

Achieving Equality of Service Response: an Action Research Approach to Tackling Institutional Racism

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Abstract

This is an empirical study of the use of critical or emancipatory action research in seeking to challenge institutional racism and achieve equality of response by health professionals in two NHS trusts in their day-to-day work with both black and white patients. The project worked in its first stage with 53 managers and staff. In its second stage, we engaged with 30 black patients of the services provided by the trusts. In the third stage about 100 staff that were central to delivering mainstream services became engaged in six self-learning groups. All three stages contributed to a powerful re-shaping of practitioner-patient relationships. Moreover, as the project ended, these engaged practitioners and managers set about re-shaping important institutional realities.

Keywords

Equality, health services, institutional racism, self-learning groups, action research, social constructionism

Introduction

Using action research to bring about change within the mainstream of operational delivery calls for the imaginative use of research methods as part of a considered process of intervention (O'Brien, 1998). Also Wadsworth argues the 'hallmark of a genuinely participatory action research process is that it may change shape and focus over time (and sometimes quite unexpectedly) as participants focus and refocus their understandings about what is 'really' happening and what is really important for them' (Wadsworth, 1998, p8).

Our work certainly did change shape and focus. It was conducted over a 4-year period and went through three stages. It was in the third stage that it became possible to focus directly with the 100 practitioners on their day-to-day work. It was essential, in the context in which we found ourselves, to conduct the first

two stages to create the conditions for focussing on what practitioners actually did with patients. In other contexts focusing and re-focusing on 'what is really important' and the imaginative use of research, methods will create work of a different shape and pattern to that presented here. We present this work as opening possibilities for others faced with their different institutional contexts.

Key definitions

It is particularly important to be clear at the outset about the way we are using key words like institution, institutional racism, and 'black and white'.

In talking about NHS trusts as institutions, we are clearly talking about organisations. We take the word 'institution' to be identified with a social purpose and permanence transcending individual human lives and intentions and constituted by governance, management, various personnel and

other 'support' procedures and practices, and various operational procedures and practices.

We are aware of the lengths taken to, as it were, institutionalise a definition of institutional racism; that the effort put into this, especially by the Lawrence family, was attempting to put the matter beyond what individuals might or might not choose to accept as a definition in voluntarist fashion. Given the processes and events leading up to the Macpherson definition of institutional racism we would like to take it as a starting point here:

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 disadvantages minority ethnic people. It persists because of the failure of the organisation openly and adequately to recognise and address its existence and causes by policy, example and leadership. Without recognition and action to eliminate such racism it can prevail as part of the ethos or culture of the organisation, it is a corrosive disease.

(Macpherson, 1999, S6.34)

In another paper, we may suggest several refinements to this definition. Given our focus in this paper we want to make one point: that this definition is capable of quite contrasting interpretations. We would like to illustrate this by distinguishing institutionalist as well as constructionist interpretations.

We take an institutionalist approach to stress compliance, the legislative, policy and procedural framework, and changing systems to achieve lasting change. An institutionalist approach also stresses leadership, sustained effort, monitoring mechanisms, and deterrence. In essence,

this interpretation omits the voices, personalities, indeed histories of those individuals who, from the contrasting interpretation, constitute the organisational/social realities deemed institutionally racist.

A constructionist interpretation places emphasis on the shared experience of being part of the institution, on the capacity of the individuals running the institution to re-shape it. The constructionist approach stresses the implicitness/explicitness of assumptions, the shared experience between those providing services and those receiving/using them, the ability of internal stakeholders to connect with one another in the interests of service users, and the capacity of governance, managerial, and a host of background supports to sustain truly responsive operational practices.

On the surface a constructionist view might seem to be about individuals and, in effect, a voluntarist perspective. However, we want to emphasise that a constructionist view is primarily about the shared experience (i.e. a transcendent experience of being part of the institution) and the interweaving of power within all relationships. From a constructionist view the institutionalist approach can seem to 'reify' the organisational. If institutionalists succeed through the policy framework, new procedures and monitoring, constructionists may question how far this has really become new operational practice 'on the ground'. Similarly institutionalists may question, how long operational practice will change given that it is, for them, dependent on particular individuals.

The work we present here expresses dissatisfaction with sole reliance on institutionalist approaches and while unashamedly emphasising a

constructionist approach does nevertheless seek to encompass institutional change. We are stressing here a tension and a need to seek to address both perspectives.

Although we have referred already to 'black and white', we are aware too of the trend in writing about various forms of oppressive experience (gender, disability, race etc) to consider things broadly. Our view is that it is still legitimate and indeed essential to be able, when working from within the many oppressive and discriminatory historical legacies to focus specifically. There are considerable obstacles in tackling institutional racism and in the specific context of this work, within these two organisations, it proved essential to put this black-white boundary around the work and we are reflecting this in the way we write about the work.

