"MAKING SENSE OF DIFFERENCE": THE SOCIAL ORGANIZATION OF INTERGROUP RELATIONS IN HEALTH CARE PROVISION

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE STUDIES

School of Nursing

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

March, 2000

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Vancouver, Canada

Date __Mar 31 00__

DE-6 (2/88)

Abstract

"MAKING SENSE OF DIFFERENCE": THE SOCIAL ORGANIZATION OF INTERGROUP RELATIONS IN HEALTH CARE PROVISION

Despite growing evidence of racialized health care experiences and inequitable health outcomes for patients of Colour, theoretical and practice responses have not typically addressed these concerns. This ethnographic study approached this problem by examining the social organization of intergroup relations in health care provision, beginning with the standpoints of nurses and patients. Over one year, the investigator conducted 220 hours of field work and interviews with 30 health care providers and five patients on three surgical units in two hospitals.

Through this process of research, intergroup relations in health care provision were revealed as more complicated than commonly represented. Under ideal conditions, intergroup provider-recipient encounters illustrated "connected care", marked by respectful interpersonal connections, an understanding of the illness experience from the patient's perspective, and a holistic grasp of the patient's health care needs. Interpretive lenses were employed by nurses to make sense of "difference" and influenced how they provided intergroup care.

However, various factors negatively influenced the provision of connected care. Depending on their interpretive lenses, individual nurses might participate in racialized discourses and practices. Recent trends brought about by health care reform, along with longstanding issues such as functional approaches, the immediate nature of nurses' work, and biomedical dominance, came together in particular ways to constitute nurses' work as disjunctured and "heavy", and mitigated connected care, especially to patients who did not speak English. Institutional and community contexts, shaped by professional and

public discourses, also mediated intergroup relations in significant ways. The social construct of *race* was mobilized in health care settings in subtle but damaging ways as common applications of the construct of culture and interpretations of "difference" often drew on colonial notions of *race,* thereby reinforcing longstanding patterns of domination and inequities.

In light of these findings, re-conceptualized theoretical approaches are recommended for more realistic and nuanced understandings of intergroup relations and transformative health care practices. Critical consciousness must be fostered among nurses in order to facilitate connected intergroup care, challenge existing work environments, and confront racializing discourses and practices.

Table of Contents

ACKNOWLEDGEMENTS

The process of completing this dissertation and my doctoral studies has been a remarkable experience. I am most grateful to the many supporters I have had throughout the process.

I am indebted to the health care professionals who participated in this study. You inspired me with your commitment, vision, and persistence in what are often very difficult circumstances.

Thank-you to my supervisory committee who provided invaluable guidance. I am grateful to my research supervisor, Dr. Joan Anderson, for holding out an ideal for me, demonstrating how to achieve such an end, and providing kind support along the way. Thank you also to Dr. Sally Thorne for your commitment to excellent nursing scholarship and your unflagging enthusiasm; to Dr. Barbara Paterson for your thoughtful comments and questions, and your good-hearted way of championing me; and to Dr. Isabel Dyck for your important scholarly contributions.

I am also grateful to my fellow colleagues in the doctoral program who have provided inspiration, support, and good times through the years. We do not undertake this journey alone!

My friends and family have found many thoughtful and creative ways to encourage me through these years, both in person and across the miles – loving childcare, encouraging phone calls, computer consultations, a firm belief that I could meet the challenges, prayers, and the list goes on.

Rebecca, our "Ph.D. baby", has been a wonderful grounding point for me, offering me perspective, love, and so much joy. I hope for a better world for her and her soon-to-arrive sibling – one that is marked by more acceptance, respect, and equity.

And to Rob – we did it!! You have been incredible, a true partner in the process, deserving of an honorary spousal degree. I would not, could not have done it without you.

Finally, an acknowledgement to the foundational belief that drives me in my life's work:

"There is neither Jew nor Greek, slave nor free, male nor female, for you are all one..."
(Galations 3:28).

CHAPTER ONE:

THE INTRODUCTION

Background to the Problem

Despite a long history of ethnic and cultural diversity, Canada continues to be constructed as a White nation, both historically and presently. Early European colonists and settlers are depicted as "true" Canadians while Blacks, Chinese, Japanese, and South East Asians who arrived as early as the 1600s and on through the nineteenth century are represented as foreigners or Other. The "imagined identity" of Canadians was and is as White. Carol Schick explains,

> In the Canadian context,...the white body is a culturally organized site of nationalism
>
> which has come to represent what it is to be defined as Canadian. The white body is
>
> read as the semiotic for nationality; it is the white body that, along with some concessions
>
> to Native people and some slights of memory, has "always been here". (1996, p. 4)

The deeply-rooted caricature of Canada as a White nation of "two founding peoples" ignores the original presence of Native peoples and the long-standing contributions of people of Colour[1] in Canada. This historical and current misrepresentation of Canada as a White nation has been challenged by the more recent increase of immigration from non-European sources[2] and, as a result, the fallacy of asserting Canada as a White nation is becoming more and more apparent.

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[1] In this current project, I chose to refer to non-European clients as people of Colour, following Carty's (1991) usage of the term. The capitalization of Colour reflects ethnic differences and denotes more than shades of skin colour. Used in this way, the term denotes a common context of struggle based on shared systemic discrimination in the Canadian social and political context.

[2] 54% of Canadian population reported themselves as non-French, non-British ethnic origin in the 1991 census, compared to 37.5% in the 1986 census. While earlier immigrants came primarily from Europe, by the mid 1990s, 78.5% of immigrants to Canada came from non-European origins such as South and Southeast Asia, Central and South America, Africa, and China. Most immigrants to British Columbia come from Hong Kong, Taiwan, India, the Philippines, and China (Statistics Canada, 1997). Demographic trends are discussed in more detail later in the proposal.

The heterogeneity of Canada's population is reflected in the health care system. Intergroup relations[3] in health care provision have taken on new forms with shifting demographic trends. Where health care providers, recipients, and institutions used to be predominantly White, there are now many providers and recipients of Colour. In response to these changes, intergroup health care provision has received increased attention as health care providers and institutions have sought to meet the needs of clients of Colour. Discourses regarding diversity in health care and the need for "cultural sensitivity" are widespread. Hospitals and health care agencies have joined together to evaluate the degree to which they are culturally sensitive (e.g., the 22 hospitals involved in the Multicultural Change in Health Services Delivery Project in British Columbia's Lower Mainland) and the majority of schools of nursing include multicultural content in their curricula[4] (Toumishey, 1991). These are encouraging signs of a general will to provide health care that is culturally relevant.

Yet, although intergroup care is commonplace in most Canadian centers, there is mounting evidence of inequities in both health outcomes and health care experiences that fall along lines of *race*[5], class, and gender. People of Colour tend to suffer poorer health outcomes than White people (Ahmad, 1993; Frideres, 1994; Krieger, Rowley, Herman, Avery, & Philips, 1993; Nazroo, 1998; Rootman, 1988; Shah & Dubeski, 1993). Both structural forces (e.g., higher incidence of poverty among people of Colour; exposure to dangerous working conditions;

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[3] Although "intergroup relations" might also refer to interactions between groups based on membership criteria such as class, gender, sexual orientation, or age, I limited my focus for this study primarily to relations between people of Colour and White people.

[4] In 1991, a questionnaire was sent to the deans and directors of schools of nursing across Canada to identify the multicultural content and teaching methods currently used. Despite the low response rate (39%), it was discovered that most programs include multicultural content in their curricula (Toumishey, 1991). While this report is encouraging, one wonders if the 61% who did not respond represent schools in which cultural content is not as valued.

[5] *Race* is italicized throughout this dissertation as a reminder of its socially constructed nature. As will be explained, it is my stance that while *race* does not exist as a biological reality, it does carry considerable social implications.

inappropriate or inaccessible health care) and individual actions (e.g., racism by health care professionals prescribing treatment) contribute to these outcomes (LaVeist, 1996). People of Colour seeking health care services describe marginalizing and racialized health care encounters (British Columbia, 1991; Browne, 1995; Chugh, Dillmann, Kurtz, Lockyer, and Parboosing, 1993; Henry, Tator, Mattis, & Rees, 1995; O'Neill, 1989). They may be excluded from negotiation with health care providers regarding their health care management, resulting in a prescription of treatment that is inappropriate or inaccessible (Anderson, 1986, 1991a; Anderson, Blue, & Lau, 1991), or may be the recipients of more blatant discriminatory actions and attitudes (Browne, 1995; Reimer, 1995; Reimer Kirkham, 1998). Such evidence suggests that the ideal of culturally relevant care has not been achieved, despite signs of a general will to provide such care and discourses in health care regarding "cultural sensitivity".

With few exceptions, health care and nursing literature, particularly in Canada, is strangely silent on matters such as inequities in health, marginalizing health care practices, racialization, and racism. Instead there has been a pervasive tendency to focus on culture as an influence (or barrier) to health and illness in an effort to account for differences in health outcomes. Differences are mistakenly attributed to cultural lifestyles (e.g., claims that Blacks have higher infant mortality rates because they do not have "proper" nutrition) or supposed inherent biological weaknesses (e.g., suggestions that Native Indians have a natural propensity to alcoholism). To credit these disparities to cultural or biological differences paints a veneer over mediating structural constraints. I concur with Lock (1993) who observes that

culture is in danger of being seized as a panacea, as the key which will open the

door to a trouble free health care system, while once again the deeper more persistent

problems which lie at the root of so much ill health, most particularly poverty,

exploitation, and discrimination, remain unexamined. (p. 145)

In the case of racialized and marginalizing health care encounters, much nursing and health care

literature explains these as an issue of individual intolerance (Culley, 1996). Within

multicultural discourses, intolerance is conceptualized as a matter of attitudes, namely prejudice.

