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Examining race in health research. the case for 'listening' to language

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ABSTRACT

Health researchers must be constantly conscious of the contribution that they may or may not make to the politics of race through language. In order to unpack concepts such as *multiculturalism*, *race relations*, *ethnic minority citizenship* and so forth at the local level, it is necessary to begin to understand concepts of *race* and *racism* in a global context, through the shifting ontological, epistemological and methodological frameworks as they relate to the study of race and racism. This paper unpacks these processes and suggests ways forward for better understanding of the *language game* and concepts of *race* in health research. To accomplish this, language, communication and knowledge transfer

in a post-modern era are explored. The 'cookbook' approach to diversity is criticised. A relationship-centred framework is suggested as an alternative, with an exploration of the meaning of the terms *ethnicity* and *race* constructed dialogically within communities. The concept of *meaning* itself is discussed as a social and political process constructed through language in health interfaces and power relationships.

Keywords: ethnic, healthcare research, intercultural communication, minority multiculturalism, race, relationship-centred care

Introduction

There is hardly a term that raises more hopes for international understanding and peaceful transaction among people, yet is more difficult to define, than *intercultural communication* (Kramsch, 2002). Nonetheless, 'advances in the articulation of multicultural practice and policy dealing with ethnic communities have focused almost exclusively on developing competency skills based on individual communication and understanding between formal service providers and clients rather than on exposing and altering institutional structures and power relations marked by racism' (Brotman, 2003). Reviews of the literature on health, ethnicity and diversity strongly suggest that dealing with institutional racism *first* will result in clearing the air for the development of meaningful communication at the interface of health services and minority ethnic service users.

In order to unpack concepts such as *multiculturalism*, *race relations*, *minority ethnic citizenship* and so forth at the local level, it is, therefore, necessary to begin to understand concepts of *race* and *racism* in

a global context. This is accomplished through the shifting ontological (the fundamental characteristics, nature, and essence of social reality), epistemological (the way in which we obtain knowledge about social reality), and methodological (the analysis of the principles or procedures of inquiry in a particular field) frameworks as they relate to the study of race and racism (Stevens, 2003). Wilkinson (2000), for example, believes that the term '*minority* serves as an anachronistic political device that obliterates natural and contingent social distinctions'. 'Dismissing race, ethnic identity, class status, and even gender through repeated use of the "minority" label reduces the ability to understand the authenticity of the life stories of distinct populations' (Wilkinson, 2000). It may be the case that concepts and terms such as *race*, *ethnicity*, *minority*, *culture* and so forth will never be entirely precise or without controversy or divisiveness. This impasse crystallises the need for investigation of terms and terminology at a deeper level, with a consideration of the theoretical concepts and principles of language,

communication and knowledge transfer. The purpose of this paper is not to suggest alternative terms, but rather, to encourage rethinking of commonly used terms within a dialogic of greater understanding and sensitivity.

Deconstructing the knowledge base

The social construction of knowledge as described by Gergen (1985) maintains that knowledge, scientific or otherwise, is not obtained by objective means but is constructed through social discourse. In any particular knowledge community, the words and stylistic conventions used typically derive their meaning from the attempt of people to co-ordinate their actions within the community (Gergen, 1997a).

These linguistic conventions evolve over time into codified symbols with the ability to compress large amounts of assumed knowledge and background information and deliver it for their intended audiences and, by intention or coincidence, to withhold such information from others. The members of different groups of scientists, policy-makers, campaigning communities and so on go through a lengthy socialisation process to enable them to produce and understand knowledge comprised of a kind of 'shop talk' that heightens participation in the language game, enabling them to ring-fence their areas of expertise. This professional 'codification' produces icons with the accumulated power to persuade, convince, establish authority and represent authenticity, but which through this very process carries the inevitability of skewing and/or stifling wider community discourse and input. (Wu *et al*, 2004)