In using the term 'white' we are drawing attention a type of power that white people can have in institutional contexts in Britain and that operates personally, professionally, and institutionally. We are not suggesting overt or explicit collusion. Ironically, we think the Macpherson definition is overly personalising in talking about '*...unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping*'. In using the word power, we are very drawn to Foucault's view of it when he says:

What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says 'no', but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than a negative instance whose function is repression.

(Foucault, 1980, p119)

For us this 'white power' is about the power comprehensively to define social realities, to define what institutional realities and operational practices will take place. Thereby, in this context, what patients will experience is something extremely difficult to define and for us Krippendorff comes closest with this definition of hegemony:

...a domination, not by individuals, but by collectivities, majorities, institutions, traditions.....All of these derive their reality through collective (widely shared and valued) commitments to rather abstract conceptualisations of systems....all these become manifest in certain valued and often routinely executed interactive practices.

(Krippendorff, 1995, p18)

We take it to be a profoundly normative kind of power. The peculiar nature of this power is for it to involve considerable denial. We also do not consider there is anything inevitable that such a type of power should continue to constitute our institutional realities in Britain's public services. That is one of the major reasons for writing about this experience here: to open up more possibilities for change.

We use the word 'black' in an equally political sense. We suggest 'white power' (as defined above), while exerting normative power simultaneously creates a 'zone of exclusion'; that those excluded by this normative power become, despite innumerable stratagems, located in a kind of mirror image but radically subordinate world. Equally, we do not consider there is anything inevitable that black people should be subjugated by 'white power'.

For us it is the 'undoing' (see Krippendorff) of these fundamentally disciplinary power dynamics that is at issue in tackling institutional racism.

Context

The locality of South West London, where our work began in the 1980s, had seen the emergence, development and funding of numerous black community networks offering community based services.

There had also been an anti racist initiative to create a network of black and white community activists and statutory sector practitioners. The local social services department had commissioned a piece of work to be done by two people from the anti-racist network to explore and report on services to black and racial minorities, especially with reference to the social work assessment process.

It was within this broad piece of work that we highlighted the issue of 'hospital discharge'. The report showed that black people and their carers were getting a considerably worse deal. They were being sent home too early, with little or no involvement with their carers. If it was bad, in the early stages of community care in this locality, for white people, it was very bad for black people.

It was through this piece of work that the local hospital trust and community trust came to be interested in responding better to black patients and their carers and ultimately commissioned the same two people to work with them towards the local health services changing their mainstream response to black people. This work took place in South West London between 1994 and 1998 and was with a large hospital provider trust and its linked community health trust. It took place prior to the creation of primary care trusts (PCTs).

The first thing we would draw from this for work in other contexts is that these two organisations felt under

considerable pressure to 'do something'. The shift in policy towards community care was making public highly divergent practices to the point that a project aiming to tackle racism, in the operational realities of both organisations, became legitimate. This was despite the culture of the NHS being dominated at that time by crisis management and a desire for shortcuts and quick solutions.

The second point is that our contacts with the numerous black community networks and our sustained involvement in a community based anti racist network enabled us to bring to the action research work with the two trusts a 'connectedness' with anti racism as a social movement. Kemmis takes the view that '*...critical or emancipatory action research is always connected to social action....Action research offers ways in which people can improve social life through research on the here and now, but also in connection to wider social structures and processes*' (1993).

This connectedness with social action is fundamentally supported when, as was the case with our work, the action researchers have a commitment to race equality and well as personal knowledge of the black communities in the area where the action research was undertaken.

The process of this work included us holding a mirror up all along the journey with the managers and staff. This was not a personal mirror. It was our understanding of racism and how it operates, in this kind of institutional context, which we had clarified and developed together with many others through our prior involvement in this 'social movement' type of context.

Methodology

Our judgment from the start was that we were not in a context where ‘imparting knowledge will have the desired effect and participants will reflect and change their behaviour’ (Bhavnani *et al.*, 2005, p138). We were facing a ‘collective failure’ which we would interpret as the ‘locked’ interaction between ‘the institutional’ and individual practice: that a mutual reinforcing is going on, on personal, professional, and institutional levels which powerfully maintains a ‘status quo’.

Both trusts had policies in place that showed an intention to create equitable services, and both focussed on the development of structures and systems as the means to change service responses. This policy and procedure framework was experienced by practitioners as overly determining: the institution handing things down to overburdened, pressurised service staff.

Service changes, and in particular changes in relationship to race, were ‘handed down as a directive, an extra piece of work’. There was no ownership or understanding among practitioners of them developing their practice or of them creating systems to support practice change.

We were drawn towards forms of action research that offered different levels of intervention and ways to progress on from a start point to other levels through cycles of observation, reflection, planning and action (Kemmis, referred to in O’ Brien, 1998, p4).

