

Nursing research for a multi-ethnic society

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PRE-PUBLICATION VERSION

Nursing research for a multiethnic society

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Summary points

- Conducting research that appropriately and sensitively pays attention to ethnicity presents an important challenge to nursing researchers and demands particular competencies.
- Nursing research must recognise the multifaceted nature of ethnicity and the varied ways in which health-related experiences and outcomes may be associated with ethnicity.
- Ethnic identities are complex and fluid so that using fixed ethnic categories in research requires careful consideration.
- Describing and explaining differences between ethnic 'groups' demands careful attention to sampling, data generation and analysis so that partial or misleading interpretations are avoided.
- Researchers should be alert to the potential for research on minority ethnic groups to do more harm than good and should seek to ensure that their research focus and approach is informed by the experiences and priorities of these groups.

Introduction

The UK is now widely regarded as a multiethnic society. In the 2001 Census, 8% of the UK population self-identified as non-White, with 13% of the population of England identifying as belonging to an 'ethnic group' other than White British. The words 'ethnic group' and 'ethnicity' are commonly heard in public policy, the media and even everyday conversation (Eriksen, 2002). Likewise, health and social research pays increasing attention to 'ethnic diversity' and 'ethnic inequalities' in experiences and outcomes. As Anthias (2001) and others have argued, 'ethnicity' is one of the major social divisions in modern societies and 'ethnic identities' have important implications for people's lives. However, the meaning of such terms

remains ambiguous and research that engages with these issues is inherently politicised and often controversial in nature. Conducting research that appropriately and sensitively pays attention to ethnicity presents an important challenge to nursing researchers and demands particular competencies (see Box 1).

There is substantial evidence that health and healthcare provision vary along ethnic lines and that minority ethnic groups are at risk of significant disadvantage across a range of indicators (Nazroo, 1997; Gill et al., 2007; Henry, 2007). UK health policy and practice directives over the past four decades have repeatedly acknowledged the need to understand and tackle ethnic health disparities (DH, 2003), identifying nursing as a key profession to contribute to this endeavour (Culley and Dyson, 2004). Further, the Race Relations (Amendment) Act (RR(A)A) 2000 places legal obligations upon all public organisations to consider the need to eliminate unlawful discrimination and to promote equality of opportunity and good relations between people from different ethnic groups.

Box 1: Cultural Competence in Nursing Research

Papadopolous and Lees (2002) suggest the following model of cultural competence in research:

Cultural awareness: Examining and challenging your own personal value base and behaviours and reflecting on how these may affect the research process.

Cultural knowledge: Understanding the similarities, differences and inequalities between and across ethnic 'groups' and the multiplicity of factors that might account for these patterns. Such knowledge should help to avoid stereotyping, prejudice and discrimination in research.

Cultural sensitivity: Challenging power relationships and oppressive practices to offer true partnership to the participants of research studies founded upon trust, respect and empathy.

Cultural competence: Synthesis and application of awareness, knowledge and

sensitivity, enabling racism, discrimination and ethnocentricity to be recognized and challenged.

Both culture-generic and culture-specific competence are considered necessary, the former being the acquisition of knowledge and skills that are applicable across ethnic groups, the latter being the knowledge and skills that relate to a particular ethnic 'group' that enable an understanding of that group's particular values and behaviours.

Given that it is now commonly accepted that healthcare policy and practice should be evidence-based, these policy directives and legal duties clearly imply the need for researchers to generate an evidence base that reflects the needs of our ethnically diverse the population. This requirement has been formally acknowledged by the Department of Health in its Research Governance Framework for Health and Social Care in which it sets out a number of general principles that should apply to all research (DH, 2001):

'Research, and those pursuing it, should respect the diversity of human society and conditions and the multi-cultural nature of society. Whenever relevant, it should take account of age, disability, gender, sexual orientation, race, culture and religion in its design, undertaking and reporting. The body of research evidence available to policy makers should reflect the diversity of the population' (Para 2.2.7)'

However, much health research does not include participants from minority ethnic groups and/or fails to give considered attention to ethnicity as an axis of analysis (Hussain-Gambles, 2003). Furthermore, despite government directives and some recent improvements, routine data collection systems such as the Hospital Episodes Statistics still achieve low coverage and poor quality information on ethnicity (Aspinall and Anionwu, 2002).