'The dominant shift within the academic analysis of ethnicity has been towards a post-modern theorization of identities as fragile, shifting, multiple, and transitory' (Husband, 2000). Post-modern theory offers the health professions opportunities to move beyond the ethnic awareness school of multiculturalism and to challenge simple solutions offered up in pre-packaged cross-cultural competencies (Husband, 2000). Research in the post-modern era compels us to think across epistemologies and support interdisciplinary efforts as well as a science that includes more emphasis on collaborations with our research participant co-authors and co-producers. This produces a social science that is relational. Central to its principles are inter-subjectivity, being together, the encounter and the collective elaboration of meaning, based in models of sociability. In constructionist thinking, no single point of view is more valid than another, because all points of view are embedded in a social context that gives them meaning. 'Such a view does not obliterate empirical science; it simply removes its privilege of claiming truth beyond community' (Gergen, 1997a). Constructionism is a simple belief system, founded

upon the basic proposition that knowledge is never true *per se*, but only relative to a culture, a situation, a language, an ideology or some other social condition (Bauerlein, 2001). Knowledge is a negotiated discursive construct that is created between people. Thus, embracing dialogue involves developing generic skills that enable us to counter the anxieties and ambiguities present in cross-cultural interactions, promoting flexibility and adaptability at the heart of the intercultural communicative competence (Husband, 2000).

Gergen (2001) alerts us to the concept that this is often accomplished by the integration of preceding intelligibilities and realignment of existing ones and their practices. This process is accomplished linguistically, that is, with language, and constructed socially to make its case. Within the literature on ethnicity/race/diversity, for example, this evolutionary process becomes particularly heightened. The words chosen, that are appropriate in terms of political correctness to use in discussions on issues of ethnicity, race and/or diversity, vary and change over time and from group to group. This is one reason why simply suggesting alternative terms will not suffice. In reviewing the literature on health and ethnicity, for example, searches using the root term *ethnic* turn up literature from many British sources. Using the search term *race* brings forth mostly American studies. It would be simplistic to come away from this finding assuming that nationalistic differences, whether historic, political and/or linguistic, alone produce this anomaly. The British literature seems particularly to back away from the term *race* and yet, the term *racism* is quite prevalent in UK policy literature. American historian Marable warns that 'the UK ignores at its peril the subject of race' (BBC-TV FOUR, 2003). Rather than suggest alternative terms, then, it makes sense to unpack these terms themselves, which are often avoided and/or glossed over.

Why is there this apparent reluctance to use the root word *race*? Several scholars note the increasing tendency to substitute *ethnicity* for *race* (see Nickerson, 2001, for example). Kenyatta and Tai (1997) conclude that some researchers 'use ethnicity interchangeably with race because they are still uncomfortable with race, racism and its role' (Kenyatta and Tai, 1997a). In abandoning the concept of race, there is a serious tendency to abandon discussions of power, domination, and group conflict. In works on *ethnicity*, the discussions quickly turn to matters of *culture* and *identity* rather than issues of political power or powerlessness (Kenyatta and Tai, 1997b). The dangers of ethnocentricity and the naïve promotion of multiculturalism lie in the fact that the fight *against* racism may very well be transformed into a fight *for* culture (Kundnani, 2002).

Researchers must be constantly conscious of the contribution that they may or may not make to the

politics of race through language. Werth *et al* (2002) caution: 'In writing about cultural diversity, summarizing research on various groups and using case examples, both authors and readers alike run the risk of stereotyping people'. Using the term *cultural diversity*, the authors speak of *culture* as referring to more than merely ethnicity. They cite Krakauer *et al*'s (2002) definition of culture as 'a constellation of shared meanings, values, rituals and modes of interacting with others that determines how people view and make sense of the world' (Krakauer *et al*, 2002, cited in Werth *et al*, 2002). Krakauer *et al* elaborate: 'Although the definitions of "ethnicity" and "culture" overlap, "ethnicity" denotes, at least in part, a shared genetic or geographical origin' (Krakauer *et al*, 2002). Following a view that diversity encompasses respect for the unique needs and wishes of each patient, Werth *et al* make the case that individuals in a group run the range of the values, attitudes and actions of the group itself (Werth *et al*, 2002).