Rather than thinking our work was primarily about changing individual beliefs we saw one aspect of it as giving primacy to the emerging of new shared talk among practitioners. This developed into a decision, taken together with a project reference group

(representing management across the two organisations), to start the work by focussing on understandings about race and racism shared among managers. We could see that this might become a way to start to unlock the ‘status quo’. In action research mode, our understandings were both shaped by and were shaping the understandings of those with whom we were working. We arrived at a decision to conduct focused interviews with the whole group of managers, some 53 of them.

In the first stage of our work with staff in the two trusts we began to look for a way to bring ‘the way of thinking’ of managers across the trusts on race and racism, into some kind of collectively shareable understanding.

We saw focused interviews as a way to ‘bring out’ views we strongly suspected would be widely shared. Through becoming ‘rationally visible’, they might become ‘undo-able’.

We conducted focused interviews with four objectives in mind. These were to:

- become clearer with each manager about their aims and values as service providers;
- understand more about their view of how the service works;
- understand their view of how black and racial minorities may or may not enter the system and receive appropriate services;
- elicit their views of the blockages and obstacles facing black and racial minorities.

Our Stage One report was circulated widely, discussed directly with managers and with the reference group. Through the action research cycle, we moved to a decision, together with the reference group, to change direction dramatically. Stage two became a period of time in

which we went to the embodied realities experienced by black patients, their family and friends and including the interactions with the various NHS practitioners.

We switched the focus of our efforts away from the powerful apex of the organisation to the experiences of black patients. We switched from a 'theoretical' engagement with mainly white managers to a very down to earth, practical shadowing of black patients experiences of their route through the health care system offered by these trusts. We ran a mini project with us, the project workers, being referred black patients as they entered and passed through the system. In this second stage, we engaged with 30 black users of the services provided by the trusts and their respective practitioners. These were not a sample selected from a wider group. They were 30 patients who were directed towards us as newly referred or self-referring at the time Stage Two began.

To make contact with elders and their carers we wrote to 75 community organisations including translated posters and leaflets. We also wrote to practitioners in community health centres and clinics, the diabetes unit, geriatric, cardiothoracic and stroke wards. We also met with district nurses, therapists, business managers and nursing staff on the wards, both as individuals and going to team meetings. While we followed the path of the first 30 referred/self referring to us, the project received a further 45 enquiries from practitioners and community organisations and we explained we were unable to do the intense 'shadowing' with this further 45 because of the time available.

We called the process of both collecting information and intervening with

patients, carers, and practitioners 'shadowing'. This involved obtaining detailed information from patients, their carers, and practitioners about the experience of the patient's stay in hospital and after care following discharge. With the aid of a detailed debriefing schedule, the project was able to gather a substantial amount of specific and detailed information.

The 30 patients broadly represented 'black and racial minority patients in terms of language, religion and ethnicity. However, it was not to generalise that we worked with them, but to gain in depth understanding of how the work of the various health professionals was experienced. We kept detailed records about the patient, their illness, treatment details, and the practitioners involved. In our conversations with patients we were trying to understand what they had been asked, what they had been told, their feelings of involvement with the process, what they understood, what was explained, whether they asked questions and how far they felt they were understood. Interviews with elders and their families took place both in the hospital and their home. This allowed the patients to reflect fully upon and articulate their experience.

It is important to stress that we also talked with practitioners to find out about their perceptions of the treatment given, involvement in discharge, provision of care and understanding and communication. We wanted to elicit not only what practitioners did but also why they did what they did in contrast to what they may have said earlier in our work with them.

Our report of the second stage was also widely circulated and by now staff and managers were keen to move towards some kind of response. The realities experienced by black patients, as

portrayed in the report, were acknowledged as basically being 'how it was'. We arrived at a consensus that a way forward that constituted a response to Stages One and Two should now take place.

We had to spend a good deal of time and effort in agreeing upon a process for the third stage which would truly shake everyone free from the disciplinary influence of the racist constructing and embedding going on in the trusts.

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' practices being challenged and unblocked by them personally with one another.

We drew on the concept of 'self-learning groups' based on work by Stacey (1992) His approach includes the establishment of a learning process which practitioners with formal roles in the structure of the organisation participate in. Put in a simplified form his argument is that the formal structure diminishes learning, especially about more complex issues. However, the formal structure must be maintained if the organisation is to achieve any degree of day-to-day efficiency. A way of learning can however be set up within the day-to-day structure and self-learning groups become a means 'to learn as well as do'. Participants accept and gain skill in operating two modes: mode A being the more familiar formal role defined structuring of responsibilities. Mode A, however, creates ambiguous, complex,

challenging issues which cannot adequately be dealt within that mode.

The paradox is addressed in mode B during which it is not the formal roles and responsibilities of individuals that count so much as individual contribution. What legitimises a mode B in the wider organisation is its contribution to making operational services more effective. The creative problem solving capacity developed between participants in a self-learning group is enhanced through complex learning associated with small group dynamics. This struck us as enabling us to 'negotiate in' a development process entirely recognisable to managers and practitioners but sited in the heart of mainstream service delivery worlds.

