he has glycosuria (sugar in the urine) and may be diabetic. Any medicine he may be prescribed should be alcohol-free, and ‘capsules should not contain gelatine’ (Community Practice, 1993, p. 333). If he requires insulin, the human form would be prescribed, because pork is a prohibited food (Pennachio, 2005). A devout Muslim would need to be able to pray five times a day while in the hospital. This is essential to well-being, although illness does allow exemptions. If it were the time of Ramadhan, he would be required to fast in the hours between dawn and sunset. This may cause personal conflict because of the treatment for his diabetes. If he is a very devout Muslim, he may refuse to take anything at all into his body – ‘through the mouth, the nose,

Reflective exercise

As a student nurse, have you ever been asked to interpret for a patient while in clinical practice?

1. If yes, reflect on the experience and consider how it affected your learning experience and the person you were interpreting for.

2. If no, consider how effective communication would be achieved without an interpreter being available for a patient unable to speak English.

Access the research studies mentioned in the previous Organisational Culture section to support your answer.
by injection or suppository between dawn and sunset’ (Henley, 1982). The Holy Qur’an (Holy Koran) allows for flexibility, and if Muslims cannot fast at all ‘they are permitted in the Qur’an to perform another virtuous act such as providing food for the poor’ (Henley, 1982).

Wehebe-Alamah (2008) believes that it is important for nurses to understand the ‘level of adherence to religious and cultural practices’ that a patient undertakes, and that beliefs range from ‘the very liberal to the extremely fundamentalist’ and in particular that:

Knowledge of generic (folk) care practices that are common among Muslims is critical to providing culturally congruent care. (p. 85)

**THE MEANING OF RACE**

There appears from the literature to be general agreement with regard to the definition of race. For example, Fernando (1991) defines race as ‘a classification of people on the basis of physical appearance ... with skin colour the most popular physical characteristic’.
Country of origin is also frequently used with this concept of race (e.g. African–Caribbean). However, race has not just been expressed in this way. Jones (1994) reminds us that in the past it was ‘a way of dividing humankind which also denoted inferiority and superiority, which was linked to patterns of subordination and domination’. She cites colour as being a very important determinant in this classification, with ‘black’ people being defined as inferior and more primitive whereas ‘white’ people were viewed as superior. However, Cashmore (1988) pointed out that the main issue is not what ‘race’ is, but how the term is used. He states that nearly all social scientists, for example, use the term to define social groups according to their physical or bodily attributes, which are then linked to their social behaviour.

Because race has become such a crucial concept in health care generally, it is important to examine how theorists view it. This will also help us to understand why and how people adopt such different views about living in a multicultural society both generally and locally. Jones (1994) believed that there are two distinct theories of race, namely consensus (functionalist) theories and conflict theories. Consensus theories suggest that following an initial disruption of society by large numbers of immigrants, ‘social consensus will be restored through resocialisation and integration’ (Jones, 1994, p. 298). It is believed that any new social group, with its individual customs, will become no different from the rest of society, and that it is they who have the ‘problem’ not the majority culture. They become ‘indistinguishable from the majority and integrate through mixing with the host society’ (Jones, 1994), while not losing their cultural norms and values altogether. Another theory is one in which there is a more liberal view and acceptance of ‘subcultures, norms and values, which are different but equal’ (Jones, 1994). In communities that adopt this view, there may be a more open acceptance of other cultures (e.g. in regular multicultural religious services).

In contrast, conflict theories view race relationships as part of an ongoing struggle between the dominant and subordinate groups in society. This creates racial conflict where they experience racism, which, according to Dobson (1991), is ‘a mixed form of prejudice (attitude) and discrimination (behaviour) directed at ethnic groups other than one’s own’. This occurs at two different levels: ‘individual and institutional’ (Dobson, 1991).

An example of institutional racism can be seen in the recruitment of African–Caribbean women to enrolled nurse and pupil nurse training because the entry qualifications for SRN training were geared to UK education criteria and values (Jones, 1994; Culley and Mayor, 2001).

Fernando (1991) stresses that in any ‘racist’ society, the identification of individuals according to their race and ethnicity is not to be undertaken lightly, and he points out that they both carry ‘racial’ connotations. He stresses that simply renaming a racial group as ‘ethnic’ does not get rid of the racial persecution of that particular group.

