Understanding equality and diversity in nursing practice

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Abstract

Equality and diversity is a term heard frequently within nursing, healthcare and the wider workplace. The concept links to the UK NMC Code and will be relevant to other regulatory Codes worldwide. This focuses on the core value of treating patients and service users as individuals and with respect and dignity. This article explores equality and diversity, the current UK legal framework behind the concept and offers specific examples of where this may be breached and how nurses can reflect and enhance their practice.

Introduction

The NMC Code (NMC 2018) remains a good starting point to examine equality and diversity. The UK Code outlines the minimum standard of care expected of registered nurses and midwives, and therefore offers the underpinning values for nursing and midwifery. Nurses must treat people as individuals and uphold their dignity. To achieve this, there is a need to avoid making assumptions about people and recognise diversity and individual choice. In addition, is the requirement to respect and uphold people's human rights (NMC, 2018). These issues, such as the practice of making assumptions, will be discussed as part of this article.

Equality and diversity engages with issues of power and social justice (Brewis 2017; Ahmed 2007). Therefore, to explore this, this article draws on the concept of discourse to support discussion of identities and power relations, and how these lead to inequalities. It is also helpful to draw on Nussbaum's (1996) conceptualisation of compassion as a means to achieving social justice. Nussbaum (1996) argues that compassion is intimately connected to social justice, as it provides a bridge between the individual and the community, "hooking the interests of others to our personal goods" (p28); it is in our interest to improve the lot of others given that we might be in their position someday. Therefore, compassion involves a recognition of shared humanity and existential vulnerabilities (Brewis 2017). This is useful when considering how discrimination and prejudice might be challenged.

Literature and resources may explore equality prior to diversity. However, this article will begin with the latter concept as a way of engaging with the power relations between people

belonging to different social groups, which can then lead to inequality. This exploration then moves logically to a focus upon equality. It considers equality legislation, highlighting some of the health-related inequalities experienced by people. Finally, a consideration of the organisational context of nursing and how this might support or prevent nurses challenging discriminatory behaviour.

Aims and intended learning outcomes

The aim of this article is to enable nurses to reflect upon the importance and value of equality and diversity in nursing and healthcare practice. After reading this article and completing the time out activities you should be able to:

- Discuss the nature and value of equality and diversity and understand their importance
- Identify the 9 protected characteristics within the UK Equality Act 2010
- Describe different forms of discrimination and identify it in the workplace
- Understand the extent of discrimination and harassment experienced by staff and patients within UK health services
- Identify 3 or 4 key actions that nurses can take to challenge the specific forms of discrimination that they may encounter in the workplace

Diversity, Power and Identity

At its most simple, the term "diversity" refers to the varied characteristics of a population or group. However, this term is not neutral when considered in relation to the institutional context in which it is most often used alongside the term equality. For example, Ahmed (2007, 2012) critically examines the use of the term diversity in the context of higher education institutions and identifies how it can be used to conceal inequality and perpetuate systematic inequality. She argues that the term diversity can only function if it is attached to histories of struggle for equality (Ahmed 2007). When considering diversity, this article takes the position that diversity and inequality are inextricably linked.

Brewis (2017) argues that diversity work engages with difference, recognising the power relations between different social groups and consequent experiences of inequality. People

are members of multiple social groups linked to their subject identities. These different social groups are embedded in, and perpetuate, discourses which are an association of values, language, thinking, acting, beliefs and so on, which people draw upon as a way of being recognised, or recognising others, as belonging to a particular social group (Gee 2005; Gubrium and Holstein 1995). However, discourses are not equal, they are positioned in a web of power relations (Gee 2008), and therefore membership of some discourses, and therefore social groups, is linked to greater power than others. For instance, the discourses of white (Bhopal 2018; Kivel 2017) and male are more powerful than black and female (Eddo-Lodge 2018; Ahmed 2017) in western society. Additionally, the multifaceted nature of our identities can mean that we are members of more than one marginalised discourse, for instance as a black lesbian (Lorde 2017), and this leads to the experience of multiple disadvantage caused by the intersection of these marginal identities. So, to summarise, our identities are derived from our membership of discourses, and these enable us to be recognised as belonging to particular social groups. These discourses, and therefore social groups, have unequal access to power and this is linked to prevailing cultural ideologies. This is important because membership of social groups with more access to power and therefore more access to social goods (Gee 2008) – educational, economic, health, social –is generally associated with better health outcomes than those social groups will less access to power (see Equality and Human Rights commission 2019c for instance).