In turn, prejudice is largely seen as the result of ignorance. The assumption follows that

education is needed to dispel prejudice and thereby eliminate intolerance. Attention to

prejudices is undoubtedly important, especially through anti-racist education. However,

interpretations of discriminatory and marginalizing practices within health care as matters to be

dealt with at the individual level disregard the ways in which intergroup health care provision

extends beyond the interpersonal level to be influenced by a complex combination of social,

ideological, historical, economic, and political forces. Heightened awareness by health care

providers of cultural differences alone will not be sufficient to address power imbalances

between dominant and subordinated groups. Thus, scholarship that typically focuses on culture

and diversity may well be masking, albeit unintentionally, racialized health care experiences

characterized by marginalization and exclusionary practices and serious inequities in health care

outcomes that fall along the lines of *race*, class, and gender. Many studies in the area of health

and *race* fail to uncover inequities in health outcomes and health care experiences because of

short-sighted focus on the individual level, and conflation of culture with *race*, resulting in a

general under-theorization of the ways in which health care is socially organized.

The connection between the provision of care to patients of Colour at the level of the

nurse-patient encounter and the larger context shaping that care has received little attention to-

date. Historical, economic, social, political and ideological structures and processes play a profound role in shaping all social institutions. For example, the social construction of Canada as a White nation continues to shape the social institutions of this nation in profound ways. Although the need to recognize different groups is acknowledged, the fundamental structures of society have not changed to be inclusive and representative of the groups that make up Canada. Institutions such as health care services remain Eurocentric and classist. Equity and equal access to health care are cornerstones of health legislation in Canada, yet closer examination reveals that these health care services are, at the core, monocultural, designed for middle-class Canadians fluent in English, and from Euro-Canadian backgrounds (Anderson & Reimer Kirkham, 1998; Henry et. al., 1995). Exclusionary practices are evident in the stratified and racialized structuring of the health care system, in which people of Colour are prominent in nonprofessional jobs (e.g., cleaning, food preparation) but noticeably absent from positions of leadership (Anderson & Reimer Kirkham; Das Gupta, 1996a; Sherwin, 1992). Ideologies employed by dominant groups are evident within health care. Biomedicine's emphasis on cure and the individual, and movements within health care reform toward self-care and de-institutionalization all reflect ideologies of individualism and egalitarianism. Furthermore, health care priorities, policies and practices in Canada, while not as immediately apparent as in the United States, are economically driven and firmly grounded in liberal, capitalist society and ultimately serve to maintain the privilege of the dominant (Navarro, 1986).

The Problem

In light of these racialized health care experiences and inequitable outcomes for patients of Colour, the central problematic addressed in this study was the nature of the social organization of intergroup health care provision. A related observation of concern was that

traditional research approaches have not accounted for the larger social structures and processes that shape intergroup health care encounters. This study built on my Master's thesis in which I examined nurses' experiences in caring for culturally diverse clients[6]. The complexities of intergroup health care quickly became evident in this qualitative study. Revealing its influence on both health care providers and recipients, the social construct of *race* repeatedly entered into the interviews with nurses as they recounted stories of racism and unequal relations within health care. As a result, the inadequacy of research focused simply on cultural differences and culturally sensitive care became visible.

Purpose of the Study

The purpose of this study was to uncover the social practices and processes that structure intergroup relations in health care provision. To address this problem, an institutional ethnography (Smith, 1987) was conducted, with the standpoints of nurses and patients in the day-to-day provision of intergroup health care as the entry point into this problematic. From these standpoints, local social relations were analyzed in order to understand how they are mediated by social processes and practices happening beyond these immediate experiences. It was anticipated that such a critical inquiry would uncover processes and consequences of exclusion and inclusion, both of which are structured by relations of power operating through everyday social and institutional practices. (See Appendix A for definitions of key terms).

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[6] The term culturally diverse clients was used in my master's thesis to refer to clients who have ethnic and social origins and cultural values and practices other than those of the Canadian majority (i.e., European descent). I have since become uncomfortable with this term because of the way in which it positions White Canadians in a dominant position and in turn represents people of Colour as Other.

The Research Questions

The overall research question driving this study was: **What is the social organization of intergroup relations in the provision of health care?** Subsumed under this umbrella question were several questions reflecting the multi-layered analysis required to understand the social organization of intergroup relations. The inquiry began at the micro level, uncovering the nature of intergroup encounters between nurses and patients. From this vantage point, I considered the meso level in order to understand the institutional setting as the everyday world of these intergroup encounters. Moving to the macro level, my goal was to explore how nurses' work processes and social practices are embedded in the social relations of extended social, economic, and political processes and are maintained in taken-for-granted ways by ideologies. Therefore, while the beginning point of this study was the everyday realities of intergroup relations in health care provision, based on the standpoints of providers and recipients, the substantive focus took into account the social organization of day-to-day health care provision at institutional and societal levels. My aim was to show the connections that exist between the micro, meso, and macro levels of health care provision.

Providing guidance in operationalizing the overall research question were the following sub-questions:

Micro Level[7]

- What are intergroup patient-provider encounters like in institutional health care settings?

- How are providers and recipients positioned in social and material relations? How do they participate in these relations?

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[7] Although I organize these questions into micro, meso, and macro categories, I recognize this division as somewhat artificial. Institutional and societal influences inevitably invade and mediate patient-provider encounters. For example, while I list the question "How is *race* operationalized in health care provision?" as a micro level question, *race* is most likely operationalized *across* micro, meso, and macro levels.

- How is *race* operationalized in health care provision?

- How are racialized identities constructed in health care? What are the consequences of these constructions?

Meso Level

- What is the character of the everyday world in which nurses provide intergroup care?

- What institutional policies, procedures, and structures shape intergroup encounters between nurses and patients?

Macro Level

- How do *race*, class, and gender intersect in health care provision?

- What social, economic, and political processes mediate intergroup relations in health care? How do ideologies and social constructions shape the provision of health care?

- How are society's relations of ruling mirrored in health care?

- Given the context of intergroup relations in health care, what should the goals of health care be? What policies, structures, interventions, and social changes will support these goals?

Organization of the Thesis

Having provided an introduction to the study in this first chapter, I turn to a detailed review of existing theoretical and research knowledge in Chapter Two. In Chapter Three, I delineate the interpretive lens brought to the study, informed by a particular theoretical and methodological framework, as well as my own social positioning. I present the research design and implementation, and discuss considerations for ensuring scientific quality and attending to ethics in Chapter Four. Chapters Five, Six, Seven, and Eight form the core of this report with presentation and discussion of research findings. Specifically, Chapter Five begins from the

standpoints of nurses in a discussion of intergroup nurse-patient encounters. Chapter Six situates these encounters in the context of nurses' work with a discussion of the implications of health care restructuring. Chapter Seven extends the analysis by locating intergroup relations in organizational and community contexts. In Chapter Eight, I offer a theoretical synthesis of the key findings of the study in an effort to extend our understanding of intergroup relations in health care provision. Chapter Nine concludes the thesis with a summary of the study, a presentation of key conclusions, and a discussion of further implications for practice, education, administration, research, and policy.

CHAPTER TWO:

REVIEW OF STATE OF KNOWLEDGE

The research problem directed me to explore a range of theoretical and empirical literature related to the social organization of intergroup relations in the provision of health care. Selecting literature for review has been no easy task, partly because the term "intergroup relations" is not commonly used within health care and nursing literature. Neither is the phenomenon represented by intergroup relations, that of individuals interacting as members of their ethnocultural communities and in the larger sociopolitical context, typically discussed. Instead, scholars tend to address a specific aspect of the general phenomenon (e.g., provider-recipient interactions). Literature presented from a culturalist perspective is also of limited relevance because its essentialist tendencies and infrequent acknowledgement of the relations of power that structure health care experiences. Because of the historical and societal specificity of issues such as marginalization and racialization stemming from the social construction of *race*, I have been most interested in Canadian scholarship. I have been, therefore, faced with at least two predicaments: (1) that of little literature dealing directly with intergroup relations in health care provision in Canada; and (2) that of a myriad of related literature regarding cross-cultural nursing, diversity in health care, and cultural differences. As a result, this review is both selective in emphasizing Canadian literature that relates most closely to the phenomenon under investigation, and broad in attempting to highlight key literature that relates directly to this study.

Notably, I am applying "intergroup relations" in a particular fashion, employing the term as a conceptual device to focus this study on the relationships negotiated between individuals acting in certain social contexts. Intergroup relations is generally used to refer to individual behaviours within the contexts of groups based on social categories such social class, gender,

sexual orientation, ethnicity, or labour movements. This broad center allowed me to focus on my specific interest, that of how culture and *race* contribute to the social organization of health care provision, while also attending to the intersection of gender, class, and other signifying categories with culture and *race*. In keeping with this approach to the research topic, I begin with a review of theoretical perspectives related to *race* and culture and draw on this theoretical foundation in the remainder of the study. In particular, I draw on contemporary critical theories that have not traditionally been incorporated into health care and nursing scholarship. Next, I include a critique of nursing theory and research to illustrate how common theoretical approaches to issues of culture and *race* may, in fact, obscure inequitable processes of inclusion and exclusion. I then present further background information providing context to the study, as I summarize the changing demographics, history, and multicultural policies of Canada, and examine the shifting and restructured health care context as the site of intergroup relations. Finally, I focus more specifically on intergroup relations in the provision of health care with a study of the disturbing evidence of inequities in health care experiences and outcomes.