A number of factors appear to have contributed to the inadequate attention to ethnicity in health (and nursing) research including: a lack of awareness of the potential significance of ethnicity; a tendency to consider ethnicity as a specialist

area of investigation; conscious exclusion of minority ethnic individuals on the grounds of added cost and complexity; and a lack of researcher confidence and skills to engage with individuals from ethnic groups that are perceived to be 'hard-to-reach'. At the same time, growing awareness of past abuses and negative experiences of research may also make individuals from minority ethnic groups reluctant to participate in research.

Research interest in ethnicity and health is, however, growing in the UK and elsewhere (Drevdahl, Taylor and Phillips, 2001). Yet, as the volume of research addressing ethnicity and health expands, so too do concerns regarding the *quality* of this research, its potential to inform changes in policy and practice that benefit minority ethnic populations, and its potential role in stereotyping and stigmatising ethnic minority populations (Gunaratnam, 2007). Indeed, much of the previous research in this field has been of dubious ethical and scientific quality and a number of persistent pitfalls are identified, including: the use of outdated, inappropriate models of ethnicity that present ethnic 'groups' as stable, discrete entities; a failure to research issues that are of concern to minority ethnic people; a lack of cultural competence in research practice; and a failure to incorporate a broader social, historical and political analysis of ethnicity (Stubbs, 1993).

Against this rather unpromising history, it is salient to stress that poorly designed and poorly conducted nursing research will, at best, fail to contribute to a better understanding of the links between ethnicity and health and how ethnic inequalities in health might be addressed and, at worst, serve to perpetuate the stereotyping and disadvantage experienced by minority ethnic groups. Conducting research into ethnicity and health appropriately and sensitively raises a range of complex theoretical, methodological and practical issues, and researchers require support and guidance if their work is to make a positive contribution to the health and healthcare received by minority ethnic groups.

This chapter introduces the reader to some of the most important issues for consideration. We encourage nursing researchers to recognise that there are often no simple, 'cook book' solutions to the complex issues that arise in researching

ethnicity and health, and to aim instead for heightened critical reflexivity in the research they conduct.

Getting to grips with the concept of ethnicity

So far our discussion has employed the term 'ethnicity' without further elaboration. However, frequent, everyday reference to 'ethnicity' and 'ethnic groups' belies the complex and contentious nature of these terms. As Mullholland and Dyson (2001) argue, nursing researchers must look beyond the popular everyday use of these terms, and the implicit meanings such use reflects, and seek a more informed appreciation of their complex and dynamic nature.

In health research (as well as wider societal and policy discourse) the term 'ethnicity' is employed in diverse and contradictory ways. In its most generic form, 'ethnicity' represents a form of social or group identity, which draws on notions of shared origins or ancestry. However, different conceptualisations of 'ethnicity' tend to emphasise different aspects of such group identity and to view differently the processes of identification through which ethnic affiliations arise. Some conceptualisations emphasise the cultural commonality within ethnic groups, identifying shared beliefs and behaviours, sameness and belonging; that is an *internal* identification. In contrast, other ideas about ethnicity place emphasis on geographical origins and shared biological features among the members of ethnic groups. Still others focus on socio-political dimensions, viewing ethnicity as the *process* through which boundaries between hierarchically organised 'groups' are constructed and symbolised, with the emphasis therefore being on the imposition of categories and labels by external forces. Indeed, some conceptualisations appear to invoke a combination of all three of these dimensions. This is why some have called ethnicity a 'biosocial' or 'biocultural' concept. Similar variability exists in the ways in which the term 'race' is employed (see Box 2).

There is also variation across research contexts in the extent to which the boundaries and characteristics of ethnic 'groups' are seen as fixed and stable. Recent years have witnessed increasing criticism of health-focused research that portrays ethnic identities as immutable and ethnic groups as homogenous and

unchanging. On the one hand, researchers who have taken the discredited view that ethnic groups display wholesale genetic differences (claimed to be the result of their different geographical and sociocultural ancestries) have tended to interpret ethnic disparities in health as resulting primarily from biological differences, ignoring the importance of culture, socioeconomic status and discrimination. On the other, there are researchers who portray the culture of ethnic groups (together with related beliefs and behaviours) as homogeneous, distinct, immutable and, in some respects, 'innate'. Such 'cultural determinism' ignores the diverse, fluid and context-dependent nature of cultural characteristics, overlooks the potential role of socioeconomic status and discrimination and contributes to the stereotyping and stigmatisation of minority ethnic populations as culturally deviant or inferior (Gerrish, 2000).