Although vast cultural differences exist in models of *the individual*, it is important to note that individual differences, no matter what the culture, cannot be reduced to concepts of *race*, *gender* and/or *social class*, nor can they be simplified as variations around these norms (Meacham, 1999). In fact, the concept of the *norm* is as outmoded as it is unhelpful, at least in post-modern times; in considerations of *ethnicity/race/diversity*, its use is more than suspect (see Calasanti, 1996). The concept of the ethnic group classification (see White, 2002) in research is ultimately a statistician's sleight-of-hand, at times inadvertently promulgating historical racism or replicating current discomfort around issues of race. For example, the 2001 UK census, for the first time, counted the religious affiliations of the population, 'a move widely thought to reflect the need to measure the size of the Muslim population' (Kundnani, 2002).

Alternatives to current discursive practices need to be developed, not solely by researchers, service providers and the like, but by dialogue with and within communities, seeking alternatives to current language and language use. It is envisaged that, by such practices, alternative terms and terminologies will evolve more naturally. For example, new terms such as *cultural competence* (Box 1), developed at community level, deserve our consideration.

The 'cookbook' approach to diversity

The 'cookbook' approach to *ethnicity/race/diversity* and service provision is often the first response to

Box 1 Cultural competence

Concepts of *cultural competence* are slowly making their way from North America to Britain. The model states that culturally and linguistically competent health promotion requires a community-level focus (National Center for Cultural Competence, 2003).

Culturally and linguistically competent health promotion:

- is always undertaken within a social, environmental and political context
- recognises the family and community as primary systems of support and intervention
- assures that its efforts exist in concert with natural and informal healthcare support systems
- assures meaningful involvement of community members and key stakeholders (National Center for Cultural Competence, 2003).

meeting the educational needs of health and social service workers when interfacing with new cultures.

The majority of published literature contained in medical or nursing libraries or located by searching in health-related bibliographic databases under headings such as ... the names of major religions ... frequently are purely descriptive, or assertive, stating the major principles of the religions concerned and seeking to spell out some of the implications of these for practice ... In the process, they may also create new myths or stereotypes, and compound this with inaccuracies or misunderstandings. (Johnson and Jones, 2002)

One of the problems with the 'cookbook' approach to the study of ethnic minorities is that aspects other than formal religious beliefs are overlooked in much of the 'how to' or cookbook literature and that not all members of an ethnic group will routinely follow the beliefs of a specific faith (see Mitty, 2001). There is a wide variation of beliefs and behaviours within any specific ethnic population (Kagawa-Singer and Blackhall, 2001). For example, other factors such as folk beliefs and folk medicine are important to many ethnic minority patients and their families (see Pachter, 1994).

The 'cookbook' approach also fails when consideration of variations within a specific ethnic group come into focus, or generational or cohort differences are considered. Ethnic differences, in many ways, reveal only the outer layer, one skin of identity, freeze-framing the person underneath. Ethnic differences are structural variables that often obscure equally important building blocks to understanding individuals or groups, which include time effects such as age

and the life course, cohort effects and generational differences, and historical trends and period effects (Miller, 2000). It is crucial throughout any considerations to keep in mind that 'individuals and groups can and do change their ethnic or cultural identities and interests through such processes as migration, conversion, and assimilation or through exposure to modifying influences' (Smedley, 1993, cited in National Center for the Dissemination of Disability Research, 1999). In the end, 'cookbook' approaches to issues of ethnicity and race do a disservice to both the diverse groups studied and the research community as a whole, and should be used with caution. 'In the light of changing cultural fashions, and variations between individuals in the observance of their faith' (Johnson and Jones, 2002), reliance on such guides is risky.