Laird (2008, p. 5) discusses the difference between street racism and institutional racism, whereby ‘the first consists of overt racism such as abusive language, criminal damage and physical assault – acts usually perpetuated in public spaces’.

Institutional racism she explains ‘includes negative stereotyping of people from ethnic minorities, patronizing language or actions due to ignorance of a person’s culture, the inequitable treatment of people from ethnic minorities and the failure to take into consideration an individual’s cultural background’ (p. 6).
To help you to explore your own views on this issue, consider the following scenario:

During attendance at a Summer School, a student is asked to share a room with a colleague who is Asian. Her reply is: ‘I’m not racist but … I don’t think that’s a good idea. I’d rather share with an English colleague just in case there are any problems with food or something, like she may want to pray on her own’.

The statement ‘I’m not racist but’ indicates that the student cannot be considered non-racist. The additional comment that she would prefer to share with an English colleague also indicates a view of culture and race that excludes members of minority ethnic communities as not being English – yet they may have been born in England.

These types of comments could be viewed as harmful if they intrude into the nurse–patient relationship. Nurses who hold such views could let them influence the way in which they deliver care. For example, if Mr Quereshi rang the nurse call bell, the response could be: ‘I’m not racist but … you go and answer that; he doesn’t make any effort to understand me so why should I go? You’re better with him than I am’.

These are examples to help you to explore your views, and they are adapted from real situations. There are examples discussing some of these issues throughout the book.

Reflective exercise

1. Examine your own views with regard to how different cultural groups should live alongside one another.
2. How could these views affect your caring for people in both community and hospital settings?

Reflective exercise

1. Consider other situations where you have heard the phrase ‘I’m not racist but …’ and reflect on how you felt when you heard this.
2. What, given your reading of this chapter, do you believe was the cause of the speaker’s statement?
3. What was the outcome?

Key points

1. The nurse has a responsibility to ensure that patients ‘come to no harm’ while in his or her care. This includes protecting them from racist behaviour by other patients and healthcare colleagues.
2. Racism can occur at both individual and organizational levels.
3. Racial discrimination and prejudice can prevent the implementation of equal opportunity policies.
The meaning of ethnicity

Jones (1994) states that the term ethnicity:

…refers to cultural practices and attitudes that characterise a given group of people and distinguish it from other groups. The population group feels itself and is seen to be different by virtue of language, ancestry, religion, common interests and other shared cultural practices such as dietary habits or style of dress. Ethnic differences, in other words, are wholly learned – they are the result of socialisation and acculturation – not genetic inheritance.

(Jones, 1994, p. 292)

However, it is important to remember that in belonging to an ethnic group, each individual within that group must still be acknowledged. In addition, using the term ‘ethnic’ to describe differences between cultures has often led to discrimination and prejudice owing to differences in customs, dress and language. Baxter (1997) defines an ethnic group as:

a group of people who have certain background characteristics such as language, culture and religion in common; these provide the group with a distinct identity, as seen by themselves and others. Although the term also covers white people (ethnic majorities) and includes such groups as Greeks, Poles, Italians, Welsh and Irish, it is often used inaccurately to describe black or ethnic minority groups in Britain.

(Baxter, 1997, p. xvii)

From these two definitions we can see that belonging to an ethnic group will affect the way in which we communicate both verbally and visually with others. They also show that we all belong to an ethnic group.

POST – Parliamentary Office of Science and Technology (2007) noted that:

Ethnicity results from many aspects of difference which are socially and politically important in the UK. These include race, culture, religion and nationality, which impact on a person’s identity and how they seem to others. People identify with ethnic groups at many different levels. They may see themselves as British Asian, Indian, Punjabi and Glaswegian at different times and in different circumstances.

However, the problem with using the terms ‘race’ and ‘ethnicity’ to differentiate between social groups is highlighted in a report published by the British Medical Association (BMA) in 1995 on the need for multicultural education for doctors and other healthcare professionals. The report considered that ethnicity has replaced ‘race’ as a health research definition but that it is ‘a fluid variable; its meaning can change over time and the borderlines between groups are not clearly demarcated’ (British Medical Association, 1995).

