DIVERSITY AND DIFFERENCE IN COMMUNICATION

STUDY TIME: 16 HOURS

INTRODUCTORY LEVEL

Diversity and difference in communication

Contents

Introduction

Interpersonal communication in health and social care services is by its nature diverse. As a consequence, achieving good or effective communication – whether between service providers and service users, or among those working in a service – means taking account of diversity, rather than assuming that every interaction will be the same. This course explores the ways in which difference and diversity impact on the nature of communication in health and social care services.

This OpenLearn course provides a sample of Level 2 study in Health and Social Care.

Learning outcomes

After studying this course, you should be able to:

- demonstrate an understanding of competing perspectives on issues of communication, difference and diversity
- demonstrate an understanding of the ways in which issues of ethnicity, gender and disability impact on interpersonal communication in care services
- apply ideas about communication and difference to everyday interactions in health and social care contexts
- analyse the ways in which ideas about difference can both reflect and reproduce inequalities between groups in the context of care services
- identify strategies for working with difference and diversity in the context of challenging discrimination in health and social care contexts.

1. Introducing diversity and difference

This course focuses on issues of difference and diversity in a specific sense. Rather than analysing diversity in terms of *kinds* of communication and relationships, the focus here shifts to diversity in terms *the people* involved in interactions in care settings. Again, it is simple common sense to state that 'good' communication in health and social care services involves acknowledging and responding to the diverse needs and backgrounds of everyone involved, whether service users or staff. In the context of care services, it is not unusual for people to say, for example, that 'everyone is different' and 'we aim to treat all our patients/clients/workers as unique individuals'. However, while agreeing that, at one level, 'everyone is different', and that each person brings a unique combination of needs, experiences and attributes to every interaction, in this course we shall claim that some 'differences' matter – or more accurately are made to matter – more than others, in people's everyday experience of using and working in care services.

The kinds of 'difference' explored in this course are related to what are sometimes called people's *social identities*: that is, their membership of particular groups that are said to share common experiences and needs. These include differences on the basis of 'race' and ethnicity, gender, disability, age and sexuality. What marks out these apparent differences from other kinds of diversity is both their importance in structuring people's everyday experience, including their experience of health and social care services, and the ways in which they are used to define certain people as 'other', or as different from a supposed 'norm'.

Issues of diversity and difference have been an important focus of discussion and debate, and a significant strand in the development of policy and practice in the care sector since the 1970s. Starting with feminist and anti-racist campaigns in the 1970s and 1980s, there have been a range of initiatives, both at the level of government legislation (NHS Executive, 2000) and in terms of specific policy and practice guidelines, designed to combat prejudice and discrimination, and develop equality of access and participation. Issues of communication have played a large part in these debates and initiatives, arising from concerns about apparent 'communication problems' affecting particular groups of service users or staff. Many initiatives in the area of diversity have been designed to address and overcome such 'problems', whether this involves providing interpreters for people who do not speak English, producing literature in community languages, or installing hearing loops and Braille signs for people with hearing and visual impairments.

However, in what ways do issues of diversity and difference impact on interpersonal communication in the context of health and social care? Is diversity a 'problem' and if so, what exactly is the nature of the problem, and whose problem is it? How is the way people think about these practical issues influenced by different ways of thinking about the nature of 'difference', and how is it produced and perpetuated? Most importantly, perhaps, how should those involved in care services respond to issues of difference and diversity, and how can they ensure that all service users are able to

participate fully in the range of interactions that take place in services on a day-to-day basis?

These are the kinds of questions explored in this course. Firstly the course looks at general issues of difference and communication, and the ways in which these impact on service users and staff. The next three sections each apply these ideas to a specific dimension of 'difference': Section 5 discusses issues of ethnicity, Section 6 gender and Section 7 disability. Since ethnicity is arguably the focus of most debate in issues of diversity and communication, this is the longest section, and here many of the key issues of this course are developed. Our choice, as authors, of these three dimensions should not be taken as an indication that they are in any way more important than others that are not discussed in as much detail, such as issues of age, sexuality and class. The decision to focus on three dimensions of difference was made mainly on the grounds of limited space. However, we would argue that issues of ethnicity, gender and disability are sufficiently important, and that there is sufficient diversity between them, to help illuminate other areas that are not covered so extensively. Finally, although we discuss these dimensions separately for reasons of clarity, it is important not to forget the ways they intersect and overlap in people's actual experience.

To summarise, this course explores the following core questions.

Core questions

1. How should difference and diversity be understood in the context of interpersonal communication in health and social care?
2. What impact do issues of difference and diversity have on interpersonal communication in care services?
3. In what ways do issues of difference and diversity reflect and reproduce inequalities of power between social groups?
4. How should people in care services respond to the issue of difference and diversity, in the context of challenging inequality and discrimination?

2. ‘Difference’ and communication

2.1 A communication ‘problem’?

This course starts by exploring at a general level the relationship between ideas of ‘difference’ and issues of interpersonal communication. In the first activity, you will consider a brief case study that offers a way into discussing these issues, which can at times seem quite complex and entangled. The case study is taken from research into the health and social care needs of black communities in the Brighton, Hove and Lewes area in the south of England (Yazdani and Anju, 1994, quoted in Robinson, 1998, p. 92).

Case Study 1: Experiencing a communication ‘problem’

My main problem is communication. Because of the language problem often I feel dumb and can’t express my positive or negative feelings … I stayed in hospital for two weeks. Two of the nurses neglected me. Of course I didn’t know whether it was because of my colour or because of the communication problem … I am still not sure about the exact medical term of the operation.

(Source: Yazdani and Anju, 1994, cited in Robinson, 1998, p. 92)

Activity 1: What is the problem?

0 hours 20 minutes

The speaker in case study 1 above is a Bangladeshi woman living in the UK. Having read the case study, think about the following questions.

1. What is the nature of the communication ‘problem’ experienced by the speaker?
2. Whose problem is it?
3. What are the consequences for the speaker?

View discussion - Activity 1: What is the problem?

This brief case study demonstrates both the importance and the complexities involved in issues of communication and difference in the context of care. The questions were not straightforward, and they were designed to show the complex and contentious nature of the issues, rather than to produce easy answers. In a sense, how you answered the questions in Activity 1 depends on your understanding of the nature of ‘difference’ – whether of ethnicity, gender or disability – and both how difference is produced and how it should be responded to.

2.2 Analysing communication problems

Below are two very different responses to Case Study 1.

1. The main cause of the 'communication problem' was the Bangladeshi woman's poor grasp of spoken English, which meant she was unable to communicate her needs clearly or to understand what was being said to her during her stay in hospital. She probably lacked confidence in herself, either because of her language difficulties or because of her cultural background. Perhaps the hospital could have done more to provide facilities to support her, but she also has a responsibility to improve her English, and maybe undergo some kind of confidence-building process to improve her ability to cope with the dominant culture.
2. The communication 'problem' arose because the hospital failed to address the indirect and direct racism inherent in its practices. Indirect discrimination was evident in the failure to take account of the diverse needs of patients, for example by ensuring bilingual workers or interpreters are available for the main community languages in the area. Direct racism was apparent in the way in which the two nurses ignored this particular patient. In addressing this problem, the hospital needs to ensure that all staff are trained in anti-racist practice and that positive steps are taken to ensure that all patients are treated equally, regardless of their ethnic, gender or other identities.

What is the main difference between these two responses, and how do they reflect contrasting approaches to issues of 'difference' and communication? One answer to this question is that the first approach locates the 'problem' in the patient herself and in the needs that derive from her ethnic and cultural background, while the second approach locates the problem in the racist attitudes and practices of the hospital. Of course, it could be argued that there is an element of truth in both responses, and that there is no need to choose between them. It may be the case*both*that the Bangladeshi woman has specific communication needs because of her cultural background*and*that part of the problem arises from the inadequate response of the institution to that identity. However, presenting the two approaches in this contrasting, if rather simplistic, way helps to demonstrate two fundamentally competing ways of understanding the nature of 'difference' – whether of ethnicity, gender or disability – and its link with issues of interpersonal communication.

Much of the discussion about issues of diversity in the context of health and social care has tended to concentrate on the apparent difference in communication styles or communication needs of particular groups, such as black people or disabled people. In the case study, there seemed to be a fairly clear-cut 'difference' related to the Bangladeshi woman's ability to speak English, although the first response also suggested 'needs' related to confidence and cultural skills. However, even where spoken English is not a problem, there is often an assumption that members of particular ethnic groups (or women, or disabled people) have specific communication 'styles' or 'needs', simply because they belong to that group. An article by Theodore Dalrymple in the Anthology suggests an assumption that Indian women tend to be emotionally inexpressive. The clear implication being that this style of

communicating – or, more accurately, failure to communicate – was directly related to their ethnicity and gender. Dalrymple also made generalisations based on age about the communication styles of older and younger British people, characterising the former as emotionally reticent and the latter as over-emotional. Other broad generalisations are often made about the ways in which people with learning disabilities communicate, and about their communication needs.

Activity 2: Talking about communication and 'difference'

0 hours 15 minutes

Think about your own experience of using or working in health and social care services. What kinds of things do people say about the communication styles and needs of particular groups of people, whether because of their ethnicity, gender, disability, age or some other kind of 'difference'?

View discussion - Activity 2: Talking about communication and 'difference'

The response to the existence of these apparent differences is often to provide specific facilities that enable better communication with particular groups, such as offering interpreters for non-English speakers or installing communication aids for some groups of disabled people. Beyond this, there is often an emphasis on training staff in 'cultural awareness' and in 'cross-cultural communication', which is designed to make workers aware of the diverse communication styles and needs of specific groups. The response may also include offering training in language skills, or more broadly in social and communication skills, for particular groups of service users. So, for example, women may be offered assertiveness training, or people of Asian origin may be taught confidence-building skills.

However, this raises fundamental questions about the nature of cultural and other 'differences'. Are there really significant differences in communicating styles and needs between groups, based for example on ethnicity or gender? If so, what is their origin, and what is the most appropriate response? Is there an alternative way of viewing difference in relation to questions of interpersonal communication?

Key points

1. Issues of difference and diversity are often associated with communication 'problems' in the context of health and social care, contributing to the failure to deliver appropriate services and the creation of barriers to full participation for all groups.
2. Examining issues of communication and difference in depth raises important questions about the nature and cause of communication problems.
3. There is a widespread tendency to assume that members of particular groups have 'different' communication styles and needs.

2.3 Ways of understanding ‘difference’

The debate about the nature and causes of ethnic, gender and other ‘differences’ is complex and contentious. Here, for the sake of simplicity, two very broad and contrasting perspectives on the issue are presented. Understanding different theoretical perspectives on an issue is important, since these perspectives impact on and influence policy and practice. In this instance, the way in which ‘difference’ is understood has important consequences for how difference is responded to, whether by individuals or by organisations.

2.3.1 An essentialist perspective

One way of understanding apparent differences in people’s behaviour and needs is to account for them as a direct result of their membership of a particular social group or category. For example, it might be suggested that a patient expresses herself in a very physical way because she is of African-Caribbean origin, and therefore because of certain innate biological or psychological attributes shared by all members of that ethnic group. Or it might be argued that a male manager behaves aggressively and competitively in a meeting because that is simply the way men are. According to this view, apparent differences in behaviour are innate within the person, as a member of a particular group, and they remain fairly fixed and stable throughout their lives. Difference is seen as an ‘essence’, something belonging to the person which they bring to an interaction. Some essentialist arguments locate the roots of difference in people’s genetic or biological make-up, while others identify upbringing and socialisation within the family (in the case of gender, for example) or within the social group (in the case of ethnicity and culture). Either way, what all essentialist views have in common is a tendency to see difference as working ‘from the inside out’, as something that is fairly fixed and stable within particular groups and the individuals who belong to them. As you might expect, essentialist approaches to issues of difference tend to be linked to various psychological perspectives. This does not mean everyone working within a psychological perspective can be labelled ‘essentialist’. However, it is broadly true that a psychological perspective tends to see differences as residing within an individual or a group, rather than as the result of social processes.

The way we understand ‘difference’ determines how we respond to it in the context of health and social care

2.4 The social construction of ‘difference’

Social constructionists take issue with psychological accounts of human behaviour, criticising them for making universal generalisations and for having too great a focus on the individual. By contrast, a social constructionist approach sees behaviour as shaped by social context, and by issues of power and knowledge.

Those arguing from a critical social perspective would criticise essentialist accounts of difference for several reasons. First, they would argue that there is a danger of making sweeping generalisations about particular groups, such as women, black people or older people, that cannot be substantiated. According to these critics, essentialist approaches tend to see ethnic and other groups as homogeneous and to overlook diversity *within* groups. Moreover, they would argue that such an approach risks ignoring important similarities *between* groups, in its drive to identify clear differences. Following on from this, a third criticism is that an essentialist view mistakenly sees the boundaries between groups as fixed and unchanging, when in fact they are dynamic and socially constructed (for example, see Ahmad, 1996).

A critical social approach, rather than looking for the origins of apparent differences *within* individuals or groups, focuses instead on the ways in which differences are ‘produced’ in a social context and as a result of social processes. If essentialists view difference as a ‘something’ that resides inside people and influences the ways they interact, those adopting a more social model regard difference as a *process* by which people are ‘differentiated’, or constructed as different.

At the most basic level, this approach suggests that different kinds of context play an important role in the process of producing difference. Dalrymple's characterisation of Indian women as emotionally reticent could be criticised on the ground that such behaviour might be specific to the immediate context, rather than a symptom of some innate cultural 'difference'. It could be suggested that the immediate interactional context – women from a marginalised group visiting a white, male doctor – might play a part in 'producing' what appeared to be a lack of emotional openness. A different kind of interactional context – for example, a consultation with an Asian woman doctor – might result in very different communicative behaviour.

An important element in the interactional context is the relationships of power between those involved, and this too needs to be considered as a factor in the production of 'difference'. In considering why people communicate in a particular way in a particular context, we need to look at the ways in which inequalities of power, based for example on race, ethnicity or disability, are at work in that setting.

One example of a critical social perspective is social constructionism: briefly, the notion that the ways in which we think and talk about phenomena such as interpersonal communication reflect the dominant ideas of our society and culture. Ideas of Michel Foucault have been extremely influential in debates about 'difference'. Foucault argues that the ways in which people think about, classify and categorise experience is influenced by wider social discourses, and that these reflect and reproduce relationships of power within society. So, for example, he argues that discourses of mental health in western societies have changed significantly over the past 200 years, and that this reflects changing power relationships and the interests of particular groups (Foucault, 1967). Categories such as 'the mad' or 'the mentally ill' refer not to unchanging 'facts out there' but to changing social constructions of the world. There is a good example of this in Foucault's work on the history of sexuality, in which he claims that although same-sex relationships are known to have existed in nearly all societies throughout history, the category of 'the homosexual' and 'homosexuality', with all that flows from it, is an invention of 19th-century European medical discourse (Foucault, 1981).

Turning to apparent 'differences' based on ethnicity, gender or disability, a Foucaldian approach would argue that such differences are socially constructed. Different societies categorise and classify people in particular ways – for example as 'black' or 'Asian' or 'women' or 'disabled' – and then use those categories to explain so-called differences between them. Social constructionists would argue that 'you find what you're looking for', and that if you imposed a different set of labels, you might find other differences – or similarities. Moreover, as explored further in Section 4, constructions of difference are never innocent or neutral. The ways in which people are categorised – 'gendered' or 'racialised', for example – tends to reflect the interests of those doing the categorising, who usually have the greater power.

Does this mean there are no 'real' differences between people, on the basis of their gender, ethnicity or disability, that impact on their experience of communication? What about the 'language problem' in the case study in Activity 1? Surely the Bangladeshi woman's lack of English was a 'fact' that meant that her communication

needs were different from those of the majority, English-speaking population? Responding to this, social constructionists would not deny that particular individuals have a range of different abilities, needs and experiences. However, labelling this woman's language abilities as 'different' is undeniably a construction – the product of a particular social context. Perhaps it is stating the obvious to say it would not represent a 'difference' if she was in hospital in Bangladesh, or using a service in the UK that had a significant number of Bangla-speaking staff. Moreover, her language abilities only become a 'problem' in a particular context: a context in which the hospital has failed to make provision for the language needs of all members of the local community. Activity 1 posed the questions: what is the communication problem, and whose problem is it? Social constructionists would add two more questions: who is constructing this situation – and this person – as a 'problem', and what kind of power relationship is reflected and reproduced in the process of doing so?