A relationship-centred approach to diversity

The interface of cultures within our contemporary society, including potential healthcare intercommunication, consists of interactions between specific population groups and an additional culture, the medical establishment and its subsets. By its nature, therefore, health service use *always* comprises an interface of cultures. In general, research on *race, ethnicity, diversity, language* and *intercommunication* within the medical subculture tends to be characterised by an epidemiological framework, while the potential insights offered by sociological and anthropological research are largely ignored. By moving beyond enumerating differences, however, communication and pathways to care can be studied as social processes subject to a wide range of influences, including cultural contexts (Morgan *et al*, 2004). If knowledge and understanding are gained through language and communication, then it becomes paramount to establish a safe space for dialogue between patients, providers, families and communities. Although questions of gender, race and/or ethnicity, class, and religion set the agenda in a great deal of the literature on the interface of health services and minority cultures, underpinning much of the discussion are the emergent themes of family systems and dual authority. A common thread throughout the literature on the interface of ethnic minority cultures and health services is a sensitivity to the varying expectations and mix of communication, in care settings, between patients, practitioners and family, including concepts of extended family and significant others (Jones, 2005, 2006). This presents opportunities for dialogue and a mix of communication between healthcare provider and patient,

patient and family, and family and provider. These socially constructed, intertwined relationships surface as critical to an integrated model of care and decision making which evolves through such discourse. Because of this triangulation of inputs, the traditional carer/patient power dyad shifts and changes.

This concept of informed communication between all parties has begun to emerge in the healthcare literature as a paradigm, suggesting ways forward to understanding the complexities of diversity. In addition, a model of the self that is embedded in social relations, and a conceptualisation of diversity that includes differences not only between racial/ethnic groups but also within them, surfaces in studies repeatedly. Thus, issues of patient autonomy become only one component of a larger dialogic system, encouraging a more holistic approach to healthcare that includes patient, family and care provider intercommunication. Central to the discussion here is the reality that the evidence repeatedly extols a family-centred approach to care that includes diversity in its wider sense, and the participation of all care partners in communication, information sharing and decision making (Jones, 2005). The fact that persons from a wide range of ethnic and/or racial backgrounds, including the white population, prefer family involvement in many healthcare decisions can no longer be ignored. Thus, intercommunication develops out of establishing new, and acknowledging and working with existing, relationships.

The move from patient-centred care to consumer-led care has recently been challenged by a *third way* approach with the model of *relationship-centred care*, emanating from the USA and proposed for British health services by Nolan *et al* (2004). The authors take a critical look at some of the assumptions underpinning the current person-centred, consumer-led trend in healthcare. They suggest that, by thinking about wider relationships within the healthcare setting, as opposed to Western patient autonomy models, the rights to medical knowledge and the cultural belief systems of ethnic minority families and their communities become central to culturally sensitive healthcare (Nolan *et al*, 2004). Relationship-centred care, therefore, champions intercommunication at the level of individual, family, community and healthcare provider relationships and by doing so, critiques current language such as 'patient-centred' (autonomous) or 'consumer-led' (economic) systems of care.

As the UK becomes more culturally diverse, the risk to minorities of poor care due to cultural miscommunication is likely to grow, just as it has in the USA (Krakauer *et al*, 2002). Movements such as patient-centred care and health consumerism, in fact, reinforce the widespread Western concept of the inalienable rights of the individual, but do not

take into account the often quite different constructs of the individual in a multiplicity of cultures as well as the sometimes contrary wishes of patients' family members. The rights of families to medical knowledge, and their roles in decision making, are just as valid, unassailable and crucial to the cultural belief systems of many ethnic minority communities as Western patient autonomy models are to the majority culture. Opening up avenues for communication and dialogue between all parties will go a long way in improving healthcare services as well as intercultural dialogue more generally.