We presented the notion of 'self-learning groups' as opening a way for participants to share their understanding of the realities and open themselves up to the critical responses of their peers.

We argued they would involve three key principles:

1. Having the freedom to operate within the boundaries provided by working together with colleagues and patients to solve problems. The members of each self-learning group being involved as equals through the contribution they make rather than on the basis of their roles in the structure.
2. Each self-learning group setting its own challenges, goals, and objectives in response to the identified problems facing the service area. Managers especially looking genuinely for new perspectives.
3. Each self-learning group having a membership drawn from different functions and levels in the hierarchy.

Six groups were set up comprising hospital, community and district nurses, podiatrists, dieticians, doctors, registrars and consultants, managers and assistant managers. We argued that each self-learning group needed its own facilitator to play a crucial role in supporting the group focus on the identification of solutions.

One of the most important aspects of the self-learning groups, established at the beginning, were four ways in which learning was being seen as taking place. Opportunities to be actively reflective with other practitioners are few. Some practitioners took a while to 'get into' this very different way of working which questions one's own practice. Having an explicit learning theory actually helped to ground the experiences being shared. The basic learning theories were:

1. Disabling blocks to learning

Groups which remain at a level of seeking knowledge and information, which were 'submissive' conforming or rebelling. Having a win-lose polarisation blocks dialogue. So too does maintaining the normal hierarchy.

2. Simple models of learning

The group appreciating just how differently people learn. Also, that one's conventionally accepted view is like the tip of a large iceberg. Under the surface lie a large body of assumptions and conditioning. Also, that gaining a new insight or idea remains theoretical until you engage in its practice. Learning through reflecting on new experiences becomes a very valuable part of learning.

3. Complex learning

This is where self-learning groups really 'get going'. This is the learning process inherent in dynamics between participants in the groups.

4. Learning into action/behaviour

Feelings brought into relationship with thoughts and ideas; gaining confidence in one's own ability implies developing the ability to respond continually to 'new' and unique circumstances.

These served as informal 'ground rules' and we would agree with Baldwin who undertook participative action research with social work practitioners. Baldwin is talking about group-work when he says:

....establishing ground rules at the earliest opportunity makes it more likely that unforeseen eventualities that might block group processes will be dealt with effectively

(Baldwin, 2000, p135)

By this third stage about 100 staff who were key to delivering mainstream services became engaged in the six self-learning groups, meeting approximately every six weeks for eight months.

What we found

The Audit Commission's report, *The Journey to Race Equality*, identifies what it calls 'groups of assumptions underpinning the main barriers to progress':

- Race equality is a low priority;
- Confusion about 'mainstreaming';
- Lack of resources;
- Difficulty connecting with black and minority ethnic communities; and
- Too many or too few targets.

(Audit Commission, 2004, para 56)

All these were present as we began Stage One. The process of going through Stage One developed an appreciation of 'the barriers' as a series

of manifestations of a particular stance or view.

We present below some views of managers from Stage One. We have selected statements which express a view shared broadly among managers as a whole.

By bringing these views out in the form of a report, this shared thinking was made 'rationally visible' for the first time. In the report, we characterised the overall stance or view as a racist one in these terms.

Culture:

The main assumption is that by increasing practitioner's knowledge and understanding of lifestyles, values, and cultural norms there will be improved access to and quality of service delivery

Service delivery:

Were black and racial minorities to take up the services, the quality and level would be the same for all patients based on the principle of equal access and service delivery to all.

The desire to change and improve service delivery is constrained by a number of pressures including demands on finance, capacity, and the inertia of established systems.

Why we saw this as a racist 'collective construct' relates to how we defined black and white earlier. There is a considerable denial of the realities actually being created and which black patients were experiencing. What came across was that changing service delivery to black people was on the margins of the trust's core operations. Our understanding of this 'way of going on' was that it has a dominating assumption that the service delivery these various measures intend to provide

access to is, by and large, acceptable to black people. In other words, these are 'linking' strategies; trying to link the existing service to black people. The managers accepted that this was a valid way to portray a dominating view; their shared view. We did not have to list the tangible expressions of the existence of this shared view since they were easy to point to. For example, the funding of 'link' workers on the periphery of and excluded from mainstream operations, time limited specialist 'race' posts and low referral rates of black patients to relevant services. In our view, these various manifestations were the result of a dominating norm. They also became, in practice, 'zones of exclusion'.

Our strategy of giving expression to a dominating managerial view, teased out through fairly standard interview methods, meant this shared 'way of going on' was no longer an implicit taken for granted. Since it stressed the shared nature of this view it was now possible to discuss it openly without a sense from individuals that they were being attacked personally.