Nursing researchers must therefore recognise the multifaceted nature of ethnicity and the varied ways in which health-related experiences and outcomes may be associated with ethnicity. It is useful to think of two broad modes of impact: first, the ways in which an individual's experience of their own ethnic identity informs their health-related attitudes, beliefs and behaviours (and thus their risks and responses to ill-health); and second, the role of ethnic identification in processes of inclusion and exclusion that can importantly determine access to a wide range of resources relevant to health (including appropriate health services). Researchers must take care to 'unpack' the concept of ethnicity so that it is clear which of its various biosocial dimensions are being explored in their work. Furthermore, researchers need to recognise the dangers of conceptualising ethnicity in ways that inadequately capture its multi-faceted, dynamic and context-dependent nature.

Adopting this inherently reflexive approach to research on ethnicity and health will frequently require researchers to explore not only the implications of ethnic identities for health experiences and outcomes, but also the mechanisms through which ethnic identification occurs (at both the inter-personal level and between groups within society at large). As Gunaratnam (2003) argues, researchers need to ask questions about why and how ethnic categories, such as 'Chinese', come to stand for diverse groups of people and what implications this labelling and homogenisation has for people's lives.

Box 2: Ethnicity or race?

Though the term 'ethnicity' is currently more commonly employed in UK health research than the term 'race', the two concepts are closely related and both are used somewhat interchangeably. It is commonly suggested that while 'race' refers to biological features (such as skin colour) to distinguish different groups of people, 'ethnicity' focuses primarily on differences in cultural practices and beliefs. In practice, however, this neat distinction is not consistently applied in either research practice or social discourse. As Gunaratnam (2003) and others have noted, 'race' may often emphasise differences in physical characteristics (such as skin colour) but 'race' has always been a far broader concept that *also* sought to reflect differences in a range of social and cultural characteristics. Likewise, though ethnicity tends to emphasise cultural and religious attributes, these characteristics are frequently represented as relatively fixed and inherent, being passed down from one generation to the next through endogamous marriage as well as processes of socialisation. Given the complex inter-relationships between the two terms it is not surprising that there is little standardisation of research practice, and there are disparate opinions as to which of these two terms should be employed by health researchers. While some advocate avoiding the use of the term race because of its association with discredited 19th century work labelled 'scientific racism', other researchers retain its use as a biological, social and/or biosocial construct. Some researchers go one step further and place the term race in scare quotes – 'race' – both to signal its contested meaning and to acknowledge that as long as racism exists within society then 'race', however problematic, will be needed in research. Few comparable concerns have been raised over the use of the term 'ethnicity' in health research, and this partly explains why it is more commonly used within the UK. However, some researchers have argued that 'race' is preferable to 'ethnicity' since the latter tends to obscure the importance of external forces, power and exploitation in the lives of people from minority ethnic groups, and instead ascribe disadvantage to the internal attributes of the groups themselves. Other researchers have suggested a compromise of sorts, in which the two terms are conflated in a joint formulation – 'race/ethnicity' – to encapsulate and signal the diverse biosocial character of both terms while retaining a focus on the role each have played in stereotyping, discrimination and

disadvantage.

Identifying a research focus

Before embarking on the details of study design, we suggest that all nursing researchers should give careful consideration to whether or not attention to ethnicity is warranted within a particular study. Clearly, there are some research issues in which ethnic identity is unlikely to play a role, such as studies exploring the functioning of a new medical device or the effects of new technologies on healthcare policies. There may also be reasons for excluding attention to ethnicity in some studies on the grounds of cost and/or complexity. However, since ethnicity is such an important axis of identity and inequality in contemporary societies there are unlikely to be convincing arguments for overlooking ethnicity in most areas of nursing research.

Where the broad topic of inquiry makes a compelling case for paying attention to ethnicity, the researcher then needs to carefully consider how to focus the research. As Johnson notes 'from the perspective of minority populations there may be both 'too much' research - insofar as their particular ('peculiar') specific characteristics may attract research attention that is unwelcome or serves to stigmatise their community - or 'too little', insofar as they may be excluded from research that has measureable benefits or informs policy and practice shaping the provision of services they want or need' (2006, p49). Framing research questions in such a way that the knowledge generated contributes positively to understanding and tackling ethnic inequalities in health requires careful thought. Key issues to consider include:

- Does the study aim to explore processes of ethnic identification (how and why individuals identify themselves and others as belonging to particular ethnic groups in particular contexts)
- Does the framing of the research avoid presenting ethnic categories as taken-for-granted, natural or neutral?
- Does the research aim to describe differences between ethnic 'groups'?

