New arenas within local public services with `social transformation` capabilities: transforming black peoples experiences of hospital and community health.

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Abstract
This paper reports a method developed jointly with a hospital and community health trust which was successful in overcoming resistance by staff to changing their own practices in responding to black patients. This is a rare public management case study about tackling racism and offers a baseline from which to develop comparable approaches with other public services. Unlike the MacPherson report, which brought the Steven Lawrence enquiry to a close, the writing up of this project identifies what can be `got at’ and how under the general heading of `institutional racism’ and which bears directly on how staff do their job (MacPherson 1999).

The then `new` public managers were responsible for setting up the project in 1994. One of the major features of the work done was to gain a shift in view to the effect that many of the new public management assumptions and practices were a substantial part of the problem. In particular that an exclusive pre-occupation ONLY with short term quantifiable outputs and tangible gains was itself undermining the ability of practitioners in taking responsibility for changing their practices. By the end of the work managers were supporting new practices in which `intangibles` in relationships between practitioners and patients were proving to be of great importance, without undermining the efficiency of the work done.

The way that some managers were `part of the problem` in part accounts for the `dialectical` movement of the project through its 3 stages. The need to demonstrate the inadequacy of `ways of thinking` became substantial information collection exercises. By analysing the material collected the weaknesses of thought could be examined without personalising. Through stage two the project came to know `how bad it was for black people` in the terms that practitioners recognised so that attempts to detract away from the true nature of the situation could no longer have effect.

It became possible to legitimise a rethink and into that `space` the project was able to bring into being new arenas of thought and action. Nevertheless the power of individual managers and staff to subvert a project of this nature should not be underestimated. In the case of this particular project we would not overstate this. In the main managers and staff were highly supportive.

One way of viewing the project is as a longer term structuring of a `meaningful` journey where one stage prepares the way for and leads into another but where these stages, cumulatively tilt the balance of the `power to define` such that management becomes engaged with and also by both black and white practitioners in a critical fashion. The generic thinking which, when woven together, generated the power to sustain this challenging engagement is drawn out. The importance of embedding within a longer term intervention, broad and well established information collection and learning techniques of social research and management development, (and which in this case encompassed survey, action- research and learning through group process) is also highlighted.

The article critically evaluates the literature on race and health showing it to be problematic in relation to the project. The main body of the article presents the three stages of the project. It
may be that there is a shorter route. One of the results of publishing this work will hopefully be that reworked versions of the approach take place elsewhere, perhaps informed by different theoretical insights. However in the climate of the mid 90s, without much to guide us and with no supporting policy framework, we felt it necessary to conduct a longer term intervention over a period of 4 years. The article ends by considering the implications of the experience of this project for efforts elsewhere to challenge ‘institutional racism’.

We would, at the outset, like to be clear that when talking about institutional dynamics we are using the language of ‘black’ and ‘white’. We hope some readers will not immediately question why more apparently embracing terminology (around which there also is never full agreement) such as ‘black and Asian’ or ‘black and racial minority’ or ‘ethnic minority’ is not being used or why the word ‘white’ is being used. In fact some of this language is used to review the literature about communities, where we feel it is misleading to represent a wealth of immense historically accumulated diversity simply by using the word ‘black’. In our view the use of the language of ‘black’ and ‘white’ is a way to focus directly on racism within institutions and its complex power dynamics without this view becoming obscured, either by a host of other relatable (and important) issues or by somewhat subjective and individualised views.

We also take the view that taken for granted norms associated with ‘white’ IN PRACTICE exclude ‘black’ (within institutions); that this is an extremely powerful dynamic which has been in operation for a very long time and that it is simply unrealistic to expect public services NOT to have to work at overcoming this entrenched historical legacy. Those public services which do not succeed in the very challenging task of harnessing this otherwise destructive dynamic will in our view exhibit the characteristics of ‘institutional racism’ of which tragic cases involving the public are but one manifestation.

Interpreting the health and race literature
This is our view of this literature. It is not an exhaustive or authoritative literature review. However we feel that it charts out the main directions in which the literature has, as it were, ‘taken the field’. In our view there is a serious omission which the writing up of this project represents. However without the literature on health and race we would not have been able to build and shape this project. The fact that our evaluation of the health and race literature is critical should not detract from the efforts of countless researchers whose underlying values may nevertheless have been very close to our own: a desire for equitable service delivery by empowered black and white practitioners through which black service users do not become systemically penalised and which could also ‘do better’ for white people.

Research on hypertension and diabetes (Fenton 1985), tuberculosis (Donovan 1984), cardiovascular disease, strokes, and heart disease (Ebrahim 1991), asthma and arthritis (Blaxter 1990) shows that whilst there are often certain similarities, there are also significant differences in the incidence of certain illnesses in black patients compared with their white counterparts. An example of writing in this genre is Ebrahim's study in Nottingham which showed that African-Caribbean elders had a higher risk of strokes and that Asian elders were more likely to suffer a heart attack (Ebrahim 1991).

There have also been research studies into the utilisation of services by black populations in comparison to their white counterparts. Johnson in the West Midlands showed that communities used GPs more often and were less likely to go directly to use acute services than were white communities because they were unsatisfied with advice and treatment given
(Johnson et al 1983) A number of studies reported low numbers of black elders on community nurse caseloads. Research in Birmingham showed that district nurses had fewer black, physically disabled, frail elderly patients (Nomann 1985).

One response to this thread in the literature has been to develop community based initiatives. McNaught studied the impact of community health initiatives broadly described as "either neighbourhood or community-based health projects run by community workers, health professionals or volunteers, to broader advocacy, self help or resource projects" (McNaught 1987). An example of such work can be seen by the development of Sickle Cell Disease support groups in Liverpool and Bradford (in McNaught 1987). McNaught's assessment of these projects is that they remained marginal to mainstream health service provision, received short-term funding and relied primarily upon the voluntary effort of local black community organisations.

Community based initiatives tend to leave mainstream practitioners `untouched`, in the sense that because the community project exists, the practices of mainstream staff are not focused on or attended to so much as the effort to 'link' the mainstream and marginal through referral systems etc. Surveys such as those undertaken by Cameron showed that mainstream practitioners often failed to include users in their treatment and assessment, "District nurses had made little attempt to encourage older black and Asian patients to discuss their life histories " (Cameron et al 1989).

As Cameron et al point out being a patient and receiving medical attention involves following specialist advice or being expected to co-operate in being 'worked upon' by practitioners. The role of patient carries with it expectations of a willingness to learn the rules of expected patient behaviour. For example, patients are generally expected to be operate within acceptable boundaries of what is considered rational, to explain their symptoms in an appropriate manner, to show pain in appropriate ways, and to comply with medical advice about diet and the therapies being administered. Medicine may therefore be seen as a social process, involving social rules, values and a culture and not simply a set of technical or scientific processes. This kind of thinking points in the direction of practitioners altering the social rules where not to do so systemically excludes black patients.

In a later study McNaught also studied the West Lambeth Health Authority formation of a race policy. The development showed that without strong central direction, policy-making was left to "committed local managers" and was subsumed by other concerns (McNaught 1988). This does not seem to suggest an adequate basis through which to arrive at 'practitioners altering the social rules'. Governments have generally been slow to turn research, in this area as well as others, into public policy. And significantly, in light of the MacPherson report, where research has been translated into policy, initiatives have resulted which also take the focus away from changing mainstream practice.

