Nurses' experiences of caring for South Asian minority ethnic patients in a general hospital in England

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Healthcare provision for minority ethnic groups in the UK has generally revealed inequalities in access and differential service provision. British healthcare policy has started to address such issues. However, very few studies have specifically examined the experiences of nurses caring for minority ethnic patients. This paper focuses on the focus group interviews of a broader ethnographic study, aimed at describing nurses' experiences of caring for South Asian minority ethnic patients, in a general hospital in the south of England. A sample of 43 nurses of all grades from six medical wards took part in the focus groups: three ward sisters, 22 staff nurses and 18 care assistants; 40 participants were white, one was African-Caribbean and two were South Asian. Data analysis revealed eight themes: changes in service provision; false consciousness of equity; limited cultural knowledge; victim blaming; valuing of the relatives; denial of racism; ethnocentrism, and self-disclosure. The study revealed a good local service response to government policies in addressing inequality. However, there was a tendency to treat all minority ethnic patients the same, with evidence of ethnocentric practices, victim-blaming approaches and poor cultural competence in nursing staff, which raise questions about the quality of service provision. The study indicates that ongoing training and development in the area of cultural competence is necessary.

Key words: cultural competence, ethnicity, nurses' experience, whiteness.

Knowledge of one's culture and an understanding by nurses of the culture of their client group is crucial to the provision of effective nursing care (Lea 1994; Duffy 2001). Despite the numerous changes in the British National Health Service, healthcare staff's knowledge and understanding of other cultures have not kept pace with the increased diversity of minority ethnic groups with different cultural patterns and health expectations (Gerrish, Husband and Mackenzie 1996; Alexander 1999; Vydelingum 2000). This report focuses specifically on white nurses' experiences of caring for South Asian minority ethnic patients, as part of a larger ethnographic study. This paper presents the findings from

focus group interviews, and, following the background to the study, the rationale and the methodology are discussed with recommendations for practice.

At this juncture, it is worth noting that my position can be located within nursing practice as a nurse, researcher and educator, hailing from a South Asian background, and currently working in a higher education institution.

BACKGROUND

The minority ethnic population is approximately 9% of the total UK's population, with African Caribbean and South Asian communities forming the largest groups (Census 2001). Inquiries that have examined the healthcare provision for minority ethnic groups in the UK have generally revealed communication and language difficulties (Murphy and Macleod-Clark 1993; Wright 1994), poor uptake and utilisation of health services (Madhok, Bhopal and Ramaiah

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1992; Bruster et al. 1994) and low levels of satisfaction with service provision (Smaje and Le Grand 1997). Current British healthcare policy has started to address such issues by ensuring that healthcare Trusts provide a culture-sensitive service that incorporates consideration for differences in religion, culture and language (Department of Health 1998; NHS Executive 2000). However, there are very few studies in the UK that specifically examine the experiences of white nurses caring for minority ethnic patients.

Equity

Equity is a complex and difficult concept to explain. Almond (2002) suggests two approaches: horizontal and vertical equity. Robinson and Elkan (1996) explain horizontal equity as the idea of treating everyone equally. This may lead to inequity, as everyone is not equal or the same. Vertical equity on the other hand, which may appear contradictory at first, involves giving unequal, but appropriate treatment or care to individuals or groups who are unequal in specified respects, therefore meriting different provision (Robinson and Elkan 1996). Such an approach is similar to the affirmative action initiatives operated in some areas of the United States.

Ethnocentrism

In Murphy and Macleod-Clark's (1993) study ethnocentric views were expressed by white nursing staff, demonstrated by negative attitudes and judgemental labels. Minority ethnic patients were generally perceived as a 'problem', not fitting in the ward routine, and the study generally revealed a lack of an holistic approach to care, with nurses showing an inability to develop a therapeutic relationship with minority ethnic patients.

In a US study (Bond, Kardong-Edgren and Jones 2001) assessing professional nursing students' knowledge and attitudes about patients of diverse cultures, it was found that students in undergraduate and postgraduate nursing programmes demonstrated a relatively poor knowledge base about specific cultural groups. Encountering difference, experiencing tensions and striving were three core themes identified by Spence (2001) in her study of nurses' experiences of caring for people from other cultures in New Zealand. The need for cultural safety and approaches in nursing education that foster egalitarian and pluralistic conversations are recommended. However, Blackford's (2003) Australian study revealed that there was an exclusionary healthcare culture, a culture of care constructed within a culture of 'whiteness' frame. Care was structured from a

position of structural advantage from which white people examined themselves and others through cultural practices that resulted in a service geared to a broadly Anglo-Saxon population. A common thread through all these studies is a discernable lack of cultural competence in nurses caring for patients from diverse cultures.