What we found in Stage Two was:

- A continual stream of black and racial minority elders admitted, discharged and re-admitted within a short period;
- Communication was not based on a dialogue between patient and practitioner. The patient was passive. Services received were based on practitioner white value based assumptions of what they believed black and racial minority patients required;
- Carers integral to the care of black and racial minority patients were overloaded by functions and excluded;

- Information given to patients and carers was either irregular in its frequency or non-existent as a result of poor practitioner relationships with black and racial minority patients;
- Patients and carers were unable to see the whole picture of health care, and 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.

Some readers may be asking, but ‘how do you know it was not like this for white patients?’ If we had been conducting more traditional forms of research, a comparative methodology would have been appropriate. However, our action research engagement was focused on bringing out the actual experiences of black patients and their carers. We were working through a dynamic that had begun in Stage One by focusing on ‘white power’.

The logic of our action research engagement had taken us to the reality being experienced by black patients needing to have a sharper empirical edge: to bring these experiences out from the ‘zone of exclusion’. We took the fact that black people were experiencing the service as we found them to be as reason enough to accept that practice needed to improve. Finally, throughout the work preceding what we are reporting here we have found that when the needs of black people become better addressed, this also improves services for white people. Recognition of this emerged among practitioners in the self-learning groups in Stage Three.

We had to be persistent with patients. To begin with they would not really open up about their experience. But when it was clear to them that we

understood what they were experiencing, a dramatic change took place, and they talked much more openly. We also made it clear we were there to make a difference. At the same time, we did not translate this into coercive relationships with practitioners. Had we done so this would have further reinforced the already disciplinary messages inhibiting the responsiveness of practitioners. Invariably it was enough to raise the question and the practitioners would then themselves say, ‘Perhaps I should do X, Y and Z?’

Of the 30, 20 had been in hospital in the previous 12 months and had no referral from GPs to community health services or contact directly with community health services. These 20 patients had no awareness of the availability of or the possibility to refer themselves to a district nurse, speech therapy, physiotherapy, and dietetics or podiatry services, despite potentially benefiting from at least one of these services.

Communication between practitioner and patient in 28 of the 30 cases was for the most part inadequate and inappropriate resulting in poor response and outcomes for patients and difficulties for practitioners in both trusts. One African elder said:

I'm getting so worried because I think they haven't told me because its not very good news. It's getting to the stage where I don't want to know.

For many elders their hospital stay was psychologically traumatic due to minimal interaction with staff and poor information and negotiation about their illness or treatment resulting in inappropriate care. Some practitioners identified black and racial minority elders as detached, problematic, private and ‘*in a world of their own...with their family to look after them*’.

In the overwhelming number of cases, it was clear that the family and carers played a crucial role in the care of the patient. Families found practitioners were happy for them to take care of their elderly relative's needs, but felt they were a nuisance or an obstruction if they began to seek involvement in the planning of treatment and gaining more information about their relative's illness.

Every day we would bring in food for my mother-in-law and that seemed fine. But it was always difficult for us to get from staff or doctors what was happening to her and what her progress was. We understand they are busy, but we have to care for her and we need to know as much as possible.

All patients, their families, and carers reported that the information they received was not adequate and left them unable to contribute fully to the planning of their care or to seek services or refer themselves directly:

When mother left hospital I was given a lot of written literature...it was hard because I do not have the time to read it because I care for her. And to be honest it is too much. I would rather talk to someone.

At the end of Stage Two, we were arguing for self-learning groups and we had been working at change in relation to many of the 30 individuals we had been 'shadowing'. We were arguing with the two trusts that 'patient-centred' meant:

- More effective communication;
- Knowledge of and efficiency of the referral system;
- Information about illness, access to services, efficacy of treatment, and discharge;
- Relationships with families.

We were arguing for self-learning groups at a time when we were working

with practitioners who were saying things like:

We never really have the opportunity to discuss these problems until it is too late.

I don't think it should be one or two people's responsibility. We all have to consider the issues. I don't think we have thought enough about it as part of our everyday practice.

Stages One and Two had the effect of creating a break and opened the space within the organisation to entertain new possibilities. This might be talked about as a point at which people in an organisation accept that the way they have been going on has to change even though they don't know what it has to change to. As we discovered in Stage Three, although they were agreeing 'things have to change', as individuals we found there was still resistance to the idea that black people were getting a poorer service. In the *Journey to Race Equality*, there is this observation:

Many officers, members and non-executive directors told us that hearing about real experiences of black and ethnic minority communities had helped them to understand why race equality mattered

(Audit Commission, 2004, para 75)

What we found was that through Stages One and Two a general resistance had been overcome, race equality begun to 'matter', however resistance was still there for many individual practitioners.