Theoretical Perspectives Regarding *Race* and Culture

Considerable theoretical challenges exist inherently in the concepts currently used to categorize and signify "difference". *Race*, culture, and ethnicity are frequently used, sometimes interchangeably, to denote "difference" (and often inferiority), with little consistency in when any one of these terms is applied. Constructions of *race* have shifted through time and across social spaces. Originally carrying a meaning that referred to biological origin and physical appearance, *race* is now understood to be a social construction manipulated to define, structure, and organize relations between dominant and subordinate groups (Henry, Tator, Mattis, & Rees, 1995). Scholars using the concept of *race*, including those grounded in critical or social

constructivist traditions, face the real danger of reifying *race*, inadvertently reinforcing the very notions they are attempting to deconstruct. In an effort to side step this risk, the concepts of ethnicity and culture have been widely used. Again, both of these concepts are not easily defined and, in the end, there is considerable slippage between these concepts. While conceptual clarity is an obvious concern with such conflation, a greater issue is the ways in which colonial legacies of *race* and racism are typically left unexamined by the constructs of ethnicity and culture, and how racialized discussions of "cultural difference" draw upon these historically grounded notions of *race* to make sense of "difference". Health care literature has drawn upon the concept of culture in particular. Often applied in a culturalist sense, culture tends to be portrayed as a relatively static set of beliefs, values, norms, and practices attached to a discrete group sharing a common ethnic background. While presented in a neutral fashion, these constructions of culture often draw on colonial images of *race* in representing "difference" and thereby re-inscribe longstanding patterns of exclusion and inclusion. Moreover, because they proceed from an *apparently race*-neutral account (i.e., without overt references to *race*), bias is typically masked rather than removed (Sherwin, 1992).

Recently, the efforts of postcolonial scholars have disrupted mainstream theorizing regarding *race* and culture by pointing to the politics of *race*, particularly in sustaining colonizing relationships. Other theoretical traditions also enrich our understandings of *race* and culture. Feminist scholarship, especially the work of feminists of Colour, has drawn our attention to intersections between *race*, class, and gender, and poststructural/postmodern perspectives alert us to relations of power embodied in the discourses of the day. In this section, I highlight new ways of conceptualizing *race* and culture brought about by the influences of these bodies of scholarship, and apply these insights to the rest of the literature review. In order

to do so, I survey various definitions and conceptualizations of the core concepts of *race*, racisms, culture, racialization and representation, construction of White identity, intersectionality, and power. My review of theoretical perspectives begins at a somewhat rudimentary level; yet, because of the paucity of careful theoretical development of concepts such as *race,* culture, and power within the health sciences literature, this elementary starting point seems justified and ultimately serves as an important foundation for the study.

Constructing *Race*

Race does not have a single-agreed upon definition. This is due, in part, to the shifting understanding of *race* through time and across social spaces. Originally carrying a meaning that referred to biological origin and physical appearance, *race* was an inclusive concept, embracing a number of ethnic groups within a given racial category. Over time, *race* shifted from this biological meaning to a social meaning in which biological differences have become markers for assignment of status. Further evolution of such assignment of status has included complex social structures promoting power differentials between Whites and various people of Colour (Pinderhughes, 1989).

Along with these shifting meanings, there are considerable gaps between theoretical understandings and practical outcomes. For example, although any biological component of *race* has been disproved, people continue to be grouped according to what are considered physical racial attributes. Despite these varying understandings of *race*, it continues as a central aspect of everyday life. "*Race* is a constitutive element of our common sense and thus is a key component of our 'taken-for-granted valid reference schema' through which we get on in the world" (Outlaw, 1990, p. 59). In the following section, I outline some of the significant constructions of *race* that represent a range of historical and ideological stances.

Race as Biologically Determined

The notion of *race* has a long history, first emerging in the English language in the early sixteenth century to explain European history and nation formation (Miles, 1989). With increased migration and contact between populations, representations of Other as different, often on the basis of physical attributes such as hair, skin colour, and stature, grew in salience. *Race* took on a more specific meaning in the late eighteenth century, referring to distinct biological groupings of people. The growing field of science claimed to demonstrate the characteristics of *races* and also asserted hierarchical relationships between *races*. David Goldberg (1993) notes that "*race* is one of the central conceptual inventions of modernity" (p. 3). Enlightenment presented social subjects as abstract, universal, divorced from the contingencies of historicity, and driven by rationality. In this context, *race* pretended to universality, bringing individuals to a cohesive identity across space and time. Liberalism, another product of modernity with claims to individualism and equality, paradoxically confirmed the ahistorical and ultimately irrelevant place of *race* while its emphasis on rationality and science made room for a biological interpretation of *race*. The basic human condition, including economic, political, scientific, and cultural positions, was taken to be *race* determined. Europeans were judged to be the master *race*, all others were subject *races*.

Dogmas about the natural, biological basis of *race* flourished during the colonial expansion era. By dismissing indigenous populations as inferior or subhuman, Europeans could exploit and oppress without remorse, guilt, or responsibility (Elliott & Fleras, 1992). By the later part of the nineteenth century, Social Darwinism, fostering the idea of "survival of the fittest" on a global basis as groups struggled over scarce and valuable resources, evolved to become a widely accepted doctrine of racial superiority that reinforced the colonialist project. Unilinear

evolution proposed that populations evolved through predetermined and progressive stages of savagery, barbarism, and civilization. Those with superior biological stock progressed to the pinnacle of the evolutionary ladder; others were left behind in the competitive struggle. As noted by Elliott and Fleras, "racial ideologies not only explained European superiority and justified outgroup exploitation, they also celebrated the virtues of capitalism and imperialism as integral to human progress and social enlightenment" (p. 39).

The conceptualization of *race* as biologically determined continued into the twentieth century with the so-called scientific field of eugenics for the improvement of the human species by purging it of unwanted specimens. Large families were encouraged among the "civilized" while "defectives" such as Blacks and disabled were sterilized. The peak of the eugenics movement occurred under the Nazi regime with compulsory sterilization and mass murders. With the development of genetics in the 1930s, the racial categorization on the basis of physical appearance was thrown into question and finally disrepute. Scientists uncovered the enormous genetic variation among individuals and pointed to more <u>intragroup</u> than <u>intergroup</u> variation. Despite the clear evidence pointing to the error of *race* as a biological entity, variations of this earlier conceptualization of *race* still exist today, including within the health care arena (Ahmad, 1993; Krieger & Bassett, 1986). Kay Anderson (1991) observes that *race* also continues to be used and promoted by many lay people, policy-makers, and journalists as a concept with scientific value.

Racisms

Perhaps the most notable, tangible outcome of a biological construction of *race* is the matter of racism. Racism is a more recent term coined during the rise of Nazism in Germany. It was first introduced by Ruth Benedict in her book *Race and Racism* that defined racism as "the

dogma that one ethnic group is condemned by nature to congenital inferiority and another group is destined to congenital superiority" (cited in Solomos & Back, 1996, p. 4). Since this early definition, racism has taken on various meanings. As with other concepts presented here, racism does not carry a commonly shared definition. Yet, the theoretical grounding and definition of such a concept is critical. When viewed in a reductionistic, narrow way, racism becomes only the problem of certain groups (e.g., non-mainstream groups) and particular individuals. On the other hand, when stretched to include multi-faceted phenomena, the need for more discriminating forms of analysis is avoided (Donald & Rattansi, 1992). The lack of a clear "common sense" understanding of what racism means has, according to Omi and Winant (1994), become a considerable obstacle to efforts aimed at challenging it. Similarly, Miles (1994) observes that a concern to name racism tends to displace the concern to explain racism. As a result, anti-racist strategies are based on inadequate understandings of racism that are often ineffective. At a praxis level (i.e., transformative knowledge), then, clearer conceptualizations of racism are needed in order to bring about social change. In an effort to bring some clarity to this discussion of racism, I highlight some key theoretical positions put forward.

Racism: One or Many?

Until not so long ago, racism was seen as a singular monolithic, repeating itself across history and setting. Racism was also naturalized as a series of events waiting to be triggered. Solomos and Back (1996) conclude that one of the key lessons gleaned from an analysis of the changing forms of racial ideas and practices over the past two centuries is that a singular understanding of racism, unchanged by history and circumstances, is impossible. Today the notion of a single racism has been replaced by the idea of multifarious racisms, transformed from one period to another. Thus, racisms are always historically specific, though they may draw on

cultural traces deposited by previous historical phases. "Racism...arises out of present -- not past -- conditions. Its effects are specific to the present organizations of society, to the present unfolding of its dynamic political and cultural processes -- not simply to its repressed past" (Hall, cited in Gilroy, 1990, p. 265).

Racisms: Structural or Personal?

Studies of racism have tended to divide methodologically between those assuming an individual orientation (i.e., racism viewed as personal prejudice[8]) and those accepting a structural approach (i.e., racism viewed as embedded in, determined by, or emanating directly from prevailing constitution of social formation) (Goldberg, 1993). There are clear implications to taking either a micro or macro perspective. When viewed as a personal problem, prejudice is too commonly represented as being held consistently and expressed in a systematic and uncontradictory manner. The personal approach to racism also assumes that prejudice is primarily caused by ignorance and therefore education about other "cultures" will solve the problem. Rattansi (1994) points to the essentialism and falsity of such assumptions, citing the complex, contextual, and contradictory nature of racisms. Moreover, the final end is a pathologization of the individual who supposedly carries unhealthy neuroses and personality traits.

A structural understanding of racism typically focuses on institutional practices of racism as well as ideologies sustaining such practices. Structural racism is thus entrenched within the structure, function, and process of social institutions. As such, the life chances of minority groups are restricted as a result of seemingly normal and neutral rules, regulations, and

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[8] There is a large body of literature, much within social psychology, that views racism as personal prejudice (Allport, 1954; Maluso, 1995). Racism is then seen as having affective (i.e., prejudice), cognitive (i.e., stereotyping), and behavioral (i.e., discrimination) components.

procedures (Elliott & Fleras, 1992). Robert Miles (1989) propounds a particular version of structural racism that limits the concept to refer exclusively to an ideological phenomenon. "Racism is...a representational form which, by designating discrete human collectivities, necessarily functions as an ideology of inclusion and exclusion....' presupposing' an explicitly negative evaluative component" (p. 79). Miles' definition has been critiqued for various reasons. Anthias and Yuval-Davis disagree with Miles' narrow view of ideology that assumes distortion: "although Miles is at pains to argue that racism is often used to provide meaning to the real conditions and experience of working-class actors, he is by default restricting it to socially determined attitudes that are false, but seized upon by individuals for functional purposes" (1992, p. 14). While many theorists agree on the pivotal role of ideology in sustaining racism, Miles' delineation of practices as falling outside of racism is less agreed upon.