Cultural competence

According to Kim-Godwin, Clarke and Brown (2001) cultural competence contains four dimensions: caring, cultural sensitivity, cultural knowledge and cultural skills. The cultural sensitivity and knowledge refers particularly to the understanding of culture, specific beliefs and behaviours of particular groups of people. Cultural skills on the other hand refer to the abilities gained in the areas of cultural assessment, advocacy and communication. Lack of cultural competence is demonstrated through cultural conflict as a consequence of using an ethnocentric cultural lens, misunderstandings or misinterpretation of the same phenomena and lack of trust and respect resulting in barriers in communication and relationship building.

Gerrish, Husband and Mackenzie (1996) found that student nurses lacked sufficient knowledge and confidence, while nurse teachers also lacked competence in facilitating the acquisition of transcultural skills in learners. It appears that, even where nurses were dealing with greater numbers of patients from minority ethnic groups, health-care was still based on ethnocentric beliefs, as similar findings were reported in a recent study (Gerrish 2001). Her study of qualified district nurses and South Asian patients and their carers raised concerns regarding the quality of care provided to non-English speaking patients.

'Ethnic othering'

In terms of culturally sensitive healthcare provision, various publications (Qureshi 1989; McAvoy and Donaldson 1990; Karmi 1996; Henley and Shott 1999) have provided guidance on how to care for Hindus, Sikhs and Muslims both in hospital and in the community. However, such work unfortunately has, on the whole, followed a familiar checklist/ cookbook pattern including guidance on a wide range of religious, cultural practices and rituals (Lea 1994). Such approaches have highlighted differences, with emphasis given to the unique, the unusual and the exotic or 'ethnic othering', suggest Ahmad (1993) and (Duffy 2001).

The term 'South Asian' used in this study refers to descendants of migrants from the Indian sub-continent, such as Bangladesh, India, Pakistan and Sri Lanka, but now

living in England, with Hinduism, Islam and Sikhism being the most prominent religions being practised.

AIM OF THE STUDY

The aim of the study was to describe the nurses' experiences of caring for South Asian patients, in a medical directorate of a general hospital in the south of England. The study was self-funded as part of a broader doctoral project and approval was sought and granted by the local research ethics committee.

METHODS

The participants

The sample could be described as purposive, or 'naturally occurring', as suggested by (Kitzinger 1995). All 90 eligible nurses of all grades were invited to participate in the focus group interviews. Forty-three members from six wards took part in the focus groups. Of those who did participate in the focus groups, three were ward sisters, 22 were staff nurses and 18 were care assistants. Forty participants were white and three were black, of whom one was of African-Caribbean origin and two were of South Asian origin. Group size varied between six to eight, though most of the focus groups had about six members of a mixed group of sisters, staff nurses and care assistants.

Data collection

The venue chosen to hold the focus groups was a seminar room, away from the ward but within easy walking distance. My role as the researcher was that of a 'structured eavesdropper', keeping detailed notes of both the verbal and nonverbal cues. A facilitator was also employed who was 'knowledgeable but not all knowing' as suggested by Macleod-Clark, Maben and Jones (1996). Data were gathered through a combination of tape-recorded interviews and field notes. A number of open questions and 'prompts', as suggested by Kitzinger (1994), about nurses' experiences of caring for South Asian patients admitted to their wards were used to guide the discussion.

Data analysis

Thematic analysis was used as a process for data reduction: data labelling, analytic codes and finally identification of themes (Miles and Huberman 1994). Sentences and paragraphs were coded to extract the essence of ideas within them. Labels were added in the margins of the text. Initial

codes were reduced into larger codes and later into themes. Deviant case analysis was carried out, as it was important to pay attention to minority opinions, in this case making sure that the voices of care assistants were heard. Variation in perceptions was noted and the focus of the analysis was on the group members' reality, not purely the individual's, as recommended by Carey (1995).