- Does the study hope to go further and seek to explore the possible reasons behind differences between ethnic 'groups'?
- Does the study seek to identify similarities across ethnic 'groups' as well as differences?
- Does the research focus too narrowly on any particular dimension(s) of ethnicity thereby closing off potentially important avenues of investigation?
- Does the research over-emphasise ethnicity, to the exclusion of other aspects of identity and difference, such as gender, age, social class and so on?

More fundamentally, researchers must ask themselves whether their focus is important and meaningful to those who are the subject of the research. Effective engagement with people from minority ethnic backgrounds can help ensure that research is adequately informed by the experiences and perspectives of these groups, but requires careful planning to achieve adequate representation of diverse views and experiences, cultural sensitivity and meaningful involvement (Johnson, 2006).

Operationalising and measuring ethnicity

In studies that gather new data, the researcher must decide how to operationalise, or measure, ethnicity within their research. Studies that explore ethnic identification as a process will need to examine the multiple and diverse constructions of ethnicity and will most often employ qualitative, inductive approaches (though some quantitative studies have offered important insights - see for example Karlsen, 2004). In such studies the researcher will generally avoid the use of predetermined, fixed ethnic categories and will instead operationalise ethnicity as a fluid property of individuals and groups. Nevertheless, there is clearly a need to start somewhere and, in most nursing studies, to identify potential respondents who might be included as sources of data. For this reason, researchers will often be guided by what Mason (2002) calls 'real-life' categories – using, for instance, self-reported religion or ethnicity, physical appearance or perhaps membership of an ethnically-affiliated organisation, to identify a selection of respondents who seem likely to have a range of relevant social positions and experiences.

Studies that seek to understand ethnicity as a potentially important determinant of health experiences and outcomes tend to be framed differently. Here the focus is usually on the characteristics, outcomes or experiences of a set of individuals categorised as belonging to an ethnic 'group'. Frequently comparisons are made between two or more such 'groups', and these can be useful in identifying areas of inequality or minority ethnic disadvantage. These studies usually need to operationalise ethnicity as a discrete categorical variable, and this can be challenging for those researchers who regard ethnicity as a fluid and context specific concept. Furthermore, attempts at categorisation and the labels employed vary over time and place, calling into question their meaningfulness and making comparison and synthesis of findings from different studies difficult. However, while accepting that ethnic classifications will *always* be crude, researchers can nonetheless seek to identify the best available categorisation for the study in hand (Ellison, 2005).

It is important to consider the extent to which the categories chosen can serve as adequate proxies for the components of interest in the current study (whether cultural, socio-political and/or genealogical factors). As such, it should be recognised that particular categorisations will have utility in some research studies but be less helpful in others. For instance, Bhopal et al. (1991) argue that the collective ethnic category 'Asian' or 'South Asian' is inappropriate for understanding coronary heart disease risk and treatment in the UK and can lead to false interpretations, advocating instead the use of the more refined categories: Indian, Pakistani and Bangladeshi. In contrast, Ali et al. (2006) in their study of patient-general practitioner interactions employed the grouping 'South Asian' and found that the 'finer distinctions' of Indian, Pakistani and Bangladeshi were neither relevant nor necessary within the context of their study.

Notwithstanding the observation that some categorisations will be more or less useful depending on the research topic, any attempt at categorising ethnicity will not get over the fundamental tension that exists in 'fixing' socially mediated categories that are inherently complex and variable.

In many instances, researchers interested in exploring ethnic variation in health and healthcare will be forced to rely on secondary data collected using standardised and

statutory classifications, categories and labels (such as those developed for use in the 2001 UK censuses, see Box 3). When undertaking new data collection more options are available but there will be pros and cons to adopting bespoke, rather than standard, classifications.

