Diversity in the medical profession essay

Business, Management

For centuries, man in his lifetime has secured methods and behavior that relate with others in his own social group based on his own experiences and structure in his society. The varying degrees of adaptation in his own natural environment spurred a distinct identification that has created a global community of complex and diverse personalities. Gaps brought about by greed and ambition widen as man’s efforts to relate with others increased. Coherent set of traits are soon distinguished to define certain groups, enumerate differences and classify one another according to culture and beliefs. Certain groups whose aims are equitable with greed and power develop means to identify an inferior group to uplift their in their own acceptability and superiority. A certain diverse contrast between people soon evolved as a means to identify cultural similarities and differences, beliefs and practices with regard to region and culture.

With the advent of diverse personalities and culture, conflicts evolved as a result of superior beliefs and practices that are heavily discouraged in the medical profession. Culture which shares a system of beliefs, values and behavioral expectations provide social structure that defines roles and human interactions within families and communities and with others (Spector, 2000)[1]. In the past our nation’s dominant culture is shaped by the way the system of health care is developed and maintained that is often enhanced by our unique political, economic, and socio-cultural factors reflected in the delivery of health care services (Scotland, 2005)[2]. Our progress with chronic illness though has been less impressive that immediately brings to concern the sincere efforts to reach out to the diverse cultures of the patients in our midst. Recognizing the need to adapt to the

varying degrees of care (DOH, 2000)[3], the nursing and midwifery profession as a profession of authority has regarded the interest and well-being of the patient as paramount (Neal, 101)[4]. Cultural diversity as an integral part of the United Kingdom and the European Union's[5] legislative efforts governing the rights of individuals and groups is acknowledged in the health profession's promotion of health in all life forms (Scotland, 2001)[6]. In meeting the therapeutic goals of the patient, the medical profession as a team needs to evaluate the varying traits and values of the patient for his treatment. The destructive approaches employed in the yesteryears have provided devastating effects for the British citizenry in general that is detrimental to the health legacy of the nation (Elliot, 2001)[7].

The health profession recognizes the need to eliminate the persistent separation of individuals according to race, religion, beliefs, affiliation and culture to improve the health outcome of the entire population (Neal, 108[8] ; Telegraph, 2005[9]). Diversification in the nursing roles towards patient care proposes to invest in a variety of means that promote incredibly a new range of skills developed alongside the initiatives such as assessment, referral, diagnosis and prescription. In the evolutionary and diversification processes, there has been a massive growth in the number and variety of public health related roles over the first few years of the twenty-first century (Leonard & Plotnikoff, 2000)[10] The public health link between socio-economical disadvantage and nursing has also been articulated by the World Health Organization since early papers in 1959 and 1961 (Edgecombe 2001; Elliott, 2001)[11]. Nurses demanding action and health service decision makers' help to enable them to take this public health lead that was

reaffirmed by government health ministers in the Munich Declaration (WHO 2000)[12]. It ratified the vision of a family health nurse at the heart of health targets for the 21st Century. It has been clarified in the UK that all nurses have a public health role in contributing to health and well-being in line with the Munich Declaration (WHO 2000)[13]. This declaration ultimately brings closer a time when nurses will be able to assess and meet the majority of the needs of any individual in the family or in the community (Macduff and West, 2003)[14]. Public health related requirements now exist for initial registration with the Nursing & Midwifery Council (NMC) that is a timely reminder for successful health education campaigns in the past that widen inequality (Macduff & West, p.

43)[15]. The policy documents did admit that the central problem causing ill health was not life style but socio-economic deprivation. With the trends of increasing cultural diversity, it is therefore necessary for nurses and midwives to have a working knowledge of other systems of care and the diverse people they serve in the current health care system (Edgecombe, 2001)[16]. Culture determines values and behaviors, but other factors within a culture influence behavior patterns and habits as well. These include a person’s age, gender, education, occupation, residence, level of acculturation, social class, life experiences, individually held beliefs, and practices including religion (Macduff and West, 2003)[17]. When a health practitioner has the lack of awareness compounded by an assumption of superiority, a serious problem for both patients and providers can result.

Even the most well-meaning professionals can fail to provide good care when cultural differences are handled incompetently (Edgecombe, 2001)[18]. It is also important to know that the present legal system in United Kingdom promotes self-determination that failure to respect a patient’s wishes can lead to legal ramifications. Nursing and Midwifery Council’s Stance on Diversity Issues The NMC is committed to valuing diversity and providing equality of opportunity across all its operations.

It rigorously values the diversity policy that promotes the fair treatment of individuals irrespective of their race, colour, religion, ethnic origin, nationality, gender, disability, working patterns, sexual orientation and family circumstances (WHO, 2000)[19]. This is ultimately seen as a right for everyone that is necessary to the improvement of service provided by nurses and midwives to the public. To comply with the legislative efforts of UK, the NMC aims to take all necessary steps to promote fairness and equal treatment (Thompson, 2006)[20].

In effect there is a regular review of procedures and practices to monitor the organization’s progress. Under the key principles of diversity, the NMC commits to ensure that co-employees and clients including their relatives are treated with equal dignity and respect free from discriminatory practice, victimization or harassment (WHO, 2000)[21]. It ensures the provision of fair and equitable procedures in relation to all personnel and operational areas (Thompson, 2006)[22] and provides decision regarding its operations and policies that consider implications for equal opportunities. In the practice of the profession, it is understood that decisions are based on a justifiable

criteria particularly in recruitment, training and promotion taking into consideration the diverse personalities of individuals and providing equal opportunities for everyone (Thompson, 2006)[23].