RESULTS

The interviews were transcribed in such a way as to preserve the richness of the interaction among the participants. Eight themes were identified as follows: changes in service (we are doing our best); false consciousness of equity (we treat everyone the same); limited cultural knowledge (we don't understand them); victim blaming (it's is not our fault); valuing of the relatives (they are very helpful); denial of racism (we don't have racism here); ethnocentrism (it's not rational what they believe); and self-disclosure (I know how they feel).

1. Changes in service (We're doing our best)

In response to a question to all focus groups from the facilitator about how they saw the current situation generally, regarding the care of minority groups at the hospital, participants talked about the recent changes in the hospital. The discussion below is typical and very much demonstrates some of the changes that had occurred in the hospital as a result of the Patient's Charter, and some of the policy changes at ward level. The recent introduction of the Asian menu across the hospital was seen as a commitment by the Trust to make real changes in practice. Participants seemed to be exploring other ways of improving practice; the excerpt below illustrates a process of evolving consensus:

> **Sister:** We've introduced the Asian menu, which funnily enough has been requested more by white patients, but they are not allowed. We don't know much about the festivals, but we're doing our best.
>
> **Staff nurse:** But what could be practical though, is a calendar of festivals so that we can book them in the ward diary. That way, all staff should know that these dates are special. That way, we could avoid sending them appointments on their holy days. Otherwise, it's like sending for someone to come into hospital on Christmas day or even Easter.
>
> **Sister:** That's a good idea.
>
> **Staff nurse:** We also need to have some standards of care for Asian patients. Something based on the religious needs. A sheet, or a checklist, which could be attached to the nursing notes.

Care assistant: We could also ask the relatives about any special requirements to make sure we do not offend their religious beliefs, I know as a Catholic, we have our funny ways too (FG 4).

The above transcript shows the lead taken by the sister in emphasising the positive changes being implemented in practice, but admits to a lack of knowledge about festivals. The staff nurse and the care assistant quickly filled in such gaps in knowledge by suggesting new ways of working. The discussion moves on to considerations of how to introduce new ideas and improve practice through checklists/standards, often seen as a common feature of nursing practice (Lea 1994). Responses from other focus groups also confirmed some of the government policy initiatives in action, such as the appointment of a multicultural adviser at the health commission and the introduction of patient leaflets in some of the minority languages.

2. False consciousness of equity (We treat everyone the same)

In the exchange below, the statements by the sister, staff nurse and the care assistant all endorse each other's, though using different words and terms. All provide strong support for a case to demonstrate a dimension of egalitarian practice in the ward. However, all appear to be operating under a false consciousness of equity, as to treat everyone the same when they are not suggests the provision of an equal service that is not individualised. These views were validated by participants in all the focus group interviews:

Sister: We treat everyone the *same as any other patients* [sister's emphasis].

Staff nurse A: They receive the same care really as all the other patients; *there are no special considerations*, except that some patients may not be able to speak English [staff nurse's emphasis].

Staff nurse B: Yes, Asian patients receive the same care as the others.

Staff nurse A: As for discharge arrangements, we would do basically the same as we do for the other patients. No, there are no specific factors that I would take into account.

Staff nurse C: We don't treat anyone any different.

Care assistant: We, for us we don't discriminate; we give the same care to all our patients (FG 2).

As can be noted in the above example, all participants seem to be referring to the concept of horizontal equity (Robinson and Elkan 1996; Almond 2002), instead of addressing vertical equity.

3. Limited cultural knowledge (We don't understand them)

In contrast to theme 1, where participants were full of new ideas to improve practice, here they seemed to react negatively to what seems to them deviant behaviour. A lot of the statements depict widely held western views about the cultural attributes and behaviour of South Asian patients (Andrews and Boyle 1995; Henley and Schott 1999). However, none of the participants was able to see beyond the given of a particular behaviour of this group. The poor knowledge and understanding about minority cultures, as demonstrated in the discussion below, clearly demonstrates a lack of cultural competence:

Staff nurse: We don't understand them. I can't stand the lack of eye contact, especially from the male Asian patients.

Sister: It's not just the language. Even for those who can speak English, I find that they are very restrained in expressing their problems. They don't always want to communicate with staff.

Staff nurse: The Asian patients have a low pain tolerance, when they've got something to be done to them. *Some patients express their pain quite loudly*, [staff nurse's emphasis] and this can be quite disturbing to other patients (FG 4).