The disadvantages of standardised schemes include the fact that they may not be precise measures of the key dimension(s) of ethnicity that the study aims to examine or they may not be sufficiently refined to differentiate between important ethnic sub-groupings (such as those with different religious, socioeconomic or ancestral characteristics). For instance, the category 'Black African' frequently employed in UK national surveys has doubtful utility in many contexts because of the substantial heterogeneity with respect to national origins, religion, and language concealed within (Aspinall and Chinouya, 2008). However, statutory categories have often gone through substantial testing and development to ensure that they are both acceptable and meaningful to respondents, a factor that may be worth bearing in mind in terms of how research findings are received and acted upon. Moreover, statutory classifications and categories are often used by a large number of studies and agencies, and therefore facilitate comparisons. However, when studies (only) use these types of classifications, they are generally constrained in the analyses and explanations they can offer.

A final issue for consideration is how ethnic category should be assigned. An individual's self-reported ethnicity will best reflect their own perceptions of who they are, and some would argue is the only ethical way to measure ethnicity. Nonetheless, assignment of ethnicity by a third party may be appropriate, particularly when the focus of study is how one person's view of other people's ethnicity (e.g. a healthcare practitioner's view of a patient's ethnicity) affects the way they treat those people.

Regardless of the exact approach to categorisation and labelling adopted, it is important to be explicit about the methods employed and their rationale so that any inherent problems and potential limitations are clearly articulated.

Box 3: Measurement of Ethnic Group in the UK Census

The most recent census in the UK, carried out in 2001, asked people: "What is your ethnic group? Choose ONE section from A to E then tick the appropriate box to indicate your cultural background."

A White. Tick box options of: British; Irish or Any other White background (please write in).

B Mixed. Tick box options of: White and Black Caribbean; White and Black African; White and Asian or any other Mixed background (please write in).

C Asian or Asian British. Tick box options of: Indian; Pakistani; Bangladeshi; Any other Asian background (please write in).

D Black or Black British. Tick box options of: Caribbean; African; Any other Black background (please write in).

E Chinese or other ethnic group. Tick box options of: Chinese; Any other (please write in).

Questions were also asked on religion and country of birth.

Adapted from information provided by the Office for National Statistics,
<http://www.statistics.gov.uk/>

Sampling

Nursing researchers interested in exploring the ways in which health experiences and outcomes are influenced by ethnicity will commonly engage with individual people - be they patients, providers or members of the public - to elicit data that is relevant to their focus of inquiry. Though the logic behind sampling in qualitative and quantitative research is very different, the approaches share important elements. First, the sample's purpose is to provide access to data that will allow answers to the research questions identified. Second, a sample must have an explicit and meaningful link with a 'wider universe' – a larger population to which the results of the research can then be applied. Third, as Mason (2002) notes, the drawing of a sample implies that other selections would have been possible and therefore demands a clear rationale for why the sample was chosen. Sampling must therefore link clearly to both the study's research questions and any planned analyses.

As suggested above, studies that seek to understand *processes* of ethnic identification will usually adopt sampling strategies that access a diversity of individuals capable of capturing the full range of ethnic identity as understood and experienced by the populations of interest. Such sampling schemes tend not to be predetermined, but, rather, are flexible and involve the selection of participants in a purposive, non-random, manner. Often data analysis and theory building take place side-by-side with data collection, so that new participants are chosen intentionally to fill gaps in understanding or to test out emerging hypotheses from the data gathered so far.

Studies that are framed more in terms of describing the experiences and circumstances of delineated ethnic 'groups' and those that aim to explain any differences (or similarities) found, can essentially adopt one of three different sampling strategies: exclusive, comparative and representative.

Exclusive sampling strategies aim to recruit participants from just one ethnic 'group' and can be justified on two grounds: first, for studies that aim to generate evidence on an issue that only, or disproportionately, affects the population concerned, and second, for studies that aim to generate evidence for an ethnic 'group' that has not previously been adequately studied with regard to the topic concerned. In quantitative work such exclusive samples should be representative of the wider population that could be categorised as belonging to the ethnic 'group' of focus. In qualitative work the exclusive sample drawn will relate to the wider ethnic 'group' in a more theoretical or interpretive way. Bearing in mind the tendency for research to stereotype and homogenise the experiences of minority ethnic groups, exclusive qualitative samples will often usefully aim to capture a diverse set of respondents.