Work has ranged from Government Health circular reports such as the National Association of Health Authorities "Action not words", a strategy to improve health services for black and ethnic minority groups, to the Asian mother and baby campaign in 1984 to the appointment of the Ethnic Health advisor by the Department of Health in 1989 and more recently in 1993 the development of the Ethnic Health Unit.

The Asian Mother and Baby campaign was a health initiative which looked at the perceived inability of Asian mothers to adequately care for their new-born children. Other Health
Authorities have responded by focusing on; translation and interpreting services to overcome perceived language and communication difficulties, increased information regarding health service provision, dietary advice and heightened sensitivity to the needs of Asian women patients. These initiatives have focused on language and cultural problems that exist within communities about their fluency of English or aspects of culture which were seen as precluding their use of service. Mainstream services, strangely did not become the focus of attention. In creating ‘link workers’ in addition to mainstream staff, it can be argued, is to create an additional ‘add on’ to an untouched core. Much of the literature on service initiatives has focused on access to services with solutions being framed in terms of communities making fuller use of the existing available service.

It made it much easier in deciding NOT to draw on this literature in formulating our intervention with the two Trusts to already have come to a well developed interpretation of racism and its operation in local public services through many years of working together prior to the project (our ‘frame of reference’) (Mukherjee et al 1987). These views were explicit to the commissioners of the project and enabled judgements to be made about what to select from the mainstream literature. Nothing that occurred during the life of the project has suggested substantially reformulating our interpretation of racism. We did not draw on a literature about epidemiology or lifestyles or a literature on community projects or a literature on health policy or even a literature on health service change. Rather, in starting to formulate the first stage of the project we decided to draw on a literature that our first target group would acknowledge and in some cases already know about; the generic literature on strategic management as well as the literature about social research. By drawing on such models and concepts we would at least have a language, which if not familiar, could not be sensibly argued against without invalidating the thinking from which those with managerial roles sought to support their very legitimacy. It is perhaps this decision, more than any other, which enabled the project to proceed past its first stage and not fall at the first fence where so many others have.

Our ‘frame of reference’ centres on power relationships between black and white people inside organisations. It focuses attention on the requirements for individual members of staff, be they black or white, to feel able to and to be capable of responding to high standards in their dealings with both black and white service users.

Our view has been that the norms of operating an organisation bring with them powerful exclusions and one of the most powerful of these is a ‘white norm’, which the parties constituting it are unable to see, but which is experienced by ‘black’ people as explicit in its processes of exclusion. As a model which attempts to symbolically depict this and as a cognitive heuristic, for use in continuing to sustain a clarity of perspective as well as action, amidst often bewildering confusion, we developed a diagram;

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Dominant white norm-the institution, its thinking, procedures, practices

Excluded black realities of a way of thinking, procedures, practices
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Our shorthand way of referring to this is to call it `the diamond`. We do not consider it inevitable that institutions operate in this manner. Nevertheless an institution where its key players fail to acknowledge this as the `taken for granted` actuality (however it is portrayed, internalised, or symbolically presented) seems to us unlikely to be capable of making substantive headway with equitable delivery. Another way of viewing our project is to see it as a lengthy and somewhat complex way to embed this kind of understanding and enable it to be portrayed, internalised and symbolically presented among a substantial body of organisational actors. It was perhaps this that we focused most on achieving, seeing the more equitable delivery as a result of changing what for us were the more basic causative processes internal to `the organisation`. The `diamond`, as heuristic, clearly carried with it in our understanding this notion of focusing on causative arenas and the possibility of ones arising through intervention which would be capable of establishing a norm of diversity with the resultant thinking, procedures and practices. Therefore equitable service delivery is not just a legitimate response to the notion of racial justice but from this perspective is also an achievable use of the collective resource available through the public sector. The implication of this view is that `poor` services experienced by black people are also `poor` services (even if `less poor`) for white people. Empowering individual service providers, both black and white, we would expect to be accompanied by demonstrable changes not just for black people (we would expect these to improve the most) but also for white people. This sort of thinking is really what was being tested out through developing this project in the way we did.

**Summarising the project and its evolution**

The project started with an audit of 53 managers `race constructs` using 1:1 focused interviews. The purpose of this was to demonstrate what the race constructs were and show, in theory, the inadequacy of these constructs.

Stage two shifted the ground to action-research to unearth black patients experience by shadowing 30 patients in depth; recording their interpretations of their experiences as well as those of the professionals working with them. This was powerfully backed by some database design work enabling full control over extremely `rich` qualitative data. This confirmed the effect of the inadequate constructs held managerially and it also convinced practitioners on the ground (still theoretically) that services were failing black patients.

Stage three opened up black and white learning dynamics across 6 staff groups (3 in the hospital trust and 3 in the community trust) through the development of self learning groups. These groups involved managers and practitioners. Each group met 6 times during the 3rd stage. Through the self learning groups individuals finally accepted in practice that their own practices and perspectives had to change. Self learning groups proved effective in overcoming deeply held resistance to facing up to the need to change `my` practice.

We represent these three stages in terms of `the diamond` as follows:
Stage One
In general within the literature on strategic management and social research we were drawn towards writers on social constructs. We had decided to set ourselves the challenge of attempting to make explicit the ways managers constructed `how the Trust should respond to issues of race and racism`. As with many who have written about the construction of reality by actors within organisations we were concerned to find a theoretical basis for both what is created and recreated by individuals as well as that which becomes shared between actors in their organisational context.

Within the literature on strategic management the text, then used widely in management courses, by Johnson and Scholes was selected because of its emphasis on organisational culture, recipes etc. They characterise a `cultural web` as;

"The set of beliefs and assumptions held relatively commonly throughout the organisation, taken for granted in the organisation but discernible to the outside observer, in the stories of organisational history and explanation of events" (Johnson & Scholes 1988:39-40).

In the way that managers talked to us during the one to one interviews in stage 1 we felt we were being given just this when they `explained` how they thought the Trust should respond to issues of race and racism.

We also wanted to have a theoretical basis for what we were able to elicit from individuals. Kellys well known work on personal constructs was at that time being written about and in use in education. In some writing about the use of social construct theory in social research, by Young and Mills we found the notion of an `assumptive world`;

"Every individual has a need to impose order on experience and does so by developing out of his/her personal experiences a model of the world which incorporates all his
perceptions, values and beliefs. This model, which may be termed the assumptive world of the individual, is the means by which the individual orders and understands complex information and is thus able to anticipate the outcome of future actions. The function of the assumptive world is to allow the individual to steer a course through the events of everyday life by providing a map of problematic social reality” (Young & Mills 1982).

Issues of race and racism clearly were `a problematic social reality` and there was no doubt that we were being given accounts by individuals which were remarkably consistent and, from our point of, quite questionable revelations of `assumptive worlds`.

We felt that these two theoretical constructs provided a basis for operationalising the collection and analysis of information from managers in both Trusts. We considered a number of methods for collecting information including diary studies, participant observation, use of the repertory grid technique and focused interviews. Diary studies would enable in house managers and staff to develop a reflective tool and provide the project with valuable insight. Participant observation would enable detailed insight both for the project and in feedback to practitioners. Young and Mills consider the repertory grid integrated into a broad research strategy in which it is used as part of an interview. This technique would draw out practitioner constructs and support practitioners to clarify their thoughts and become a form of self reflection and analysis. Focused interviews allow trust to develop providing openness and honesty and clear insight into responses of practitioners and interest and commitment shown by the interviewer which, often produces far better results than clinical detachment.

In total 53 practitioners and managers from both Trusts and the Health Authority were interviewed using an interview schedule which covered their perceptions of;

1. their aims and values as service providers,
2. how the service works,
3. how black and racial minority communities may or may not enter the system and receive appropriate services,
4. blockages and obstacles to achieving the above.