Racism has commonly been categorized as individual, institutional, and systemic in order to reflect the different levels at which it is enacted. Essed (1991) explains the problem of depicting individual and institutional racism as two distinct types. A false dichotomy is created, placing "the individual outside the institutional forms of racism, thereby severing rules, regulations, and procedures from people who make and enact them, as if it concerned qualitatively different racism rather than different positions and relations through which racism operates" (p. 36). Nonetheless, as a conceptual tool, there is some merit to differentiating between individuals who discriminate or are promotive of racial inequality and racial stratification resulting from structural barriers and processes (King, 1996). Notably, racisms do not require intentionality -- any acts, policies, or structures, whether intended or unintended, that result in negative or unfavorable consequences for recipients from racially dominated groups are considered racist (Essed).

Bearing these varying theoretical perspectives in mind, what might be an ideal model for conceptualizing racisms? I agree with Essed (1991) who argues that any definition of racism must take into account both macro properties and micro inequities perpetuating a system of domination. The constraining impact of entrenched ideas and practices on human agency must be taken into account along with the system that continually invades everyday life. There is a need to develop a model for conceptualizing racisms that is (i) sensitive to local and contextual manifestations of racisms and (ii) able to connect local manifestations with wider or national public discourses (Solomos & Back, 1996). Within such a model, racisms must first be situated in their specific context before moving toward a more general account.

Racisms: Power and Exclusion

Whereas past racist forms defined and fueled colonialist expansions with insistence on racial inferiority, racisms today are visible in isolationist images of nation, in cultural differentiations, and in exclusionary or anti-immigration policies. Goldberg (1990, p. xiv) reflects on this current characteristic of racisms, "at the most abstract of theoretical levels, all forms of racism may be linked in terms of their exclusionary or inclusionary undertakings". Such undertakings constitute a special case of power. This power has been theorized in different ways: as belonging to individuals; groups; or to dominant society. Some theorists have drawn on the concepts of ideology and hegemony in explaining the power to enact exclusionary and inclusionary practices. Others have taken a Foucauldian approach to the micro-politics of power in which power is seen as diffuse and not located only in central apparatuses such as social institutions.

Because of the centrality of power in understanding concepts such as *race*, racism, and racialization (discussed in more detail later in this chapter), further attention is given here to the

key conceptualizations of power that inform theorization in the area of *race*. *Race* theorists have often drawn on the notions of ideology and hegemony in explicating how power is operationalized through constructions of *race*. Ideology, for example, is understood as a political instrument in sustaining racist domination. Broadly defined, ideology is "a set of beliefs, perceptions, assumptions, and values that provide members of a group with an understanding and an explanation of their world" (Henry et al., 1995, p. 13). Terry Eagleton (1991) maps various interpretations of ideology including disputations about whether ideology (a) is primarily a feature of the dominant social power, (b) inherently suggests distorted beliefs or false consciousness, and (c) reflects not only distorted beliefs but unconsciously held beliefs. Most commonly, *race* theorists draw on an Althusserian view of ideology in which ideology thrives beneath consciousness at a level of "normal common sense" (Hebdige, 1979). Within our complex society, multiple ideologies may co-exist but those representing the groups in power are most likely to prevail. Thus, ideologies become less neutral when one considers how some gain dominance and others remain marginal.

Hebdige draws on the Gramscian notion of hegemony in explaining how dominance is maintained within society. Hegemony refers to a situation in which a "provisional alliance of certain social groups can exert total social authority over other subordinate groups, not simply by coercion or by the direct imposition of ruling ideas, but by winning and shaping consent so that the power of the dominant classes appears both legitimate and natural" (Hebdige, 1979, p. 15). Thus, in keeping with Gramsci's conceptualization, hegemony is always composed of a mix of coercion and consent. Although rule can be obtained by force, it cannot be secured and maintained without the element of consent (Omi & Winant, 1994). Ideology plays a key role in maintaining such consent through a popular system of ideas and practices within the realm of

"common sense". People come to interpret their own interests and consciousness of themselves in light of this "common-sense" ideology and ultimately in a unifying discourse supporting hegemonic rule. Kay Anderson (1991) perceives this interplay between ideology and hegemony in sustaining racist practices in British Columbia:

> *Race* has been a most effective unifying concept in the making and extension of European global hegemony. With more or less force in different colonial settings, racial ideology was adopted by white communities, whose members from all classes indulged it (often in contradictory ways) for the definition and privilege it afforded them as insiders. The *race* paradigm gave white groups the power of definition in cultural and ideological terms, as well as more instrumental power in the hands of politicians, bureaucrats, owners of capital, labour unions, judges, police, and other influential members of the ruling sector. (p. 25)

According to common conceptualizations, ideology and hegemony, then, are modes through which power operates, with power centralized within those representing dominant interests.

While such traditional theories of power have assumed that power is possessed (e.g., by a class or group of people, by the state), flows from a centralized source from top to bottom, and is primarily repressive, Foucault proposes that we think about power outside the confines of state, law, or class. Sawicki (1991) observes that Foucault does not deny such a traditional model of power (referred to as a juridico-discursive model of power), but that he "merely thinks that it does not capture those forms of power that make centralized, repressive forms of power possible, namely, the myriad of power relations at the microlevel of society" (p. 20). She goes on to explain that Foucault's theory of power differs from the traditional model in three basic ways: Power is exercised rather than possessed; power is not primarily repressive, but productive; and

power is analyzed as coming from the bottom up. Drawing on detailed analyses of the "genealogies" or historical accounts of various institutional and social discursive practices (e.g., mental hospitals, prisons, the process through which the modern individual has come to see himself/herself as a sexual subject), Foucault develops the notion of disciplinary power, exercised on the body and soul of individuals rendering them docile. However, in his more recent writings he expands on this notion of docility by defining power as dependent on resistance: "…as soon as there's a relation of power there's a possibility of resistance. We're never trapped by power: it's always possible to modify its hold, in determined conditions and following a precise strategy" (Foucault, cited in Sawicki, p. 25). An understanding of the micropolitics of power allows for more nuanced interpretations of how *race* operates and accounts for shifting patterns of domination and oppression.

Cultural Racisms

Influenced by the work of scholars at the Centre for Contemporary Cultural Studies, University of Birmingham, and others such as Stuart Hall, theorists have distinguished new types of racisms that have emerged over the last decade. In Britain and Europe, these racisms are referred to as cultural or "new" racism; in the United States, as aversive racism; and in Canada as democratic racism. Generally, such racisms are based not on biological differences, but on the supposed incompatibility of cultural traditions. As Torres, Miron, and Inda put it, "This new cultural racism, rather than asserting different natural endowments of human races, notions which have generally lost credibility, emphasize differences of cultural heritage and their incommensurability" (1999, p. 8). Culturalism forms the basis of these racisms, along with a definition of *race* as a matter of difference rather than a question of hierarchy. Goldberg (1993) notes that these racisms are rooted in liberal traditions that emphasize individualism and

autonomy. Therefore, they are described as more subtle, silently sophisticated, and "contradictorily celebrated as multicultural diversity just as it (they) rationalize(s) hegemonic control of difference, access and prevailing power" (Goldberg, p. 8). The subtleties of these racisms are demonstrated in discourses "coded" to circumvent accusations of racism (Solomos & Back, 1996). However subtle these discourses, closer examination reveals the assumption of binary opposites, in which the national or citizen is on one side, and the alien, foreigner, immigrant or "other" is in opposition. The supposed shared unity of the nation is threatened by the presence of "other" and therefore they are relegated to the margins of society and blamed for many social and economic ills (Torres, Miron, and Inda).

Within the Canadian context, Henry et al. (1995) characterize democratic racism as an ideology based on two conflicting sets of values made to be congruent with each other. "Commitments to democratic principles such as justice, equality, and fairness conflict but coexist with attitudes and behaviors that include negative feelings about minority groups and differential treatment of and discrimination against them" (Henry et al., p. 21). Democratic racisms, thus, are less likely to be challenged as they continue in a more silent manner, often under the guise of celebrating diversity. They call attention again to the shifting nature of racism and the need for specific, contextual responses for each form of racism.

This brief overview of cultural racisms points to a shift from biological constructions of *race* to a social constructivist position, and also suggests a displacement of *race* as a neutral biological "fact" to *race* as a subtheme within discourses of culture. These shifts are the subject of the next section.

Race as Socially Constructed

Influenced by postcolonial scholarship, social scientists have incorporated *race* into their theorizing with a new understanding of the concept emerging, that of *race* as a social construct. By this understanding, *race* is a socially constructed category used to "classify humankind according to common ancestry and reliant on differentiation by such physical characteristics as colour of skin, hair texture, stature, and facial characteristics" (Henry et. al., 1995, p. 328). As such, *race* exists as a social construction that is manipulated to define, structure, and organize relations between dominant and subordinate groups.