Shotter (1993) talks about arresting or interrupting the spontaneous unselfconscious flow of our ongoing activity. For example, by giving prominence to distinctions and forms of talk being overlooked or showing the possibilities present in the circumstances. This was the substantive activity conducted from within each self-learning group: moving on, stopping to re-examine, moving on again, stopping and so on.

In arguing for self-learning groups in Stage Three our expectation was that 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 Audit Commission report *Change Here* has a very telling observation:

But it is often precisely where individuals feel disempowered and distant from decision making that change is resisted most successfully. Conversely, autonomy and delegated decision making can be powerful allies of change.

(Audit Commission, 2001, para 21)

Our expectation of self-learning groups was that individuals would begin to feel more empowered and as they did so much of the resistance would disappear.

We ourselves facilitated each self-learning group and this proved vital as many issues about race and racism which had not yet been dealt with emerged. We found most of the self-learning groups started by strongly questioning and getting clarification about the nature and existence of discriminatory practice. At the root of this was a view that their practice was (and should remain) the same for all. Initially they did not accept that black patients (despite all the evidence of Stage Two) received a poorer response. This kind of resistance was sometimes allied to attempts to go straight to problem solving solutions at the expense of agreeing the basis for the work. A key

part of the work in these groups was to keep the focus on black patients; coming back to concrete examples and not letting the group focus instead on 'externals'. Sometimes it felt as if they would do anything rather than focus on the working dynamic with black patients.

Despite the initial resistance, which in all cases was strong and in some 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.

In each group, one or two practitioners eventually began to lead the change:

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.

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.

As the process of change picked up momentum with more and more practitioners questioning their practice, we asked them to put down what they had learnt through the 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.

Another practitioner narrated her experience of an angry African patient. The practitioner had also become angry with the patient and also tried to ignore her. This had been going on for some time. The practitioner was now

beginning to question her own actions and consider what different action she should be taking. In the self-learning group she revealed her own assumptions, *'I felt she did not like white people and that her family, although pleasant, intimidated me...'* In the next group meeting, this practitioner talked about how she had 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 a different and service that is more appropriate made available. As she put it in the group, *'My inability to recognise these assumptions seriously affected the relationship'*. This experience had a powerful effect on all members of this group, leading on to more questioning of assumptions by people in the group.

We present below statements from practitioners across the 6 self-learning groups, at this stage in the work:

I will think about how I communicate to patients/ carers and whether I am really getting across.

I realise how much of a 'professional' I become often to the detriment of my own culture.

I will try not to make assumptions that the family will manage but explore the reasons why they do not want services.

It was good to be able to talk freely about what it feels like to be black and working for the organisation.

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 staffs experience and perspective was invaluable and it gave me insight into how other staff approach situations.

Our values and ways of working are also shaped by our organisation's expectations. Have we questioned enough the culture of our organisation and its impact on our communication.

The two trusts set up their own evaluation process, whereby every participant in a self-learning group provided written feedback, and each group produced its own brief report. The in-house evaluation was co-ordinated by a quality manager who drew together an overview. In it, she expressed the view that *'the learning groups have had influences across services through a ripple effect, and gradually upwards through the two organisations towards policy level'*. As our work with the two trusts came to an end, the reference group which included the business and strategic managers of the trusts continued meeting, as a self-learning group. As the trusts' overview stated:

Because of the complex learning process it has gone through, there are opportunities to continue exploring strategic and operational issues across both trusts and how progress with this agenda can be influenced.

The six learning groups continued meeting and further self-learning groups were set up. trust-wide workshops were held to disseminate the learning and process. There were numerous institutional changes made as a result of the self-learning groups to specific policies, systems including monitoring and evaluation, referral processes, assessment procedures and processes, new induction plans, changes to education and training programmes, a new examination of staff-management diversity policies and a number of specific service reviews initiated. Numerous leaders and responsibilities were designated to advance and monitor progress many of whom emerged from the learning groups. Business plans were now stating this area of work as a priority and building in the process as a coherent aspect of the trusts' mainstream approach.

On a general note the overview concluded:

The self-learning groups widened the recognition at service level of the 'intangible' nature of services; that it is in the inter-action with patients that much of the quality of service as experienced is created. If the culture within each organisation only really values tangible products or outcomes, the recent gains from these learning groups will gradually be eroded. The priority must be to raise awareness of the value of these 'intangibles' and individualised service responsiveness through the influence of individuals and their experiences.

The *Journey to Race Equality* argues:

We need to get better at identifying the expected benefits from investment and assuring the delivery of results...Its difficult to free up investment when you don't have hard information that it will result in improvement.

(Audit Commission, 2004, para 85)

As we pointed out earlier in this paper, there were significant pressures on these organisations which served to legitimate this work. From the work, it is clear that service delivery had to and indeed did change significantly. However, we would recommend 'soft' information about intangibles is far more consistent with patient/user and practitioner experiences of service delivery. Indeed collecting the evidence of these could be part of establishing the value of these as part of the culture.