Evidence of poor cultural knowledge was also noted in the participant observation field notes. Other examples of cultural insensitivity during other focus groups interviews related to a lack of understanding of South Asian diabetics' dietary needs, Asian women's refusal to undress and be examined by male doctors, and negative comments about their relatives coming in droves during visiting times.

4. Victim blaming (It's not our fault)

The facilitator introduced a scenario using a real recent incident that had occurred in one of the other wards, not involved in the study. However, it is interesting to note that the staff nurse and sister were defensive, with minimal engagement with the scenario put forward by the facilitator. It is interesting that there was no outright condemnation from the participants that such nursing practices would be unacceptable whatever the patients' religion. Such an approach is what Puzan (2003) refers to as 'acting white', when participants adhere to the behaviours, values, beliefs and practices of the dominant white culture, and engage in discourses of what constitutes accepted and unaccepted practices:

Mrs X (facilitator): (Recalls a recent incident that happened in one of the wards): A young male Asian patient had died on the ward. His mother was called in to see the body.

She had been horrified to find him in bed lying in a pool of vomit. She was very distressed as the picture of her son, in such a disgusting state in that bed, had been haunting her ever since. The nursing staff's comments were that as he was a Muslim, they did not think they were allowed to touch the body. 'We usually let the family deal with the body.'

Staff nurse: The nurse was following the guidelines. But it's not our fault, is it? We can offer the services but we cannot force people if they don't take up the services. Now can we?

Sister: I think we manage quite well (FG 8).

The above discussion shows clearly how stereotyped assumptions about Muslims created cultural barriers within patient care, and led to a failure to provide culturally sensitive care. It also demonstrates evidence of 'ethnic othering' (Duffy 2001), with a tendency for highlighting differences and the exotic nature of practice rather than commonalities in caring for people from diverse cultures. Caring, in this context, should have meant cleaning up the vomit and making the body presentable before allowing the relatives to come in, and ensuring that gloves were worn in case the body was touched.

5. Valuing of the relatives (They are very helpful)

The comments from this theme were unsolicited, but volunteered by one staff nurse. The result was a quick affirmation by the rest of the group. The published literature has not reported any similar statements in relation to minority cultures:

Staff nurse: I find the relatives very helpful. I am more appreciative of the help they give us in helping to wash the patient and also without forgetting with the interpreting. I don't know what we would do without them.

Sister: They can be a Godsend, especially when the doctors come and we have no one to interpret.

Care assistant: I find that the patients are very clean and very keen to maintain their cleanliness. Especially the Muslim patients they want to wash regularly.

Care assistant (Asian): The relatives tend to come to me because I am Asian, both patients and relatives are very pleased to see me when I'm on the ward (FG 7).

Examples in other focus group interviews indicated the opposite view about relatives. Most of the comments created an image about relatives as deviants and a nuisance, and as asking lots of questions and disrupting ward routines by staying for much longer in the wards than the relatives of white patients.

6. Denial of racism (We don't have racism here)

The response to the facilitator asking the participants what they thought about racism was quick. Instead of answering the question, there was a strong denial of the existence of racism with the lead taken by the sister. There was also a depersonalisation of racism and instead a discussion of attitudes from the wider community. However, the suggestion of bigotry by the care assistant allowed the focus group discussion to move from categorical denial of the existence of racism to racism being perhaps more common in older age groups, while the statements clearly showed negative cultural stereotypes about black people:

Sister: I don't think there is racism at our level, as we see all the patients and we treat them all the same.

Care assistant: I don't think it is racism, it's bigotry, yes I think I'd call it bigotry among the white patients.

Staff nurse E: I think there is more racism among the older age group, for example my parents' age group. For younger people, they go to school together and mix with all races that cut down barriers.

Staff nurse D: It's not always true as recently there were reports of racial attacks at a local school.

Staff nurse E: I suppose, what I mean is that people will make their own judgement about black people. As some come with a lot of 'traditional baggage'.

Sister I: I work with an Indian person, my nursing auxiliary, and we don't have a problem. I'm fearful of West-Indians really, they are different with their postures and their rhythms and the way they walk.

Sister J: I don't think this is the same thing. You're not likely to know from your own staff. It's different (FG 4).