When we interact with colleagues and patients, we do so from the perspective of our membership of particular social groups. In meeting people from other social groups who are different from us, there is the possibility of drawing on stereotypes that are culturally available as way of framing our interactions (Kunda 1999). This can lead to interactions which are based on assumptions and possibly prejudice about people belonging to particular social groups.

Time out 1.

Think about the different social groups to which you belong. How does membership of these social groups shape your assumptions about others? How does your membership of these social groups position you (in terms of power) in relation to your colleagues or the people you

provide nursing care for? This may seem a hard task, but persevere and maybe make some notes to achieve this.

END

Prejudice is when we value a person negatively because of their perceived membership of a particular social group (Kunda 1999). Neuroscientific evidence suggests that even those without apparent prejudice can experience activation of negative stereotypes in some contexts (Forbes et al 2012; Kunda 1999). This suggests that there is potential for anyone to act in a prejudiced way. However, there is evidence that the brain can override this and prevent prejudice from guiding our actions (Forbes et al 2012; Kunda 1999).

The roots of prejudice

Stereotypes, and therefore prejudice, are understood to have roots in the culture in which individuals are raised (Kunda 1999). People are therefore very often unaware of their prejudices until they are activated in particular interactions. Active reflection on thoughts, feelings and behaviours might enable identification of prejudice and support the goal of working in a non-judgemental manner. This may be something to do as part of revalidation or renewal of registration, rather than perhaps focusing on skills and knowledge deficit alone.

A move away from drawing on stereotypes can be made by engaging with the experience of people who belong to different social discourses from ourselves. Nussbaum (1996) in her conceptualisation of compassion, argues for an increase in "compassionate citizenship" (p51) through engagement with the "diversity of circumstances in which human beings struggle for flourishing; this means….being drawn into those lives through the imagination, becoming a participant in those struggles" (p51). Such imaginative engagement is possible through film, literature (fiction and non-fiction), and through other art forms.

Time out 2.

Reflect on a film or book (fiction or non-fiction) that you have read that gave you insight into the experience of people who belong to a different social group to you. What did you learn

about how people from that social group experience the world? How could you use that understanding to inform your nursing practice?

END

Equality

The above sections have discussed diversity and power, identifying how people occupying different identities experience unequal power. Working with diversity requires nurses to be vigilant about how others are treated, ensuring that people are not treated differently on the basis of their identity. Equality is concerned with fairness (Brewis 2017) and the goal of fair treatment of people regardless of the social group to which they belong. This work is framed in the UK by The Equality Act 2010, which makes it illegal to treat people differently on the basis of a set of nine protected characteristics (Box 1).

Box 1: The nine protected characteristics

- Age
- Disability
- Sex (gender)
- Sexual orientation
- Gender reassignment (this was renamed Gender Identity by the Women and Equalities Committee (2015/16) report on Transgender Equality).
- Marriage and Civil partnership
- Pregnancy and maternity
- Race
- Religion and belief

Equality and Human Rights Commission 2019b

Under the Act, it is unlawful to discriminate against people on the basis of one (or more) of these protected characteristics. Whilst many people with these protected characteristics may not experience discrimination, some will. Discrimination can take a number of forms (Box 2)

Box 2: forms of discrimination

- **Direct discrimination** is where a person is treated less favourably than others on the basis of one or more protected characteristics which they possess.
- **Indirect discrimination** is where an institution puts rules in place that will disadvantage those with particular protected characteristics. It is worth noting that putting rules in place can be lawful if it is able to be justified.
- **Discrimination by association** is where a person is discriminated against because of their association with someone with a protected characteristic.
- **Discrimination by perception** is when someone is discriminated against because of a protected characteristic that they are perceived to have.
- **Harassment** is where unwanted behaviour towards a person on the basis of a protected characteristic results in violation of their dignity and the development of a hostile, degrading or offensive environment.
- **Victimisation** is unfair treatment linked to the fact that an individual has made a complaint about discrimination or harassment.

Equality and Human Rights Commission 2019a

Discrimination can feel complicated and it can be difficult to decide whether an action is deliberate or inadvertent. Reflecting on a pattern of behaviour might provide clues as to whether it is discriminatory or not.