Discussion

Translated into health and social care practice contexts what is distinctive for us about a racially unaware white view is its inability to acknowledge itself. Just as we might see much historically conditioned 'white culture' as assuming its universality, so we can also see a 'historically conditioned' white professional practice as assuming its universality. One of the managers

interviewed during Stage One expressed this:

We get a number of black and racial minority elders on the ward but we don't treat them any differently. Why would these people be treated any differently, aren't their problems the same as the indigenous population?

In Stage Two practitioners were saying things to us like:

We never treat anybody any different here. They are all the same to us.

We know there are problems, but isn't it the same for white people?

This assumption about universality is very much an NHS aspiration. Both managers and practitioners were 'stuck' on a particular interpretation of this. Stages One and Two set the scene for both managers and practitioners themselves to begin to take responsibility and change the way they understood universality to be about the way the work is done with each person's unique situation and needs in focus. What we found was that self-learning groups were an effective way to move the shared understandings forward to a view of universality in which individuals need to be responded to individually: that it is an equality of uniquely tailored responses because of the unacceptable inequalities now acknowledged to arise from 'the same' response.

Foucault talks about docile subjects who practice unthinkingly and how modern disciplinary power is exercised through its invisibility (Foucault, 1972; 1978; 1980). He has tended to be interpreted as arguing there is no escape from such dominating disciplinary discourses. Shotter profoundly disagrees with the inevitability of 'docility' arguing that through the arresting of the ongoing flow and new forms of talk emerging, that the shared talk gradually moves out from under dominating disciplinary

discourses (Shotter, 2004; 2005). The point we would make here is that although we needed to have a well developed critical consciousness of the nature of racism and white power within institutional contexts like the local NHS, in order to make changes in day to day practice, the managers and practitioners with whom we worked did not need to develop an equivalent level critical consciousness. Rather than trying to convince those with whom we worked about a way of thinking about racism, we used our understanding as a mirror during the work. When this was done within self-learning groups, it had an emancipatory effect among practitioners and managers.

The managers we worked with in Stage One did not see themselves in terms of race and racism, with that as a central part of their identity. Through the Stage One work, it became clear to all that the institutional discourse about responding to black people had a disciplinary quality and was a conditioned stance. Moving through to the self-learning groups our impression was that by this stage they had really made the link between having a sense of who they are in terms of their race and racism and what the outcomes are for black people.

For us the core change process was about identity, power, and language (as shared talk and ways of doing things). At the heart of tackling institutional racism for us are moments of change in 'ways of looking' and the discussion going on between practitioners. We have been struck by the metaphor of social poetics developed by Shotter and Cunliffe (2003). We feel this is very applicable to health and social care worlds of work. It gives a way to grasp how the work going on is a shared creation: between practitioner and user but also, crucially, between practitioners as well as with managers. Social poetics

as practice can be seen as distinctive methods used by a group of practitioners in coming to a more articulate grasp of their own practices, thus to develop them 'from within'. We take this as one of the goals of 'tackling institutional racism'.

In the discussion papers on race equality, *Are we there yet?* Butt (2005) points out that, 'to promote diversity effectively you need not only stop doing the things that create barriers but start doing the things that break down barriers' (p16). This may go some way to explain why we had a Stage One and a Stage Two, which we would associate with 'stopping doing the things that create barriers'. We would associate our Stage Three with 'doing the things that break down barriers'.

Bhavnani and colleagues talk about successful interventions with racism, '*Not only should successful interventions address the causes of racisms and their everyday reproduction, they should also address the why, what and the how*' (2005, p133). In other words there needs to be a clear linkage or mechanism of change between the situation at the start and the change that occurs. What changes also needs to be captured. We feel the work we have presented very much supports their view of what constitutes an effective addressing of local racisms, however unlike most of their examples, our work took place at the core of mainstream institutional delivery.

We are also very struck by their view that, '*Any intervention needs to work through a situated social dynamic*' (p133). This is extremely important in drawing lessons for work in other contexts from the experience we have presented.

From our constructionist view, it is the very determining, reified experience of

the institution handing things down to overburdened, pressurised service staff that was an obstacle at the start. But, having engaged operational staff, we developed from our constructionist approach, a reactivated professional reflexivity, autonomy, and judgment, and from this institutional change happened.

The core change process revolved around power, identity, and language. The form it took involved focused interviews took the form of focused interviews, 'shadowing' black patients, and self-learning groups. We would also include in this our direct discussions with the reference group and impact of the reports at each stage and the discussions on them. All these processes emerged through dialogue.

We want to emphasise that we are pointing towards core change processes and that the forms these take can vary considerably depending on context. Managers may be in a different 'space' in another context. It cannot be assumed that other contexts necessarily would have managers sharing the kinds of views we found. Similarly, in other contexts, practitioners themselves may have already moved forward and a Stage Two may not be needed. Nevertheless, Butt's point about barriers needs to be born in mind.