It also promotes the appropriate publication and use of language and illustrations which are not discriminatory. Certain procedures that resolve complaints of discrimination is therefore developed and communicated to everyone and breaches of the diversity policy are dealt with disciplinary procedures. There is likewise a regular monitoring and review of the action plans developed. The Reflective Process in Managing Diversity In the delivery of care, the total situation for the patient and family requires competence that a nurse must possess as a knowledge base of skills and abilities to provide optimum level of care to the diverse clients. This is important to achieve high levels of patient and community satisfaction among diverse cultural groups (Thompson, R, 2003)[24]. It does not require one to be an expert on other cultures or social groups. However it necessitates sensitivity to diverse cultures by demonstrating an awareness acknowledging that health care has its own deeply held beliefs and practices (Leonard & Plotnikoff, 2000)[25]. Employing the process of reflection as a dialogue with oneself provides a way to listen to our own meaning of the actions or words that is important in dealing with diversity.

Using the double loop learning technique, on the other hand carries the nurse-practitioner to a level where there is more authentic communication taking place. The reflection my run deeper but since organizations often require a higher level of authenticity, any simplistic level is careful to avoid

any conflict. This is therefore not conducive in dealing with diverse patients as oftentimes a level that employs active communication exchange should take place. In the medical profession, a simplistic level may also not play out to manage diverse rules but can be fitting in the management of patient relations. Setting a composition, to those of the same gender or cultural identity can be grouped together but defeats the purpose and motivation in reflection as the advantage lies in assigning people to sets rather than participants determine for themselves their counterparts. Maintenance of a learning log or a diary helps us to monitor the needs of the culturally-different client that at the same time shows our obstacle encountered with the possible solutions to manage the situation. Creating questions relevant to the unfamiliar situation may open our eyes for the possible opportunities that may not have been present before. This learning log gives out a record of events and personal views that best interpret the findings seen.

Sometimes the learning log should be maintained for more than a few days o one can arrive at a significant situation in dealing with the different behavior of the client and family. In the process of gleaning pertinent data for patient care, inducing reflection is formed as members of the family and the patient himself set the history around a narrative life story. It is more conducive for easy understanding than the resume style that enumerates everything lifelessly. Trust is also developed as the interaction between client and nurse-practitioner becomes evident. The writing of the life story in fact already creates a reflective impact that repeats the whole dialogue in the written form. Every observation encountered at the same time needs to

be recorded in the session that includes the observers as participants. My Own Reflection for client Xa.

Dealing with a patient with a diverse culture and personality was an experience that brought initial feelings of apprehension and fear. Working with the rest of the team did not help either as I was alone in taking the patient history while the rest of the family was looking at me as if I was asking irrelevant questions. I fought for control as questions on my capability to handle the situation seeped in.

b. As I reflected, I realized that I was terrified of the learning process in general and a fear of the behavior of my patient. Having reflected on my initial misgivings, I felt I could handle them better as they could easily understand and speak the same language with me. c. Learning about my client’s cancer condition stretched my skills at a level that I have several studies and exposure on.

d. Discussions within the context of care prior to surgery soon evolved and the patient’s anticipation of the outcomes described their sentiments that provided an insight to their familial closeness and the different personalities of each family member that took part in the decision and discussions. Having aired out their apprehensions, each member suggested means to contribute in the care and conceptualization of the entire ailment. Somehow it was almost difficult to participate as everybody in the family was adamant to be heard. e.

The process encouraged the family to open up and accept the cancer condition of their mother and could somewhat help the situation head-on. f. I have always though that I would not be capable to handle the scenario particularly with a family of Asian background who at times would discuss in their own language their ideas but the process created trust and confidence as I was able to listen to their ideas. g.

Reflecting on the experience, this has taught me to enhance my self-esteem particularly when dealing with patients. Knowing a subject matter helps a lot to booster one’s confidence that comes prepared in the advent of questions. h. Personal histories. This assignment enabled me to reflect on the over-all attitude of the patients and their significant family members. It enabled me to understand how they relied on one another for support and decisions particularly in an event that they would often relate as a “ disaster in their lives”.

In effect this gave me the idea that to deal with a patient is to deal with the entire family at the same time to promote the optimum level of care required for the patient. Self-awareness and an honest exploration of one’s own cultural values, beliefs and prejudices against other cultures helps as much as providing health-care for the patient. Intellectual awareness requires a heartfelt effort that acknowledges learning about the diverse people in the health setting. Humility builds the process of trying to identify the differences and learning to accept them without boundaries. Watching movies, learning about diverse cultures in books and in the Internet provides an insight on how to deal with the lives and culture of different clients to

support care providers in trying to learn how to care for them and in doing so, clients are more likely open to share their fears and plans in this case, for their mother while maintaining respect to the older members of the family.

In the end, the surgery came out successful.

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[13] Ibid.[14] Macduff, C. and West, B. J. M. (2003), Evaluating Family Health Nursing Through Education and Practice. Edinburgh: Scottish Executive.

[15] Ibid, p. 43.[16] Supra, see Edgecombe.[17] Supra, see Macduff.

[18] Supra, see Edgecombe.[19] supra, WHO.[20] Thompson, Neil, 2006,[21] Supra, see WHO.[22] Ibid, see Thompson.

[23] Ibid.[24] Thomson, R. (2004), Safe at the centre. Nursing Standard 19 (7), 20.[25] Supra, See Leonard & Plotnikoff.