This is unlike race, which is related to physical attributes (Cashmore, 1988). The report concludes that this makes it very difficult to create an effective system for differentiating between groups in order to determine specific health needs. There are problems with any such classification system. A system that is based on racial categories fails to take into account the many individual and cultural differences between groups, and one that is based on ethnicity may not address specific issues about ‘discrimination and equal opportunities’ (British Medical
Association, 1995). From April 1995 it has been a mandatory requirement by the Department of Health that ethnic monitoring of inpatients takes place (Karmi, 1996). Previously this was undertaken mainly for ‘employment practices’ but it has now become increasingly important for monitoring health services (Department of Health, 2007). Karmi (1996) believed that:

…if properly implemented, ethnic monitoring can provide valuable information on the epidemiology of disease in ethnic groups. It can also reveal inequalities of access. The information can be used to make changes, which should go towards improving the service and ensuring that it is sensitive, equitable and appropriate.

(Karmi, 1996, p. 10)

However, as noted previously, there are limitations to any classification system, and if it is not used properly (i.e. collecting the data without any consequent change), then it could be viewed suspiciously as collecting ‘race data for clandestine use’ (Karmi, 1996). The Department of Health in the United Kingdom published a practical guide to ethnic monitoring in the NHS and Social Care, which includes an outline of why ethnic monitoring is important in ensuring equality of health and social care provision to all cultural groups (Department of Health, 2007). The data enables health inequalities to be identified, in particular ethnic health inequalities (POST, 2007). They offer examples of this in Box 1.4.

**Box 1.4 Examples of ethnic health inequalities (From Parliamentary Office of Science and Technology: Postnote, 2007)**

**Cardiovascular disease (CVD)**

Men born in South Asia are 50% more likely to have a heart attack or angina than men in the general population.

Bangladeshi have the highest rates, followed by Pakistanis, then Indians and other South Asians. By contrast, men born in the Caribbean are 50% more likely to die of stroke than the general population, but they have much lower mortality to coronary heart disease. Classical risk factors like smoking, blood pressure, obesity and cholesterol fail to account for all these ethnic variations, and there is debate about how much they can be explained by socioeconomic factors. Many researchers think that there are biological differences between ethnic groups, and a lot of research has been carried out on the potential mechanisms.

**Cancer**

Overall, cancer rates tend to be lower in BME groups. For lung cancer, mortality rates are lower in people from South Asia, the Caribbean and Africa, which relates to lower levels of smoking. The highest mortality is found in people from Ireland and Scotland. Mortality from breast cancer is lower for migrant women than for women born in England and Wales. Researchers think this reflects the fact that it takes time to acquire the detrimental lifestyle and other risk factors associated with living in this country.

*continued*
During the assessment process on admission to the hospital, nurses may be required to collect data on ethnic origin, and it is important that they explain to patients the rationale for this in terms of healthcare planning.

**CULTURE, RACE AND ETHNICITY IN NURSING AND HEALTH CARE**

In order to establish an understanding of these concepts as they apply to healthcare practice, consider the following case study:

Mrs Dorothy Jones is a 60-year-old woman from Jamaica who moved to the United Kingdom in 1952 with her parents. She has worked as a nursing auxiliary for the past 30 years in a large teaching hospital and has been married to Ernest for 40 years. They have 4 children and 10 grandchildren who, apart from one daughter who is a ward sister at the hospital, have all made their home in Jamaica. For the past four years, Dorothy's diabetes has been gradually getting worse, and she has now developed two large ulcerated areas on both legs. This has necessitated long periods off work, and she is becoming increasingly house-bound. The district nurse, Sister Jan Rowan, visits Dorothy daily and has experienced some difficulty in trying to encourage her to lose weight. Dorothy is reluctant to do so, as she says she is happy with her body and her shape. Jan has recently completed a short course on cultural awareness and is trying to understand Dorothy's health and illness beliefs in order to
help her. Unfortunately, Dorothy does not have a good relationship with her general practitioner (GP), Dr Vijaykumar Patel, a Hindu man. She feels that he has not been very helpful with pain relief, and she has no faith in the medication he does prescribe. Dorothy and her husband would like to retire to Jamaica, as she feels that this is where she ‘belongs’, but her health problems are making it less likely to happen. She feels that her only link to her home is the Pentecostal church, which she is now also finding increasingly difficult to attend.