Similar views to the above were evident in the other focus group interviews in response to this question. Such discussions have similarities to 'white talk' described by McIntyre (1997). This is a negative strategy used by whites to circumvent their own roles in perpetuating racism, while sharing dominant perspectives and positions within the nursing community.

7. Ethnocentrism (It's not rational what they believe)

The following excerpts reveal not only a high level of misunderstanding about different religious and cultural practices but also about the strength of the use of a dominant cultural lens in interpreting other cultures:

Mrs X (facilitator): Some religions like Islam, Judaism, Hinduism, Sikhism have certain rules about names, hygiene, fasting and other religious observance.

Care assistant: Yes, also about blood donation or transfusion and also rituals about death and dying.

Staff nurse: I've heard that Hindus and Muslims are opposed to postmortems.

Mrs X: Basically it's to do with people's core beliefs. Hindus believe in reincarnation and some have been told quite erroneously that at postmortems, parts of the body are cut away and discarded in the bin. There is always the fear that if the body is either cremated or buried without all the organs, this might affect the reincarnation of the spirit.

Sister: *But this is ridiculous* [sister's emphasis]. It's not the body that is reincarnated, but it's the soul. How can people believe in such things?

Care assistant: Muslims and Jews are much stricter about their diets, too. Aren't they? They have to have Halal meat.

Sister: It's *not rational belief*, these [sister's emphasis]. Those ways of butchering are cruel to animals and anyway nowadays, there are more humane ways to kill animals for consumption (FG 2).

The above comments were typical on this subject in all the focus groups. Yet again, the cultural biases, misunderstandings and colour/culture-blind conversations indicate the inherent white power structure, the power to define other beliefs and practices as irrational and lacking in worth, when compared to 'white' culture (Puzan 2003).

8. Self-disclosure (I know how they feel)

The following answers came as a response to a question by the facilitator related to staff's own experiences. It was very interesting to see that some participants were able to reveal personal details and negative experiences about their own beliefs. Such revelations revealed a high level of sensitivity by some staff, especially about the lack of language facilities and how hard it may be to learn a new language by some people. It is notable that some participants exposed feelings of conflict if they made allowances for certain groups of patients, such as relaxing rules for visitors:

> **Care assistant:** I am from a minority Christian religion and I can assure you that certain beliefs and principles are central and are not negotiable, such as organ transplant and blood transfusion. I get a lot of stick and rejection from colleagues for my beliefs, especially when we have a patient on the ward that refuses blood transfusion. I can understand how some South Asian patients may feel about similar prejudice.

> **Sister:** For me, I find the issues re visiting quite stressful, on the one hand not to be seen as unfair to other patients. There are also the fire regulations to consider. I feel trapped between the two, really. Could this be racism?

> **Staff nurse:** I can appreciate the problems of racism, being Irish myself and having lived in the Midlands with a high Asian population. I cannot see why some staff do not accept that it exists.

> **Sister:** It's not easy learning a foreign language. It's easier said than done. I lived in Germany for three years and I have not learnt very much German either. I think because we were with English folks all the time, and you don't need to. I can empathise with some of the Asian patients who cannot speak English (FG4).

The above excerpts summarise the eight themes of the findings from the focus group discussions. The findings also demonstrate the interactive processes, which inform the reality of the experiences of nurses caring for South Asian patients (Reed and Payton 1997).

DISCUSSION

Theme 1 indicates that positive changes are happening at the point of service delivery. For example, the introduction of Asian menus, translation of leaflets in minority languages, and the appointment of a multicultural adviser at the local health commission have been noted. Such evidence indicates a positive local service response to government policies (Department of Health 1998; NHS Executive 2000; Department of Health 2000). However, the policy change initiatives are contradictory to the participants' actual knowledge and understanding of cultural requirements. The participants' request for checklists to enable them to access information about religious and cultural norms and practices of minority ethnic groups has been popular (Karmi 1996). However, such guides on their own offer no substitute for proper understanding of minority ethnic peoples' cultures and practices (Gunaratnam 2001). Use of such checklists lends itself to 'ethnic othering' (Duffy 2001), where differences are highlighted and emphasis is given to the unique, exotic and the unusual, and where care of minority ethnic patients becomes a case of looking for and treating exotica (Ahmad 1993), resulting in victim blaming.