From the interviews with managers and practitioners a structured account representing their 'shared thinking' about black and racial minority patients emerged. We identified the main elements as: culture, language, demand for and use of service, aspiration of universally available service, differential responses to black and racial minority patients and perceived solutions.

Individuals did vary in their perceptions and views, but not to the degree that the proposing a model of `shared thinking` was called into question. Broadly speaking the `shared thinking` elicited by interviewing in both Trusts comprised far more that was similar than different.

The views broadly shared by actors across the Trusts were;

1 Access to services can primarily be improved using formal communications in the form of leaflets and visits to community organisations. Existing referral processes are seen as adequate but new ways need to be found to `take them` to `black people who do not yet make use of them."

2 It would be adequate for practitioners to know about `lifestyles`.

3 If translators were `on tap` this would lead to the same standard of service.
4 Were more black people to access and take up services they would get it at the same quality and level as white people do.

5 Lack of finance and the inertia of established systems and approaches to service provision are real constraints.

At this stage we also developed our own model of how patient practitioner relationships might look were the underlying thinking to be different. We tried to model a context in which individual practitioners were taking responsibility for reworking their one to one work with black patients. This became a list:
- ensure the patient is comfortable about treatment or advice received
- enable patients to trust in the relationship to question clearly and ask for further information
- show a supportive attitude without making prejudgments about the patient and their families
- treat patients' experiences, descriptions of illness and concerns seriously and demonstrate this to them
- have an understanding of the language, religion and culture of the patient and demonstrate a sensitivity in assessment of the importance of the patient's language, religion and culture in responding to their health care
- act out of a recognition that patients will, in the majority of cases, have no understanding of the services, contact people and procedures.

While we were unable to make direct use of the model at this stage it provided us with a vision of an alternative reality. Along with `the diamond` this began to steer our work and how we were conceptualising what we needed to do next.

In communicating the results of stage one we felt we also needed to maximise the opportunity that it represented. From a social constructivist viewpoint there was a real possibility (and we would not wish to overstate this) that in reading about their perspectives on issues of race and racism they themselves would begin sanctioning different possibilities and that the situation across the Trusts would itself in perhaps small or even subtle ways begin to change.

In the way we communicated we were also mindful that while some individuals might see the point and be open to reconsider their ways of thinking, at the very same as this happened there would in all likelihood come to the surface expressions of resistance. We decided that if we were going to stress what we thought needed to change in their constructs about race and racism we should at the same time communicate reassurances about what needed to remain in place. Our ability to think in this manner was aided by the impression we had that managers were wanting to know what we thought was `wrong` with their approach and were for the time being at least expressing their openness to reconsider. It was as if we had, by conceptualising this as a first stage of a longer process, taken away the desire for immediate results. There were however one or two managers who were still insisting on immediate short term tangible results. We simply proceeded as if conducting a slow moving dialogue on a large scale. It was as if in the interactive manner of our interviewing and the analysis of the results into a model of `shared thinking` we had attracted their attention and with that attention came some possibility of change on their part. Clearly had the intervention stopped at this point very little change would have resulted. However we had no intention of leaving the intervention at stage 1.
Our reassurances are instructive. We suggested that certain fundamental values needed to be preserved and that they were;

1. The importance of the patient-practitioner relationship.
2. The importance of having sufficient language for patients and practitioners to be able to communicate.
3. The centrality of a professional set of values to the work of practitioners and health professionals. These might be conventional medical values or involve critiques and departures from a conventional medical model.

Whilst acknowledging the centrality of a set of professional values, we maintained that improved service responsiveness does not involve new information which is processed, as it were, ‘on top of’ an existing model. We preferred to conceptualise an appropriate ‘surround’ to the current set of values, interacting with their core professional values, and which was specifically about the patient-practitioner relationship and not just a layer of new ‘information’. In our reporting we attempted to redefine the challenge into how a practitioner further develops the professional base of their work in such a way that black patients are likely to find the health professionals practices and interactions more acceptable. The managerial challenge became not just a matter of changing constructs but of how to support this change by practitioners.

Once we had written up stage one, communicated it in written reports and through meetings, and engaged in one to one dialogue to the extent that our point had been broadly accepted, we set about conceptualising the second stage. Our thinking was that by having had extensive direct contact with individuals in both Trusts we could see that, whilst most managers were now saying they were more supportive, practitioners were still far away from being willing to really change their practices. They simply were not ready. Through stage one we had been able to get behind the public ‘face’ of both organisations. Our sense was that the majority of practitioners were not seeing their responsibility for changing what they did and were not motivated to consider changing their practices. Despite what we were attempting to communicate they still had a sense that they were being asked to do something on top of overload. It struck us that they were still obscuring from us the true nature of the relationships that had developed with some black patients. We began to explore a line of thinking which asked what would happen if we knew first hand just how bad it was in some cases? We began to consider action-research modes of engaging which would put us alongside practitioners and bring us out from direct association with ‘the management’. It also struck us that this route would also deliver some immediate short term tangible gains and possibly quieten those minority voices which were growing in intensity to the effect of ‘where was all this going?’

**Stage 2**

In stage 2 we wanted to get a ‘rich picture’ of how black patients, their carers and families were experiencing health provision from the two Trusts and via their GPs. We could conceptualise the action research aspect of this phase as broadly us, the project workers, being referred black patients as they entered and passed through the system. We anticipated a willingness on the part of these patients to allow us to shadow their experiences because, as they might see it, it would give them a voice. We were not so much concerned to establish a representative sample as to find cases from which we and practitioners in the two Trusts could learn. While our presence would enable us to gain insight it would also lead into action and thereby change the experiences we were shadowing. We would not stand by heartlessly watching something ‘going wrong’ when, through intervention, different contacts might be
made or new information obtained. However the initial contact would for a time give us a `rich picture` of what it was like for black patients. As it turned out the various interventions made did not substantially alter the picture gained. Our interventions were minor compared with the force of the context generated by the two Trusts, the GPs etc etc.

How to capture the rich picture? We decided to explore database design information collection techniques. From our standpoint we had the range of health interactions in view centred around a patient. By designing a data structure which might capture the range of interactions we would at the same time build in a check on coverage for each patient shadowed i.e. we would notice NOT collecting information. We would also be able to associate the largely qualitative information against some key parameters by being able to bring the data together across the patients shadowed. We were interested in being able to detect patterns across the information. As with the decision to use the strategic management literature in stage 1 there was some consideration to do with maintaining our power position vis a vis the managers and staff with whom we were working. At that time for the project to develop a database concretised the second stage and for some `new` public managers turned it into a `tangible outcome`. The fact that their own information systems did not enable them to capture what we proposed to capture was also a factor.

The design we eventually used in structuring the database was as follows;

![Database Design Diagram]

The lines with `crows feet` show a `one to many relationship` which is just a way of separating out different types of information so that endlessly long tables in databases do not come about. Put into English and starting at the top left with the patient/carer it means that for any patient there are potentially many illnesses each with potentially many treatments, each of which in turn may involve many procedures. Illnesses, treatments and procedures each in turn potentially involve many practitioners. Lastly we brought our own project (HAP) into the picture and logged the interactions between patients/carers and ourselves. A total of 80 information fields comprised the database. The database design was piloted with 4 cases. This showed that it reflected accurately the structure and nature of material needing to be collected.