Key points

1. There are varied and competing ways of understanding issues of difference and diversity.
2. An essentialist perspective views differences as innate and as either biologically or psychologically determined, or as the result of socialisation within a particular group.
3. Essentialism has been criticised for overlooking diversity within groups and similarities between groups.
4. A social constructionist perspective views difference as a process rather than an essence, and understands it as being produced in social contexts and constructed within wider discourses of knowledge and power.

2.5 'Difference' and identity

If differences on the basis of gender, ethnicity and disability are socially constructed, how should people view their identities, for example as men, or disabled people, or people of African–Caribbean origin? Where do such identities come from, and how useful are they in explaining people's experience of communication in care services?

Foucault's ideas about changing discourses, and the ways in which they construct people's view of the world, can be applied to issues of ethnicity and gender. The dynamic and fluid nature of ethnic and gender categories is apparent even in the language and terminology used to describe people. Think, for example, about the different labels that have been used to describe black people of Caribbean heritage living in the UK over the past 50 years, and about the different meanings attached to those labels. Terms such as 'Negro', 'coloured', 'West Indian', 'black' and 'African–Caribbean' have different connotations. Firstly, each term has included and excluded different sets of people. 'West Indian' implicitly excluded people from Caribbean countries that had not been British colonies, for example, while 'coloured' and 'black' were also applied at various times to people of African and Asian origin. Some terms referred to skin colour, others to national or geographical origin. Some terms had

strongly negative connotations, or their connotations changed over time. Moreover, the terms had different meanings for different people. Avtar Brah describes how the term ‘black’, which was originally pejorative, was taken up and used as a source of pride and as a political identity. It was also assumed for political reasons for a time by people of Asian, Turkish and Arab origin resident in the UK (Brah, 1992). More recently, and as a result of complex political and cultural processes, religion has played a greater part in the ways in which both society classifies people and people identify themselves. So in some contexts the term ‘Muslim’ now assumes greater importance than other ‘ethnic’ classifications, such as Asian, Arab or North African, with which it intersects.

These examples point to the contextual nature of identities. Another example of this is how different identities become important for people in different settings, as you will see when issues of ethnicity are explored later. Stuart Hall, a leading writer on issues of culture and identity, suggests that the word ‘identifications’ is preferable to the term ‘identities’, reflecting a view that identity is a process rather than something fixed and unchanging (Hall, 2000). Furthermore, assuming an identity takes place in a social context. As Hall makes clear, the identities that people take on always come with a history and are to some extent ‘given’ by society, although people may attribute different meanings to them.

The next activity is an opportunity to reflect on your own social identities, and the meanings they have for you.

2.6 Reflecting on identity

Activity 3

0 hours 20 minutes

How would you describe your identity or identities? What kind of words would you use to describe yourself in terms of:

- gender
- ethnicity
- age
- class?

You may also want to describe other aspects of your identity that are important to you, such as nationality or regional identity, sexuality, religious or political beliefs, occupation or voluntary roles, family roles, interests and abilities, and so on. Use as many or as few terms as you like.

When you have made some notes in answer to this question, think about the following questions.

- Which of these identities (one or more) is / are the most important to you at this point in your life – and has this changed overtime?
- Would you have described your identity / identities differently 10 or 20 years ago? In what way?

View discussion - Activity 3

2.7 Aspects of identity

2.7.1 Identities are plural

Every person has a range of identities, according to how they see themselves (and how others see them) in terms of gender, ethnicity, sexuality, age, and so on. This means that seeing an individual in terms of one aspect of their identity – as a black person, for example, rather than as (say) a black working-class woman who is also a social worker, a mother and a school governor – is inevitably reductive and misleading.

2.7.2 Identities are dynamic

The identities people assume, and the relative importance they attach to them, change over time because of both personal change in their lives and change in the external world (for example, as a result of changing ideas about disability). Consequently, identity should not be seen as something 'fixed' within people.

2.7.3 Identities have different and changing meanings

Aspects of identity may have different meanings at different times in people's lives, and the meanings that they attribute to aspects of their identity (for example, ethnicity) may be different from the meaning it has for others (for example, being black may be a source of pride for you, but the basis of someone else's negative stereotyping).

2.7.4 Identities are contextual and interactional

Different identities assume greater or less importance, and play different roles, in different contexts and settings, and in interactions with different people. Different aspects of people's identity may come to the fore in the workplace and in the home, for example, while people might emphasise different aspects of themselves to different people (and different people may see different identities when they meet them).

2.7.5 Identities are negotiated

In constructing their identities, people can only draw on terms that are available in society at that time, which have meanings and associations attached. However, people may attribute different meanings and importance to those labels. This means people always negotiate their identities, in the context of the different meanings attached to them.

Taking this view of identity, as a social process that people engage in, rather than as a fixed essence inside them, is not to deny that particular identities are extremely important for certain groups and individuals. Being a Sikh, or a woman, or gay, may feel like the most important and 'deepest' part of you. However, a more dynamic and social model of identity is useful because it makes it difficult to reduce people to any one aspect of their identity, or to use social identity as a way of explaining every aspect of their behaviour and needs, including their communication needs and behaviour.

Key points

Social identities, whether based on ethnicity, gender, disability or other factors, should be seen as:

- plural
- dynamic
- contextual
- negotiated
- produced in social and interactional contexts.

2.8 'Difference', power and discrimination

These first few sections have emphasised the point that differences are always produced in a social context, and that a key part of that context is power relationships. As pointed out earlier, a key element of Foucault's social constructionist approach is that the way in which people are categorised in society (for example, by gender, ethnicity or age) involves an exercise of power that reflects the ideas and interests of dominant groups. One of the key arguments against essentialist views of difference is that they reflect, and at the same time help to perpetuate, inequalities of power and status.

Section 3 noted that the ways in which the terms used to describe people from certain ethnic, geographical or national backgrounds have changed significantly over time. In addition in the British context, the labels attached to people seen as 'minorities' have always been defined by the white majority, that is by those with power. Labelling a group of people as 'different' in some way can itself be seen as an exercise of power, a way of putting people 'in their place' and fixing them there. Defining an individual primarily in terms of their apparent ethnic identity – for example as black, or African–Caribbean, or Asian – is a way of defining them as 'different' from a supposed white 'norm', and of playing down any similarities with others. The same can be said of

attaching labels to people on the basis of a supposed disability, or sexual preference, or age.

The construction of people in terms of their supposed ‘differences’ from an imagined ‘norm’ or ‘majority’ tends to involve making sweeping generalisations about people on the basis of categories such as their ethnicity or gender. Individual differences, as well as similarities across groups, are lost as people are seen primarily as disabled, or ‘elderly’, or gay, for example. Decisions about individual needs, such as those relating to health and social care services, are then based on widely shared assumptions about people belonging to that group.

Often, these generalisations about groups – or stereotypes – are negative, since they reflect the differential power between those in the ‘majority’ and those categorised as ‘minorities’ or ‘different’. So, for example, women may be defined as less rational than men, or black people as less intelligent than white people: in these instances, men and white people respectively are characterised as the ‘norm’. These negative stereotypes both reflect existing inequalities – patterns of sexism and racism in society – and at the same time help to perpetuate them, for example by denying women and black people access to jobs that require a ‘cool head’ or complex intellectual skills. In other words, stereotyping people as ‘different’ can lead to discrimination.

So attributing fixed ‘differences’ to people is not a neutral process but one that both reflects and reproduces inequalities of power and status. The next activity is an opportunity to reflect on your own experience of prejudice and discrimination.

2.9 Experiencing prejudice and discrimination

Activity 4

0 hours 20 minutes

Look again at your answer to Activity 3. Now think of an experience when an aspect of your identity (for example, in terms of ethnicity, gender, disability, class, sexuality or age) resulted in you:

- being discriminated against or badly treated by comparison with others
- being treated more advantageously than others in a similar position
- being placed in a position of power over others.

View discussion - Activity 4

Individual examples of prejudice and discrimination should not be seen as isolated or free-floating. Within organisations, stereotypes and prejudice are often dismissed as the attitudes of a small minority, and instances of discrimination as ‘isolated incidents’. However, a social model of difference would view them as reflecting wider institutional patterns and structures. Stereotypical views held by individuals do

not materialise out of thin air. They often reflect deeply rooted social attitudes, which are themselves grounded in processes of oppression and exclusion going back hundreds of years. For example, stereotypes about African, Caribbean and Asian people can be seen as deriving ultimately from Britain's long involvement in slavery and colonial exploitation (Fryer, 1984). Similarly, feminists argue that negative images of women have their origins in patriarchal structures and practices going back millennia (Abbott, 2000).

Processes of racism and sexism play a part in producing and perpetuating supposed 'differences' between people based on their ethnicity and gender. Moreover, as you saw in the case study in Activity 1, these processes of prejudice and discrimination can lead directly to people's diverse needs not being met appropriately. Adopting this approach does not mean denying the existence of difference, but acknowledging that responding to difference also means challenging and changing practices and structures that exclude and disadvantage people on the basis of supposed 'differences' from the norm.

This discussion is developed further in the next three sections with specific reference to issues of ethnicity, gender and disability.

Key points

1. Attributing fixed 'differences' to particular groups of people can be seen as part of a process that reflects and reproduces inequalities of power.
2. Stereotypes of people based on their social identities tend to be negative and to define them in relation to their difference from an imaginary 'norm'.
3. Stereotypes can lead to prejudice and discrimination, which themselves reflect and perpetuate wider processes of oppression, such as sexism and racism.

3. Ethnicity

3.1 'Race', ethnicity and communication

As noted in the Introduction, much of the debate about difference and diversity in health and social care has focused on issues of 'race' and ethnicity. It is perhaps the area that first comes to mind when there is discussion about issues of communication and difference in care services, but it is also an area where the arguments are most complex and contentious.

As you saw in Section 1, 'racial' or ethnic diversity has often been constructed as a 'problem' for health and social care services, rather than as a cause for celebration and affirmation. Your work on Section 1 demonstrated the important part played by language and terminology in the construction of differences. Nowhere is this truer than in the area of 'race' and ethnicity, where attention has been focused on 'using the right words'. It is not uncommon for meetings and staff development sessions on anti-racism to get 'hung up' on issues of terminology, with white workers in particular anxious to discover what are the 'correct' or 'appropriate' terms that should be used for certain ethnic groups. Although this can sometimes be a distraction from facing up to racism at a structural level, it reflects an intuition that language *is* important in constructing the ways in which issues of 'race' and ethnicity are approached.

Since there is often much confusion about the terms 'race' and 'ethnicity', this section begins with a brief analysis of how they are used, and how they are used in this course. At the outset, we should say there is a growing body of literature on these issues, and how these terms and concepts are used does not stand still but is perpetually being revisited and redefined (Barker, 1981; Brah, 1996; Hall, 1992; Gilroy, 2000; Gunaratnam, 2003a).

3.2 'Race'

The word 'race' has largely been discredited in academic and policy discussions. You will notice that in this course, as elsewhere in the course, we have adopted the now common practice of putting the term 'race' in inverted commas, or 'scare quotes' as they are sometimes tellingly known. This is to indicate that, in current thinking, the idea of there being distinct 'races' and that human beings can be divided up on 'racial' grounds has been discredited. Racial thinking was at its height in the 19th and early 20th centuries and was associated with the ideologies of empire and colonialism. Ideas about distinct racial groups with distinct characteristics were developed to support the notion that some 'races' (those of white, European origin) were innately superior to others (usually 'non-white races' of African or Asian origin).

Many writers in this field argue that 'race' is socially constructed, as part of a process in which individuals are assigned to particular 'racial' categories (Banton, 1977; UNESCO, 1980; Miles, 1982, 1989). Certain physical characteristics, such as skin colour, become markers of social difference, as part of a process of 'racialisation' in

which the concept of 'race' is given specific social meaning. People assigned to a particular 'racialised' group are perceived to have specific characteristics: for example, black people may be deemed to be better at some sports than white people, but also not as intelligent. In fact a great deal of early scientific research on 'race' focused on trying to determine intelligence by examining the size of the brain in different 'racialised' groups (Huxley and Haddon, 1935; Jensen, 1969; Eysenck, 1971; Banton, 1977; Barkan, 1992). This research was inconclusive and no 'racial' differences were found.

However, there are some genetic differences between groups of people which seem to have a geographical origin. For example, some inherited disorders are more prevalent in certain areas of the world and in communities that have migrated (Weatherall, 2001). Thalassaemia is more prevalent in Greek-Cypriot communities, whereas cystic fibrosis is more prevalent in North European communities (Ward, 2001). Some writers (for example Jensen, 1969; Eysenck, 1971) argue that this demonstrates the reality of 'racial differences'. However, others have argued that such 'differences' are largely insignificant, and that in fact there are more genetic differences within 'racial groups' than between them (Woodward, 1997). According to the sociologist and psychodynamic writer Michael Rustin:

> 'Race' is both an empty category and one of the most destructive and powerful forms of social categorization … differences of biological race are largely lacking in substance. Racial differences go no further, in their essence, than superficial variations in bodily appearance and shape – modal tallness of different groups, colour of skin, facial shape, hair, etc. Given the variations that occur within so-called racial groups … it is hard to find any significance in these differences except those which are quite arbitrarily assigned to them … Racial differences depend on the definition given to them by the other – that is to say, on the definition of the other- and the most powerful definitions of these kinds are those which are negative – definitions that we can call racist.
>
> Rustin, 2000, pp. 183, 184

More significant than any minor genetic differences is the way in which supposed 'racial' differences have been used to explain people's behaviour and to place them in a hierarchy in society. To quote social policy writer Esther Saraga:

> From a social constructionist perspective what is important is the ways in which these terms link together to produce a social relation, which organizes how people are placed in society. From this viewpoint, to construct groups of people into 'races' involves a threefold process:
>
> 1. Human populations are divided into discrete categories on the basis of variations in physical features.
> 2. Meaning is ascribed to this physical variation and it is then said to be possible to know the potentialities, behaviours,

needs and abilities of a person on the basis of their 'racial' belonging.

3. This social process of categorization and classification is then said to be a product of nature – that is, racial division is said to be natural.

Saraga, 1998, pp. 99–100

3.3 Ethnicity

By contrast with 'race', 'ethnicity' is still widely used to describe differences between groups, although like 'race' it is a contested term. The terms 'ethnic' and 'ethnicity' are commonly used to denote groups of people who share common national or geographical origins, values and beliefs, and customs and traditions. Unlike the notion of 'race', ethnicity does not imply innate biological differences but rather similarities derived from belonging to, or being brought up as part of, a specific group (Nazroo, 1997).

As with all terms in this area, there is a need to be wary about how 'ethnicity' is used. Sometimes the word 'ethnic' is misused to denote 'otherness' from the (white British) norm, as in the terms 'ethnic dress', 'ethnic food' and 'ethnic music'. This assumes that white people do not have an ethnicity, and constructs ethnicity as pertaining only to minority groups. Often the category 'white' is used in the UK context to obscure differences between people from a wide range of 'ethnic' groups, such as Irish or Italian. Moreover, the idea of 'ethnicity' assumes that everyone can be categorised as belonging to one, fixed grouping, which can then be used to explain their behaviour and needs. But some people are of dual or mixed heritage and do not fit neatly into the categories offered, thus calling into question the whole process. How should you define your ethnicity if one of your parents is African–Caribbean and the other white, for example, or if (like the British fomer Labour MP Oona King) you are both black and Jewish?

Is ethnic identity a useful concept in thinking about people's interactions in care settings?