Comparative sampling strategies aim to recruit participants from two or more ethnic 'groups' to assess the relationship between ethnicity and the outcome of interest (e.g., health or healthcare). An important consideration in such quantitative designs is the need to ensure that the ethnic categories used are equally diverse, capture an equivalent focus on ethnic identity (and on the cultural, socio-political and/or genealogical dimensions of ethnicity) and that the samples of each are of a comparable size. These are complicated technical issues that need not undermine

simple *descriptive* comparisons, but are worthy of consideration by a qualified statistician when designing studies that aim to explore causal relations between health/healthcare and ethnicity. Similar concerns arise in qualitative work when comparisons are drawn between predefined ethnic 'groups' that do not necessarily include individuals with uniform or meaningful experiences, and thereby lead to misleading or partial interpretations. However, the qualitative researcher has greater flexibility to investigate ethnic group identification and, if appropriate, to modify the sampling strategy as analysis proceeds. For instance, a study initially designed as a comparison between two ethnic 'groups', might, as analyses proceed, be re-configured as a three-way comparison if the findings reveal important unforeseen diversity within one of the 'groups' as originally delineated. Such a development in theory might lead to subsequent sampling of respondents to allow further investigation of these 'intra-group' differences.

Comparative sampling strategies also need to generate an equivalent volume of data relating to each of the ethnic 'groups' of interest, whether qualitative or quantitative in nature, to ensure that any comparisons are not compromised by spurious or inaccurate data which can arise from smaller samples. Quantitative surveys often include so-called 'boosted' samples to generate adequate data for minority ethnic 'groups'. Researchers using comparative sampling also need to consider how many different ethnic 'groups' to include. Qualitative studies should generally not try to include too wide a range of ethnic 'groups' because they are likely to provide greater clarity and depth of understanding when fewer categories are considered (Atkin and Chattoo, 2006). Practical considerations may also limit the number of 'groups' that a quantitative study can sample, particularly since costs can be considerable when seeking to access 'boosted' samples from small and geographically dispersed populations.

Finally, representative sampling strategies aim to ensure that the ethnic diversity found within the study's sample is the same as that found in the wider 'target' population to which the study's results are intended to apply. This notion is fundamental to quantitative research and researchers should strive to ensure that their sampling strategies generate samples that are representative of their target population. However, the fluid and context-specific nature of ethnicity means that

careful consideration should also be given to specifying the target population to which findings can be most safely extrapolated (for instance in terms of geographical location). A final word of caution is also offered. Representative samples from ethnically-diverse populations will ordinarily include participants from a range of different ethnic groups and it is important to recognise that samples of this sort are often inappropriate to use for comparative analyses. This is because, except in the case of extremely large study samples, representative sampling strategies inevitably generate samples of different ethnic groups that are of very different size with very different statistical power.

The principle that a sample should be empirically representative of the wider (target) population is rarely adopted by qualitative researchers on both theoretical and practical grounds. Nevertheless, qualitative researchers should consider whether their samples adequately offer the potential to generate data that is generalisable. Indeed, even when there is no intention to perform systematic comparative analyses across ethnic 'groups', it will often be desirable for qualitative work to generate findings that have a wider resonance with the diverse experiences of multiethnic communities.

Generating data

Nursing researchers have a wide range of methods to choose from when deciding how to generate the data needed to address the research questions at hand. Here we highlight some general issues relating to data generation that are worth considering when researching the field of ethnicity and health.

First, ethnicity is a multifaceted concept that can be a marker or proxy for a wide range of factors. Studies that seek to do more than simply document differences between ethnic 'groups' will therefore need to adopt data generation methods that yield information on a variety of potentially important dimensions of ethnicity. In particular, there are concerns that health-related research has been poor at addressing the sociopolitical dimensions of ethnicity (including the effects of racism) (Gill et al., 2007) and that innovative tools are needed to effectively capture these dimensions (Gunaratnam, 2007). Studies that exclude attention to particular dimensions of ethnicity run the risk of producing partial and superficial findings.

Second, ethnicity research will frequently imply the need for researchers to work across languages and cultural contexts. In quantitative work, careful attention is needed to ensure the equivalence of standardised measurement tools and caution should be exercised when employing measures and tools for which cross-cultural/cross-language validity and reliability have not been established. Standard guidelines exist for translating between languages (Behling and Law, 2000), but in general the focus should be on ensuring conceptual equivalence (Atkin and Chattoo, 2006). We would strongly recommend the inclusion of multilingual researchers within the research team rather than reliance upon interpreters and translators who are unfamiliar with the context and purpose of the research.