1. How are culture, race and ethnicity reflected in this Case Study?
2. Has Mrs Jones become integrated into UK society?
3. What are the specific ethnic differences between Mrs Jones, Sister Rowan and Dr Patel?
4. What needs to happen in this healthcare scenario to enable Mrs Jones to improve her health?
5. Reflect on your personal experiences of caring for patients in similar situations and identify personal objectives for future learning needs.

Some key points that you could explore in your reflections could include:

- Mrs Jones’ ‘cultural’ roots in Jamaica and her need to return there to live with her family;
- The use of the term African–Caribbean (or Afro-Caribbean) which Karmi (1996, p. 44) defines as being a term used to ‘describe people of African origin, who came to Britain from the Caribbean Islands, notably Jamaica, Trinidad, Tobago, Grenada, Dominca, Barbados, St Lucia and the British Virgin Islands’.
- Her health and illness beliefs with regard to her body and body image (see Chapter 3);
- The three different cultures of Mrs Jones (patient), Sister Rowan (healthcare profession – nursing) and Dr Patel (healthcare profession – medicine);
- Dr Patel and Sister Rowan’s own cultural and religious beliefs as well as their professional ones;
- The need for Mrs Jones to improve her health by losing weight;
- An altered diet would also improve the diabetes and healing of the leg ulcers;
- Mrs Jones’ personal beliefs may not help the district nurse to implement a mutually agreed plan;
- Mrs Jones’ poor relationship with her GP – a man from another culture and healthcare profession – is also contributing to her non-compliance with care/treatment which would help her to realize her long-term goal of ‘going home’ to Jamaica.
Pierce and Armstrong (1996) believe that:

... diabetes is a particular problem for African–Caribbean people living in the UK, for two reasons. The first is that rates of diabetes are very high in this population ... reflecting the high prevalence of the disease in the Caribbean ... and is according to Alleyne et al. (1989) a leading cause of death in Jamaica ... The second reason why diabetes is a particular problem is the importance of patients’ beliefs about diabetes and their effect on health-related behaviours.

(Pierce and Armstrong, 1996, p. 91)

In the Case Study above, Mrs Jones would have to make radical changes to her lifestyle in order to manage her diabetes with any degree of success (Brown et al., 2007). However, as Pierce and Armstrong (1996) have highlighted, the cultural beliefs of African–Caribbean people about their diet and body shape (e.g. the relative merits of African–Caribbean food versus English food and the concept of ‘ideal’ body size) can make it very difficult for health professionals to recommend changes with which Mrs Jones would agree (see Chapter 3 for further information on food and diabetes in African–Caribbean culture).

CONCLUSION

As the above Case Study illustrates, it is essential to understand all three cultures in a nurse–patient encounter in order to ensure culturally safe and appropriate care. It is important to recognize that the nurse’s own culture can influence the nurse–patient relationship. The responsibility for ensuring that nurses have the knowledge and skills to do this should lie with both them and their employers.

CHAPTER SUMMARY

1. Any understanding of the terms culture, race and ethnicity is essential if culturally safe and appropriate care is to be ensured.
2. In every nurse–patient relationship there is a meeting of three cultures, namely those of the organization, the patient and the nurse.
3. Racism, discrimination and prejudice continue to prevent the implementation of care that is culturally safe and appropriate.

FURTHER READING

This book introduces theories of race, ethnicity and racism and explores how an understanding of these can help nurses and other healthcare professionals meet the needs of minority ethnic communities.

This book written by Sujani Reddy ‘examines the consequential lives of Indian Nurses whose careers have unfolded in the contexts of empire, migration, familial relations, race and gender’. It is a new find for me and having begun reading the book I can see it is full of wonderful stories that intersect with each other in terms of topics to be discussed. Issues such as the Indian caste system are discussed in different ways.

This book is called a Handbook for Practitioners and it certainly offers a broad spectrum of content related to these issues of ethnicity, race and culture in relation to mental health in the context of mental health services. Not only does it look at such various illness models to help practitioners understand patient illness, but it also considers the education and training required for developing competence from within the organization’s own needs and interpretation of its meaning. It also offers excellent case studies throughout.