In theme 2, however, a conflicting picture emerges. Within the theme of 'treating them all the same', a consensus view emerges that, by treating everyone the same, nurses do not discriminate and that they are being fair. Robinson and Elkan (1996) refer to such a concept as horizonal equity. Pearson (1986) argues that, while a commitment to uniformity as suggested by the statement, 'we treat them all the same' may appear egalitarian, it by no means objectifies any meaningful concept of equality in a diverse multiracial society. To treat everyone the same when they are very different can be to treat some unequally. In practice, treating everyone the same no doubt means treating them as 'white' or western, which the majority of patients are. 'Same' thus probably signifies treating South Asian patients as whites, rather than taking account of individual differences, and such approaches can camouflage racism (Puzan 2003).

Despite numerous educational and service initiatives taking multiculturalist approaches, many minority ethnic service users still experience forms of exclusion, both from and within services (Bradby 1995; Gerrish 2001; Gunaratnam 2001).

A strategy of treating everyone the same thus tends to deny the existence of cultural differences, the central importance these play in the delivery of care, and the reality of minority ethnic people's lives. Such a practice would appear to create a false consciousness of equity. The resultant culture/colour-blind approach is what Puzan (2003) calls 'acting white'. Acting white, she argues, is practice that ignores, overrides, discounts, rejects and violates the integrity of individuals or groups who do not model the characteristics of the dominant culture.

Lack of cultural competence, theme 3, has potential for serious implications for care. This is shown in the poor understanding of cultural traits such as the avoidance of eye contact or the lowering of gaze in front of an authority figure as a sign of respect (Henley and Schott 1999; Andrews and Boyle 1995). Poor understanding of cultural differences in pain tolerance levels and experience (Andrews and Boyle 1995) was also evident. Lack of cultural competency skills would not only result in communication difficulties and interfere with patient assessment of needs, but may also result in inaccurate and insensitive treatment approaches, thus exacerbating patients' dissatisfaction with their care (Murphy and Macleod-Clark 1993; Smaje 1995). Potentially, white culture dominance could result in routine invasions of privacy and a disregard for personal ethnic rituals, Puzan (2003) argues.

In theme 4, a victim-blaming approach is demonstrated. Letting relatives deal with religious and cultural aspects of care may indicate sensitivity, but in reality may lead to the marginalisation of culture (Ahmad 1993; Culley 2001). Participants offered no debates, discursive responses, or any other explanations for what many nurses would consider poor nursing practice, by leaving a recently deceased patient lying in a pool of vomit. The lack of a critical response could be a reaction to the negative connotations inherent within the scenario.

While the information contained in guidelines may be beneficial in certain instances, overreliance by healthcare staff on such tools may not only marginalise minority ethnic groups, but also act as a form of oppression. Such categorisations may eventually lead to the reinforcement of negative stereotypes because they emphasise the 'strangeness' or 'alienness' of such people rather than celebrating the diversity of cultures (Lea 1994; Duffy 2001). Such recipe-book practices permeate reductionist approaches that allow nurses to see minority ethnic patients not as themselves or as 'whole'

persons, but instead as a series of 'dos' and 'don'ts'. Nurses' request for checklists to enable them to access information about the religious and cultural practices of minority ethnic patients has resulted in 'ethnic othering' (Duffy 2001). However, such guides on their own offer no substitute for a proper understanding of minority ethnic cultures (Gunaratnam 2001). A proper understanding of minority cultures is developed through the recognition of the 'self' as cultural beings, by emphasising commonalities instead of differences (Lea 1994; Duffy 2001), and by seeing variations in family patterns not as natural but as the result of complex socio-economic and cultural processes.

The valuing of South Asian patients and relatives (theme 5) has not been found in the literature of hospital nurses. This theme possibly occurred as a result of the synergistic effect of the interaction. The pattern of interaction could have been influenced by the presence of the South Asian care assistant. It is possible that an earlier discussion about visiting hours and how the relatives tended to flout the 'two by the bed' visiting rules may have appeared rather negative, so the staff nurse proposed the statement. This may be a particular finding related to the synergistic effects inherent in focus group discussions.

In theme 6, participants tended to skirt round the word 'racism'. There has been a tendency to avoid use of the word 'racism' in conversation or in the context of healthcare delivery, because racism has connotations of hatred and overt discriminatory practices (Miles 1989), which participants did not feel actually happened in the directorate.