Examples of discrimination

A black or minority ethnic (BME) colleague is repeatedly overlooked by their manager who provides opportunities for advancement and training to a range of other white colleagues at similar stage in their career. This would be regarded as direct discrimination if it can be proved

that the motivation for overlooking this BME colleague is their race or ethnicity. An example of indirect discrimination is a policy where there is inflexibility around mealtimes in a health or social care setting which might not allow for the observation of Ramadan by some patients or residents. Another example is a policy where everyone is expected to work on a Sunday, but which does not support a person's religious beliefs. Not considering particular care options with a person because you assume they have a learning disability, would be an example of discrimination by perception. Discrimination by association might take the form of being disciplined for having to take time off to look after a disabled child.

Time out 3. After reading the discrimination examples here, reflect on what might make it challenging to identify whether or not an action is discrimination. You might want to consider factors such as the context, relationship with colleagues, power, the culture of the workplace/organisation. Reflect on how you might act if you were a witness to any of the examples in this article occurring in your workplace. Where might you seek support to help you identify or challenge such discrimination? – this might be people you trust or policies to support your actions.

END

Discrimination in the workplace

In the UK, The NHS Staff survey (NHS 2019) found that 12.6% of staff reported experiencing discrimination at work. For almost 50% of these respondents this was on the basis of ethnic background. Others were discriminated against for gender (just over 20%), age (20%), disability (just under 10%), sexual orientation (5%) and religion (5%). All public bodies have a responsibility to ensure that people are protected under the Equality Act 2010. Workplaces should have an equality and diversity policy which sets out the employer's expectations in relation to working within the legislative framework of the Act upholding the healthcare organisation's duty.

Time out 4.

Take time to read your workplace's equality and diversity policy. How does the policy shape your interactions with colleagues and the care that you provide? What are your views on it in

relation to everyday nursing practice? What are the discussions, if any, about Equality and Diversity within your workplace in relation to patients and workforce?

END

This next section explores the inequalities experienced by some patients and staff in relation to five protected characteristics: age, disability, sexual orientation, gender identity and race. Drawing on recent research, the intention is to highlight some key issues for reflection. It is unfortunately not within the scope of this article to provide such detail for all of the 9 characteristics.

Age

Age based discrimination is the most commonly experienced form of discrimination in the UK and Europe (Royal Society of Public Health 2018). Discrimination within the NHS because of age, such as access to treatment, was made illegal in 2012 (DH 2012). However, the Department of Health identifies that this is a complex issue as some decisions might be quite appropriate to base on age (DH 2012). It emphasises that the potential for the decision to be discriminatory comes when the decision is made on the basis of 'stereotypical' notions of age. To prevent such risks of discrimination occurring, it is therefore important to make decisions based on a detailed understanding of the patient's individual situation.

There is evidence that ageist attitudes impact health of older people, impacting life expectancy (Royal Society for Public Health 2018). In their study of age discrimination and health, Jackson, Hackett and Steptoe (2019) analysed data from the English Longitudinal Study of Ageing (ELSA). Beginning in 2002, ELSA follows a large (n=11,391), representative cohort of people 50 years and over in England (Steptoe et al 2013). Cross-sectional analysis of data from 2010-11 (n=7771) and 2016-17 (n=5595) demonstrated a statistically significant association of perceived age discrimination with self-rating of health as fair or poor and the presence of chronic disease and depressive symptoms. Longitudinal analysis of the 6-year period between datasets found a statistically significant association of perceived age discrimination with deterioration of self-rated health status and incidence of chronic disease

and depressive symptoms (Jackson et al 2019). These findings of a causal link between age discrimination and physical and mental health highlight the need to talk with older patients about perceptions of discrimination in order to highlight potential for future ill health, but also to engage them with potential resilience-building support (Jackson et al 2019).

Disability

Under the Act, a person is described as experiencing a disability if they "have a physical or mental impairment that has a substantial, long-term adverse effect on his/her ability to carry out normal day-to-day activities" (Equality and Human Rights Commission Scotland 2017: 6). Data published by the Department for Work and Pensions (2017) from their Family Resources Survey, which gathers data from a representative UK sample of over 19000 households, identifies that 21% of respondents reported a disability. Some of the disabilities experienced by people may be hidden.