We also developed several pro formas on paper to use in the field in different contexts to capture information in written form. The process of both collecting information and intervening with patients, carers and practitioners we have called 'shadowing'. This involved obtaining detailed information from patients, their carers and practitioners about the experience of a patient's stay in hospital and after-care following discharge. With the aid of a
detailed debriefing schedule and a number of interviews, the project was able to gather a substantial amount of detailed information. We then input this information into the appropriate fields in the appropriate tables in the database. The experience of working with the information in this way also helped us to see possible connections and generally make sense of what we had been experiencing first hand alongside patients; exploring the understanding black patients had of health services (based on the current as well as previous experiences), and the thinking and understanding behind practitioners’ actions towards black and racial minority patients and their carers. We should also make it clear that in becoming directly involved a considerable amount of prior consideration within the Trusts was required to ensure ethical and other issues were adequately dealt with. The experience and qualifications of the two project workers who did the shadowing were considered as part of this process.

The purpose in having a database was to be able to get at information which mirrored the patients’ total experience of health services AND the views of the practitioners who worked with them. We were influenced in our thinking about capturing ‘total experience’ by Normann’s work in service industries. This thinking contrasted markedly with that of some of the managers with whom we were working. We pull out three key points among many here:

1 Service involves personal relationships. These are highly personal, involving people as individuals where ‘service’ is defined as, "The total object of transaction (including intangibles) between the provider and consumer";
2 The notion that services are ‘co-produced’ i.e. the provider of service can include carers as well as patients themselves;
3 Management needs to consider this perspective, “The only way to really control decentralised operations is by infusing the organisation with values directly related to the success of the business” (Normann 1984).

We saw health services as extremely personal interactions between individuals and wished to collect information, analyse and present back to (thereby mirroring back to) practitioners the substance of how these interactions were working as interpreted and understood both by the black patients and their carers with whom we were working as well as the practitioners with whom they interacted. This balanced view turned out to be extremely important when we presented our ‘findings’ back to the Trusts. It also enabled the project to more fully actualise this notion of ‘total experience’ which we had taken from Normann. It was the variation of interpretations of the experience for both parties which provided valuable insight.

What did we find? The first area we concentrated on in reporting back was about the referral systems. We found there were weaknesses in the referral systems which led to significant difficulties for black and racial minority patients. There was a continual stream of black and racial minority elders admitted, discharged and re-admitted to hospital within a short period of time who would have benefited from access to community health services and improved discharge arrangements to help them manage their illness more appropriately or prevent it from re-occurring.

Communication was not based on a dialogue between patient and practitioner, it was a one-way process where the patient was passive. Assessments undertaken by practitioners did not allow patients to express their needs fully. As a result, services received were based on practitioner assumptions of what they believed was required and so were founded or reliant on how they normally responded to ‘everyone’. This situation, coupled with practitioners’ anxieties, perceptions and approaches, served to reinforce the gap between black and racial minority patients and health practitioners.
Carers mostly felt overloaded by functions they felt they had to perform, including interpreting, bringing in food to the hospital and co-ordinating the after-care. Despite having a major role of caring for their elder, carers had effectively been excluded from the planning of treatment and from having a meaningful dialogue with practitioners about their relatives' illness and the process of care to be received whilst in hospital.

Information given to patients and carers about their illness, treatment and care during and after hospital was either irregular in its frequency or non-existent. We felt this was primarily because communication, and especially the relationships necessary to build good communication between practitioners and carers, were inadequate. In certain service areas leaflets were available, however these were rarely read as the patient and carer had little time to read. These were sometimes given at inappropriate times. Some patients/carers said they had difficulty understanding what was written.

'Poor information' also encompassed patients and carers being unable to see the whole picture of health care. They consequently viewed the service they received in a compartmentalised fashion. It was not possible for them to make the links between the various services they may have required. For example, a patient who had had a stroke and suffered from diabetes remained unaware of the possibility of receiving a chiropody or dietetics service.

We have included below a mini case study of the experience of a black patient and her carer which illustrates many of the issues also highlighted by the experiences of the others we shadowed.

The Case of Mrs I

Mrs I is a 68 year old Muslim woman who suffered a heart attack just over a year ago, six months later a stroke and recently had her diabetes controlled. She has difficulty in moving around and suffers with arthritis. Her speech is affected and sometimes she gets confused.

Mrs I and her daughter (who she lives with) were not aware what was required to try to prevent another stroke. The relationship with her GP is difficult. Mrs I and her daughter were unaware of speech therapy, district nurses, physiotherapy or dietetics services.

Mrs I had attended the diabetes clinic where she was "told off" for not coming to see the doctor after she had had the stroke. Mrs I's daughter did consider making a complaint about the doctor though she realised her mother had to go back to see him.

Mrs I was admitted to hospital after she got pains in her chest during which felt as if "a balloon" were inside it. Her daughter had called the GP who hung up during the call so she decided to take her mother to casualty. Mrs I was then moved from casualty to one ward and then another. It was two days before Mrs I and her daughter got some information as to what the problem was and what was required to treat her, "Because mum does not speak much English no one had told us anything. I left my number when I had to leave but no-one phoned. It took me 45 minutes to find her when I came back".

No interpreters were involved and no effort made to communicate with Mrs I, "I was always treated as though I didn’t talk, no-one ever really spoke to me and even when they were about to do something to me they didn’t tell me what they were going to do".
This worried Mrs I and she became increasingly scared to ask questions in case it was bad news. Her daughter would try to find out all the information after each visit though this proved difficult. The doctor told her daughter she was not going to die and how long she would need to stay in hospital. Mrs I felt once she knew what was going to happen it made her feel a lot better.

The absence of discussion between Mrs I and the nurses meant she missed food when her daughter was unable to come as no other arrangements were made, sometimes she would not be washed for up to 5 days and she had not been able to get to the toilet on time.

A ward nurse involved said that, "Mrs I must have felt very isolated as no one approaches her because we cannot talk to her, we have got some translations for her to use". On her discharge the nurse said. "Because we were not really able to speak to her I think there is probably more we could have done, we sometimes were able to see her daughter and she would ask questions, apart from that we kept an eye on her ".

On discharge Mrs I’s daughter was not aware she was leaving hospital until the night before she was due to go home and she did not know how she would cope as she did not feel confident about knowing what her mothers needs would be;

"I had to do all the running around after the people in the hospital and if I didn’t they never bothered to tell me anything. I was very worried because mum was anxious to go home as soon as possible as she was getting very low".

She returned home without any services or support being offered. There had been talk in the hospital of a home carer but nothing had happened. Three months later a referral was made by the project to physiotherapy and speech therapy and they were contested on the grounds that the GP had said a referral was not needed and both services had seen her before and said there was nothing they could do. There was real reluctance to take on the referral. Yet both services agreed, in discussions with the project, about the need to provide a service.

The physiotherapist felt that Mrs I’s daughter did too much for her mother though she never said this to her. The whole of the assessment and associated tests were carried out by communicating through the daughter which clearly compromised the physiotherapist and her ability to speak openly with the carer. The physiotherapist spoke a lot about the behaviour of the client being based on an "over reliance on the family". The physiotherapist described how, in her view, Asian patients created an unhealthy dependency with members of their family which clashed with how she did her work. The therapist acknowledged that it was not really possible to make an accurate assessment because it was difficult to perform tests on a patient who did not have enough understanding to be able to contribute to the tests. Mrs I was very frightened and did not find it easy to move her body.