Conclusions

Communicating with people from other cultures can often cause anxiety and stress for both sides of the dialogue. Stress is raised to higher levels by learning new communication rules and behaviours, completing more complex tasks and increased lack of control in work situations (Ulrey and Amason, 2001). Ulrey and Amason (2001) state that gaining effective intercultural communicative skills should result in lowering such stress. We must, however, abandon the hope for unitary, naively simplistic alternatives to language and communication issues in favour of recognising the diversity of intersecting identities and needs that people from minority ethnic groups present (Burman *et al*, 2003). Understanding, a two-way process, is, in fact, gained through language, communication, intercultural sensitivity and dialogue. Consideration of common factors found in models across a wide variety of cultures provides one useful way to bridge the gap between culturally specific and universal approaches to better intercultural communication.

According to a UK Department of Health review of research on language, communication and the minority ethnic population and its interface with Western medicine (Szczepura *et al*, 2005 – see Box 2), change first needs to take place by mobilising resources at the community level (Husband, 2000), particularly in communication-dependent practices such as health promotion. In many minority cultures, a sense of identity (the concept of identity as 'fragile, shifting, multiple, and transitory' (Husband, 2000)) is constructed first within the family and then at the level of the cultural community, rather than simply at the individual level. The minority ethnic service user is often, therefore, better engaged in meaningful communication through dialogue at both the family and community levels (Lodge, 2001).

Wittgenstein stated: 'For a large class of cases – though not for all – in which we employ the word "meaning" it can be defined thus: the meaning of a word is its use in the language' (Shawver, *circa* 1998).

Box 2 Reviewed literature on ethnicity, health and communication

A review of research on language, communication and the minority ethnic population and its interface with Western medicine (Szczepura *et al*, 2005) suggests that:

- communication is a means to shared knowledge
- models of knowledge exchange too often remain within the dominant culture
- 'race' and racism need to be understood at local, state and global levels
- ethnic 'identities' are fragile, shifting, multiple, and transitory
- knowledge, scientific or otherwise, is not obtained by objective means but is constructed through social discourse
- a critical reflexivity and more dialogic consideration of explorations of knowledge on the part of academics and policy makers will produce more enlightened evidence reviews, thus more transparently influencing everyday, commonsense discourses and better-informed practice
- third-order principles, developed through syntheses of evidence from a variety of health-care systems and cultures, provide emergent knowledge upon which to explore new considerations for policy and practice in the UK.

Thus, the term *meaningful communication* itself needs to be further developed through exploration at individual, family and community levels. To many members of minority ethnic communities, *meaning* in healthcare settings is more frequently constructed by dialogue in the family and community, rather than simply between autonomous individuals, such as a patient and her/his care provider. 'To treat ... meaning ... as transparent and trans-contextual is to deny its history, to suppress its broad web of interdependencies, and prevent its potentials for creative and variegated usage' (Gergen, 1997b). For example, the *meanings* of the terms measured in ethnic headcounts and the like already have meaning in everyday life, governed by grammar. What does *communication* mean and to whom – the researcher, the subject, or the community at large? Whose community? These concepts often used in measurement studies and the like are, in reality, founded on common-or-garden concepts and are, therefore, ultimately community or populist perceptions. They are simply not organised around finite sets of behaviours (Maraun, 1998) or fixed meaning, but evolve and change with use and user. According to Foucault, discourses do not just reflect

or represent social entities and relations, they construct them. It is argued that the changing terminology of care reflects emerging and competing ways to talk about the care provided to patients. It is a social and political process, which displays broader tensions and reveals power positions in society (Payne *et al*, 2002).

By acknowledging the complexities involved in intercultural communication, and the importance that language plays not only in such interfaces and power relationships but also within the language used in researching and reporting findings, we can begin to clear a space for meaningful dialogue and expose and alter institutional structures and power relations marked by racism in our practices. Knowledge itself is constructed through language and dialogue. This opens a space for understanding intercultural communication at a deeper level, by consideration of theoretical concepts and principles, producing emergent knowledge that is truly discursive and enriched through the exploration of innovative means of knowledge transfer. Sensitivity to language within our methods of knowledge mining and knowledge transfer will also contribute greatly to intercultural understanding at individual, group, community and institutional levels, reducing racism.

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CONFLICTS OF INTEREST

None.

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