Disability can be conceptualised from different perspectives. The two main perspectives are the medical model, and the social model. The medical model views disability from an individualistic deficit perspective, focusing on physical or mental deficits, prevention and rehabilitation. This perspective often leads to the development of separate specialist services rather than promoting social and environmental adaptation and inclusion. An alternative perspective is to understand disability as created by a dis-abling social and physical environment. This social model (cf Oliver 2013, Shakespeare 2014) promotes social inclusion through the development of policies and practices that remove physical and social barriers to participation in everyday life. It has been a powerful tool for social change (Oliver 2013; Shakespeare 2014) however, it is not without its critics who problematise the dichotomisation of disability and impairment (for a discussion of critiques see Shakespeare 2014).

To provide care that upholds people's dignity and human rights requires an understanding of whether, and how, they experience any disabling effects of their condition. This can be achieved by exploring with the person how their condition interferes with their ability to manage day-to-day life as well as their strategies for dealing with this. By doing this, nurses

can avoid making assumptions and base their decisions and care on an understanding of the individual. This is particularly important in enabling people to maintain their independence.

Time out 5.

Reflect on your experiences of caring for someone with disability. What assumptions did you make about their experience of living with the disability and the impact it had on their everyday life? Did you take any steps to discuss their experience of disability? If so, how did talking with them impact the assumptions you had made initially? If you did not have this discussion, reflect of why this was the case.

END

Sexual orientation

Sexual orientation is defined as heterosexual, gay, lesbian or bi-sexual (Equality and Human Rights Commission 2019b). As identified above, staff working within the NHS, report discrimination on the basis of sexual orientation (NHS 2019). However, this finding may underrepresent the extent of such discrimination, as Somerville (2015) reported a rate of 26% in a representative sample of 3,001 health and social care staff.

A survey of 5,000 lesbian, gay, bisexual and transgender (LGBT) respondents (Bachmann and Gooch 2018a) and findings of an integrative literature review (Nhamo Murire and Mcleod 2018) identify a range of discriminatory experiences of lesbian, gay and bisexual (LGB) people accessing healthcare. These include a lack of LGB specific healthcare knowledge, judgemental and heteronormative attitudes of staff, having their sexual orientation revealed without consent and inappropriate curiosity by healthcare staff.

Somerville (2015) found that 10% of their sample of health and social care professionals felt they did not have the skills and knowledge to support LGBT patients. Additionally, many respondents reported treating everybody the same, not taking into account sexual orientation as a potentially important factor in somebody's health. Somerville (2015) points

out that this is contrary to the notion of person-centred care. The various sexual identities can seem complex and Grundy-Bowers and Read (2019) offer a useful overview of this topic.

Time out 6

Identify your understanding of LGBT specific healthcare issues and consider how this shapes your interactions with patients. What skills and knowledge do you need to enable you to improve your confidence in providing care in this area? Identify resources you can use to begin to address this gap.

Gender identity

This protected characteristic includes those living as, or making a transition to living as, a person of a different gender than their biological sex at birth. Gender identity is the term used here to describe this protected characteristic, in line with the recommendations of the Houses of Parliament Women and Equalities Committee (2016) report on Transgender Equality. This identified that the terminology used in the Equality Act (2010), which refers to gender reassignment, was outdated and may not provide protection to all of those in the transgender community.

In their UK survey of 871 transgender and non-binary (not identifying as specifically male or female) participants, Bachmann and Gooch (2018b) noted that 41% of participants reported staff lack of knowledge relating to transgender people's health when accessing general healthcare services. People who identify as transgender also report inappropriate curiosity by healthcare professionals, inappropriate raising of their transgender identity when they seek help about unrelated issues (Equalities and Human Rights Commission 2015). Somerville (2015) found that 24% of respondents felt unprepared to support transgender people with their healthcare needs.

Bachmann and Gooch (2018b) recommend that staff should receive mandatory diversity and equality training, and that there should be clear, zero tolerance policies on discrimination, bullying and harassment on the basis of gender identity, gender expression or sexual orientation.

Time out 7.

Reflect on your knowledge of transgender identity. What do you know about the language around these identities? How confident do you feel about discussing health issues sensitively and appropriately with a person who identifies as transgender? What education needs do you feel you have to improve your understanding and competence?

Race

Within the Equality Act (2010) race refers to "a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins" (Equality and Human Rights Commission 2019b). Race can refer to colour or nationality, even if a person's current nationality is not the same as their ethnic or national origins. Race also refers to membership of a racial or ethnic group.