In Activity 3 you reflected on your own identity. How easy or difficult was it to define your ethnicity? How important was your ethnicity to you? The next activity is an opportunity to focus specifically on your ethnic identity.

3.4 Describing your ethnicity

Activity 5

0 hours 15 minutes

The list of 'ethnic' groups below is taken from the UK census of 2001. Read through the list and then decide which term best describes you.

Irish

White British

Any other White background

Black British

Black Caribbean/West Indian

Black African

Any other Black background

British Asian

Indian

Bangladeshi

Pakistani

Any other Asian background

Chinese

Arabic

Mixed Origin

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed background

View discussion - Activity 5

3.5 Ethnic categories

As we noted in Section 1, the names and labels used to denote specific differences – including those relating to ethnicity – are always changing. For example, the term 'mixed background' was first introduced in the 2001 census; also, different categories were used in the Northern Ireland census. So ethnic identities say something about how society categorises people, not about unchanging facts 'out there'. You may also have noticed that the categories in the list refer to different things: some are about skin colour, while others refer to national or geographical origins. Then again, the list does not include some categories that people might regard as ethnicities, or might have been regarded as ethnicities in the past. One example is Jewishness, which might have been included when anti-Semitism was perceived to be the main 'racial' issue in the UK.

How useful is 'ethnicity' in understanding people's experience of care services, and specifically their interactions and relationships within them? Several writers on 'race' and social policy have criticised the ways in which ethnicity has been used to account for people's needs, a process that the writer Avtar Brah terms 'ethnicism':

> Ethnicism, I would suggest, defines the experience of racialized groups primarily in 'culturalist' terms: that is, it posits 'ethnic difference' as the

> primary modality around which social life is constituted and experienced. Cultural needs are defined largely as independent of other social experiences centred around class, gender, racism or sexuality. This means that a group identified as culturally different is assumed to be internally homogeneous …
>
> Brah, 1992, p. 129

Brah makes two important points here. One is that defining people in terms of their ethnicity reduces them to one aspect of their identity, and overlooks needs that may derive from other aspects. Secondly, the process tends to assume that all members of a particular 'ethnic' group have similar needs. Brah also suggests that explaining people's experience in this way overlooks the experience of racism, a point that is also made by health researcher and writer Waqar Ahmad:

> A major issue in the racialization of health research is that it is assumed that the populations can be meaningfully divided into 'ethnic' or 'racial' groups, taking these as primary categories and using these categories for explanatory purposes. Stratification by class, income and so on is then seen as unimportant; issues of institutional and individual racism as determinants of health status or healthcare become peripheral at best.
>
> Ahmad, 1993, p. 19, quoted in Kelleher, 1996, p. 72

Elsewhere, Ahmad echoes Brah's concern when he argues that too rigid a conception of ethnicity or culture 'provides a description of people which emphasises their "cultural" difference and helps to obscure the similarities between broadly defined cultural groups and the diversity within a cultural group' (Ahmad, 1996, p. 190).

Does this mean that terms such as 'ethnicity' and 'culture' have no value in helping to account for people's experience of using or working in care services? While acknowledging the reservations expressed by Brah and Ahmad, David Kelleher, a health researcher and medical sociologist, defends the use of these terms in some contexts, specifically referring to the experience of people of Bangladeshi origin in the UK:

> Being regarded as different may lead to people becoming more aware of their ethnicity and cultural identity. Recognising their difference and turning it into a source of strength is one reason why people may emphasise cultural differences in terms of what they eat and how they dress, and this may lead them to maintaining an allegiance to the religion of their group and to become even more aware of what it is to be a Muslim than are the people in Bangladesh. This is one of the paths which some young, second-generation Bangladeshi people are taking. So, while for some their religion has become the most important structure of relevance in their lives, for others a more important focus for their life may be being a student, or a businessman or a doctor.

Kelleher, 1996, p. 81

So ethnic identity may assume greater or less importance in people's lives depending on their experience of racism or other factors. Kelleher's argument reinforces Hall's suggestion, noted in Section 3, that identity, whether on the basis of ethnicity, gender or other factors, should be seen as a dynamic and active process of identification, rather than a reflection of some fixed or innate 'character'. By seeing ethnic identity as, in some instances, a response to the experience of racism, Kelleher suggests that ethnic difference can be a product of 'racialisation', rather than its cause. Next we move on to discuss the ways in which fixed ideas of ethnic difference can be used to disadvantage and discriminate against some groups in the population.

Key points

1. The idea that the human population can be divided into separate 'races' with significant innate differences has been discredited, but elements of 'racial' thinking persist.
2. 'Ethnicity' is used to refer to the shared origins, values and traditions of particular groups. Although ethnic identity can have a value for people in certain circumstances, a rigid idea of ethnicity can be used to define people as 'other' and to overlook diversity within groups and similarities between groups.

3.6 'Racialisation' and racism

Section 1 made the point that attributing fixed 'differences' to particular groups can be seen as an exercise of power, by which certain people are defined as 'other', and usually as inferior. 'Racialisation' can be described as the process by which people are defined according to apparent differences of skin colour, national origin or other attributes, and positioned as different from the (usually white) majority.

The following series of linked activities gives you an opportunity to explore how 'racialisation' works in practice, and its implications for interpersonal communication in health and social care.

3.7 The process of 'racialisation'

Stereotypes of African–Caribbean families

There are many African–Caribbean families in British inner cities – London, Leeds, Manchester and Liverpool. African–Caribbean communities tend to live in sections of the city where there may be poor housing but they prefer to live where there are other African–Caribbeans who can provide support and where there are local shops selling Caribbean food. Most African–Caribbeans are extremely religious, attending fundamentalist churches. The families are matriarchal – often men are present only as visiting partners and may have several families they 'visit'. Mothers are very strict

and see it as their duty not to ‘save the rod and spoil the child’. Women start their families very young, but the mother of a teenage mother provides a lot of support. Generally, African–Caribbean women do not believe in contraception but the rate of abortion is very high.

Activity 6

0 hours 15 minutes

The description above of African–Caribbean families in the UK reflects some popular stereotypes. As you read it, think about the kind of picture that emerges of people of African–Caribbean origin.

View discussion - Activity 6

This description can be described as ‘essentialist’ (or, to use Avtar Brah’s term, ‘ethnicist’) in that it reduces people to one aspect of their identity, presents a homogeneous and undifferentiated view of a community, and overlooks the dynamic nature of ethnic and cultural identity.

Stereotypes of this kind are not uncommon and their pervasiveness can have serious consequences for people’s experience of care services. The next activity explores some of these implications.

3.8 The impact of 'racialisation'

Activity 7

0 hours 20 minutes

Imagine that you are a white advice worker who has had little contact with African–Caribbean families. Your view of African–Caribbean people has been informed by the kind of stereotypical views reflected in Activity 6. Now imagine that you have been asked to visit an African–Caribbean mother and her 15-year-old daughter who is pregnant, and who have asked for advice.

What assumptions might you have about the young woman’s and the family’s needs, and how might these assumptions influence the way you communicate with them?

View discussion - Activity 7

In other words, the generalised assumptions that you brought to this individual case would shape your attitudes and actions in very real and practical ways. At this point, note that, as the authors of this course, we debated the dangers inherent in setting this activity. There is a risk that a case study including a pregnant African–Caribbean young woman may itself perpetuate certain stereotypes. As you will see, the next

activity attempts to challenge this kind of stereotypical thinking, but negative images are difficult to dislodge.

In the next activity you will reflect on what might be the impact of negative stereotypes on people at whom they are directed.

3.9 Being on the receiving end

Case Study 2: The Cameron family

David and Marie Cameron, a married couple in their 40s, live in a middle-class suburb. Marie teaches French at the local secondary school, while David is a full-time official for a clerical workers' union. Both are active in the local Labour Party but, although Marie is from a Catholic background, they are not particularly religious. Both David and Marie were born and educated in the UK, although their parents were migrants from the Caribbean in the 1950s: David's from Jamaica and Marie's from Martinique. Their son, Michael, is away at university, while their daughter, Louise, is studying for her GCSEs. Louise has recently come under peer pressure at school to hang out with a group of white boys, and at a particularly wild party one of the boys forced Louise to have sex. The family have recently discovered Louise is pregnant. The young man, whose father is an influential local businessman, denies using force and, under pressure from the police, the Camerons have decided not to press charges. After a lot of family discussion and heart searching, Louise has decided to keep the child, and her parents have agreed to help look after him or her, when she eventually leaves home to pursue her ambition to train as a psychiatric nurse. David wanted to be present for the meeting with the advice worker, but was called away at the last minute for an urgent union meeting.

Activity 8

0 hours 15 minutes

The case study above is of a family in similar circumstances to those described in the previous activity.

Now imagine that you are either Louise or Marie, her mother, and that you are meeting the advice worker. Imagine, too, that the advice worker brings to the meeting the kinds of assumptions about African–Caribbean families expressed in Activity 6. How do you think you would feel in this situation? In answering this question, you might want to draw on any experiences you have had of being on the receiving end of 'racialisation' of this kind.

View discussion - Activity 8

So the process of 'racialising' particular people, defining them in terms of their supposed 'differences' from the wider population and overlooking diversity within

groups can have significant consequences. It can lead to poor communication and the failure to provide adequate or appropriate services that meet individual needs.

Key points

1. 'Racialisation' is the process whereby certain people are defined as 'different' on the basis of an apparent ethnic identity. It involves making stereotypical generalisations that overlook diversity within groups.
2. Assumptions based on racial or ethnic stereotypes can lead inadequate or inappropriate provision of services.

3.10 Working with difference

If 'racial' or ethnic differences are produced as part of a process that 'racialises' certain groups as 'other', how should services respond to the issue of difference? What practical steps can service providers take to ensure all members of the population, whatever their assumed ethnicity, have equal access to services and can participate fully?

Lena Robinson is a psychologist and social work educator who has written extensively on issues of cross-cultural communication for people in the caring professions. The next activity involves reading a chapter that was adapted by its author for this course.

Click to read: Beliefs, Values and Intercultural Communication

Activity 9: Beliefs, values and intercultural communication

0 hours 45 minutes

Read the extract 'Beliefs, values and intercultural communication', by Lena Robinson.

As you read, make a note of what the author says about:

1. the reasons for a lack of trust between service users and health and social care practitioners
2. the steps practitioners can take to address this.

View discussion - Activity 9: Beliefs, values and intercultural communication

You may have noted that Lena Robinson starts by stating explicitly that she is writing from a psychological perspective. Section 2 noted that there is a link between psychological perspectives and essentialist ideas of difference, although the point was made that not all psychologists can be described as essentialists. Where does

Robinson's approach fit into this debate? Does she tend to see differences as intrinsic to individuals and groups and working 'from the inside out', or does she treat them as the product of social processes that reflect differences of power?

Robinson is not afraid to make general statements about people's communicative behaviour, based on their ethnicity. For example, she states: 'Africans and African Caribbeans tend to be emotionally expressive, while white people have a more emotionally self-restrained style and often attempt to understate, avoid, ignore, or defuse intense or unpleasant situations', and she quotes without comment Segal's description of Indians as 'reserved and reluctant to discuss their problems outside the family'. Writers such as Avtar Brah or Waqar Ahmad might take issue with this kind of statement, on the grounds that it generalises about very diverse groups. At the same time, though, Robinson does not ignore the importance of racism and discrimination in framing black people's experience of communication. One of her repeated points is that white practitioners may fail to communicate effectively with black people precisely because they do not share their experience of racism. However, Robinson's overall view is that discrimination results from white people's failure to take account of what she would regard as significant differences in styles of communication.

3.11 Ethnic matching

As Robinson acknowledges, effective practice in inter-ethnic communication is fraught with difficulties and dilemmas. It has been suggested that communication may be assisted by appointing health and social care workers from the same ethnic background as patients and clients and that this promotes greater understanding between care providers and users (Papadopoulos et al., 1998). The next activity provides an opportunity to explore some of the issues surrounding 'ethnic matching'.

An account of ethnic matching

[GL] So you are saying then really that management definitely have a view on 'race' and ethnicity? How would you describe this view?

[Participant] Their view is difficult to pin down and it always strikes me as being convenient because on that level they won't challenge black workers because they don't want to be seen as racist. But on another sort of level, a practice which is common where white workers feel or will say 'I think this family needs a black worker', but it is often convenient to get us to work with black families. The white workers can't cope really in that case.

The contradiction is that for black workers they will be working with white families, very complicated cases because of the nature of the work and you get stuck sometimes, it gets difficult, because we can't say we think this family needs a white worker. What I'm saying is that white workers when they are stuck use us as an excuse, their whiteness to get out of work, and then it is said to black workers 'what it needs is a black worker'.

Now that is quite convenient for managers, because managers are white yeah?… And they often agree with the white worker, that this case, that they are not getting anywhere with them, yeah? Whereas if you have a black worker take it, somehow you are expected to be able to work with them …

White managers, white workers won't acknowledge or are [not] even aware of these sorts of intrinsic sort of issues involved for black workers, professionalism and boundaries, how you negotiate relationships with black families when they see you as a befriending person, you are having to assert that you are a professional person and that it is a professional relationship.

(Source: Lewis, 2000, pp. 147–8)

Activity 10: Ethnic matching

0 hours 20 minutes

The extract above is from an interview with a black social worker (participant) carried out by social policy researcher Gail Lewis (GL). As you read it, make notes on any problems that you identify with 'ethnic matching' as an approach.

View discussion - Activity 10: Ethnic matching

Yasmin Gunaratnam, a writer and researcher on 'race' and ethnicity, challenges this assumption and claims it is important for people to reach a shared understanding even though they may be from different 'racial' or ethnic backgrounds, by taking the time to explore meanings through discussion and dialogue (Gunaratnam, 2003b). She further argues that the present literature on cross-cultural communication in health and social care focuses on the technical aspects of communication and hence takes attention away from the difficulty of dealing with the emotional pain of the client:

> I would argue that technical preoccupations with meaning in cross-cultural encounters can serve as a defence against the anxiety of witnessing and holding emotional pain in health care interactions.
>
> Gunaratnam, 2003b, p. 1 19

Perhaps you noticed that in this quotation Gunaratnam uses psychodynamic language. Psychodynamic writers on issues of 'race' and racism, such as Rustin (2000), argue that it is important to acknowledge the emotional component of cross-cultural encounters, and the ways in which racism can build on unconscious defences and anxieties.

3.12 Services for inter-ethnic communications

Another way in which services have attempted to respond to issues of inter-ethnic communication is the provision of services for people whose first language is not

English. You may remember this appeared to be the key 'problem' in the case study which launched the discussion of 'difference' in Section 1. As noted there, poor communication in health services can have serious consequences, leading to misdiagnosis, ineffective interventions and, in extreme circumstances, preventable deaths. Where appropriate interpreting and translating services do not exist, children are often put in the position of translators. At the Royal College of Nursing Congress in 2002, the RCN Health Visitors Forum urged the government to invest in skilled interpreters within the National Health Service (RCN, 2002).

It is not just people whose first language is not English who may want to use interpreters or link workers. Other people may experience difficulty when trying to access health and social care because of language difficulties. Health and social care providers may adopt a particularly 'professional' way of speaking which uses elaborate codes, which individuals who use different ways of speaking may find difficult to understand. This may be off-putting not just to users from black and ethnic minority communities but also to people from other backgrounds, for example people who speak with a range of regional and national dialects, people with learning disabilities and those with mental health problems.

However, for people who do not understand or speak English there is a particular need. The next activity explores some of the issues about using interpreters in care services.

Royal College of Nursing motion

'This meeting of the RCN Congress urges the Government to invest in skilled interpreters within the National Health Service'.

Sandra Rote, RCN Health Visitors Forum, introduced the resolution by noting that the importance of communication was now recognised on pre-registration courses.

She asked how nurses are supposed to deliver care if they cannot talk to patients? She deplored the use of family and friends as interpreters. She mentioned cases where asylum seekers were unable to describe their health needs to nurses and said that many clients did not want to disclose health issues to a friend or family member who could translate.