Just what is meant by "socially constructed" requires further explication. Peter Berger and Thomas Luckman in their now classic book *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (1967) contend that sociology must focus on its proper object of inquiry, namely, "society as part of a human world, made by men (sic), inhabited by men (sic), and, in turn, making men (sic), in an ongoing historical process" (p. 189). They focus on the everyday life as it is experienced and interpreted as meaningful by people. This everyday life is "not only taken for granted as reality by the ordinary members of society in the subjectively meaningful conduct of their lives. It is a world that originates in their thoughts and actions and is maintained as real by these" (p. 19). In essence, Berger and Luckman challenge us to an ontological shift from a stance of realism to a stance of historical constructivism[9]. *Race* as a social construct, then, exists only as it is shaped or imagined through relationships. As explained by Solomos and Back (1996), "*race* can be seen as a discursive category through which differences are accorded social significance. But it is also more than just a discursive category

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[9] I am drawing on Guba and Lincoln's (1994) taxonomy that contrasts the paradigms of positivism, postpositivism, critical theories, and constructivism. While they categorize the ontology of constructivism as relativism with local and specific constructed realities, I contend that Berger and Luckmann's ontology is more of a historical

since it carries with it material consequences for those who are included within, or excluded from, a particular racial identity" (p. xiv).

Under the general rubric of conceptualizing *race* as a social construct, various positions or debates can be identified. Howard Winant asserts that

> the main task facing racial theory today...is no longer to critique the seemingly "natural" or "commonsense" concept of *race* -- although that effort has not by any means been entirely completed. Rather, the central task is to focus attention on the continuing significance and changing meaning of *race*. (1994a, p. 14)

One of these variations regarding the meaning of *race* involves whether or not it solely is an ideological construct. Philomena Essed (1991), for example, contends that *race* is more than a social construction because it has never existed outside of a framework of group interest and is therefore best understood as an ideological construct. Robert Miles, a leading scholar in the field, posits that any reference to *race* necessarily rests upon a biological reference lacking all objectivity and theoretical content and so *race* ought to be analyzed as nothing more than an ideological construct (cited in Goldberg, 1993). On the other hand, Winant (1994a) argues against the assertion that *race* is an ideological construct in the sense of a false consciousness that explains other material relationships in a distorted fashion. According to Winant, viewing *race* as an ideological construct overlooks the salience developed by the construct over the years and the very real everyday experience of *race* as part of our identities.

Another area of debate involves the "death" of the construct *race*. Some theorists argue that the concept should not longer be acknowledged for to do so simply reifies something that is not. Robert Miles argues that "*race* is an idea that should be explicitly and consistently confined

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constructivism that takes into account the historical influence of social, political, cultural, economic, ethnic and gender values over time. Thus, while meaning is local, it is shaped by larger historical forces.

to the dustbin of analytically useless terms" (cited in Solomos & Back, 1996, p. 72). He puts forth *racialization* as a replacement concept. Perhaps the more concerning argument for the death of *race* comes from neoconservative camps who maintain that the concept no longer has relevance in a society that has overcome racism. Such a stance leads to "colour-blind" racial politics and a "hands-off" policy orientation (Omi & Winant, 1994).

A further trend in approaching *race* is assigning objectivity to the concept (Winant, 1994a). While firmly opposed to a biological interpretation of *race,* an unproblematic objectivism occurs in many arenas. In such cases, the shifting nature of *race* is not acknowledged; "in this logic there is no reconceptualization of group identities, of the constantly shifting parameters through which *race* is thought about, group interests are assigned, statuses are ascribed, agency is attained, and roles are performed" (Winant, p. 17). Although theoretically recognized to be a sociohistorical construct, *race* in practice is often treated as an objective fact. One simply is one's *race*. *Race* serves to naturalize the groupings it identifies in its own name (Goldberg, 1993). People are viewed as belonging to one of several *races* (e.g., white, black, brown)[10] without recognition of the reductionist and essentialist nature of such ascription. Many people do not fit easily into such categories. Neither does the objectivist approach account for the negotiation of incoherent and conflictual racial meanings and identities in everyday life.

A related matter of disagreement involves the replacement of *race* with other supposedly more objective categories like ethnicity[11], nationality[12], culture, or class[13]. Each of these efforts

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[10] A common use of this categorization is the assignment to racial groups common in many censuses and other surveys in the United States.

[11] Ethnicity is a closely related concept to *race*. It refers to a sense of identity and belonging among those who share an identification or affiliation with a common set of symbols pertaining to birthright, homeland, language, culture, and heritage (Elliott & Fleras, 1992). It generally is construed as a more positive concept than *race* and is therefore often used interchangeably. Racial formations are then reduced to ethnicity while ignoring the specific

represents the tendency to reduce *race* to a mere manifestation of other supposedly more

fundamental social and political relationships. Such reductionism fails to grasp the uniqueness

of *race*, its historical flexibility and immediacy in everyday experience and social conflict (Omi

& Winant, 1994, p. 2). As will become increasingly obvious, the case of culture replacing *race*

is most salient to a critique of nursing literature. In the past several decades, the cultural

conception of *race* has tended to eclipse all other conflations of *race* (Goldberg, 1993). A

culturalist perspective directs attention to cultural differences while ignoring the materialist

effects of the underlying notions of *race*. When *race* is identified with identity and culture,

careful language enables people to "speak about *race* without mentioning the word" (Gilroy,

cited in Henry et. al, 1995, p. 18). In the next section, I extend this discussion of the conflation

of culture and *race* by examining theoretical constructions of culture in more depth.

Constructing Culture

As with *race*, the construct of culture carries a range of meanings, to the extent that

Raymond Williams has observed that culture is one of the two or three most complicated words

in the English language (cited in Lock, 1993). A recent burgeoning in the study of culture in

virtually all fields of human science (e.g., as "cultural studies") has resulted in extensions to

commonly held understandings of culture. Lock explains that early meanings conveyed "the

idea of a process, and in particular with the tending of something, usually crops or animals" (p.

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experiences of racially defined groups (e.g., such as a history of colonization, slavery, exploitation) (Goldberg, 1993; Winant, 1994a). Further, ethnic identity is almost uniformly viewed as relevant only to minority groups, leaving majority identities unexplored (Solomos & Back, 1996).

[12] Goldberg (1993) notes that while there is some tendency to conflate nation with *race*, they are better understood as intersecting discourses, both "largely empty receptacles through and in the names of which populations groups may be invented, interpreted, and imagined as communities or societies" (p. 79).

[13] Anthias and Yuval-Davis (1992) note that one of the most important debates within theoretical work on *race* addresses the connection between *race* and class. The traditions of critical theory have in particular privileged class over *race* (Outlaw, 1990). Although there are many different positions regarding the connections between *race* and class, I agree with Anthias and Yuval-Davis who conclude that racism cannot on its own be an adequate explanation for economic position and that *race* is an epiphenomenon of class.

144). This was followed in the 18th and 19th centuries by the idea of civility, distinguishing "educated people who were cultured and enlightened from 'uncivilized' peasants...." (p. 144). The evolutionary meaning of culture effectively distinguishes between "us" and "them", representing "ethnic minorities" and "immigrants" as on the whole irrational, unscientific, and hence childlike and primitive (Lock, p. 145). While these earlier meanings are still held within the notion of culture, today culture is commonly understood as a template or blueprint for human behavior, grounded in the "values, beliefs, norms and practices of a particular group that are learned and shared" (Giger & Davidhizar, 1991, p. 4). In practice, this interpretation most often translates into culture being understood as identification with a particular ethnic or religious background.

This widespread understanding of culture derives from the social theory of cultural pluralism (also known as multiculturalism) informing much policy development today. At its core, cultural pluralism holds to the ideal of the harmonious coexistence of differing cultural or ethnic groups in a pluralistic society (Cashmore, 1996). Built on the notions of unity-within-diversity, cultural relativism, and often drawing on folkloric traditions, multiculturalism has been put forward as official state policy in several countries (e.g., Canada, Australia). However, there has been a range of critique directed toward multiculturalism, most of which centers on the ways in which multiculturalism addresses ethnic and racial difference as a question of 'identity' rather than of history and politics, and translates difference as an intrinsic property of 'cultures' and as a value to be 'represented' as such (Bennett, 1998). Donald and Rattansi (1992) offer a summarizing critique of multiculturalism and the culturalist perspective:

By focusing on the superficial manifestations of culture, multiculturalism failed to address the continuing hierarchies of power and legitimacy that still existed among these

different centers of cultural authority. By exoticizing them, it even colluded in their

further disenfranchisement. Despite its apparent relativism, in practice it defined

alternative centers of cultural authority primarily in terms of their difference from the

norm of English culture, not in their uniqueness and their discontinuities. (p. 2)

Notably, cultures within this perspective have been portrayed as static and passed down through

generations with the resultant possibility of developing tidy taxonomies of cultural beliefs and

practices. Culture becomes a fixed property of social groups rather than a relational field in

which they live in relationship. Despite such critiques, the culturalist perspective with its

underlying liberal ideologies of individualism and egalitarianism still carries considerable

influence within health care and nursing circles.

More recently, there has been a shift within certain schools of thought to a more

constructivist and political view of culture. For example, postcolonial scholars such as Stuart

Hall (1986/1997) and Homi Bhabha (1990, 1994, 1998) have provided us with more nuanced

conceptions of culture. Hall points to the personal and structural aspects of culture:

I learned about culture, first, as something which is deeply subjective and personal, and at

the same moment, as a structure you live....I could never understand why people thought

these structural questions were not connected with the psychic – with emotions and

identifications and feelings because, for me, those structures are things you live. I don't

just mean they are personal, they are, but they are also institutional, they have real

structural properties, they break you, destroy you". (cited in Chen, 1997, p. 488)

This dual nature of culture offers important clarification, uncovering the societal structures that

silently operate to disadvantage on the basis of culture. Hall also understands culture as carrying

an ideological or "common-sense" component that leaves these structures unexamined. "By

culture here, I mean the actual, grounded terrain of practices, representations, languages and customs of any specific historical society. I also mean the contradictory forms of 'common sense' which have taken root in and helped to shape popular life" (Hall, 1986/1997, p. 439).