The physiotherapist felt that an interpreter would answer question’s `for' Mrs I and wanted to do another assessment at the therapy centre, "They answered and interpreted saying much more than I said to them, I did not trust them " . The physiotherapist also found working alongside the voluntary project brought in by Mrs I’s daughter difficult, "There was no rapport they were invasive”. She could not understand why they were present. Mrs I was extremely frightened by the experience and she found she could not respond very well when she was upset.

The physiotherapist saw the problem as the patient expecting to be looked after and playing a
passive role, "All my colleagues agree with this". The physiotherapist thought the daughter did too much for her mother as was demonstrated by the fact that the patient was more responsive to her.

Ending stage 2
Practitioners showed genuine willingness to reconsider their practices as they accepted our mirroring back accounts (of which the above is but one small example) without, in the main attempting to defend their practices. This was a turning point in the project. The road was now clear to find a way to turn their motivation to reconsider their practices into an arena or method through which whole teams could do this. We were concerned to find a way to break through beyond change becoming based on the willingness or motivation of individuals acting on their own. We were also aware that throughout this process there had been no real active engagement in it by the bulk of the black practitioners. Up until this point we had been working primarily with what we had earlier described as a `white norm`.

Just as we had ended the first stage with a vision of how the relationships between practitioners and black patients might be different so too as we drew to the close of this stage we developed the list further in light of our findings. This is how we now envisioned the possible future;

The interaction between patients and health practitioners, in our view, needed to be able to transmit messages of the kind that;

- ensures that the patient is able to approach practitioners to discuss concerns and anxieties;
- enables and encourages patients to have enough trust in the relationship to question clearly and ask for further information;
- shows practitioners are acting out of a recognition that patients, in the majority of cases, have no understanding of their illness, treatment, services available, contact people or procedures;
- ensures information is given at an appropriate time regarding illness and treatment, with practitioners checking that it has been understood and making themselves available for patients questions;
- ensures the patient is comfortable about treatment or advice received;
- recognises the importance of family and carers role in overall care and treatment of elder;
- encourages practitioners to show a supportive attitude without making prejudgments about patients and their families;
- enables practitioners to treat patients’ experiences, descriptions of illness and concerns seriously and demonstrate this to them;
- enables practitioners to demonstrate a sensitivity in assessing the importance for the patient of their language, religion, diet and culture as fundamental elements in the provision of their health care;
- shows practitioners willingness to offer a full explanation of their own role and those of colleagues, as well as details of other services available;
- allows practitioners to show confidence and willingness in communicating and working with elder and family, as a result of their ability to develop dialogue rather than making assumptions based on fear or negative labelling;
• highlights an awareness of the need for patients, carers and practitioners to use interpreting services appropriately to facilitate and support dialogue;
• enables patient and family to be confident in managing self care and to be aware of warning signs;
• reveals that practitioners remain open to new options and possibilities in treating the patients health needs.

The list had expanded dramatically, in a sense the power of the experiences collected in stage 2 also expanded our consciousness of how much needed to change. We also developed this list primarily to guide our own sense of where we needed to get to. We were very aware that lists of this sort would prove useless in the live processes of delivering services. We began to search for a methodology which would enable managers and practitioners to become active participants in their own processes of change.

Stage 3
Both Trusts focus on the development of structures and systems as the means to change service delivery. They tend not to focus upon the change that practitioners can bring about through learning based upon their own experience. We wanted to find a methodology which would counter the feeling, expressed by practitioners, that service change in general but particularly in relationship to 'race' is something that is handed down to them as a directive, and which is then seen as an extra piece of work, lacking any kind of ownership or full understanding.

We began to explore the idea of change taking place through a process of self-learning that focuses on practitioners and managers empowering themselves through their own ways of working, on cultural realities being acknowledged, challenged and unblocked by them personally. This process could take place within a grouping of colleagues selected from a cross section of all levels of the service area.

Any changes implemented in order to improve the quality of service responses must, we felt, at their core, involve the input of patients, their families and carers and be co-operative between professionals and patients. Through the critical and interactive appraisal of their own experiences and values, practitioners would be able to reflect upon and change their practice by becoming co-producers of services or having a real partnership with patients and carers and other professionals. This would enable the development of a continually evolving, individually owned practice which embraces the perceptions of the patient about the service in the one to one relationship and empowers practitioners in the organisation to take responsibility for change.

The primary inspiration guiding our thinking in the third stage was the concept of "self-learning groups" based on work by Stacey (Stacey 1992). His approach includes the establishment of a learning process which practitioners with formal roles in the structure of organisation can participate in. His argument is that the formal structure shuts off learning. However the formal structure has to be maintained if the organisation is to be efficient. A way of learning can however be set up within the day-to-day structure and self-learning groups offer a means 'to learn as well as do'. This amounts to participants in organisations accepting and becoming skilled at operating in two modes: mode A is the formal role defined structuring of responsibilities. Mode A creates ambiguous, complex, challenging issues which cannot adequately be dealt with in mode A. Hence the need for mode B in which it is not the formal roles and responsibilities of individuals that counts. In mode B participants are
learning to see each other completely equally. What counts is the individual contribution and its effect on the learning of both the contributor and others. Stacey’s use of mode B hinges on complex learning associated with small group dynamics.

We presented the notion of a "self-learning process" that would involve three key principles for practitioners and managers;

- Having the freedom to operate within the boundaries provided by working together with colleagues and patients to solve problems that have existed within the structure of their service area. Members are involved as equals in self-learning groups because of the contributions they can make rather than according to their roles.
- The self-learning group sets its own challenges, goals and objectives in response to the identified problems facing the service area. Central to self-learning groups is the requirement of service managers to be looking genuinely for new perspectives.
- Having membership drawn from a number of different functions and hierarchical levels within the service area. Practitioners and senior practitioners are closer to patients and as a result are more likely to detect the opportunities and obstacles to developing new service improvements.

Our characterisation of the opportunities presented through self learning groups encompassed several points. The learning process enables a break in tradition, allowing practitioners to step out from replicating existing roles and ways of doing and seeing things, unlocking resistant and reinforced patterns of unchanged practice. It permits practitioners to develop communication with people who are not communicating. A self-learning group would provide challenging tasks, with its members probing different solutions based on real circumstances and contexts. Contributions would be valued and not based on status in the organisation, with each member of the group taking equal responsibility to tackle and solve problems.

A self-learning group sets up a situation where all individuals have an understanding of the realities and are in a position to offer real solutions. They have insight and understanding of how their practice could be undertaken differently. A self-learning group brings the 3 main health resources together: 1) the patient, 2) the practitioner and their services and 3) the family and the carers. The current position is in the main characterised by a divergence of these resources. The working of these resources in concert has a direct bearing on patients perception of the service.

It took a while to communicate the proposals for stage three. They were responded to eagerly in the main. The lengthy period of preparation had, in this sense, paid off. Careful consideration was given to the composition and number of groups to be started. In the end six were started; three in each trust. Staff time to attend was agreed to as were the written objectives. Each group was to be facilitated by one of us. Having someone with the kind of thinking which we presented as our underlying perspective (‘the diamond’) proved vital as many issues which had not been dealt with emerged. The starting point in setting up the groups was for facilitators to share specific models of learning. The models presented in each case to guide and underpin learning were;

1 Disabling blocks
This was presented as remaining at the level of only seeking knowledge or information. Groups which were ‘submissive’, conforming, rebelling or in which participants did not feel free to make their own agenda were also seen as remaining blocked. Since dialogue is crucial
to self learning groups, having a 'win-lose' polarisation was also seen as blocking. The maintenance of the normal hierarchy also blocked learning.