She praised the work of Language Line but said that interpretation also meant understanding body language and inferences. She said that it was not just a question of more staff but called for interpreters to be on permanent contracts and have access to training. She also said that staff should be trained to work with interpreters.

The first speaker was a school nurse who knew of cases where children were used as interpreters and said this was a major concern for school nurses. She also said that communication meant understanding languages and culture and the real meaning of words.

The next speaker mentioned that translation services were a target in the NHS plan and called upon them to be available for all patients.

A nurse from London said she was privileged to work in an area of great cultural diversity and couldn't practise without good translation services and remain within the code of conduct. She described the situation of using a relative to break bad news to a patient as being unbearable and said an interpreting service was a basic human right.

The next speaker said that interpreting services should include prison service health centres. She was followed by a speaker who said that communication and informed choice were basic human rights and called for sign language to be included too.

A freelance interpreter recalled a case where she was called to translate during a woman's third appointment with a consultant. When she informed the consultant that the woman was in pain she discovered there was no mention of pain in the notes. The woman, whose husband usually translated said 'I know he had never mentioned my pain. He thinks it is all in my head.'

The next speaker said that interpretation services were essential to delivering the Congress theme of putting care first and said it was important that interpreters were trained in terminologies.

Another speaker described a personal experience of health visiting a family who she later discovered were living in extreme poverty.

The last speaker said that the profession needed to be sensitive and culturally aware. She said some of Milburn's millions should be used to train interpreters.

In summing up, Sandra Rote said the provision of such services was a basic human rights issue.

Background information

The UK is now an established multi-cultural community. Health care providers need to be able to communicate with people from all backgrounds and ethnic groups so as to ensure the best possible care is provided.

Unfortunately, in some instances, language barriers have compromised care outcomes. Nurses and others find it hard to assess people's needs in the absence of interpreters. The NHS does not have a national standard for the provision of interpreter services. On many occasions relatives and friends of patients have to be relied upon to act as translators, a situation which guarantees neither accuracy nor confidentiality. The situation has been compounded over recent years by the increase in number of asylum seekers and refugees. These people have often fled their own countries and may have been subject to a high degree of stress, abuse, and even torture. To communicate with these people, even if they did have a good command of English, would be difficult let alone when a translator may be required.

Some areas of the NHS have invested in high quality translation services, for example 'Language Line'. Language Line provides a telephone-based interpretation service and can assist with translation of text to speech and English text to other languages. The service is able to provide help with over 100 languages, yet it is not a face-to-face service. The NHS plan (England) sets a target of free translation services to be nationally available from all NHS premises via NHS Direct by 2003.

In a few areas of Scotland a number of agencies have come together to provide interpretation and translation services across all public sectors, e.g. health, police, local authorities etc. The Scottish Executive recently published the report *Fair for All: NHS Scotland and People from Ethnic Backgrounds* (2001). Information provision, access to services, including interpreters, will be progressed by NHSS Boards and a new Ethnic Minority Resource Centre.

A number of Health Boards in Northern Ireland are working with The Equality Commission to publish information booklets in a number of languages and to supply interpreters.

(Source: RCN, 2002)

3.13 Employing interpreters and link workers in health and social care

Activity 11

0 hours 20 minutes

Read the report on the previous screen of the RCN Health Visitors Forum in 2002 and, as you do so, list the key reasons Sandra Rote gives for employing interpreters.

View discussion - Activity 11

Having access to an interpreter can be seen as a basic human right

Issues surrounding language and ethnicity are complex and contested. At the time of writing, there are suggestions that competence in English should be a requirement of British citizenship, while other people suggest that the diversity of languages in the UK should be a cause for celebration. Clearly, there are implications for service provision. If new migrants are required to learn English, there may be less emphasis on providing translators and interpreters. There is a danger of overlooking the difficulties involved in learning a new language. For many women from South Asia and from parts of Africa such as Somalia, the inhibiting factors may be that English language classes are often held in the evening, when caring responsibilities in the home and the fear of racial attacks or abuse on the streets may prevent them from attending.

The provision of interpreter services in the context of health and social care is patchy across the UK, but there are many examples of good practice: for instance, the Sandwell Integrated Language and Communication Service (SILCS) in the West Midlands of England (Box 2).

Box 2 SILCS

No agency can provide a fair or effective service to people with whom it cannot communicate.

The effects of non-communication can lead to the build-up of frustration, anger, misunderstanding, time wasting, inappropriate intervention, withholding entitlements, misdiagnosis or even miscarriages of justice.

(Source: Sandwell, accessed 10 October 2006)

Here a range of local health organisations – health authorities, NHS Direct, primary care groups, local authorities and voluntary agencies – worked together to provide a pooled resource for spoken, written and telephone translation and interpreting as well as sign language interpreters. The initiative provides appropriate training for interpreters and translators. It is also important to provide training for staff on using interpreters, as the three-way dialogue can be extremely confusing. Furthermore, there may be different norms and traditions in language which mean that when an interpreter is asked to translate what appears to be a simple question, a much longer dialogue is needed before the question itself is asked. Interpreting is extremely complex in that interpreters must ensure that the patient or client easily understands the language they use. Again other factors, such as class, region, religion and geography, may impinge on the process of interpreting and communication – such that just speaking the same language may not necessarily mean the same understanding will follow. Sometimes people are reluctant to use interpreters who are from the same geographical locality or community for fear that personal information will not be kept confidential. This is less likely to happen where trained interpreters are used but, in some situations, anyone who is perceived to speak the required language may be asked to interpret and these processes are far more likely to remove confidentiality.

More recently *link workers*, rather than just interpreters, have been employed by health and social care organisations. Link workers are perceived to have a broader role, which includes advocacy. However, it can be very difficult for link workers to be true advocates because of their position within the organisation. Link workers are often employed on fairly low salaries and sometimes on short-term contracts from specific funding for black and ethnic minority communities. This may mean they are unable to complain on behalf of a patient or client or to challenge or demand the delivery of appropriate services on their behalf.

More health and social care organisations are recognising the need to provide written information in a range of languages. Translating information from English to other languages can present a range of problems as a literal translation may have little meaning once translated into Urdu or Punjabi, for example. This is also true of translation to Braille. Some agencies have resisted translating written materials because of a perception that individuals from different parts of South Asia may not be literate in their first language. Several research projects have demonstrated that, while literacy varies depending on the average age of the community, the area from which they migrated, class and gender, large percentages of people from South Asian communities can read translated materials (Robinson, 2002). It is important for such translations to be in a dialect that is easy to understand. Literal translations from English run the risk of being culturally inappropriate; therefore, provision must be made to ensure that translations meet the information needs of black and ethnic minority communities and are culturally relevant. Guidelines on producing written information for black and ethnic minority communities (HEA, 1997) suggest that written materials should be based on research that identifies the information needs of particular language groups first, and then specific communities should be involved in producing the material and checking that it is culturally appropriate.

The use of translated signs and information in health and social care buildings not only provides people from black and ethnic minority communities with valuable information for finding their way around – which can be daunting – but also can be welcoming and reassuring.

The examples of 'ethnic matching' and the provision of translators and interpreters demonstrate that responding to a diversity of communication needs is not straightforward. Providing an appropriate response needs careful thought if services are not to end up reinforcing rigid notions of ethnic difference.

Key points

1. One approach to issues of ethnicity and communication emphasises the diversity of communication styles and needs in the population, and the necessity to take account of them.
2. 'Ethnic matching' is one response to diverse communication needs, but it has been criticised for overlooking diversity within ethnic groups.
3. There is a need to employ trained interpreters and translators for people whose first language is not English.

3.14 Challenging racism

Section 2.3 explored strategies for 'working with difference' in care services, based on an approach that acknowledges diversity in communication needs. You saw that there are dangers in strategies that adopt too rigid a notion of ethnicity, such as the danger of homogenising diverse groups of people. There is also a danger that such strategies might result in a reinforcement of discriminatory practice.

Although the approach to inter-ethnic or cross-cultural communication described by Lena Robinson acknowledges the role played by racism in black people's experience, it suggests challenging racism indirectly, by providing appropriate services that meet the diverse cultural needs of the population. Other approaches have argued for a more direct challenge to the structures and practices of racism. In social work, in particular, there has been an attempt to develop 'anti-oppressive' and anti-discriminatory practice, which aims to address class, gender, 'race', ethnicity, sexual orientation, disability and age, and to develop an understanding of the interconnections between different oppressions. In social work, anti-oppressive practice was developed in the 1990s, building on feminist, anti-racist and radical social practice. Dominelli (2002, p. 4) argues that 'anti-oppressive practice, with its value commitment to the realisation of social justice, is one variant of a range of emancipatory approaches to social work.'

The next activity is a useful introduction to some of the key principles of anti-oppressive practice.

3.15 Exploring anti-oppressive practice

Click to read: Anti-Oppressive Practice

Activity 12

0 hours 45 minutes

Read the extract ‘Anti-oppressive practice’, by Beverley Burke and Philomena Harrison and make notes on the key elements of anti-oppressive practice. How might you apply these ideas to your own experience or practice?

View discussion - Activity 12

One of the driving forces of anti-oppressive practice is being able to challenge inequality and recognise that challenges are not always successful and may be very painful both for the person or group being challenged and for those who are challenging. One important aspect of challenging inequality is being self-aware and understanding how your own social location affects the communication between yourself and the individual or group you may be challenging. The process of thinking and reflecting is a core part of working in an anti-oppressive way.

Burke and Harrison offer the following set of challenges for people wanting to work in an anti-oppressive way which:

- is flexible without losing focus
- includes the views of oppressed individuals and groups
- is theoretically informed
- challenges and changes existing ideas and practices
- analyses the oppressive nature of organisational culture and its impact on practice
- includes continuous reflection and evaluation of practice
- has multidimensional change strategies, which incorporate the concepts of networking, user involvement, partnership and participation
- has a critical analysis of the issues of power both personal and structural.

Describing the fragmented and highly contentious notion of anti-oppressive practice, Lena Dominelli argues that:

> Challenging inequality and transforming social relations is an integral part of anti-oppressive practice. Knowing oneself better equips an individual for undertaking this task. Self-knowledge is a central component of the repertoire of skills held by a reflective practitioner … Moreover, reflexivity and social change form the bedrock upon which anti-oppressive practitioners build their interventions.
>
> Dominelli, 2002, p. 9

If Lena Robinson's approach draws on a psychological perspective, anti-oppressive practice clearly derives from a more critical, social model of ‘difference’. Anti-oppressive practice builds on a social constructionist model of ‘racial’ and ethnic differences, as well as differences of other kinds, as produced within a context of unequal power relationships in society. Rather than having a sensitivity to apparent ethnic or cultural ‘differences’, anti-oppressive practice argues that what is needed urgently is practice that challenges and changes structures of inequality at every level.

In terms of ethnicity, this means starting from an acknowledgement that racism is endemic in organisational structures in health and social care services, as in society more generally. The MacPherson Report, produced in the aftermath of the murder of Stephen Lawrence, offers the following definition of institutional racism:

> The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.
>
> MacPherson Report, 1999, para. 6.34

Institutional racism has been a factor in the experience of black staff in health and social care services. Building on what Burke and Harrison say about the intersection of different kinds of oppression, it is worth noting that black women in particular have experienced discrimination, particularly within the National Health Service. The NHS, like many other organisations, reflects a history of discrimination in its employment practice. Research into the experiences of black women health workers has identified many areas of discrimination (Baxter, 1997; Doyal et al., 1980). Early studies showed clearly that black women from the Caribbean who migrated to England in the 1950s and 1960s were channelled into ancillary and auxiliary jobs within the NHS. Even when they attempted nurse training many were offered training opportunities within the less senior State-Enrolled Nurse (SEN) programmes. This reduced career opportunities severely and limited the career development of many black nurses up until the present time. Indeed, changes in nurse training and promotion policies in the 1990s have weakened the position of SENs still further (Beishon et al., 1995).

Black nurses were also channelled into the least prestigious areas of work – in particular, psychiatric and geriatric nursing. Baxter (1977) argued black nurses were an endangered species, with discrimination operating in schools and colleges. This coupled with the knowledge of discrimination and lack of promotion prospects has meant fewer and fewer black women are choosing to do nurse training. A report in the mid-1990s from the Policy Studies Institute (Beishon et al., 1995) highlighted the fact that ethnic minority nursing staff often suspected racial discrimination by their managers, that they identified racism within working relationships and often experienced blatant racial harassment from patients.

At the time of writing, there are very few black women senior managers in the NHS. A survey of non-executives of health authority and trust boards reported that only 45 out of 1531 non-executive members of regional health authorities, NHS trusts and special health authorities in March 1993 were from black and ethnic minority communities (3%) (National Association of Health Authorities and Trusts and the King's Fund Centre, 1993). Similarly, only 4 out of 534 chairs of health authorities and trusts were from black and minority ethnic communities and only one of those was female. This demonstrates the difficulty black and ethnic minority women have with both race and gender discrimination.

The staff shortages within the NHS at the time of writing have led to a recruitment drive somewhat reminiscent of the 1950s and 1960s, when people were recruited directly from the Caribbean to staff a newly developed NHS. At that point processes and policies were not developed to ensure Caribbean nurses and auxiliary staff were not discriminated against. Many agencies have employed Filipino and South African nursing staff on limited contracts.

An anti-oppressive approach to ethnic diversity and difference would begin by acknowledging the impact of racism on the experience of both staff and service users. The next step would be to challenge existing structures and practices, for example in relation to employment, training and promotion within services, to ensure they did not discriminate against people from particular backgrounds. In terms of work with service users, an anti-oppressive approach would challenge the ways in which current practices disadvantage, either directly or indirectly, patients or clients from different ethnic groups. This approach would not ignore ‘differences’ in terms of needs but, rather, would see such differences as the result, at least in part, of existing racist and discriminatory practices.

Key point

Anti-oppressive and anti-discriminatory practice emphasise the impact of racism and the need to challenge racist structures and practices in health and social care organisations.

4. Gender

4.1 Thinking about gender

So far in this course you have considered some general issues concerning difference, diversity and communication in care services, and how these issues relate specifically to ‘race’ and ethnicity. In this section we move on to another area that has been the focus of debate and of initiatives in policy and practice. As with ethnicity, the roots of much current thinking about gender in health and social care are the campaigns of activists in the 1970s and 1980s. However, it is also important to repeat the point that, although (as Burke and Harrison argued) there are commonalities between ‘differences’ and between intersecting processes of differentiation and discrimination, there are factors that are specific, for example, to gender.

Perhaps the most distinctive feature in discussions of gender issues, compared with debates about ‘race’, is the greater emphasis on the biological roots of gendered behaviour. Whereas biological arguments about ‘racial’ difference are now largely discredited, theories of gender that appeal to innate, biological differences between women and men are still respectable, and indeed are enjoying a revival at the time of writing. A second distinctive feature is that gender is widely acknowledged to affect everyone and to be a structuring factor in everyday experience. In the case of ethnicity, you saw that those in the ‘majority’ – in the case of the UK, white people – can disown their own ethnicity and use the word ‘ethnic’ only for people who are constructed as ‘others’ or ‘minorities’. Although in some circumstances masculinity is represented as the norm, there is perhaps a greater acceptance that gender affects the experience of both men and women.

In what sense is gender an issue in interpersonal communication in health and social care? In the first activity in this section you will think about the ways in which gender is talked about in the care setting you are most familiar with.

4.2 Talking about gender

Activity 13

0 hours 20 minutes

Think about the health or social care service you know best, as either a worker, carer or service user. Think of times in the recent past when gender came up as a topic or a factor, in talk or in writing. Your example might be drawn from casual conversation with other service users or colleagues, or from more formal discussion in meetings, or from written reports, guidelines or policies.