Homi Bhabha, bringing together postcolonialism, postmodern, and psychoanalytic genres, integrates themes such as contingency, partiality, and indeterminancy into the discussion of culture. For example, he extends the thinking around culture as he points to the partiality of culture with the notion of hybridity, which brings about a "third space" by drawing on what he refers to as "incommensurable" forms of culture to bring about something "new and unrecognisable" (1990, p. 211). Further,

> ....Hybrid agencies....deploy the partial culture from which they emerge to construct visions of community, and versions of historic memory, that give narrative form to the minority positions they occupy: the outside of the inside: the part of the whole. (Bhabha, 1998, p. 34)

Bhabha here is representing culture not only as negotiable, but also as positionality mobilized by resistive agents. His reference to "partial culture" suggests that cultures are less epistemological sureties than they are places of enunciation and negotiation. Throughout his work, Bhabha also emphasizes the importance of seeing culture as linked to colonial histories.

We seen then that culture, as *race*, is also a disputed concept, to the extent that Abu-Lughod (1991) suggests that the notion of culture, despite it a long usefulness, may now be something anthropologists would want to work *against* in their theories, practice, and writing (p. 138). She comments that

> If "culture", shadowed by coherence, timelessness, and discreteness, is the prime anthropological tool for making "other," and difference....tends to be a relationship of

power, then perhaps anthropologists should consider strategies for writing against culture.

(p. 147)

Perhaps her commentary here is less of a disavowal of the notion of culture per se than it is a warning against the historical tendency to essentialize and signify with the concept of culture. In this sense, Abu-Lughod echoes Hall's explication of culture as " institutional" with "real structural properties" (cited in Chen, 1997, p. 488) resulting in the material effects of othering, oppressing, and disadvantaging. Thus, we see that the influence of critical theories has shifted discourses on culture from those grounded in cultural pluralism theory to reflect culture as constructed, shifting and contextual.

In summary, the concept of culture, though often used as a more neutral way of discussing "difference", is also a term that requires problematization. When *race* is recognized as a subtheme in culture discourses, we are alerted to potential problems in the application of this concept. In the review of nursing theory and research that follows later in this chapter, the limitations of a culturalist approach will be revisited. The remainder of this overview of *race* theory will consider the applications of *race* through the processes of racialization and representation.

Racialization and Representation

Race has fashioned and continues to mold personal and social identity, the bounds of who one is and can be, of where one chooses to be or is placed, what social and private spaces one can and dare not enter or penetrate....The history of racialized expression has served to fix social subjects in place and time, no matter their spatial location, to delimit privilege and possibilities, to open opportunities to some while excluding the range of racialized Others. And in so fixing, these imposed and imagined

histories freeze not only the racial Other but also those so privileged into given identities, perspectives, and dispositions. (Goldberg, 1993, p. 206)

Because *race* is not a natural attribute but rather a socially and historically constructed one, the analysis of how racial meanings are formed and racial identities assigned becomes important (Winant, 1994a). As highlighted by Goldberg in the preceding quote, *race* pervades every aspect of life, at both macro and micro levels. Individual psyches and relationships among individuals are shaped by *race*; collective identities and social structures are racially constituted.

The term racialization was first coined by Frantz Fanon and adopted by Robert Miles to capture the idea of the representational process whereby social significance is attached to certain biological features for the purpose of categorization into social collectivities[14] (Miles, 1989). Miles defines racialization as "a process of delineation of group boundaries and of allocation of persons within those boundaries by primary reference to (supposedly) inherent and/or biological (usually phenotypic) characteristics. It is therefore an ideological process" (p. 74). Racialization, in effect, suggests that a particular population can only be understood as a supposedly biological entity (Cashmore, 1996) and therefore takes place within the realm of conceptions of cultures as static and homogenous and having a biological basis. This is then extended to notions of cultures having direct relationship to attitudes, expectations, and behavior (Ahmad, 1993). The processes of racialization are characterized by their contingent and dialectic natures.

The Contingent Nature of Racialization

Because of the social and historical nature of *race*, the resultant social structures, identities, and signification systems (i.e., racialization) must be understood as flexible and

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[14] Howard Winant (1994a) uses the term "racial formation" to portray a very similar process of social signification.

contested (Winant, 1994a). Particular racial meanings and social structures are always context-specific. For example, the racialization process of assigning Aboriginals to reserve lands has been relatively fixed over the last century in Canada; the ensuing racial order is "naturalized" and publicly unproblematized. Yet, when this order is resisted and violently threatened (as in the Oka crisis and the Gustafson Lake stand-off), there is possibility for a shift in the established patterns of racialization. In another historical Canadian example, Irish immigrants were racialized as a distinct and inferior group in the 19th century. More recently, with the increase in non-White immigrants, the Irish are easily integrated as "mainstream" Canadians. Similar shifts have occurred for Eastern European immigrants (e.g., Ukrainians, Mennonites).

Racialization is particularly contingent upon class and gender. People of Colour in upper classes may be categorized and signified in different ways than those in lower classes. To illustrate, business-class immigrants from Hong Kong may be highly regarded for their business acumen, but may still be categorized as Other and demeaned in everyday life or excluded from certain social privileges. Likewise, men and women with similar ethnocultural backgrounds may be racialized in different ways.

The Dialectic Nature of Racialization

Miles (1989) observes that racialization is a representational process of defining an Other (usually, but not exclusively) somatically. Through racialization (i.e., defining Other), self is defined by the same criteria. This process of representation has a long standing history within the Western world about populations elsewhere. European explorers, merchants, and missionaries represented those they came in contact with according to perceived physical and cultural norms, using their own sense of "normal" to identify abnormal characteristics in others. The period of colonization saw an intensification of representations, sometimes consisting of

positively evaluated elements (e.g., the "noble savage") and sometimes consisting of negatively evaluated elements (e.g., heathen, cannibals). As Miles (1989) suggests, representations of Other became increasingly interwoven with justifications for the exploitation of the colonies. For example, representations of Other as inferior were central to the enslavement of the African in America. Said (1978) makes a similar point in his widely read book, *Orientalism*, arguing that "European culture gained in strength and identity by setting itself off against the Orient as a sort of surrogate and even underground self" (p.3). Other postcolonial writers such as Frantz Fanon also speak powerfully of the dialectic nature of racialization and constructing Other. Fanon, in *Black Skin, White Mask* (1967), convincingly argues that the black man is the symbol of Evil. In contrast, white is the symbol of goodness, purity, and light.

> The torturer is the black man, Satan is black, one talks of shadows, when one is dirty one is black -- whether one is thinking of physical or of moral dirtiness.... Blackness, darkness, shadow, shades, night, the labyrinths of the earth, abysmal depths, blacken someone's reputation; and on the other side, the bright look of innocence, the white dove of peace, magical, heavenly light. A magnificent blond child -- how much peace there is in that phrase, how much joy, and above all how much hope! (p. 189)

> Through the dialectic process of racialization, Other may adopt the content of the

racialized discourse to identify itself as Self, essentially internalizing the representation. This may be either positive or negative. Winant (1994a) observes that the dynamics of racial signification are necessarily relational and questions how much autonomy an individual has to choose her/his racial location. Himani Bannerji (1995) speaks eloquently to this area known as identity politics and notes the power of self-naming.

When I looked to Black history, to history of Indigenous people of the Americas,

and re-read the anti-colonial struggles, I took strength from an identification with

Vietnam, Cuba, and subsequently from the African and Central American revolutionary

movements. The word "Black", then a political metaphor rather than a territorial

politics, filled me with a sense of pride and dignity, spelling a shared culture and

politics of resistance. Those who dismiss so disdainfully all projects of self-naming

and self-empowerment as "identity politics" have not needed to affirm themselves

through the creative strength that comes from finding missing parts of one's self in

experiences and histories similar to others. (p. 9)

Read in isolation, this selection from Bannerji may leave the impression that the dialectic nature

of racialization can easily be turned into a positive exercise of self-naming and agency by Other.

However, the growing body of colonial discourse analysis by scholars such as Homi Bhabha

(1994, 1998) and Gayatri Chakravorty Spivak (1988) belies such a simple conclusion. Spivak's

interrogation of the question "can the subaltern speak?" uncovers the networks of imperial and

indigenous class and patriarchal power that silence the voice and agency of Other.

The Construction of Whiteness

Notably, but often overlooked, racial signification includes the construction of White

racial identity. There is now a growing group of scholars who are exploring the politics of

Whiteness[15] and an increasing awareness of the importance of such an enterprise. "The power,

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[15] Fishkin (1995) notes that with the publication of *Playing in the Dark: Whiteness and the Literary Imagination,*
Toni Morrison launched an eloquent and provocative challenge to the privileged, naturalized whiteness of American
literature. In this book, Morrison (1992) probed the influence of Afro-Americans on American literature and
challenged scholars to examine Whiteness as an imaginative, social, and literary construction. In keeping with this
challenge, an interrogation of Whiteness has begun in disciplines such as literary criticism (e.g., Shelley Fisher
Fishkin's *Was Huck Black? Mark Twain and African-American Voices*), history (e.g., David Roediger's *The Wages
of Whiteness: Race and the Making of the American Working Class,* 1991; Vron Ware's *Beyond the Pale: White
Women, Racism, and History,* 1992), cultural studies (e.g., bell hooks *Outlaw Culture,* 1994), anthropology (e.g.,
Beth Ellis's thesis *Representation of Race and Gender: The Social Construction of "White" and "Black" in Early*

valorization and experience of 'whiteness' as a form of contemporary ethnicity needs serious

theoretical and critical attention" (Williams & Chrisman, 1994, p. 17). Solomos and Back

(1996) assert that "clearly there is a need for a research agenda which looks at the way white

subjectivities are racialized, and how 'whiteness' is manifested in discourse, communication, and

culture" (p. 23). They go on to point out that one of the central criticisms of studies in *race* and

ethnic relations is that the focus has too often been on the victims rather than the perpetrators of

racism. Likewise, Toni Morrison in her analysis of Whiteness in American novels comments,

"My project is an effort to avert the critical gaze from the racialized object to the racial subject;

from the described and imagined to the describers and imaginers; from the serving to the served"

(1992, p. 90). Including Whiteness as an area of critical inquiry has the potential to shift the

gaze from minority communities to ideologies and structures that often go unnoticed. Michelle

Fine (1997) explains the importance of such endeavors, "whiteness and 'colour' are...not merely

created in parallel, but are fundamentally relational and need to be studied as a system; they

might, in statistical terms, be considered 'nested' rather than coherent or independent variables"

(p. 58).