Within healthcare, race and ethnicity are recognised as a key health determinant, with health-related outcomes for people from minority ethnic groups generally poorer than for those of white British people (Public Health England 2017). In fact, that lack of improvement of the health outcomes, and the continued poor experience of doctors, from ethnic minority backgrounds prompted the British Medical Journal to more recently publish an editorial on the topic and call for papers for publication of a special issue on the topic (Kmietowicz et al 2019).

The NHS Workforce Race Equality Standard (WRES) data monitors the representation and experience of staff who identify as black and BME within NHS Trusts in England. Data from the Trust and from the NHS staff survey are used to measure Trusts' performance against 9 indicators. The most recent data indicates that people from BME groups make up 19.1% of NHS England's workforce (WRES 2019). However, only 6.9% of very senior management positions in NHS England are held by people from BME groups. Additionally, there are disparities in the rate at which BME are shortlisted for interview in comparison to white applicants, and in relation to opportunities for career advancement (WRES 2019). Harassment from patients and their families was reported by 29% of BME staff, and from colleagues by 28% of BME staff (WRES 2019). The most recent NHS staff survey identified that over 40% of

BME respondents had experienced racial discrimination in the previous 12 months (NHS 2019).

Eddo-Lodge (2018) argues that challenging racism is not about acting in a way that ignores colour as that perpetuates structural racism by refusing to engage with its existence. Acting in this way is also invalidating of BME people's experiences of the world (Eddo-Lodge 2018). Instead, it is necessary to notice how colour and race interact with the structures of the institution to produce the discriminatory effects identified above.

Challenging discrimination

It is clear from this discussion that despite the legislative framework people continue to experience discrimination. Any consideration of how discrimination can be challenged must take account of the organisational culture of the institution. Organisational culture is a complex concept but is essentially the values and beliefs that underpin a workplace (Nightingale 2018). This will feed into what behaviours and attitudes are deemed as acceptable and indeed tolerated. This may even, at times, run counter to what is more formally expected of staff and teams. A range of inquiries into healthcare organisations has identified organisational culture as a key factor in the perpetuation of poor practices, difficulties in raising concerns (Francis 2013; McLean 2014; Kirkup 2015) and difficulties being heard by the organisation (Jones and Kelly 2014). Such inquiries also generated debate on whether nurses lacked compassion (Stenhouse et al 2016). It could be argued, following Nussbaum (1996), that the culture of an organisation directly impacts the compassion of the workforce. She argues for compassionate institutions, where compassion is embodied in the structures and processes of the institution, shaping the development of compassion in the workforce and thus the potential for social justice.

The setting of the cultural tone within an organisation comes most powerfully from those in leadership positions. Therefore, those leaders at the top of the organisation should consider how they role model and set management and policy direction to reduce potential for, and challenge, discrimination. Within the individual clinical area, leaders should role model practice that is non-discriminatory and engages with diversity. This can be a very powerful message. Bouten-Pinto (2016) suggests that a leadership approach which includes reflexive

engagement between managers and staff can enable "sense-making and considering of aspects of diversity in an organisation when and where they matter most to the people involved" (p141). Through her work as a diversity consultant, Bouten-Pinto (2016) realised that what enabled organisations to move forward and become more inclusive was a shift away from the top-down flow of communication to a situation where there was dialogue. Leaders and staff were able to reflect on workplace issues together, exploring their different experiences and perspectives, enabling greater understanding of the impact of the issues and facilitating the development of collaborative solutions.

Staff should have access to quality equality and diversity training specifically focusing on the issues relating to healthcare. Staff should also take responsibility for identifying their own learning needs in relation to specific equality and diversity issues and seek out further educational opportunities. This can form part of more formal processes, such as appraisal, personal development needs and revalidation/registration renewal.

In reality, some staff may find themselves working in an organisational culture that does not support them to raise concerns in relation to practice and does not align with equality and diversity values explored in this article. In these situations it can be useful to contact someone external to the organisation for support in raising concerns. Such support is available from the Royal College of Nursing or other nursing unions, or in the UK, through contacting the national whistleblowing helpline Speak Up. Additionally, there may be local support networks available.

Conclusion

Issues around equality and diversity can be complex but it is important for nurses to engage with these to enable them to fulfil their professional responsibilities to patients and colleagues. Whilst there is legislation to support equality, the data continue to show that both staff and patients continue to experience discrimination within the healthcare context. The organisational culture is central to supporting the development of practice that upholds the values of equality and diversity, placing importance on leaders to set an open cultural tone to support nurses to practice in a way that aligns with strong equality and diversity values as well as supporting staff to raise concerns.

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