View discussion - Activity 13

From the examples above, gender appears to be a factor in two distinct, although linked, ways. One set of issues revolves around gender and *power*, which means the ways in which inequalities of power between men and women are evident, and either reinforced or challenged, in everyday interactions. The example of the male manager who did not allow space in a meeting for women's voices shows one way in which gendered power can be a factor in communication. However, the course tester who gave this example also referred to the 'male' way she thought the manager handled the meeting, which introduces a second set of issues. In this example, and in the others given by our testers, there was evidence of gendered *differences* being discussed as a key factor in interactions and relationships. For example, in the experience of the family centre worker, there was an assumption that men might be more reluctant to share their feelings in a group than women. The examples of the male midwife and the man who wanted a male key worker both suggest that male and female service users, and male and female staff, might have different styles of communicating, and different communication needs. This recalls the discussion in Section 2 of claims that different ethnic groups have distinctive communication behaviour and needs.

Earlier you were presented with competing perspectives on 'difference'. Before moving on to explore in more detail the ways in which issues of gender, power and difference operate in everyday interactions, it is worth pausing to reflect on the nature and origin of gender differences. What is the nature of gender, and what are its roots or origins? At this point, we should make clear the distinction between 'sex' and 'gender'. Whereas 'sex' refers to basic biological and physiological differences between people designated as male and female, 'gender' refers to the meanings, associations and identities that are connected with these basic sexual differences.

The next activity involves thinking about your own gender identity and what it means to you.

4.3 Reflecting on gender and identity

Activity 14

0 hours 20 minutes

First, look back at what you wrote (if anything) under 'gender' in your response to Activity 3.

How did you define your gender? What kinds of words did you use?

When you think about your gender identity, what sort of things come to mind, for example in terms of qualities and attributes, skills and abilities, interests and activities?

Does your list include anything that refers to the ways in which you communicate with or relate to other people – and, if so, what?

As with ethnicity, identifying ourselves in gender terms is a dynamic and negotiated process, in which we actively associate ourselves with a particular category but within a context of definitions provided by the wider society. But where does gender come from? Is it innate and unchanging, or is it influenced to some extent by social and cultural contexts?

The debate about the roots of gender 'differences' mirrors those concerning ethnicity. As with ethnicity, views that could be characterised as 'essentialist' propose that gender is something we are born with and is 'hard-wired' into our genes. According to this view, each one of us is born with a fixed and distinctive male or female identity, and this shapes our behaviour in direct and significant ways throughout our lives. Some versions of this argument rely less on genetic conditioning and more on the influence of psychological conditioning early in life. However, there tends to be an assumption that this process of socialising boys and girls is universal and inescapable.

By contrast, a social constructionist perspective maintains that gender is not so much something we 'are' as something we 'do' and 'become'. Although accepting that there are some basic differences between male and female human beings, this approach argues that they have very little influence on the ways people behave. Instead, social constructionists argue that gender differences *emerge* in the context of social interactions, and in specific social, cultural and historical contexts. People 'do' or 'perform' gender in different ways, depending on the social context. Moreover, people live out their gendered identities in different ways according to the society, culture and historical period in which they are living. The attributes, skills and activities that are associated with being a man or a woman depend largely on the ways in which gender is constructed within a particular society.

For example, one of the most persistent and powerful ideas about gender difference in western societies, until very recently, was that caring is a woman's 'natural' role, that men are less capable in this area and, indeed, that caring (especially for young children) is somehow 'unmanly'. However, evidence from other societies and historical periods suggests this need not be the case. For example, in traditional Himalayan societies such as that in Ladakh, both boys and girls are brought up to have a role in the care of young children. According to writer Helena Norberg-Hodge:

> Taking responsibility for other children as you yourself grow up must have a profound effect on your development. For boys in particular, it is important since it brings out their ability for caring and nurturing. In traditional Ladakh, masculine identity is not threatened by such qualities; on the contrary, it actually embraces them.
>
> Norberg-Hodge, 2000, p. 66

Because of this cultural variation in ideas of gender, it is common for social constructionist accounts to refer to 'masculinities', for example, to emphasise the idea

that gender identities are plural and constructed in social contexts, rather than being a singular, fixed essence ('masculinity') residing within the individual (see Connell, 1995). However, social constructionists, drawing on the work of Foucault, would go further than this and argue that our habit of categorising the world in a 'gendered' way is itself a social construction. Once again, the argument runs, you tend to find what you are looking for. If you see the world through the lens of gender differences, such differences will tend to be 'found' (McNay, 1992).

As with ethnicity, social constructionist arguments have been used, in this instance by feminists, to challenge inequality. According to many feminist writers, ideas about essential differences between men and women have been used to legitimate inequalities based on gender. In the same way that the development of racism as an ideology had an intimate link with the rise of the slave trade and the expansion of empire (Fryer, 1984), so it can be argued that an ideology of fixed gender differences serves to reproduce gendered inequality and oppression (Abbott, 2000).

How relevant are competing ideas about gender and identity to your experience? The next activity is a chance to reflect on your own sense of the roots of your gender identity.

4.4 Where does gender come from?

Activity 15

0 hours 20 minutes

In Activity 14 you described your gender identity. But where does this identity come from? Think for a few minutes about your sense of yourself as a man or a woman, and reflect on the following.

- To what extent is your gender identity something you were born with, and to what extent has it developed overtime? (Think about the qualities, attributes, abilities and interests that you associate with your gender.)
- If you believe your gender identity has developed overtime to some extent, can you think of any factors that have contributed to its development?

View discussion - Activity 15

Viewing gender as something dynamic, rather than fixed or 'given', has important consequences for any discussion of the role of gender in interactions in care settings. Rather than seeing gender as something people bring to their encounters with each other, we shall focus instead on the ways in which relationships of gender are produced or constructed *in the course of* encounters and relationships. We shall see interactions in care settings as one of the many sites in society where gender is 'made', where it emerges or comes into being. This means a different way of

analysing encounters, looking for the ways in which gender and gendered relationships are produced and reproduced, as well as possibly challenged or undermined. The following analysis concerns the reproduction, firstly, of relationships of *power* in health and social care, and then relationships of *difference*.

Key points

1. Gender is an important factor in the way people think and talk about interpersonal communication in health and social care services. Discussions tend to focus around linked issues of power and difference.
2. Essentialist views of gender see it as something innate within individuals and conditioned by either biology or upbringing.
3. A social constructionist perspective proposes that gender is produced in specific social contexts and is as much something people 'do' as something they 'are'.
4. In a social constructionist view, everyday interactions are one of the sites where gender relationships are produced and reproduced.

4.5 Gender and power

Feminist writers have documented the ways in which inequalities based on gender are reflected and reproduced in health and social care services. Although the majority of workers in care services are women, men are over-represented in management and in positions of authority, and male-dominated professions, such as medicine, tend to exert more power than those, such as nursing, in which women are the majority. For example, whereas women make up 75% of the workforce in the NHS (Doyal, 1999), the bulk of decision-making power resides with the medical profession and senior management where women are vastly under-represented. Women tend to fill most of the lower-paid and lower-status roles in care services and women are the majority of unpaid carers.

What are the implications of these structural inequalities in terms of interpersonal communication? The under-representation of women in management, and in high-status professional groups, can mean women are routinely excluded from discussions in which decisions are made and policies formulated. However, even where women *are* represented, gendered power may operate in less direct and obvious ways. You may recall the course tester in Activity 13 who mentioned the male manager who excluded women's voices from discussions in meetings. Even where women are well represented in a meeting or workplace, they may think their voices carry less weight or influence than the men's. Men may use their organisational power, either consciously or unwittingly, to silence or bypass women's voices. At an organisational level, certain kinds of discourse – ways of thinking and talking about issues – may be privileged over others. Female staff may have a sense that certain kinds of 'masculine' discourse have greater power and influence in the organisation than ways of talking and thinking that are perceived to be more 'feminine'. This is a difficult subject to broach without making sweeping (and essentialist) generalisations about

men's and women's styles of communication. Later in this section we shall address the question of whether men and women actually do tend to communicate in different ways, and how to account for these apparent differences.

The next activity gives you the opportunity to reflect on the ways in which gendered power operates in a workplace familiar to you.

4.6 Gender and power in the workplace

Activity 16

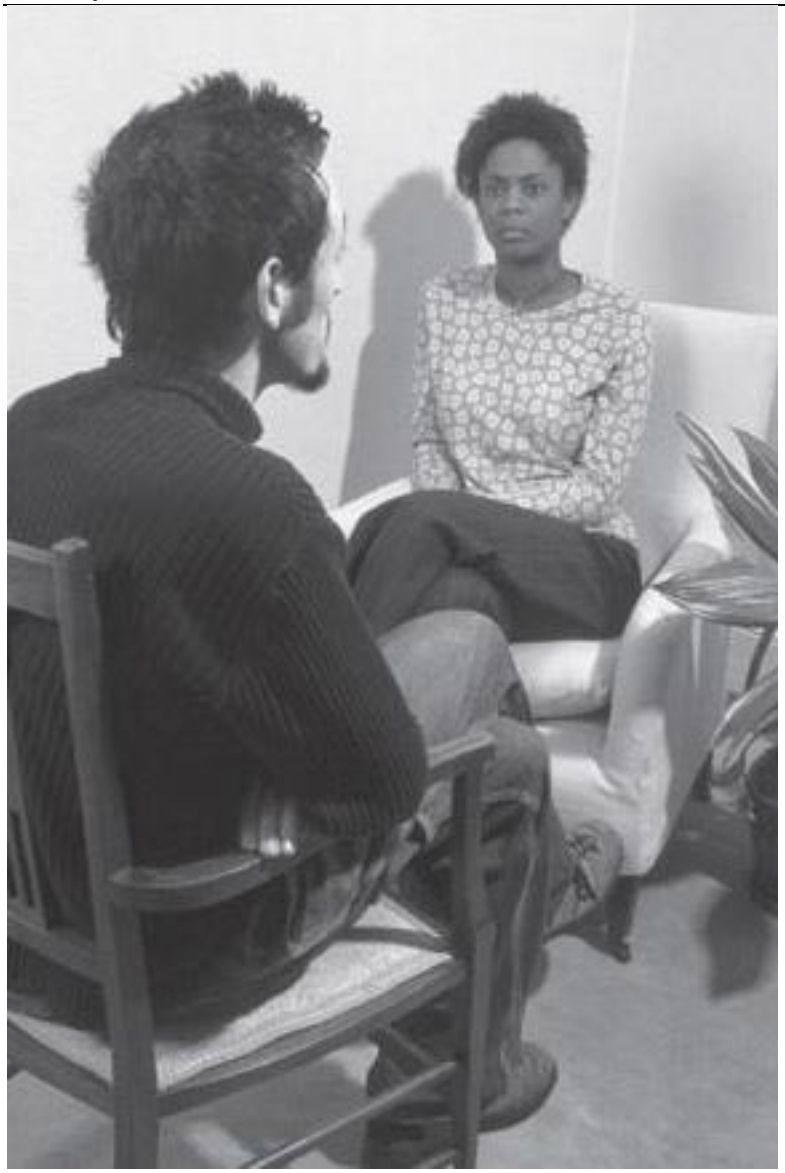
0 hours 20 minutes

If you are, or have been, employed in a health and social care service, think about the ways in which gendered power 'works' in that setting. If you are a service user, you might consider a care service that you know well, or you might prefer to reflect on your experience of working in a different kind of organisation.

Can you think of ways in which the structures and practices of the organisation reflect and reproduce inequalities of power between men and women?

View discussion - Activity 16

Issues of gender and power also shape encounters between staff and service users in care settings, especially where those taking part are different genders. In the next activity you will reflect on the issues that may arise from this.



Encounters between men and women in care settings may reflect and reproduce differences of power based on gender

4.7 Gender and power in helping relationships

Activity 17

0 hours 30 minutes

Think about the following two scenarios.

1. A female worker (e.g. social worker, nurse, residential worker) helping a male service user.
2. A male worker helping a female service user.

For each scenario, think about how gendered power might be a factor in the encounter. If it helps, make the encounters specific to the service setting you know best.

View discussion - Activity 17

Key points

1. Despite most workers in care services being women, there are inequalities based on gender both in organisational structures and processes, and in interactions and relationships with service users in health and social care.
2. Gendered power can manifest itself both directly and indirectly.
3. Gendered power operates interdependently with other kinds of power, such as professional or organisational power.

4.8 Gender and difference

The discussion above referred to some of the stereotypes about the ways in which men and women supposedly communicate and interact with each other. For example, there is a view that in meetings men tend to talk in a supposedly rational way, while women's talk is associated more with feelings and emotions. It was also suggested that male workers are more likely to be intimidating or overwhelming in their relationships with service users and, by implication, that female workers might be less intimidating and more facilitative, for example.

The second main way in which gender is present as a factor in interpersonal relationships in health and social care is as *difference*. Sometimes this takes the form of an evaluative judgement, in which women are seen to be 'better' at interpersonal relationships than men. It is a short step from this to say that women are 'natural' communicators and 'good with people', whereas men are poor at talking about emotions, combative and competitive in conversation, and so on. Since a certain kind of facilitative communication is seen to be at the heart of, and essential to, 'people work', this notion plays into a discourse in which women are classed as 'natural' carers, better suited by either biological make-up or conditioning to working with people. The corollary of this, of course, is that men are not natural carers, and therefore should not be encouraged into such roles.

The feminist critique of social work has argued that gender differences in the use of services has further reinforced gender and power inequality. Women have often been seen as natural carers, which means they frequently take on the physical and emotional burden of caring. Sometimes professionals assume that the women in families will be responsible for caring for children or older relatives. As noted earlier, women outnumber men in many branches of care work. The reasons for this are complex, and not easily reducible to one factor. However, it is important to acknowledge the power of the 'natural carer' discourse in explanations of women's over-representation. For this discourse, the presence of women in such large numbers

in nursing, social work, etc. can be explained simply by reference to their ‘natural’ (biologically or psychologically determined) capacity to care for and relate to other people.

4.9 The revival of gender essentialism

After falling out of fashion in the wake of feminist influence in the 1970s and 1980s, there are signs that the notion of ‘essential’ gender differences is undergoing a revival. At an academic level, this has been stimulated by work within genetics, evolutionary psychology and neurology (see Baron-Cohen, 2003). At a more popular level, self-help manuals which apparently ‘explain’ the differences between men's and women's behaviours, and offer advice on coping with them, have become huge bestsellers. Some of these self-help books specifically address ‘differences’ in communication styles. There is a prominent example on the cover of Deborah Tannen's book '*You Just Don't Understand: Women and Men in Conversation*' (1991), which describes it as ‘the classic that shows us why we find it so difficult to talk to the opposite sex.’ Tannen's objective is to demonstrate that men and women have ‘different *but equally valid* styles’ of communication (Tannen, 1991, p. 15). Although she claims to be aware of the dangers of generalising about gender and behaviour, she states: ‘There *are* gender differences in ways of speaking, and we need to identify and understand them’ (p. 17). Having given an example of miscommunication involving her husband and herself, Tannen draws this conclusion:

> Having done the research that led to this book, I now see that my husband was simply engaging the world in a way that many men do: as an individual in a hierarchical social order in which he was either one-up or one-down. In this world, conversations are negotiations in which people try to achieve and maintain the upper hand if they can, and protect themselves from others’ attempts to put them down and push them around. Life, then, is a contest, a struggle to preserve independence and avoid failure.
>
> I, on the other hand, was approaching the world as many women do: as an individual in a network of connections. In this world, conversations are negotiations for closeness in which people try to seek and give confirmation and support, and to reach consensus. They try to protect themselves from others’ attempts to push them away. Life, then, is a community, a struggle to preserve intimacy and avoid isolation. Though there are hierarchies in this world too, they are hierarchies more of friendship than of power and accomplishment.
>
> Women are also concerned with achieving status and avoiding failure, but these are not the goals they are focused on all the time, and they tend to pursue them in the guise of connection. And men are also concerned with achieving involvement and avoiding isolation, but they are not focused on these goals, and they tend to pursue them in the guise of opposition.
>
> Tannen, 1991, pp. 24–25

In other words, according to Tannen, men and women seek very different things when they communicate, and operate according to different rules. John Gray's enormously popular 'Venus and Mars' books have further popularised this kind of thinking. Like Tannen, Gray argues that understanding gender differences in communication can help to improve relationships between men and women. He claims:

> Not only do men and women communicate differently but they think, feel, perceive, react, respond, love, need, and appreciate differently. They almost seem to be from different planets, speaking different languages and needing different nourishment.
>
> Gray, 1993, p. 6

Gray goes on to claim that 'A man's sense of self is defined through his ability to achieve results' (p. 20), while 'A woman's sense of self is defined through her feelings and the quality of her relationships' (p. 23). Of course, it follows from this that women are better at communication and personal relationships. Gray says that for women:

> Relationships are more important than work and technology … Personal expression, especially of their feelings, is very important… Communication is of primary importance. To share their personal feelings is much more important than achieving goals and success. Talking and relating to one another is a source of tremendous fulfilment.
>
> Gray, 1993, p. 23

What was your reaction to this brief summary of Tannen's and Gray's ideas on communication and gender? Did you nod in agreement, or did you want to take issue with their claims? The next two linked activities give you the opportunity to respond to these ideas.