Deconstructing the meanings of Whiteness is a beginning step in challenging the silence

and "naturalness" of Whiteness[16] and has the potential to yield fruitful investigation into

everyday racial inequities. However, there are also some inherent pitfalls in such a project.

There is the danger of bringing Whiteness into the center of all discourse and thereby continuing

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British Columbian Historical Discourses. 1858 - 1900, 1996) and education (e.g., Christine Sleeter's essay, How White Teachers Construct Race, 1993; Leslie Roman's essay, White is a Colour! White defensiveness, postmodernism, and anti-racist pedagogy, 1993a). Recently, Michelle Fine, Lois Weis, Linda Powell, and L. Mun Wong (1997) have edited a collection of essays by educators and psychologists deconstructing "Whiteness", entitled *Off white: Readings on race, power, and society.*

[16] This project of deconstructing Whiteness is essentially a Western one. Because of the contingent and shifting nature of racial identity, my discussion here applies to the Western world in which Whiteness has maintained hegemony.

the long-standing pattern of relegating contributions of non-Whites to the margins. In the process of such analysis, there is also the danger of reifying Whiteness[17] as a fixed, singular category (Fine et. al., 1997; Solomos & Back, 1996). In order to avoid this reification, any discussion of Whiteness must be carefully located in a specific historical, political, and social context. Further, Whiteness cannot be explored outside of the ways in which it is classed and gendered (Spelman, 1988; Ware, 1992). Solomos and Back's instruction regarding any efforts at deconstructing Whiteness serve as useful summary: "The need to comprehend the social construction of whiteness as a form of identity and a political discourse must (i) focus on decolonising the definition of 'normal', and (ii) simultaneously prohibit the reification of whiteness as a social identity" (p. 24).

Whiteness has been constructed as natural or the norm in the Western world, carrying with it notions of purity and multiple privileges. Ruth Frankenberg (1993), in her much cited book *White Women, Race Matters: The Social Construction of Whiteness* based on in-depth interviews with White women, argues that *race* shapes White women's lives. She presents a set of linked dimensions that reflect the privileged and social construction of Whiteness as a standpoint of structural advantage and set of cultural practices that are typically unmarked and unnamed.

When Whiteness is understood as this privileged social construction, the locations, discourses, and material relations (often relations of domination) shaping Whiteness are acknowledged. Elizabeth Spelman (1988) notes that, generally, the self-esteem of White people is deeply influenced by their difference from and supposed superiority to Black people. While many White people do not consider themselves as racist, their self-esteem is propped up by a

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[17] This danger of reifying Whiteness could be compared to the reification of culture that has also been critiqued (e.g., Allen 1996a; Whittaker 1992).

sense of self based on the racism (e.g., systemic) that unfairly distributes benefits and burdens to Whites and Blacks. From this position of superiority, Whites can choose to acknowledge or overlook racism. Jennifer Simpson, in her essay entitled "Easy Talk, White Talk, Back Talk: Some Reflections on the Meanings of Our Words" (1996), makes the point that Whites do not have to monitor their speech but can engage in selective hearing, creative interpreting, and complicitous hearing; "talk we rarely notice or respond to, talk that occasionally gives us a strange feeling ('Was what I just said offensive?'), talk that most often simply slips through the conversation, not noticed, not even forgotten because it was never remembered" (p. 378). Peggy McIntosh (1995) expands on this notion of White privilege by listing a concrete inventory of privileges she enjoys as on a daily basis as a White person. She notes "I have come to see white privilege as an invisible package of unearned assets that I can count on cashing in each day, but about which I was 'meant' to remain oblivious" (p. 76). The theme of the privilege of Whiteness is the most prominent and frequently presented theme in the discussion of the construction of Whiteness and certainly carries far-reaching implications for both everyday life and theoretical endeavors.

Yet, while the privilege and purity of Whiteness is prominent, Whiteness is also constructed as terrorizing by people of Colour. Scholars such as Frantz Fanon (1967), bell hooks (1992), and Himani Bannerji (1995) provide graphic accounts of the terror instilled in them by White people. bell hooks, in her landmark essay entitled "Representations of Whiteness in the Black Imagination" (1992), describes the "special" knowledge of Whiteness gleaned by black folks from a shared fascination with difference and close scrutiny of White people:

> Collectively Black people remain rather silent about representations of Whiteness
>
> .....many of us pretend to be comfortable in the face of Whiteness only to turn our

backs and give expression to intense levels of discomfort. Especially talked about

is the representation of Whiteness as terrorizing....This representation of Whiteness as

terrorizing emerges as a response to the traumatic pain and anguish that remains a

consequence of White racist domination, a psychic state that informs and shapes the

way black folks "see" Whiteness. (p. 169)

Himani Bannerji (1995) similarly testifies to her terror as a recently arrived immigrant in

Canada.

My experiences very often spoke of violence and violation. They consisted of

humiliation in the institution called the university...fear of the state at visa offices,

borders and at home, of being judged an unfit parent. There were fears in the

street for clothes I wore, the body I carried with me, for my child in her present

and future, and a continual sense of non-belonging.... (p. 7)

These representations of Whiteness as terror are likely not incorporated into the self-

image of most Whites. bell hooks (1992) recounts the disbelief, shock, and rage of White

students when they listen to Black students talk about Whiteness. "In White supremacist society,

White people can safely imagine that they are invisible to Black people since the power they

have historically asserted, and even now collectively assert over Black people, accorded them the

right to control the Black gaze" (p. 168). The theme of the representation of Whiteness as

terrorizing adds another important dimension to the construction of Whiteness.

The privilege of Whiteness, rampant in both health care theory and practice, has not yet

been interrogated to any degree. Health care systems remain embedded in the ideologies and

practices of White dominant society, reinforced by the legitimizing individualistic and

"scientific" hegemony of biomedicine. Deconstruction of Whiteness in Canadian health care

theory and practice is urgently needed as a strategy against the subtle and not-so-subtle racism exercised in health care settings. Furthermore, the reality of the embodiment of racial identity requires exploration, particularly in light of the terrorizing effect of Whiteness on people of Colour. Fanon (1967) reminds us that

> in the White world the man of color encounters difficulties in the development
>
> of his bodily schema. Consciousness of the body is solely a negating activity.
>
> It is a third-person consciousness. The body is surrounded by an atmosphere
>
> of certain uncertainty.... (p. 110)

This carries particular salience within the fields of health care that are so focused on the body.

Race, Class, and Gender: Intersecting Oppressions

In an effort to understand oppression, I briefly review two main theoretical positions, that of neo-Marxists who tend toward economic determinism in their theorizing, and that of Black feminists who emphasize the intersectionality of multiple oppressions. Both of these camps build on the basic Webster's (1994) definition of oppression as the burdensome and unjust use of power. Oppression may operate in subtle, taken-for-granted ways when the structuring of societal norms, laws, and other assumptions routinely disadvantage certain groups. Oppression thus becomes a consequence both of the manner in which society is structured and also of the fact that this structure is not questioned (Northway, 1997).

Bolaria and Li (1988) note that oppression implies that the dominant group has the power to oppress and the subordinate group has fewer resources to resist the oppression. They exemplify the neo-Marxist tradition in their description of racial oppression:

> Racial oppression has a number of dimensions, ranging from physical coercion to
>
> ideological control. These levels of oppression are means to control the subordinate

group, with the *ultimate purpose being to exploit its labour power, or to remove its sovereignty from land and resources*". (p. 23; italics mine)

Bolaria and Li go on to observe that while racist ideologies are rooted in the process of material production, they are supported by other social institutions such as inferior education, residential segregation, and poor health care. Although scholars like Bolaria and Li tend to reduce racial oppression to a matter of economics, they have brought balance to the more orthodox literature on *race* and ethnic studies that stresses culture and confines itself to issues such as adjustment, adaptation, and assimilation.

There are, however, problems in reducing *race* to a matter of class (or gender). Analyses that do not consider the intersectionality of these concepts are more likely to present incomplete pictures of processes of domination and exclusion. Black feminists such as Rose Brewer, Hazel Carby, Patricia Hill Collins, bell hooks, and Himani Bannerji have been particularly instrumental in drawing attention to the error of privileging gender or class over *race*. Collins (1993) emphasizes that intersectionality is not about additive analyses of oppressions but rather about seeing the oppressions of racism, classism, and sexism as interlocking categories of analyses. She (Collins, 1990, p. 6) expands the conceptualization of oppression to include three interdependent dimensions:

1. Economic -- the ghettoization of Black women into service occupations;

2. Political -- the denial of rights and privileges routinely extended to White male citizens (e.g., vote, public office, education); and

3. Ideological -- the process by which certain assumed qualities are attached to Black women and how those qualities are used to justify oppression (e.g., Jezebel, welfare moms).

The matrix of domination in economic, political, and ideological spheres is a complex one that cannot be reduced to either/or dichotomies. Collins insightfully observes that depending on the context, an individual may be an oppressor and an oppressed simultaneously (e.g., a white woman may be penalized by gender but privileged by *race*). Similarly, Rose Brewer (1993) argues that *race*, class, and gender cannot be understood apart from each other; each are embedded in the contexts of the others. Acknowledging the interrelatedness of *race*, class, and gender provides important insight for this study and guards against incomplete and simplistic analyses.