Butt also argues that the role of the front line workforce is fundamental saying:

'While much of the debate suggests the need to focus on training to develop the skills and knowledge of all workers, there is little in the research literature, to date, that highlights how this might be done effectively.'

(Butt, 2005, p19)

And he goes further:

'We are unable to identify the critical path for any process of change. This means that organisations embarking on

the process of change are faced with taking a significant number of steps at the same time'

(Butt, 2005, p20)

Our work has perhaps identified one critical path in two organisations: one that focuses on mainstream service delivery and institutional change. However, what Butt is suggesting is that this is a very rare development. We would, again, caution against any simplistic transfer of our stages one, two and three to other contexts. There may be other learning strategies that achieve the results of self-learning groups and even if self-learning groups are felt by practitioners to fit their context, the route to them may be quite different.

Nevertheless what achieves equality of health service response, from this experience, is the creation of an environment in which practitioners can become self motivated in re-working, as it were 'with and for themselves', the way they work with patients/users.

We think this is the way to greater equity in health provision, where more empowered, self-motivated practitioners and managers are the route to more empowered patients. Tackling institutional racism using processes which empower can be a powerful route to more humanistic respectful ways of managing and delivering these very 'relational' public services.

References

Audit Commission (2001). *Change Here! Managing Change to Improve Local Services* London: Audit Commission. <http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=98088E3C-BC44-4dd8-8DEF-1416C99FE430>.

- Audit Commission (2004). *The Journey to Race Equality: Delivering Improved Services to Local Communities*. London: Audit Commission Publications. http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/EA59CF1B-0157-4cdb-BCA5-D9579C4DBFE5/Workbook_FINAL.pdf.
- Baldwin, M. (2000). Learning to practise with the tensions between professional discretion and agency procedure. In L. Napier & J. Fook (Eds.), *Breakthroughs in Practice: Theorising Critical Moments in Social Work*, pp. London: Whiting and Birch Ltd.
- Bhavnani, R., Mirza, H.S. & Meeto, V. (2005). *Tackling the Roots of Racism: Lessons for Success*. Bristol: The Policy Press in association with JRF.
- Butt, J. (2005). Are we there yet? Identifying the characteristics of social care organisations that successfully promote diversity. In J. Butt, B. Patel & O. Stuart (Eds.), *Race Equality Discussion Papers*, pp. 4-28. London: Social Care Institute for Excellence.
- Foucault, M. (1972). *The Archaeology of Knowledge*. New York: Pantheon Books.
- Foucault, M. (1978). *Discipline and Punish: the Birth of the Prison*. New York: Pantheon Books.
- Foucault, M. (1980). *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*. New York: Pantheon Books.
- Krippendorff, K. (1995). Undoing power. *Critical Studies in Mass Communication*, 12 (2): 101-132.
- Macpherson, W. (1999). *The Stephen Lawrence Inquiry, Cm 4262-I*. London: The Stationery Office. <http://www.archive.official-documents.co.uk/document/cm42/4262/4262.htm>.
- O'Brien, R. (1998). An overview of the methodological approach of action research. In R. Richardson (Ed.), *Teoria e Prática da Pesquisa Ação [Theory and Practice of Action Research]*, pp. <http://www.web.net/~robrien/papers/arfinal.html>. João Pessoa, Brazil: Universidade Federal da Paraíba.
- O'Brien, R. (1998). An overview of the methodological approach of action research. In R. Richardson (Ed.), *Teoria e Prática da Pesquisa Ação [Theory and Practice of Action Research]*, pp. <http://www.web.net/~robrien/papers/arfinal.html>. João Pessoa, Brazil: Universidade Federal da Paraíba.
- Shotter, J. (1993). *Conversational Realities: Constructing Life through Language*. London: Sage Publications Ltd.
- Shotter, J. (2004). *On the Edge of Social Constructionism: 'Witness'-thinking versus 'Aboutness'-thinking*. London: KCC International.
- Shotter, J. (2005). The role of 'witness'-thinking 'going on' inside chiasmically-structured processes, *Organization Studies Summer Workshop on Theorizing Process in Organizational Research* (pp. <http://pubpages.unh.edu/~jds/Santorini.htm>). Santorini.
- Shotter, J. & Cunliffe, A.L. (2003). Managers as practical authors: everyday conversations for action. In D. Holman & R. Thorpe (Eds.), *Management and Language: The Manager as a Practical Author* pp. 15-38. London: Sage Publications.
- Stacey, R. (1992). *Managing Chaos: Dynamic Business Strategies in an Unpredictable World*. London: Kogan Page.
- Wadsworth, Y. (1998). What is participatory action research? *Action Research International* (Paper 2): <http://www.scu.edu.au/schools/gcm/ar/ari/p-ywadsworth98.html>.

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