4.10 Men and women communicating differently?

Activity 18

0 hours 20 minutes

Reread the summary and quotations from Tannen's and Gray's work on the previous screen, and then make notes in answer to the following questions.

- Can you think of examples from your experience that support these claims about gender differences in communication?
- Can you think of examples from your experience that undermine such claims?

View discussion - Activity 18

This course has offered a social constructionist critique of generalised accounts of difference, whether based on ethnicity, gender or some other factor. How might a social constructionist respond to the kinds of generalised claims made by writers such as Tannen and Gray? The next activity gives you an opportunity to critique 'essentialist' notions of gender difference for yourself.

4.11 Critiquing gender essentialism

Activity 19

0 hours 30 minutes

Look again at what Tannen and Gray say about men's and women's communicative behaviour. Then review the description of essentialism and the social constructionist critique of it in Section 1.2. What criticisms might be made of Tannen's and Gray's claims?

View discussion - Activity 19

Because of their popularity at a 'common-sense' level and their renewed academic respectability, ideas about fixed gender differences should not be dismissed lightly. They have important implications for the ways in which people think about and practise interpersonal communication in health and social care.

4.12 The implications of gender differences in communication

Activity 20

0 hours 20 minutes

If it were true that men and women tend to communicate in very different ways, what might be the implications for health and social care in terms of:

- The allocation of staff?
- Staff training and development?
- Working with male and female service users?

View discussion - Activity 20

As you worked on this activity and read the comment, you may have wanted to take issue with the social constructionist critique that was developed here. Perhaps, while accepting that writers such as Tannen and Gray simplify matters in order to sell books, you wanted to hold on to the idea that there are, after all, some evident differences in the ways that most (if not all) men and women communicate and relate.

Your own experience, perhaps of working in a team or providing services for male and female service users, may have left you with a sense that differences remain and need to be addressed.

Is it possible to accept that some gendered differences *do* exist, without buying into the kind of stereotypical gender-essentialist approach explored here? Some feminist writers have argued that there are, indeed, identifiable differences in the ways men and women tend to interact. Carol Gilligan, for example, argues that a male-dominated society has acted to suppress and devalue women's 'difference' from the male norm. She identifies two 'voices' or gender-related ways of communicating and relating: 'one voice speaks of connection, care and response, while the other speaks of equality, reciprocity, justice and rights', the former being characteristically feminine and the latter masculine (Gilligan, 1988, p. 8). She sees men and women as having different moral orientations, women's outlook implying 'a sense of self and other as interdependent and for relationships as networks created and sustained by attention and response' (p. 8).

4.13 Gender and parenting

Other feminist writers have used psychodynamic ideas to support their argument that gender differences, while 'real', are not inevitable but the result of the ways in which children are socialised in contemporary western societies. Nancy Chodorow, for example, claims that the isolated nuclear family in contemporary capitalist society is responsible for creating 'specific personality characteristics in men':

> For children of both genders, mothers represent regression and lack of autonomy. A boy associates these issues with his gender identification as well. Dependence on his mother, attachment to her, and identification with her represent that which is not masculine; a boy must reject dependence and deny attachment and identification. Masculine gender role training becomes much more rigid than feminine. A boy represses those qualities he takes to be feminine inside himself, and rejects and devalues women and whatever he considers to be feminine in the social world.
>
> Chodorow, 1978, p. 181

Chodorow argues that the experience of being parented by a woman makes women more likely to seek to be mothers, while the same experience leads to men experiencing themselves as separate from others: 'Men … do not define themselves in relationships and have come to suppress relational capacities and suppress relational needs. This prepares them to participate in the affect-denying world of alienated work' (p. 207). These ideas may sound close to those propounded by Tannen and Gray, the key difference being that Chodorow locates their cause in the way society is currently organised and children are brought up, rather than in some kind of essential and universal masculinity or femininity.

Jessica Benjamin is another feminist and psychoanalyst who argues that gender differences are the result of 'current gender arrangements' and that it is possible to imagine the situation being otherwise. She cites psychodynamic writers who describe boys as losing the sense of a 'vital source of goodness inside' when they separate from their mothers, and thus needing to substitute the conquest of 'outer' space for access to inner space (Benjamin, 1998, p. 163). She claims:

> The denial of identification with the mother …tends to cut the boy off from the intersubjective communication that was part of the primary bond between mother and infant. Emotional attunement, sharing states of mind, empathically assuming the other's position, and imaginatively perceiving the other's needs and feelings -these are now associated with cast-off femininity. Emotional attunement is now experienced as dangerously close to losing oneself in the other; affective imitation is now used negatively to tease and provoke. Thus the intersubjective dimension is increasingly reduced, and the need for mutual recognition must be satisfied with mere identification of likeness … The devaluation of the need for the other becomes a touchstone of adult masculinity.
>
> Benjamin, 1998, pp. 170, 171

Benjamin also suggests that 'the changing social relations of gender have given us a glimpse of another world, of a space in which each sex can play the other and so accept difference by making it familiar' (p. 169).

Social constructionists would agree with these feminist writers that it is possible to imagine the disappearance of gender differences, in the context of changed gender relationships in society. Gender relationships in the family and in society at large are changing and there is often a greater emphasis on equality in both the home and the workplace, even if the reality has yet to catch up with the rhetoric in some instances. Earlier in this course you were introduced to the social constructionist idea that people construct their everyday experience in the context of powerful 'discourses', or ways of thinking and talking about particular issues. For example, discourses concerning gender and caring have altered considerably in the past 30 years or so. The entry of women into the paid workforce in large numbers has contributed to a reassessment of men's roles within the family, and to a greater emphasis on men's involvement in the care of young children. Government and the media have helped to shape a new discourse in which men's practical and emotional involvement in child care is now seen as 'a good thing'.

This involves an important change in ideas about *masculinity*. In British society masculinity was once associated with being a breadwinner, with patriarchal authority and with keeping a certain distance from child rearing. Now increasingly being a (real) man is seen to involve taking some responsibility for activities, such as child care and household chores, that would have been deemed 'unmanly' in the past. This is powerful evidence for the social constructionist argument that gender identities – in this case masculinity – are fluid, dynamic and shaped by social and cultural context.

In this changing context, men are beginning to reshape their sense of themselves as men.

The final activity in this section draws on research into fathers' identities as an example of the ways in which men's gender identities are changing, and how this process reflects wider social discourses.

4.14 Changing fatherhood identities

Click to read: Men Talking About Fatherhood: Discourse and Identities

Activity 21

0 hours 45 minutes

Read Martin Robb's chapter on ‘Men talking about fatherhood: discourse and identities’. As you read, think about and make notes on the following questions.

- How do the ways in which the men interviewed talk about their experience as fathers reflect changing discourses of fatherhood?
- What dilemmas and tensions do the men mention?
- How do men ‘position’ themselves as fathers?

View discussion - Activity 21

This reading gave one illustration of the dynamic and changing nature of gender identities. As you reach the end of this section, you may still be debating whether gender differences are innate within people, or the result of conditioning within the family and society, or simply ‘constructions’ that reflect inequalities of power and status between men and women. You are not expected to reach a fixed conclusion at this point, but you may want to review your thinking at the end of this free course, once you have finished working on the third and final ‘dimension’ of difference: disability.

Key points

1. Feminists have argued that ideas about fixed gender difference serve to reinforce unequal power relationships between men and women.
2. Ideas about gender differences, including supposed differences in communication style, have enjoyed influence at an academic level and popularity at an everyday level.
3. Essentialist notions of gender differences have been associated with the view that women are ‘natural’ carers and are better at interpersonal communication and relationships than men.
4. Some feminists have used psychodynamic ideas to argue that, while gender differences exist, they are not inevitable and might disappear if family and social structures were changed.

5. Social constructionists claim that gender differences are produced by specific social and cultural contexts and that these can change.

5. Disability

5.1 What is disability?

The focus in this section is on how disability can impact on communication and relationships in the context of health and social care. The section is structured around four main activities: there are three readings for which you should set aside at least one-and-a-half hours. Activity 26 asks you to consider the issues that people with disabilities raise about their own needs, by visiting one of three online support groups. The final activity is based on a case study that involves exploring what you see as the main barriers to effective communication and relationships in health and social care. However, before embarking on these activities, there is a need to unpack the meaning of the term 'disability', which as you might expect is not straightforward.

Richard's story

During the long transition from believing that I was 'normal' to believing that I was 'disabled by an incurable disease' there were many little incidents which stick in my mind. For example, I remember my boss at the time who joked that I would lose the use of my legs when he spotted me taking the lift to go up one floor. Most people who saw me stumbling about assumed that I was drunk.

(Source: Were, 2000, p. 140)

Activity 22, What is disability?

0 hours 15 minutes

Read the account from Richard Were above who was diagnosed with MS in 1992 when he was 52 years old. Make notes on what this tells you about the meaning of the term 'disability'.

View discussion - Activity 22, What is disability?

There are many debates about what it means to be 'normal' but, for the moment, continue to consider the ways in which disabled people are marked out by society as being different from 'normal' people. The term 'disability' includes a range of physical and mental impairments but a social constructionist approach would argue that society 'disables' by labelling people and by perpetuating stereotypical ideas about what a person with a disability might feel, think or do.

Deborah Lupton and Wendy Seymour are two social scientists who have explored the relationship between the body and technology ('Technology, selfhood and physical disability', by Deborah Lupton). As part of their study they interviewed people with disabilities about how they used technology to overcome aspects of their disability. The authors argue that disability is a form of social, political and material

disadvantage, as well as being a socially constructed state. They argue further that ‘disabled bodies’ both represent and reproduce meanings. Disabled bodes are usually constructed as being ‘lacking’, ‘deviant’ or ‘grotesque’ and, as such, people with disabilities are marginalised by society. Therefore, since bodies that are ‘not normal’ are usually stigmatised, overcoming the material disadvantage of disability would seem to be both positive and helpful.

As noted in the general discussion of difference in Section 1, and again in the more detailed discussions of ethnicity and gender in Sections 2 and 3, social constructionists would argue that difference is a process, not a ‘thing’. This means seeing ‘disability’ as a process by which society (or institutions within society) ‘disables’ particular people in specific ways. This involves a certain way of thinking and talking about some groups of people, positioning them as ‘other’ on the basis of their supposed physical or intellectual capacities. However, it also involves ‘disabling’ people in very practical and material ways, preventing them from participating fully in society, or in particular aspects of it (such as health and social care services).

5.2 Technologies of help?

Click to read: Technology, Selfhood and Physical Disabilty

Activity 23

0 hours 30 minutes

Read the chapter on ‘Technology, selfhood and physical disability’, by Deborah Lupton and Wendy Seymour.

Make some notes listing the positive attributes that the study participants identify as being helpful to their sense of self and their ability to engage more easily in relationships.

Compare your notes with the comments below and add anything you missed out.

View discussion - Activity 23

Clearly, while technologies can appear to help overcome some of the technical barriers associated with disability, this is only one aspect of the context of relationships. There are also wider issues related to the position of disabled people in society that affect the quality of communication. Sally French and John Swain are academics who write about disability. They argue that the medical model of disability orientates disabled people towards so-called ‘normality.’ For example, people are helped to walk, to see and to hear. Conversely, a social model of disability, rather than identifying the individual as a person with a problem that needs to be solved, instead argues that disability is a political issue. There are two points to note here. First, a medical definition of and response to ‘problems’ both defines the problem as being

medical and, as such, constructs it as a medical event. Also, constructing something as a medical problem means it ‘requires’ a solution and the medical response is further justified. Secondly, this serves to individualise the problem and keeps the focus on the person with the disability and away from social causes and consequences. All of this adds up to what has been termed ‘blaming the victim’ (Ryan, 1971). Recognising that disabled people are in a position of relative powerlessness in society in comparison with so-called able-bodied people means there need to be different approaches to rectifying their position to one that is more just and equitable. However, the next two linked activities involve studying their chapter in the Reader with specific reference to issues of disability and communication.

5.3 Disability and communication

Click to read: Disability and communication: listening is not enough

Activity 24, Barriers to communication

0 hours 30 minutes

Read the chapter on ‘Disability and communication: listening is not enough’, by Sally French and John Swain, to the end of the section ‘Experiencing disabling communication barriers’. As you do so, make brief notes on what the authors identify as the barriers to two-way communication.

View discussion - Activity 24, Barriers to communication

This explanation offers a sense of disabled people's position in society as being both socially produced and also socially constructed. For example, poor access to buildings can increase inequality in a very practical sense, while at the same time the discourse that disabled people are ‘less able’ constructs and reinforces this inequality. The authors go on to advocate what they term ‘inclusive’ communication, which you will explore in the next activity.

Here a disabled person provides care for his partner

Click to read the chapter from: Towards Inclusive Communication

Activity 25, Making communication effective

0 hours 30 minutes

Read the rest of the Chapter, from ‘Towards inclusive communication’ to the end. Make a list of the principles by which inclusive communication can be achieved.

View discussion - Activity 25, Making communication effective

Did you note all these points? At its simplest French and Swain are advocating that the way forward is for service providers to actively listen to the needs of service users who are disabled. Many disabled people have become politically active in order to be ‘heard’ as people in their own right. The next activity is an opportunity to explore some examples of this.

5.4 The politics of disability

Activity 26

1 hour 0 minutes

Below you will find links to three support groups. You can select just one of the groups or you may choose to look at all three. Answer the two questions following the links .

- Lupus Site
- Royal National Institute for the Blind
- Terrence Higgins Trust : the HIV and AIDS Charity for Life

1. What concerns do these groups raise about communication and relationships?
2. How does this connect with the Chapters in Activities 23 and 24?

View discussion - Activity 26

So far our discussion in this section has been based on an assumption that disabled people are likely to be users of health and social care services. Positioning disabled people as always the receivers of services is part of the way in which disabled people are constructed in society. However, they are also service providers and can be workers in and managers of services. French and Swain claim there is discrimination against disabled people who want to work in health and social care services. The final activity in this course explores this issue further.

Jack's ambition

Jack is partially sighted and wants to work in the NHS as a nurse. He believes he has excellent communication skills and many of his friends and acquaintances would agree with his view. He has overcome many of the difficulties that are associated with living in the 'sighted' world and does not see why he should not succeed in his ambition. A colleague who works in the NHS has advised Jack that he will find it very difficult to be accepted into training and that he should choose a more realistic job.

Activity 27, Doing the job

0 hours 20 minutes

Read the fictional case study above.

Now make notes in answer to these questions.

1. Do you think that Jack should apply for the nursing position or would you advise against this?
2. Give some reasons for your view.

View discussion - Activity 27, Doing the job

This activity raised many issues about the nature of disability and the ways in which it is constructed and can serve to exclude people from certain types of work in which their skills might be valuable. This section, like Sections 2 and 3 on ethnicity and gender, aimed to raise questions about the nature of the ‘differences’ that are ascribed to people on the basis of their physical or mental capacities. Taking a mainly social constructionist line, this section tried to show that ‘disability’ is a social process rather than something fixed and essential within individuals. For health and social care services, responding to the communication needs of disabled people involves acknowledging the ways in which structures and processes within organisations can themselves disable and disempower some people, and working to put in place processes that enable and empower people to participate, whether as service users or as workers, on an equal basis.