The denial of racism, where it occurs, is a major shortfall in service provision and should be an area for further research. Mares, Henley and Baxter (1985) contend that racism is a central feature of the life of most black people in Britain and that to ignore or choose to deny the existence of racism may give the impression of condoning it. Dominelli (1992) explains that one of the strategies employed by staff is denial by expressing disbelief, indignation and even surprise at the slight suggestion of the existence of racism. However, if the meaning of an utterance is located within an existing social institution, then that institution necessarily exerts control and power over it (Cherryholmes 1988). Some nurses' utterance about the non-existence of institutional racism nonetheless represents power within the organisation. Such dominant narratives in health institutions have previously been reported (Porter 1993; Modood, Beishon and Virdee 1994; Gerrish 2001).

Ethnocentric views, revealed in theme 7, were also found in Murphy and Macleod-Clark's (1993) study. The tendency to view others from the dominant cultural lens and not accept or value the cultural differences, norms and practices

of others raises questions about uneven power relationships (Hugman 1991; Alexander 1999).

The ethnocentric views and attitudes expressed by some participants had racist undertones, as such expressions not only tended to locate western culture as superior and rational, but also located the South Asian patients' culture as inferior, bizarre and irrational. It shows how white people occupy hegemonic positions that enable them to maintain that what they say is neutral or unsituated, human and not raced (Puzan 2003). The reluctance of some participants to accept the religious beliefs and practices of their patients, as shown in this theme, raises questions, not only about their cultural competence, but also about their ability to apply core nursing principles enshrined in the Nurses and Midwives Council's (NMC) Code of Practice (NMC 2002).

Aspects of self-disclosure (theme 8) — white nurses 'putting themselves in their shoes' while looking after South Asian patients — have not been found in the literature; however, the opposite has been reported by Murphy and Macleod-Clark (1993). Other reflections disclose how some participants drew analogies with their own religion both in terms of experiences regarding pastoral care and in terms of discrimination. However, Marx and Pennington (2003) found, in a study of teachers using critical cultural therapy, that participants became aware of the ways in which their whiteness and racism influenced their beliefs interactions.

The findings reflect the group perspectives among that particular group of nurses, and as such represent displays of cultural and moral forms of that group (Reed and Payton 1997). Although it is recognised that the findings of this qualitative study are not generalisable to the wider population, theoretically they point to wider implications for practice.

RECOMMENDATIONS

Cultural competence

The findings clearly show poor cultural competence in nurses. Cultural competence training should involve a shift away from 'ethnic othering' and victim-blaming approaches of checklists, and instead focus on commonalities between groups as a way of improving knowledge and understanding, raising cultural awareness and improving cultural assessment skills (Duffy 2001). Cultural assessment training should be instituted as part of preregistration and postgraduate nurse training, with a view to eliciting shared beliefs, values and customs that have relevance to health behaviours (Tripp-Reimer, Brink and Saunders 1984). The findings suggest that cultural assessments should be performed to identify patterns that may help or interfere with nursing interventions.

Critical race theory

The fact that the participants were reflexive opens the way for improving cultural competence, as noted by Marx and Pennington (2003). Critical race theory draws on ideas challenging discourses of 'other' and uses reflection on current perceptions to develop greater cultural awareness. Such an approach operates through a rejection of conventional understanding of language as the only ways of knowing, by confronting white privilege through an examination of systemic oppression, with adequate multiethnic representation (Puzan 2003).

Transformative cultural education (TCE)

TCE is a process that affects the attitudes, knowledge, behaviours and feelings of the learner's or practitioner's own culture. Both Anderson (2000) and Duffy (2001) suggest that TCE starts with the assumption of shared power between members of equal but different cultures and acknowledges colearning and cocreating.

Government policy

The Department of Health recommends that ethnic minority health be embedded into mainstream healthcare delivery (Department of Health 2004). It advocates three critical processes to be in place for support of such changes in practice: leadership, linkage and the maintenance of lasting change.

CONCLUSION

The study has revealed a local service response to government policies in addressing inequality in accessing health services. However, such initiatives have made little difference to nurses' knowledge and cultural competence in enabling them to provide culturally sensitive care, raising questions about the quality of service provision. Greater efforts need to be made by both practitioners and educators towards ongoing staff development and training to address cultural competence and to improve antidiscriminatory practice. Nursing faces major challenges because of the dominant discourses and institutional power of 'whiteness'.

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