2 Simple models of learning
Simply to see things from different viewpoints implies learning. This is especially true where one's own conventionally accepted views are challenged. To do this effectively in a group requires an appreciation that people learn very differently. Some people learn through reflection others through doing. Groups were simply asked to acknowledge these differences.

A model of learning was presented to groups which pictured one's conventionally accepted viewpoint as the tip of an iceberg. Under the surface lie a large body of assumptions. Learning was presented as getting at these assumptions.

Learning is also 'theoretical' in so far as you have a new idea. However, in carrying out the idea by putting it into practice an experience is gained. What started as an idea becomes an experience. The experience is very often different from what we thought it would be beforehand. Hence the ability to learn through reflecting on experience is very valuable and again intrinsic to learning through self learning groups.

3 Complex learning
Where self learning group really 'get going' is with complex learning. This type of learning is also appropriate to the challenges inherent in becoming aware of the dynamics of racism as a black or white individual, as a professional and as someone becoming more attuned to and able to influence one's employing institution.

Through complex learning, 'personal constructs' can change. Conflict and emotion can surface into the group as bizarre dynamics. Quite deeply held beliefs are sometimes challenged. It is the learning processes inherent in the dynamics between people in a group which offers the most complex learning.

4 Learning into action/behaviour
Gaining confidence in one's own ability implies developing insight into being able to behave differently in the 'same' circumstances. Feelings need to be brought into relationship with thoughts and ideas. By becoming more aware of these different actions can result.

In practice self learning groups used all of the above types of learning and this, in part, accounts for the wealth of personal experience communicated within and from the groups. All the groups went through the threefold process of:

1 Unblocking resistance to learning;
2 Doing the learning;
3 Turning the learning into action.

It would not be true to say that this process was experienced equally by all participants. In practice what seems to have happened is that some individuals engaged in complex learning first and then shared this with other members who then initiated their own learning etc. The initial experiences had a powerful impact on the group and enabled other members to re-think their own practice.

Most of the groups started by strongly questioning and getting clarification about the nature and existence of discriminatory practice. Some practitioners felt that white patients receive the same type of service. Some argued that a study would be necessary on a comparable group of
white patients in order to give this work validity. Others simply stated that their practice was the same for all groups. It was necessary to draw out the differences by reflecting on practitioners responses to black patients and families and presenting this back to group members. It was essential to work through and overcome the resistance to an acceptance that black patients (and this still needed to be done despite all the evidence of stage 2!!!) get a poorer response.

In another group it required the facilitator to resist the groups attempts to go straight to problem solving solutions at the expense of agreeing the basis for the work. There appeared to be some advantages in this group also being an established multi disciplinary team. However the continuity and consistency in the formal roles were getting in the way in the informal self learning group mode of working. When in the self learning group participants had to stand back from their established pattern of relationships in order to establish the groundwork and analysis of race and racism. From our perspective the black staff in this group tended to be the most marginalised in terms of their contribution, at this stage. One member of this group commented;

"It is interesting that these cases we are raising are all the ones we usually define as difficult ones. Yet they never see the light of day as I guess we just brush over them because I, for one, don't like admitting that I got it wrong."

Another said;
"We do not give enough time to question our motives and reasons for doing things in our practice. We hold on to our way of doing things previously."

The number of 'blocks' to learning about race and racism within one’s own work practice are considerable in any organisational context. Despite the work in the previous stages most groups began by seeing the problems faced by black patients as being to do with lack of information or 'cultural awareness'. Despite the previous work some staff were still saying things to the effect that if only staff were more culturally aware (about the black communities, their lifestyles etc) the service response would be hindered less. Some were still talking about tackling discrimination as more work on top of a very busy workload. We had to remind ourselves that the only institutional response staff had encounterd to do with tackling racist discrimination was 'ethnic monitoring'. Most staff saw this as a number crunching exercise. They never received back information from the figures they collected.

Despite the initial resistance, which in all cases was strong and in some was prolonged, most individuals in the self learning groups were able to arrive at a point where their own responsibility for service improvement and what they could do had become the focus. They then became much more reflective about their own assumptions and how these directly affect patients. Learning through reflecting on their experiences became a key feature of the self learning groups.

One practitioner recalled how they had begun to look at their engagement with black patients and their families differently. She was also aware that by doing things differently her patients were more comfortable. Because they were more comfortable they were more responsive and as a result her practice, with them, was improving.

The fundamental principle of self learning groups, that membership be drawn from a cross section of practitioners and managers reflecting the service make up, proved essential to the achievement of real change at all levels.
For many groups there came a growing realisation that the culture of their practice and organisation had to change. One service area took justifiable pride in the fact that they had broken down the traditional medical model when delivering their service. However they had also become aware that in making this change they were still not wholly responsive to black patients and their families. Rather than going back on their previous learning they decided to build further on their initial premise that their practice should be patient focused. They still had the challenge of developing their responsiveness to black people. This required continued reappraisal of their practice, but with confidence that change was not something to be feared; "Automatically I found that I was raising issues with practitioners who had not been in a self learning group as a matter of course and seeking to develop solutions".

Extracts from the groups own evaluations
All the participants of the self learning groups were sent a questionnaire and individuals in each group undertook to draw the responses together as a group report. We include below some extracts from the groups own evaluations;

Group 1
“I will now think of how I come over as a professional and what it might represent to the patient /carer”.
"I will be myself as far as possible"
"I will think about how I communicate to patients/ carers and whether I am really getting across"
"I now have a more open approach to each individual patient and recognise that there may be underlying issues behind their behaviour”.
"I consider the feelings of families more in terms of whether they've been able to express their own emotions and whether we as a service we can help / support them."  
"I realise how much of a `professional` I become often to the detriment of my own culture".
"I didn't want to be seen as putting in too much care to someone of my own culture but now I feel more relaxed about it."
"I am actively seeking out ways to improve my service”.
"I am in the process of evaluating the uptake of my service by minority groups and finding ways of resolving the problem"
"I will try not to make assumptions that the family will manage but explore the reasons why they do not want services."

Group 2
"It offered the opportunity to discuss and challenge current professional practice."
"It was a very good learning style as all group members were very open and able to freely discuss patients past or current and receive open and constructive advice / opinions."
"Everyone in the group was given the chance to speak and to put their views forward without intimidation."
"It was good to be able to talk freely about what it feels like to be black and working for the organisation."
"It felt good."
"At first I couldn't see that we would achieve anything but after much discussion I have got more than I expected."
"The input from other staff's experience and perspective was invaluable and it gave me insight into how other staff approach situations."
Group 3
All members of the group agreed that essential and effective learning had taken place and that the changes to practice were subtle but significant. A common sense of purpose had been achieved, plus a heightened awareness of patients' rights and needs and changes in personal attitudes and behaviour were reported. The issues around black and racial minorities were now seen as requiring a multi-disciplinary approach. The project work undertaken produced useful information on discharge arrangements for black and ethnic minority elders although the group were mindful that this information, now circulated to other wards, needed to be kept up to date and, if only written as part of an admission/discharge checklist, could become a mechanistic ritual. Each member of the group also worked with individual patients and their families, exploring both their own personal attitudes and the service they provided. Each reported that, following the sessions, their work was more focussed on individual needs and they made fewer assumptions. Greater attention was paid to why some older black and ethnic minority patients became withdrawn when in hospital, and therefore assessments included asking more questions about individual needs and offering more information for support in and out of the hospital setting. Two members had some difficulties with the project work because they did not carry a patient caseload but they were able to influence decision-making about this client group. Some discussion also took place about attitudes towards black and ethnic minority staff by 'white' patients and, although it was not in the remit for this project, was felt to be worthy of consideration in the future”.