Key points

1. Whereas a medical model of disability focuses on an individual's disability as a ‘problem’, a social model analyses the ways in which services, and society as a whole, ‘disable’ people through their structures and processes.
2. Overcoming barriers to effective communication involves addressing these structural factors and aiming for a model of inclusive communication.

6. Conclusion

This course explored at length some of the difficult issues around the topic of communication, difference and diversity. The analysis of three specific dimensions of 'difference' – ethnicity, gender and disability – showed some of the complexities involved in any discussion of these issues. As you reach the end of this free course, you may feel overwhelmed by the range of perspectives and approaches described. The Introduction claimed that good or effective communication involves taking account of issues of difference and diversity, rather than treating everyone as if they have the same needs. This course has shown that putting this into practice is never an easy process. Although we may not have suggested any straightforward answers, we hope that raising some of the difficult questions will help you to develop your own practice in this area. As with the other course concepts, issues of diversity and difference recur throughout this course and you may want to revisit this course at a later point, perhaps to review and challenge your own thinking.

Course summary

Issues of diversity and difference are a key factor in interpersonal communication in care services. The ways in which these issues are approached depends to a great extent on the perspective on 'difference' that is adopted. Essentialist approaches view differences of ethnicity, gender and disability as innate, whereas a social constructionist approach sees difference as produced in social interactions and contexts. There is a danger that essentialist approaches overlook diversity within groups and produce stereotypes that can reinforce prejudice and discrimination. Working with diversity and difference in health and social care services involves challenging structures and processes that disadvantage particular groups, as well as responding actively to the diversity of needs and interests within the population.

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References

Abbott, P. (2000) 'Gender', in Payne, G. (ed.) *Social Divisions*, Basingstoke, Macmillan.

Ahmad, W. I. U. (1996) 'The trouble with culture', in Kelleher, D. and Hillier, S. (eds) *Researching Cultural Differences in Health*, Chapter 9, London, Routledge.

Banton, M. (1977) *The Idea of Race*, London, Tavistock.

Barkan, E. (1992) *The Retreat of Scientific Racism*, Cambridge, Cambridge University Press.

Barker, M. (1981) *The New Racism*, London, Junction Books.

Baron-Cohen, S. (2003) *The Essential Difference: Men, Women and the Extreme Male Brain*, London, Allen Lane Science.

Baxter, C. (1997) *Race Equality in Health Care and Education*, London, Bailliere-Tindall.

Beishon, S., Virdee, S. and Hagell, A. (1995) *Nursing in a Multi-Ethnic NHS*, London, Policy Studies Institute.

Benjamin, J. (1998) *The Bonds of Love: Psychoanalysis, Feminism and the Problem of Domination*, New York, Pantheon.

Brah, A. (1992) 'Difference, diversity and differentiation', in Donald, J. and Rattansi, J. (eds) *'Race', Culture and Difference*, London, Sage/The Open University.

Brah, A. (1996) *Cartographies of Diaspora*, London, Routledge.

Chodorow, N. (1978) *The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender*, Berkeley and Los Angeles, University of California Press.

Clifford, D. J. (1995) 'Methods in oral history and social work', *Journal of the Oral History Society*, Vol. 23, No. 2.

Connell, R. (1995) *Masculinities*, Sydney, Allen and Unwin.

Dominelli, L. (2002) 'Anti-oppressive practice in context', in Adams, R., Dominelli, L. and Payne, M. (eds) *Social Work: Themes, Issues and Critical Debates*(2nd edn), Basingstoke, Palgrave.

Doyal, L. (ed.) (1999) *Women and Health Services*, Buckingham, Open University Press.

Doyal, L., Hunt, G. and Mellor, J. (1980) *Migrant Workers in the NHS. A Report to the Social Science Research Council*, London, Department of Sociology, Polytechnic of North London.

Eysenck, H. J. (1971) *Race, Intelligence and Education*, London, Temple Smith.

Foucault, M. (1967) *Madness and Civilisation: A History of Insanity in the Age of Reason*, London, Tavistock.

Foucault, M. (1981) *The History of Sexuality, Volume 1: An Introduction*, London, Pelican.

Fryer, P. (1984) *Staying Power: The History of Black People in Britain*, London, Pluto Press.

Gilligan, C. (1988) 'Remapping the moral domain: new images of self in relationships', in Gilligan, C, Ward, J. C. and Taylor, J. C. with Bardige, B. (eds) *Mapping the Moral Domain: A Contribution of Women's Thinking to Psychological Theory and Education*, Cambridge, MA, Harvard University Press.

Gilroy, P. (2000) *Between Camps: Nations, Cultures and the Allure of Race*, London, Penguin.

Gray, J. (1993) *Men Are From Mars, Women Are From Venus*, London, Thorsons.

Gunaratnam, Y. (2003a) *Researching 'Race' and Ethnicity*, London, Sage.

Gunaratnam, Y. (2003b) 'More than words: dialogue across difference', in Sidell, M. et al. (eds) *Debates and Dilemmas in Promoting Health: A Reader*, Basingstoke, Palgrave.

Hall, S. (1992) 'New ethnicities', in Donald, J. and Rattansi, A. (eds) *Race, Culture and Difference*, London, Sage/The Open University.

Hall, S. (2000) 'Who needs "identity"?', in du Gay, P., Evans, J. and Redman, P. (eds) *Identity: A Reader*, London, Sage/The Open University (D853 Reader).

Health Education Authority (HEA) (1997) *Many Voices, One Message: Guidance for the Development and Translation of Health Information*, London, Health Education Authority.

Huxley, J. and Haddon, A. C. (1935) *We Europeans: A Survey of 'Racial' Problems*, London, Cape.

Jensen, A. R. (1969) 'How much can we boost IQ and scholastic achievement?', *Harvard Educational Review*, Vol. 39, pp. 1–123.

Kelleher, D. (1996) ‘A defence of the use of the terms "ethnicity" and ‘’culture”,’ in Kelleher, D. and Hillier, S. (eds) *Researching Cultural Differences in Health*, London, Routledge.

Lewis, G. (2000) *‘Race’, Gender, Social Welfare: Encounters in a Postcolonial Society*, Cambridge, Polity Press.

MacPherson Report (1999) *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William MacPherson ofCluny*, Cm 4262–1, London, The Home Office.

McNay, L. (1992) *Foucault and Feminism: Power, Gender and the Self*, Cambridge, Polity Press.

Miles, R. (1982) *Racism and Migrant Labour: A Critical Text*, London, Routledge & Kegan Paul.

Miles, R. (1989) *Racism*, London, Routledge.

National Association of Health Authorities and Trusts and the King's Fund Centre (1993) *Equality across the Board*, London, King's Fund Centre.

Nazroo, J. (1997) *The Health of Britain's Ethnic Minorities*, London, Policy Studies Institute.

NHS Executive (2000) *The Vital Connection: An Equalities Framework for the NHS*, London, Department of Health.

Norberg-Hodge, H. (2000) *Ancient Futures: Learning from Ladakh*, London, Rider.

Papadopoulos, I., Tilki, M. and Taylor, G. (1998) *Trans cultural Care: A Guide for Health Care Professionals*, Salisbury, Quay Books.

Robinson, L. (1998) *‘Race’, Communication and the Caring Professions*, Buckingham, Open University Press.

Robinson, M. (2002) *Communication and Health in a Multi-Ethnic Society*, Bristol, The Policy Press.

Royal College of Nursing (RCN) Health Visitors Forum (2002) ‘Investment in Interpreting Services’, www.rcn.org.uk/news/congress2002/congressitems/interpreting.php [accessed 24 July 2003].

Rustin, M. (2000) ‘Psychoanalysis, racism and anti-racism’, in du Gay, P., Evans, J. and Redman, P. (eds) *Identity: A Reader*, Chapter 16, London, Sage/The Open University (D853 Reader).

Ryan, W. (1971) *Blaming the Victim*, New York, Pantheon.

Saraga, E. (ed.) (1998) *Embodying the Social: Constructions of Difference*, London, Routledge/The Open University.

Tannen, D. (1991) *You Just Don't Understand: Women and Men in Conversation*, London, Virago.

UNESCO (1980) *Sociological Theories: Race and Colonialism*, Paris, UNESCO.

Ward, R. (2001) 'Genetic variation and ethnic variability in disease risk', in Macbeth, H. and Shetty, P. (eds) *Health and Ethnicity*, London, Taylor & Francis.

Weatherall, D. (2001) 'The inherited disorders of haemoglobin', in Macbeth, H. and Shetty, P. (eds) *Health and Ethnicity*, London, Taylor & Francis.

Were, R. (2000) 'Living with M.S.', in Dickenson, D., Johnson, M. and Katz, J. S. (eds) *Death, Dying and Bereavement*, pp. 136–41, London, Sage/The Open University (K260 Reader).

Woodward, K. (1997) *Identity and Difference*, London, Sage/The Open University.

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Chapter 14 'Anti-oppressive practice' by Beverley Burke and Philomena Harrison

Chapter 18 'Technology, selfhood and physical disability' by Deborah Lupton and Wendy Seymour

Chapter 24 'Disability and communication: listening is not enough' bu Sally French and John Swain

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Activity 1: What is the problem?

Discussion

Note that the speaker herself identifies the existence of a ‘problem’ and relates it specifically to ‘communication’. Initially, she analyses this as a problem of ‘language’. Presumably (although we do not have all the facts) she is referring to her perception that her spoken English is not sufficiently proficient to enable her to express her feelings as she would like to. She goes on to mention a specific experience, in which she was in hospital for two weeks. Here the precise nature of the problem becomes rather less clear. She says that two of the nurses ‘neglected’ her, and that she is unsure whether this was ‘because of my colour’ or because of the ‘communication problem’, by which presumably she means the language issue she mentioned earlier.

This raises the question of whether the real communication ‘problem’ was the woman’s inability to speak English, or the racism of some of the hospital staff, which resulted in them failing to communicate important information to her. That racism might have been expressed in a very direct way – simply by ignoring the patient ‘because of my colour’ – or more indirectly, by failing to provide the services (perhaps a bilingual worker or an interpreter) that would have made communication possible.

Whatever the nature of the ‘problem’, the consequences were potentially very serious, in that the speaker was discharged without knowing the precise nature of the surgical procedure she had undergone. A failure or breakdown in communication can lead directly to poor quality care being provided.

Back

Activity 2: Talking about communication and ‘difference’

Discussion

Here are some examples reported by course testers.

- African–Caribbean people tend to use their bodies more expressively than white people when they’re communicating.
- Asian women lack confidence in talking to white workers.
- People with learning disabilities find speaking in groups very stressful.
- Women tend to let their emotions get the better of them when they’re under pressure.

These examples show there is a tendency in care services, as elsewhere in society, to associate membership of a particular group or category with specific ways of communicating, and particular communication needs.

These apparent differences in communication style are frequently represented as a ‘problem’ and as contributing, as in the case in Activity 1, to a breakdown in communication. ‘Differences’ are seen as a problem if they mean service users are unable to express their needs adequately or if they fail to understand (or they misunderstand) what they are being told by professionals. As a result, communication ‘differences’ are often presented as a barrier to the full participation of members of particular groups in services, whether as users or as workers.

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Activity 3

Discussion

We asked members of the course team, and some other people we know, to complete this activity. Here are some aspects of people's identities as they saw them.

- Male, white, middle-aged, working class
- I get into difficulty when I try to describe my nationality. Being born in England of Irish parents, I was made to feel Irish when I was growing up – as a matter of pride from my parents and discrimination from others. It was an identity I didn't talk about all through my 20s and 30s. Living in Ireland for three years confused my identity further since I could not relate to the culture 'back home'. So now I'm London Irish or European and I'm happy with that.
- I needed to think about this question for some time as there are so many different aspects to my identity. I would describe myself as an African/Caribbean woman born in the UK. In terms of age I am middle-aged and I guess in terms of my current profession and location I am middle class but my parents were working class and migrated from Jamaica to the UK in the 1950s. I am a mother, wife, sister, daughter and friend – which are all important aspects of my identity. Professionally I am a senior lecturer with The Open University.
- A woman, white (Northern Irish), born and brought up in the West Midlands, middle-aged, working-class background.

This is what people said about which identities were most important and the ways in which this had changed overtime.

- The most important things to me are my job, and being good at it, coming from a working-class background in Birmingham, being a good cook, a vegetarian and an ethical consumer. On the negative side, I have a disability which affects my mobility, and I am single with no family.
- Parent would be more out front 10 years ago.
- All of these identities are important to me at this point in my life and the challenge I have is being able to give space and time to the competing demands that each aspect of my identity poses. My ideal would be to have a life that was completely balanced and allowed the opportunity for each identity to be fully expressed and actualised… Twenty years ago I didn't have children and had a different occupation, working as a manager of health promotion services in the NHS, but I would have described my identities in the same way.
- Ethnicity is an identity that has taken on new importance. Although I am a Canadian, I worked for many years in race relations in

California. Because I am white and talked like many other white people, I was indistinguishable from the dominant group there. Now living in the UK, I can't hide my 'accent', my different background, views and values. For the first time, I have a more real understanding of what it's really like to be different in ways you can't hide. Being different, I have found, often means 'less than', because of assumptions that I am an American, about my intelligence, education, values – especially right now.

- Ten or 20 years ago I would have laid more emphasis on my role as a mother and nurse and midwife since those dominated my life. In 1990 I would also have called myself a full-time postgraduate student. As a younger mother after the birth of the second child, I would say that my identity was consumed by being a mother.

Although we cannot know the details of your answer, we would guess that your response reflected some of the complexities and tensions in the above examples. Some conclusions that we drew from this activity are discussed below.

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Activity 4

Discussion

Here is an example from a course team member, which you may want to compare with your own answer.

I grew up with the reality of poverty and anti-Irish prejudice. Later, as a nurse, I found that I was in an inferior position to male doctors and was even bullied and harassed by senior staff. This was part of the culture of being a young nurse. As a senior nurse, I was often in charge of shifts, so that power was afforded to my position. Later in life, as a midwife, I acted as an advocate to the women in my care and challenged oppressive behaviour towards them. I was often consulted over care decisions and seen as someone who was powerful and assertive.

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Activity 5

Discussion

Here are our responses to this activity.

> Jenny: I define myself as ‘African–Caribbean’ – but this only has meaning in the UK. I would not necessarily use the same terminology in the Caribbean. What might be important in the Caribbean is that someone of Caribbean parentage has been born in the UK, hence someone might use nationality in this context, i.e. ‘British’ or ‘Black British’.
>
> Carol: When I have to agree to a category like these, I define myself as ‘White British’, but I don’t like to think of myself in this way because I see nationalistic identities as potentially dangerous. I prefer to call myself ‘Irish’, because my father was from Northern Ireland – although this qualifies him as British too!
>
> Martin: I would have to say ‘White British’, although I am unhappy about this for a number of reasons. Firstly, it seems to gloss over the parts of my ‘ethnic’ identity that are important to me, such as my Englishness, my Scottish ancestry, and my working-class London background. Secondly, both ‘White’ and ‘British’ are associated with histories of oppression – ‘British’, for me, has imperial connotations – whereas I am committed to equality.

How did you get on with this activity? Like us, but perhaps in different ways, you may have thought the census categories were too limited and rigid and did not match the way in which you perceive your ethnic identity. However, we hope that doing this activity has helped to illustrate some important points about the nature – and limitations – of the idea of ethnicity, some of which are explored below.

Back

Activity 6

Discussion

The impression given in this account is that all African–Caribbean people are similar, with similar family forms, lifestyles, values and beliefs. The description presents a stereotype of African–Caribbean family life, rather than a reflection of diversity within the population. It fails to represent differences within African–Caribbean communities in terms of class and religion, and between generations.