**WEBSITES**

http://anthro.palomar.edu/culture/culture_2.htm
A website which discusses through exercises and examples the nature of human culture and its characteristics and the methods used by anthropologists to study it.

http://visiblenurse.com/nurseculture6.html
This website focuses on aspects of Kaminski’s study of nursing culture and gives access to her whole study to download as a Pdf document. The study is called: Nursing through the lens of culture: A multiple gaze.

This site links to a Guide for Racial Equality in Health and Social Care: Good practice guide for the Department of Health, Social Services and Public Safety. The ‘At a Glance Summary’ of this guide offers translation in Chinese, Urdu, Portuguese and English, on key issues for racial equality in health, such as communication, diet, religion and patient choice (accessed via Google on 16 March 2016).

This site offers a wide range of resources with regard to equality and diversity. Here, for example, is a link from this page to many issues related to Black health:
http://www.nhs.uk/Livewell/Blackhealth/Pages/Blackhealthhub.aspx
This site offers guidance on a number of health issues such as diabetes and sickle cell anaemia.

http://www.raceequalityfoundation.org.uk/dh-strategic-partners/ITS/resources
This link offers resources regarding interpreters and translation for different cultural groups and health services. It also offers many more resources on aspects of racial equality such as access to the NHS Report called Beyond the Snowy White peaks of the NHS examining the lack of equality of black and minority ethnic staff in the NHS, http://www.raceequalityfoundation.org.uk/resources/downloads/beyond-snowy-white-peaks-nhs.
Culture, race and ethnicity: Exploring the concepts
http://anthro.palomar.edu/culture/culture_2.htm
http://visiblenurse.com/nurseculture6.html
http://www.nhs.uk/Livewell/Blackhealth/Pages/Blackhealthhub.aspx
http://www.raceequalityfoundation.org.uk/dh-strategic-partners/ITS/resources

Cultural care: Knowledge and skills for implementation in practice
http://www.gypsy-traveller.org/health/health-status
http://www.aacn.nche.edu/education-resources/toolkit.pdf
https://www.youtube.com/watch?v=-pgCPJSiKoo
https://www.youtube.com/watch?v=V8tOasE3hEU

Religious beliefs and cultural care
http://www.bbc.co.uk/religion/religions
http://www.rcseng.ac.uk/publications/docs/jehovahs_witness.html
http://www.scottishinterfaithcouncil.org/resources/Religion+and+Belief.pdf
At website: http://adc.bmj.com/content/90/7/715.full
https://www2.rcn.org.uk/development/practice/spirituality/about_spirituality_in_nursing_care

Understanding the theory of health and illness beliefs
Working with health and illness beliefs in practice

Women and health care in a multicultural society

Men and health care in a multicultural society
Wilkins, D., Payne, S., Granville, G. and Branney, P. L. 2008. The Gender and Access to Health Services Study. London: Men's Health Forum and University of Bristol, Department of Health,

Child and family centred care: a cultural perspective


Care of older people from black, Asian and minority ethnic groups


Culture and mental health


http://www.mentalhealthcare.org.uk
http://www.nrpsi.org.uk/about-us/professional-standards.html
https://www.evidence.nhs.uk/search?q=barriers+to+communication+with+different+cultures (accessed 10 April 2017)

Caring for the health needs of migrants, refugees and asylum seekers


http://www.amnesty.org/
http://www.asylumaid.org.uk
http://www.better-health.org.uk/resources/research/race-health-driving-forward-race-equality-nhs
http://www.refugeecouncil.org.uk/
https://www.freedomfromtorture.org/
http://www.unhcr.org/
http://www.who.int/en/
http://www.unhcr.org/pages/49c3646c4b8.html
https://www.youtube.com/user/unhcr: (accessed via Google on 13 March 2016)
https://www.youtube.com/watch?v=PGjDNUtTX1w (accessed via Google 13 March 2016)
http://www.scottishrefugeecouncil.org.uk/how_we_can_help/other_useful_websites/sanctuary
http://www.scottishrefugeecouncil.org.uk/what_we_do/refugee_storiesreport

Death and bereavement: A cross-cultural perspective


Cultural diversity and professional practice


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