Group 4
The nurses have a weekly "critical incident analysis". We document these sessions and some of them have reflected on the way care is given to ethnic minorities. This means that we are building up a library of practice that we can refer back to. It was certainly worth it--it has made some real differences to our practice and attitudes. I hope that the alterations that we have made in service delivery mean that the changes will last....

Group 5
It all took much longer than I anticipated, but then, changing things does take a long time. The composition of the group should ensure the project stays in our minds for the time being.

I see it as my task to keep reminding the group of objectives not yet fully achieved, so that these can eventually be incorporated into the way we work.

Group 6
Another person gave an experience of an angry African patient with whom she also became angry OR she tried to ignore them. This had been going on for some time. She was now beginning to question her own actions and consider what different action she should be taking. Through discussion with the group she was able to recount experiences this patient had, both with her service, and with that of other health professionals, none of which had been helpful. She began to understand the anger of this patient and recognised for herself the importance of acknowledging and discussing openly these poor experiences to ensure future contact took account of these concerns. Through discussion in the SLG she revealed her own assumptions and fears to herself and the others: “I felt that she did not like white people and that her family, although pleasant,
intimidated me, particularly when they were together and I did not think that they were looking after her”.

In the next group meeting this practitioner was able to narrate how she approached the family differently and had had a good discussion with the patient. What made this a 'good discussion' was that the patient had expressed herself and her concerns, resulting in different and more appropriate services being offered. Once the patient had stated her real needs the practitioner was able to respond. As she put it in the group, "My inability to recognise these assumptions seriously affected the relationship." What she also realised was that a catalogue of things had reinforced a pattern of behaviour creating a vicious spiral of treatment not meeting needs thereby perpetuating the situation. This experience had a powerful effect on all members of this group, leading on to more questioning of assumptions by people in the group.

The Trusts` evaluation
The Trust`s own evaluation considered the following points. Looking at the groups overall in many instances the changes related to increased awareness of the importance of communication issues. At a personal level, practitioners came to terms with the importance of being honest when they did not know what to do or say, and asked direct questions to patients and families about what they needed. There was an acknowledgement that differences are important. There was an increased recognition of issues relating to clinical practice and a desire to change. For example, recognition that less formal approaches to care are needed, institutional solutions are often not acceptable, and that family and patient perspectives need careful balancing. There was an acknowledgement that good assessments take time as does "going the extra mile" and that often practitioners make assumptions to try to save time. Practical changes were introduced to referral forms, assessment forms, and check lists to ensure issues of language support and cultural needs were tackled. In addition the benefit of this inclusive approach means that this practice is integrated into the current work of all those coming into contact with these teams.

Where to from here? As one self learning group put it;

“It was exciting to have participated in the process of change and learning within this group, and it is encouraging to see how we are all applying the learning to our work. Perhaps the opportunity to go through a similar process can be offered to other staff”?

One of the central comments in the report evaluating the project produced jointly by the Trusts said;

“The evaluation of this piece of work demonstrates that tangible differences to service provision for black and racial minorities can be achieved through this method. Although essentially a bottom up approach, the impact resulting from increased recognition of need for different perspectives and approaches has spread across to other services and upwards within both trusts…Although this may be seen as a small beginning, the power of such change should not be underestimated”

The Trusts have decided to support having self learning groups and have, using practitioners who played a leading part in the project, begun developing new self learning groups.

It is also worth pointing out that managers played a critical role in supporting the self learning groups. It is this dynamic between managers and practitioners mediated through norms, values and concretely through systems and procedures in the pursuit of some kind of accountability which can change ‘institutional racism’. With more empowered staff, a clarity of what supports are needed from managers ensues. These might be to do with service monitoring or supervision. Changes in practices don’t take place out `on a limb` but in becoming embedded, change management.
What is `institutional racism`?
The work which we had drawn on in shaping this project, the impact of which we summarised in our earlier characterisation of `the diamond` had the notion of `institutional racism` at its core. This work had taken place throughout the 1980s and had focused on enabling participants in a variety of training programmes to understand how racism operates for us as individuals, as professionals and within our organisational contexts. Our conceptualisation of `institutional racism` included the working together of these three aspects of our lives; personal, professional, institutional.

Our experience of developing an analysis of `institutional racism` was one way to `prick the bubble` within any institutional context. We see it as highly significant that with the passage of a decade during the 90s, it has taken an individual case, and the campaign mounted as a result of the failed investigation by the police of the murder of Stephen Lawrence, to bring `institutional racism` back onto the UK public sector`s agenda. For us this represents a completely separate strand of experience and thinking, carried out by individuals, in institutional contexts different from our own.

How then has this, now influential, strand of thought characterised `institutional racism`? Their starting point appears to be that the notion of the universality of public provision cannot be assumed as actually operable just by believing that provision OUGHT to be universal;

“….officers may mistakenly believe that it is legitimate to be "colour blind" in both individual and team response to the management and investigation of racist crimes, and in their relationship generally with people from minority ethnic communities. Such an approach is flawed. A colour blind approach fails to take account of the nature and needs of the person or the people involved, and of the special features which such crimes and their investigation possess. As Mr Dan Crompton, Her Majesty's Inspector of Constabulary (HMIC), helpfully said to us it is no longer enough to believe "all that is necessary is to treat everyone the same. ...."(MacPherson: 6.18)

This was,in effect, one of the major barriers necessitating our stage 1. Even in stages 2 and 3 practitioners were still caught up in the assumption that NHS services were to be provided equally to all. Later on the MacPherson report quotes Holdaway;

"By policing normally, in what officers regard as common sense ways, in failing to reflect on the implications of their ideas and notions, negative relationships between the police and ethnic minorities are created and sustained" (MacPherson: 6.19).

We could substitute `district nursing` for `policing` in this and have an accurate reflection of `life before self learning groups` in this project. This is a powerful `recipe` suggesting that in order to change `institutional racism` it is necessary to gain legitimised and authentic levels of comprehension amongst staff of the public service, that operating differentially IS the route to universality. Some of evaluations from the self learning groups (above) draw out this point eloquently. The paradox appears to be that when the underlying recipe is one of the universality of provision and this is taken for granted, it is accompanied by an actuality that is highly discriminatory.

The MacPherson report draws together a variety of definitions of `institutional racism`. Those of us who had been working on `institutional racism` throughout the 1980s were very familiar with the Scarman report and its use of the words `unwitting` and `unconscious` (Scarman 1981). To these the MacPherson report adds a third: `unintentional`. We extract six
attempts at defining `institutional racism`, which perhaps in itself suggests there are
tremendous difficulties of meaning and communication bound up with this (our emphases);
1 “systematic tendency that could unconsciously influence police performance generally.”
2”What may be termed collective organisational failure of this kind has come to be labelled
by academics and others as `institutional racism”.
3”... the way the institution or the organisation may systematically or repeatedly treat, or
tend to treat, people differentially because of their race. So, in effect, we are not talking about
the individuals within the service who may be unconscious as to the nature of what they are
doing, but it is the net effect of what they do”.
4 "..... racism can be systemic and therefore institutional without being apparent in broad
policy terms” AND....”how operational policing decisions are carried out and
consequently implemented, and indeed how existing policy is ignored or individual officers'
discretion results in racist outcomes”.
5 “However, some discrimination practices are the product of uncritical rather
than unconscious racism. That is, practices with a racist outcome are not engaged in without
the actor's knowledge; rather, the actor has failed to consider the consequences of his or her
actions”.
6 “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: 6.5;6.22;6.28;6.29;6.33;6.34)

What we see here from our point of view are `parts of the elephant`. However this is an elephant that
changes its appearance depending how aware you are of racism and its dynamics. This is one reason
we have put `institutional racism` in inverted commas throughout this discussion. For those who
cannot see it, it does not exist. Nevertheless the evidence of some sort of systemic dysfunctioning is
there in the experiences of black patients, black communities etc.