More generally, researchers must be alert to the possibility that their data generation methods may operate differently among different sets of participants. For instance, methods that depend heavily on respondents' narratives may lead to erroneous interpretations if there is significant diversity in forms of expression among 'groups' of study participants. Further, the identity of the researcher/data gatherer and their interactions with research participants deserve attention. Notions of 'insider' and 'outsider' status are complex and there are no simple rules regarding ethnic matching (Gunaratnam, 2003). Indeed, the personal characteristics and skills of the data gatherer are likely to be just as important as any marker of social identity in gaining the trust of participants and generating credible findings.

Analyses and interpretation

As we have seen, much health-related research that pays attention to ethnic diversity takes a comparative approach, often comparing outcomes and experiences of minority ethnic groups to the majority (usually the White or White British group). While this approach may be a useful way of flagging up inequalities, caution is needed in both the analytical procedures employed and the interpretations drawn.

First and foremost, researchers should recognise, and counter, the tendency for *associations* to be interpreted as *explanations*. Instead, it is important that analyses seek to identify underlying causal factors, rather than simply inferring their existence. Where such data on potential causal attributes are unavailable, analysis and

interpretation must be cautious and speculative. It is also important that researchers are aware of factors that may importantly shape minority or majority experiences but may be beyond the scope of their analysis (such as geographical concentration of particular ethnic groups, historical factors or wider social structures). As described earlier, researchers should also recognise that analyses taking an ethnicity-focused approach may fail to capture the diversity of experiences *within* groups. In both qualitative and quantitative work it is useful to explore the ways in which other factors, such as age, gender, class and so on, inter-relate with ethnicity to create divergent experiences and circumstances within delineated groups.

Finally, it is important that analyses explore absolute levels of particular outcomes and experiences, in addition to relative differences between 'groups', and that comparisons are drawn with a range of 'groups' rather than with the majority White category alone. This approach helps to avoid the tendency to overlook important issues facing minority ethnic 'groups' just because they are similar to those experienced by the majority White 'group'.

Ethics, representation and dissemination

Many general issues of research ethics apply quite straightforwardly to research that gives attention to ethnicity. However, a further point worth emphasising is the potential for group harm that can ensue from research that includes minority ethnic individuals. Attention to this issue is warranted at all stages in the research cycle, but particular care is needed in the presentation and dissemination of findings.

Researchers must be alert to, and should manage from the outset, the ways in which the findings of their work might be interpreted, distorted and (mis)used by the media and others – particularly in establishing or contributing to the stereotyping and stigmatisation of ethnic groups, and the threat of breaching the confidentiality of data collected from very small ethnic groups. Indeed, it has been argued that researchers should even consider withholding findings from dissemination where there is the potential for harm to the individuals and communities represented.

In general, researchers should consider carefully the best way to represent and disseminate the findings of their research. As with all good nursing research, it is important to ensure effective communication to all stakeholders, but particularly to

ensure that the minority ethnic individuals and communities who are the subject of the research have ready access to the findings in a format that is accessible and relevant. Standard reports and academic publications may usefully be supplemented with innovative dissemination media such as participatory workshops, radio broadcasts and use of the arts.

Conclusions

Many of the issues raised above relate fundamentally to sound research practice. Clear conceptualisation, careful measurement, strategic sampling, rigorous analyses and accurate representation are clearly generic elements of good nursing research. However, the dangers of poor research are much greater when the focus of our research is ethnicity. Indeed, there are concerns that such research, if poorly executed, may do more harm than good. While there are no simple answers to some of the issues we have raised, critical reflexivity and a cautious approach to interpretation can go a long way to improving the quality of research and the usefulness of findings.

We urge nursing researchers not to shy away from these complex and contentious issues, but rather to accept their responsibility to generate an evidence base that informs positive change in nursing policy and practice for all members of contemporary multiethnic societies.

Further reading and websites

Nazroo, J. (ed.) Health and social research in multiethnic populations. Routledge: London.

Centre for Evidence in Ethnicity, Health and Diversity:

<http://www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth/>

Discussion list on minority ethnic health:

<https://www.jiscmail.ac.uk/cgi-bin/webadmin?A0=MINORITY-ETHNIC-HEALTH>

Information network on good practice in minority and migrant healthcare:

http://mighealth.net/index.php/Main_Page

NHS Evidence - ethnicity and health (*formerly a Specialist Library of the National Library for Health*) <http://www.library.nhs.uk/ethnicity/>

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