Back

Activity 7

Discussion

Influenced by the kind of stereotypes outlined in Activity 6, you might expect the family to be living in a poor part of town close to other African–Caribbean families. You might expect that the young woman's father is not living with the family and is not part of the picture. You would probably expect the mother to be furious with her daughter, and you might be on the look-out for signs of physical abuse. Paradoxically, you might also expect a degree of understanding from the mother, as she probably had the same experience of teenage pregnancy. Given the apparently matriarchal nature of African–Caribbean families, you might be keen to speak to the young woman separately from her mother, in case she felt intimidated. When you interview the young woman, you might expect to discover she has slept around and not used contraception, but also that she is reluctant to keep the baby. As a consequence, you might arrive prepared to give contraceptive and abortion advice, or offer a referral to a family planning clinic.

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Activity 8

Discussion

It is difficult to imagine how this might feel, unless you had experienced something similar. I guess that I would feel as though my individual needs and circumstances were being pushed to one side, and that I was being treated as a ‘type’, rather than as an individual. I would probably feel as though one aspect of my identity, my ethnicity, was being made to count more than other elements of my personality and experience, such as my education, class, political beliefs, and so on. I might also feel as though I were being treated as an ‘other’, as different from the majority (represented by the white worker), rather than as having anything in common with other people in similar circumstances. I imagine that I would feel angry at being ‘positioned’ in this way and at any suggestion of being looked down on because of certain aspects of my background.

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Activity 9: Beliefs, values and intercultural communication

Discussion

1. Robinson suggests that a lack of trust between service users and health and social care practitioners may be due to incongruity between expressed beliefs, attitudes and values, on the one hand, and actual behaviour on the other. Drawing on the work of Kluckholm and Strodtbeck and their theory of value orientation, Robinson explores disparities that may exist in beliefs, attitudes and values between communicators of different ethnic backgrounds.
2. Robinson argues that individuals have multiple identities and that, in working across cultural boundaries, we all need to develop skills of listening and learning about individuals whose realities may be very different from our own.

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Activity 10: Ethnic matching

Discussion

You may have agreed with the suggestion that this approach assumes homogeneity within ethnic groups and does not take account of other differences such as gender, class, age and sexuality. In addition, religion may present challenges and complexities. Often the subtleties of religious beliefs are not recognised or indeed the fact that religious practices are not homogeneous. It could be argued that this 'ethnic matching' solution is based on a fact file' approach to ethnicity that reinforces racial and religious stereotypes. Not only does it assume that individuals in particular 'racial', ethnic or religious groups have the same values and beliefs, but also it assumes that individuals of the same ethnic group give the same meanings and understandings to particular words and phrases. Thus communication difficulties' are addressed purely by providing a worker of the same ethnic, religious or 'racial' background, and diversity is ignored.

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Activity 11

Discussion

The main reasons for employing interpreters were as follows.

- Relatives or friends may not have received appropriate training.
- They may offer their own views and opinions rather than relaying the needs and wishes of the person for whom they are interpreting.
- This can lead to misdiagnosis and inappropriate treatment.

The main principle put forward is that having access to an interpreter is a basic human right and that it impacts fundamentally on the quality of care.

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Activity 12

Discussion

Although the concept of anti-oppressive practice is highly contested, Burke and Harrison argue that (social work) practitioners have 'a moral, ethical and legal responsibility to challenge inequality and disadvantage.' They remark that anti-oppressive practice is a 'dynamic process based on the changing complex patterns of social relations.' They use the definition of anti-oppressive practice espoused by Clifford, who uses the term 'anti-oppressive':

> to indicate an explicit evaluative position that constructs social divisions (especially 'race', class, gender, disability, sexual orientation and age) as matters of broad social structure, at the same time as being personal and organisational issues. It looks at the use and abuse of power not only in relation to individual or organisational behaviour, which may be overtly, covertly or indirectly racist, classist, sexist and so on, but also in relation to broader social structures for example, the health, educational, political and economic, media and cultural systems and their routine provision of services and rewards for powerful groups at local as well as national and international levels. These factors impinge on people's life histories in a unique way that have to be understood in their socio-historical complexity.
>
> Clifford, 1995, p. 65

In considering how you could apply anti-oppressive principles to your own work, you would need to think about the following.

- Social differences and understanding how they interconnect and overlap.
- Linking the personal and the political, particularly when examining and trying to assess individual life experiences.
- Addressing power and powerlessness.
- Locating events within a historical and geographical perspective.
- Practising reflexivity and mutual involvement.

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Activity 13

Discussion

Here are some examples provided by course testers.

- When I was expecting, I recall talking with another woman on the ward about why I felt uncomfortable being examined by a male midwife.
- I thought of a meeting chaired by a male manager which he handled in a very ‘male’ way, not allowing any room for women's voices to be heard.
- There was a heated discussion in the team about whether we should allocate a man as a key worker to a particular client, as he seemed to respond badly to female staff.
- The family centre where I work has been trying to attract dads to some of the sessions, but they don't seem to be interested in sharing their feelings in a group, so we're going to try a more indirect approach, perhaps starting with something a bit more active and sporty.

Were your examples similar to any of these, or did you think of different ways in which gender was introduced as a factor? From our testers’ responses, and perhaps from your own, you can see that gender is certainly an important factor in the ways people talk and think about interpersonal relationships in care services. Next we analyse in more detail some of the different ways in which gender is present as a factor in everyday discourse in the context of care.

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Activity 14

Discussion

When we asked members of the course team to describe their gender for Activity 3, most used one-word answers such as ‘woman or ‘male’, although for some the intersection of gender with other factors was important, as in descriptions such as ‘an African–Caribbean woman born in the UK’. Others were unhappy with some aspects of gender identity that were imposed. One person described himself as ‘a man, but a pro-feminist one’, while another wrote:

> Although I am married I would never refer to myself as a wife and resist this as part of my identity. Likewise, I have not changed my name to that of my current husband. Can rejection of aspects of identity be part of our identity?

However, another person clearly saw her gender identity as a cause for affirmation and celebration:

> Gender female and ‘I enjoy being a girl!’ It's still the first thing anyone notes after ‘white’ and is what begins to define difference in my identity… with all that goes with it.

Perhaps, like some course team members, you found defining your gender identity fairly straightforward – it was a ‘given’ – or perhaps, like others, you were uncomfortable with some of the associations attached to being a man or a woman.

How easy was it to describe the associations your gender identity has for you? You may have found it difficult to escape from conventional descriptions of male and female attributes – such as the notion that women are more sensitive, or that men are more action-oriented. Your list may have included attributes or skills that were specifically relevant to communication, such as the capacity to listen or to analyse situations. These notions of gendered difference are examined in Section 3.3.

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Activity 15

Discussion

You may have thought your gender identity is something you were born with, which has remained the same throughout your life. If, on the other hand, you thought your sense of yourself as a man or a woman has changed during your life, you might have identified particular experiences, events or relationships that helped to define it. This was quite a difficult activity, but a useful one in helping to reflect on some taken-for-granted assumptions. Given that the view of gender as an inner, unchanging essence or a personal possession is deeply rooted in the 'common sense' of society, your own view will probably reflect this. However, reflecting on your gender identity more critically may lead you to challenge aspects of this, and to see your own 'gender' as something rather less fixed and stable, possibly more mutable and fluid, and liable to vary to some extent depending on who you are with, what you are doing, and differing social attitudes and expectations.

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Activity 16

Discussion

One course tester wrote:

> I worked for a while as part of a small team, where all the members were women, except for the manager who was a man. He was quite a 'traditional' man in many ways, and he tended to use personal charm to influence things – I think we saw him as a kind of father figure or benevolent uncle. He used humour quite a lot to oil the wheels. I suppose it was quite a benign use of male power, but it was power all the same, and the result was that women's voices, and maybe women's way of doing things, were marginalised.

This is an example of gendered power operating indirectly, and in an apparently benign way. You may have thought of more direct and perhaps less benign and more oppressive examples of gendered power. One tester experienced a workplace where the manager and most of the staff were women, and thought men had less power in that situation. It is important to remember that gendered power can work both ways, while not overlooking the wider inequalities experienced by women in society as a whole.

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Activity 17

Discussion

1. The institutional power of the female worker has some bearing on what happens, especially if the worker has the power to 'section', or to decide or withhold treatment, or to use other sanctions, or has the power of the professional 'expert'. The service user will feel relatively powerless in the face of this institutional power. However, in a society where the power of men over women is still present, he brings a certain kind of gendered power to the encounter. For many female care workers, the fear of violent and sexual abuse deployed by a male service user, even if it is an unwarranted fear, is a reality in their encounters with them. This is especially true for workers in vulnerable situations: for example, those who meet service users alone, or away from their 'home' territory.

   At a different level, female workers may be made uncomfortable by the sexual gaze of a male service user, as this too is a form of gendered power. In cases where treatment involves touch – such as nursing, and some forms of body therapy and residential care – the worry about the encounter taking on sexual meanings becomes more overt. Male service users, despite their relative institutional powerlessness, might also deploy the kind of strategies that were identified in professional relationships. They may use certain ways of talking and arguing that are intended to intimidate a female worker, making her job more difficult.

2. In this instance the male worker's gendered power, reflecting men's power over women in the wider society, might act to reinforce the institutional power of the worker over the service user. The example that is often cited is consultations between male doctors and female patients, especially when this involves physical examination. At the same time, female patients or clients may complain of feeling intimidated or bullied by doctors or other male professionals. Of course, this is not to say that female workers cannot be intimidating towards either female or male service users. However, in these cases institutional or professional power is not backed up by the gendered inequalities that persist in the wider society.

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Activity 18

Discussion

You may well have thought there is some truth in the claims made by Tannen and Gray, and that to some extent these claims are borne out by your own experience: perhaps in your personal life, or in your experience of working in or using health and social care services. You may even have recognised aspects of yourself in their descriptions of 'typical' male or female communicative behaviour. Or you may have thought of people (again, perhaps, including yourself) whose style of communicating contradicts such statements: perhaps a particularly sensitive male colleague, or an especially competitive female manager.

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Activity 19

Discussion

As with ‘stereotypical’ accounts of ethnic difference, a social constructionist critique might argue that these are huge and generalised claims that overlook the enormous diversity of communicative behaviour that exists among men and women. Do all men and women communicate in these ways, in all contexts? And can these claims be applied to men and women in other societies and cultures, where gender relationships are very different? Following on from this, it might be argued that these generalised claims overlook similarities between men's and women's ways of communicating, and the importance of factors that they might have in common, based for example on their social class, education or age. Tannen's and Gray's analyses make gender the main tool for explaining people's behaviour and (like ‘ethnicist’ ideas) risk reducing complex individuals to one aspect of their identity. Then again, there might be other contextual factors that account for the ways in which people interact with each other, including the relationship between them.

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Activity 20

Discussion

If there is any truth in the claims that men and women have very different styles of communication, it would make sense to allocate male and female staff to different kinds of roles. For example, an organisation might decide to allocate tasks involving sensitivity and the expression of feelings, such as counselling, exclusively to female staff, and jobs that need a degree of competitiveness to male workers. Staff training and development would include courses to make all staff aware of men's and women's different styles of interacting. It might also focus on developing male workers' sensitivity and female workers' assertiveness skills. Finally, in working with service users, different approaches might be needed to engage the interest and involvement of men and women (remember the course tester whose family centre had tried to attract fathers through sporting activities).

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Activity 21

Discussion

The men's depiction of fatherhood as being primarily about emotional and practical involvement reflects changing discourses about fathers' roles. The men who were interviewed expressed tensions between responsibility and freedom, and between a sense of fatherhood as struggle and fatherhood as pleasure and enjoyment. They position themselves mainly in relation to other men, especially their own fathers.

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Activity 22, What is disability?

Discussion

I thought it was interesting to note that Richard did not identify himself as being disabled and yet some of his behaviour was marked by the comments other people made about him not being ‘normal’. This suggests it is possible to recognise disability as ‘not normal’. (In addition, being perceived as drunk carries its own prejudices and sanctions.) Richard's boss seemed to make a judgement that might fit into a moral category: that is, Richard could deserve to lose the use of his legs if he squandered them. Whatever your view of these comments, it is clear that people have ways of marking differences between what is ‘normal’ and what is not ‘normal’.

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Activity 23

Discussion

I was interested to note that some of the study participants revealed that attributes such as control, avoiding embarrassment, as well as providing the means by which people could engage in society were important.

The study also revealed that the use of technologies as a means to overcome aspects of disability is not welcomed by all groups of disabled people. The example of cochlea implants to overcome deafness can be called ‘normalisation of impairment. Here the ‘deficit is overcome by a technical fix. You will explore the way this has been highlighted as a medical response to disability in Activity 25, but the focus here is that the means used to overcome impairment has other far-reaching consequences.

Lupton and Seymour also found that even those people who welcomed the values of technology in facilitating and enhancing communication expressed concerns about the way technology could highlight their difference and affect how people perceived them. For many participants, being identified as disabled could impact on the way other people treated and responded to them. You may remember Tom's statement about how the use of a white stick meant people not only identified him as being blind but also made assumptions about his intelligence. You might be familiar with the negative experiences of wheelchair users whose position can also construct them as being ‘lower human beings’.

Lupton and Seymour conclude by arguing that technologies can be conceptualised as tools that fit well into their own notions of self and body and that these seem to single people out as disabled’. What is particularly interesting from reading their chapter is that technologies highlight some of the complexities involved in the way disabled people are represented in society through their ‘disabled’ bodies.

Some issues of identity (which Lupton and Seymour call ‘selfhood’) and disability mean that people who are identified as being disabled might be labelled in a way that affects how people relate to them. This labelling could affect people's basic rights and their ability to communicate. However, as Ian, one of the participants, notes, while a wheelchair marks him out as being disabled, without it he would be in bed all day.

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Activity 24, Barriers to communication

Discussion

The authors locate the barriers to effective two-way communication within the power relationships between professionals and clients, and they start from a social model of disability that understands the unequal treatment of disabled people as built into organisational structures and 'into the language, communication and client–professional discourse'. This context means that identifying barriers to communication recognises the complexities of the process and the diversity of disability. Among the specific barriers they cite are attitudinal barriers, access issues, and a lack of emotional response by professionals.

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Activity 25, Making communication effective

Discussion

Course testers noted that French and Swain list the following principles.

- Participation in the planning and evaluation of policy, provision and practice.
- Accessible communication that is based on the views and needs of disabled people, who have been consulted at every stage of the process.
- Diversity and flexibility by listening to disabled people and allowing them to take control.
- Human relationships that include a shared sense of humanity.
- Use of inclusive language that involves more than a recognition of terms that are exclusive and the thinking that underpins the commitment to inclusion.

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Activity 26

Discussion

You probably found in your exploration of support groups online that people using them express some of the concerns explored in the chapters by Lupton and Seymour and by French and Swain, most commonly the need for information, practical help and support, and campaign issues to improve their situation in society.

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Activity 27, Doing the job

Discussion

This is an emotive issue. You might have agreed with Jack's friend on the basis that Jack might experience rejection and so perhaps it would be better for him if he was protected from this and not ‘set up to fail’. You might have considered the possible dangers to patients of having a partially sighted nurse caring for them.

My first reaction was it would be very difficult for Jack to do the tasks that require vision. I thought of examples such as reading prescription charts and administering drugs. Using a syringe to give an injection requires nurses to be able to see the markings clearly, so the right amount of drug can be administered. This could make it impossible for Jack to fulfil a key part of the role as a nurse. I also began to ask myself, what about reading monitor screens on a cardiac unit, or noticing a person's skin colour after surgery when there is a need to recognise poor circulation?

I then started to consider whether or not there were ways around these practices that were entirely designed and maintained by sighted people. Although it seemed possible to overcome many of the obstacles I considered, extra resources would need to be in place. In addition there would need to be a commitment to overcoming the barriers that have increased Jack's impairment.

Apart from making sure that Jack is ‘doing the same as everyone else’, there are also questions about the extent to which it is necessary. This challenges the ways nursing is performed and what the job must include.

Finally, the challenges that disabled people make to established ways of doing things can be perceived as threatening by other people.

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