In the light of our project what are we to make of unwitting, unconscious, and unintentional? For us
this legitimises our stage 1 work. In our view it is possible to `get at` personal constructs, using a
number of well established social research methods. Indeed the use of the personal construct theory is
well developed in educational research. In our project work we would not claim to have done justice to
the methods available or to Kelly’s original conceptualisations and their later developments (Kelly
1955; Pope & Kean 1992; Hunter 1997). Nevertheless it does suggest that we should move in more
cognitive directions in work which addresses `institutional racism` and not be so `blighted` by
reference to apparently hidden matters. It would seem to us that there is enormous support  for greater
cognitive emphasis through interpretive methodologies supported by metatheories which stress for
example, how actors construct social actualities which in turn influence actors constructs or how
meaning constructed collectively is never fixed and the human being is capable of shifting
interpretations in a literally indeterminate number of ways (Giddens 1984; Cooperrider & Srivasta
1987). It is also plain to us that the reflective work of academics is `mirrored` back at some level to
those who run and work for large public service organisations. In our view the analytic commentary on
`institutional racism` needs to move away from a stress on the unconscious and towards the get at-able
cognitive area of personal constructs. Such mirroring back is likely to be far more empowering,
bringing a practical thrust to the very point before the `bubble has been burst’ when staff are
convinced their service is fair and universally available to all `regardless of…..`

We agree with the use of terms like systemic and collective failure. We think these terms are
adequately reflected in our stage 1 and 2 work.
Definition 3 appears to us to `reify the organisation` and this is another reason we have put `institutional racism` in inverted commas. If by `organisation` we actually mean the coming together of personal, professional as well as institutional then there would be place in this for what individual actors bring with them through their practice.

Definition 3 shifts to the consequences or net effect. What it seems to us to highlight is that `treating people differently` is being talked about in two completely different ways. The racist version is that by having a universal or colour blind view practitioners will end up treating people differently in ways that black people will experience as highly racist (whatever those doing think about it). The anti-racist version of `treating people differently` (earlier we used the word `differentially` which implies consideration) is to say that a so called universalism is a myth. Personal as well as professional constructs come into play in these highly personal encounters between `the public servant` and `the black person`. All practitioners have the task of working out what an appropriate response will be. They can do this through sharing the question of `how to proceed in the case of Mrs I?` with other practitioners who are also engaged in finding out how to respond `in this situation`. In other words all public service practitioners are needing to learn how to `treat people differently` in the positive `translating the professionalism into best practice` sense, because failing to do so causes immense harm by treating people differently in the negative `my professionalism works for everybody` sense.

The fourth definition brings policy into the equation suggesting that policies throughout the public sector need to legitimise NOT assuming universality. This is much trickier than might be imagined. It is not as if some new mega policy about institutional racism is required so much as the specifying and listing of ways EXISTING policies are to be changed. We are looking therefore to change a `pattern` IN what exists rather than `add to` what exists leaving the pattern unchanged. A more robust supportive policy framework bearing on each public service through substantive modification in its existing set of policies would in our view do much to reduce resistance and is not currently in place. The astonishing possibility exists of staff, managers and users of services for whom the bubble has well and truly burst, contributing to a view by government of how existing policies should be modified!

The fifth definition seems to us to have the virtue of focusing on `my practice` i.e. what I do as a member of staff, a manager etc. This has clearly been the thrust of our work, to `get at` what individuals do and how they decide what they do. The word `discretion` appears to us to need qualification. Public services whose `net effect` is to treat black and white people equitably in service delivery, by developing the ability to be professional differentially, also need discretion. To operate positively the discretion needs to be contextualised by shared processes of professional questioning. Personal constructs need to be `up for change`, as it were. Just as we need a positive and negative account of `treating people differently`, so too we need a positive and negative account of `discretion`.

Definition 6 seems to us to be moving in a direction more consistent with our work. The word `uncritical` seems to us far more fitting in so far as it has powerful `cognitive` associations. Our stage 3 work with self learning groups was really about the `failure to consider`.

Thus we arrive at definition 7 which is the one proposed by MacPherson. It is clearly an improvement on others previously considered. It is also a very difficult `thing` to wrap into a few sentences. In having to respond to sensibilities we would perhaps never be able to replace `unwitting` with `uncritical`! Although were institutional racism to have been the subject of sustained effort and had a number of influential bodies had the experience of `bursting the bubble` and come through some structured process of change, no doubt `uncritical` would be possible. The danger of re-ifying the organisation is here in this definition. But inserting `personal, professional…` again might be seen as
risking offence to those still in `the bubble`. In light of our work we would perhaps prefer specific reference to personal constructs and to individual practice. But perhaps our most fundamental point of issue is seeing the more equitable delivery as a result of changing what for us were the more basic causative processes internal to `the organisation` i.e. to concentrate on trying to change service delivery without paying attention to the more basic `causative` arenas in the organisation seems to us futile. Intrinsic to this we would expect meaningful engagement with black staff and demonstrable improvements in services for white service users. This is perhaps also a key point of departure between the two strands of experience and thought. In our view, to put it simply, when public services fail black people, as staff and service users, they fail white people too, both as staff and service users.

Definitions matter. Thinking that by merely getting acknowledgement to the existence of `institutional racism` and hiring in more black staff, then `institutional racism` will be changed, reflects a certain definition. By focusing on what can cause change in service delivery we think we have shown it is possible to `get at` personal constructs, norms, practices and procedures as well as `an ethos` all of which contribute to change the `net effect`. We would also expect to see the understanding of `institutional racism` reflected in the approach to critically framing the need to change the `pattern` of much existing public policy.

Perhaps one of the most significant omissions in the MacPherson definition is reference to and emphasis on management. We started with managers` constructs! We then moved to the patient and their histories and experiences. We tracked that through and into the organisation. This opened up a complex organisational labyrinth, which we were able to unpack and deconstruct to identify and work on the key linkages. It always found its way back to the pinnacle: management. The qualities of management, especially the capability and leadership qualities of individual managers proved critical. Deep down we were really giving them confidence to lead and confidence in their own thinking. What we enabled for those managers was a way to get a connection with practitioners and the direct work being done with patients. It seemed to us that a key feature of the context was how little time was directed to the fundamentals and how much more of the managers time seemed absorbed dysfunctionally in `organisational arrangements` from which no real direct benefit in the health of patients seemed likely. The group of managers with whom we worked were central to the transformation that occurred through the self learning groups. They owned that change: a kind of ripple going in the other direction. Without the ownership and empowering of managers we see little real prospect of changing `institutional racism`.

There is nothing fixed about the way we structured this intervention and it is perhaps unrealistic to expect other contexts to resource intervention to the extent we were in terms of time and the support from managers and staff to respond to our lead in thinking and re-thinking. We do think however that it points to the need to be clearer about how `institutional racism` is to be tackled. It might be possible to go straight to stage 3 but in our opinion some way of bringing shortened versions of stages 1 and 2 together in one `cut down` stage is likely to be needed to `burst the bubble`. We should not wait for people to be killed for it to be burst.

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