Summary of *Race*-related Knowledge

In sum, *race* provides the categorization for the process of exclusion (i.e., marginalization) and inclusion (i.e., privilege) of individuals on the basis of what are seen to be immutable biological or physiological differences that may be expressed through culture and life-style (Anthias & Yuval-Davis, 1992). The shifting nature of *race* through time demonstrates the remarkable resilience of the concept, adapting to various contexts to serve particular ends. "...*Race* is a fluid, transforming, historically specific concept parasitic on theoretic and social discourses for the meaning it assumes at any historical moment" (Goldberg, 1993, p. 74). While *race* is clearly not a biological entity, it denotes a particular way in which communal differences come to be constructed and therefore it remains as an important concept. Winant (1994b) speaks to the paradoxical nature of *race*, "at once evanescent and ferocious, ephemeral and intense, conspicuous and unspecifiable, *race* is a fascinating and terrible problem precisely because of its slippery and contradictory character. It is nothing but a contradiction, an absent presence, a present absence" (p. 267).

In an effort to summarize the *race*-related theory reviewed, I conclude this section with what I consider the key points.

- *Race* is a social construct with ideological and material components for the process of exclusion and inclusion of individuals on the basis of supposed physical or cultural differences. It carries significant implications in everyday life.

- The importance of an explication of *race* lies in the material practices that result when *race* is enacted as a category. These material practices vary in keeping with how *race* is conceptualized. To illustrate, *race* as biologically determined led to extreme practices such as the eugenics movement and less extreme but still false notions of IQ today. *Race* as culture results in the denial of disadvantage on the basis of racism, focusing instead on disadvantage as an outcome of cultural differences.

- *Race* is often mobilized as a concept to sustain dominant group relations.

- Although widely acknowledged as a social construct, *race* continues to be objectified as a real entity.

- The culturalist approach to *race* is a primary and often unrecognized mode of maintaining dominant group hegemony. The risks of the culturalist approach include essentializing culture, abstracting culture away from its social, political, and economic contexts, and conflating *race* with culture.

- Racialization, the signification process of assigning individuals to racial groups on the basis of physical or cultural attributes, is contingent and dialectic in nature.

- Racism is the ideologies, structures, and practices by which exclusions are enacted on the basis of *race*. The exercise of power is a key component of racism.

- The oppressions of racism often intersect with the oppressions of sexism and classism and should therefore not be viewed in isolation from each other.

These summarizing points served as guiding premises in the data generating and analysis phases of this study and thus contributed substantially to its theoretical foundation. Drawing on this review of *race*-related scholarship, I turn now to an analysis that uncovers how intergroup relations are typically represented within nursing literature.

Nursing Theory and Research: Culturalist Approaches

The culturalist perspective, with its emphasis on culture as a neutral system of shared beliefs, meanings, and practices, has had a pervasive influence on nursing theory and research. This reliance, however, needs to be understood within a historical context in which notions of culture were not typically integrated into nursing scholarship until the 1960s and 70s. Initially, anthropological theories were predominantly drawn upon, and it is only recently that more critical and/or constructivist traditions have begun to be incorporated. In this way, the trajectory of theorizing and research in nursing is not all that much different than that of other health care and social sciences. Therefore, despite its limitations, the interpretive framework of culturalism should be understood as a sincere attempt to replace earlier approaches to *race*. Stubbs, in his discussion of various models for health research, remarks that the "ethnic sensitivity" and "anti-racist" frameworks attempt to "replace crude 'colour-blind' or 'assimilationist' models through which black and ethnic minority populations were either ignored or seen as 'integrating' into the supposed norms of the 'host society'" (1993, p. 38). Yet, several clear limitations of the culturalist perspective can be identified. Nursing has widely defined culture as static and deterministic, and thereby the relational aspects of culture tend to be overlooked. With this static view of culture, cultural groups have been easily defined and associated health care beliefs and

practices have often been organized into neat taxonomies, leading to generalizations and stereotypes. Much greater attention has been devoted to developing nursing cultural awareness than to the social and economic contexts in which minority patients live and, as a result, individualistic and interventive practice has been promoted that helps clients adapt to oppressive environments. Self-awareness, when addressed, has focused on individual level prejudice rather than any significant locating of the nurse within larger societal ideologies and structures. Structural issues have been either neglected or intentionally ignored under the guise of cultural relativism (Meleis, 1996).

Moreover, several ideologies (individualism, egalitarianism, and caring) are firmly embedded in the culture of nursing and, though often invisible or taken-for-granted, exercise considerable influence over the provision of intergroup care. First, the ideology of individualism is pervasive throughout nursing. Nursing, as biomedicine, has traditionally taken a micro focus, considering the health and illness of the individual apart from the larger environment in which they occur (Anderson, 1996; Chopoorian, 1986; Kleffel, 1991; Stevens, 1989). Chopoorian points to a sharp discrepancy between nursing practice and theory: although nurses continually witness the human responses to the underlying social dynamics of poverty, unemployment, undernutrition, isolation and alienation precipitated through the structures of society, nursing theory does not generally encompass a perception of environment as intolerable circumstances for large numbers of society. Second, a related ideology, that of egalitarianism, purports nurses as unbiased and aspiring toward the ideal that "everyone should be treated the same way". This egalitarian ideal, underscored by a concern to avoid favoritism, is often accompanied by the expectation of efficient care (Majumdar & Hezekiah, 1990). This ideology fits with the "colour-blind" stance in which it is assumed that everyone has equal opportunities and should be treated

the same, regardless of *race*, and therefore fails to account for individual and structural disadvantages that influence health. Finally, caring has been widely espoused as the essence of nursing (e.g., Bevis & Watson, 1989). Deeply rooted in humanist traditions, the caring ideology puts forth the ideals of respect and tolerance for others and, in the process, undermines the irrationality of prejudices and racisms. Mulholland (1995) argues that, in effect, the caring ideology encourages inattention to a critical analysis of social realities. Caring ideology, then, falls neatly into the culturalist approach to *race*, emphasizing an appreciation of diversity and tolerance for others. The following discussion of nursing theory and research is located within this conceptualization of the historical evolution of the concept of culture within nursing science and the key ideologies that operate within the profession.

Nursing Theory

Stemming from a widely shared desire to provide culturally appropriate care in the face of increasingly diverse societies, much of nursing's approach to issues of "difference" currently tends to be "constructed as centring on the discourse of 'culture' and the distinct ethnicities of different groups" (Culley, 1996, p. 565). Here I outline some of the most dominant theories pertaining to culture and health that have been developed within nursing and have been drawn upon extensively.

Leininger's Culture Care Diversity and Universality Theory

Nursing's reliance on the concept of culture has evolved over the years, drawing heavily on anthropological perspectives integrated into nursing. Madeleine Leininger began incorporating cultural perspectives into nursing theory and practice as early as the mid 1950s. The goal of her theory, coined as "culture care" (also widely referred to as transcultural nursing), is to "provide culturally congruent nursing care in order to improve or offer a different kind of

nursing care service to people of diverse or similar cultures" (Leininger, 1996, p. 72). The Culture Care Theory emphasizes the use of three culture-related nursing care actions: cultural care preservation/maintenance, cultural care accommodation/negotiation, and cultural care repatterning/restructuring. Caring is described as the essence of nursing and culture as the "blueprint for determining human decision making and actions" (Leininger, 1984, p. 42). Therefore, cultural factors need to be considered in order to give even the most basic care to clients.

With this theory, Leininger has drawn attention to the importance of integrating cultural care into day-to-day nursing care at a time when society has become increasingly ethnically diverse and when assimilationist policies are being questioned. An impressive body of nursing theory has resulted from this early attention to the ways in which nurses provide care to diverse populations. Despite its widespread adoption, there is a growing critique of transcultural theory that follows along the lines of the critiques against culturalism already presented in this chapter (see pages 28 and 59). Concerns have been raised regarding how culture is conceptualized as stable and pre-existing within this theory (Mason, 1990; Meleis, 1996), and as abstracted away from social, economic, historical, and political variables (Bruni, 1988; Swendson & Windsor, 1996). Moreover, Mulholland (1995) notes the inadequate theorization of power within the transcultural nursing model, and a hegemonic and assimilationist stance in which nurses are implicitly assumed to be White, requiring education to deal with "different" cultures has also been noted (Bruni, 1988; Mulholland, 1995). Nonetheless, despite these limitations, the work of Leininger has been pivotal in drawing attention to the importance of culture in the realm of health and health care.

Cultural Assessment

Among the mid-range theories developed to provide guidance to nurses when caring for clients from various ethnic groups, several assessment models have been developed (e.g., Giger & Davidhizar, 1990, 1991; Tripp-Reimer, 1984; Tripp-Reimer & Brink, 1985). Giger and Davidhizar (1991) present an assessment model for the evaluation of six essential cultural phenomena evidenced among all cultural groups: communication, space, social organization, time, environmental control, and biological variation. Once again, this particular cultural assessment model is based on a static and deterministic conceptualization of culture. Culture is defined as "a patterned behavioral response that develops over time as a result of imprinting the mind through social and religious structures and intellectual and artistic manifestations....Culture guides our thinking, doing, and being and becomes patterned expressions of who we are" (Giger & Davidhizar, p. 3). With such a portrayal of culture, any critical analysis of the historical nature and material consequences of *race* is unlikely. Yet, while there are significant limitations in the theoretical underpinnings of these assessment models, it must be noted that they alert nurses to the variations within client experience and therefore preclude a singular (i.e., colour blind) approach to all clients, regardless of ethnicity.

Negotiation and Cultural Brokerage

Mid-range theory has also been developed to address the "how-to" of interactions between nurses and clients. Negotiation is a common theme in such models and is often derived from the work of Arthur Kleinman[18] (1978). A central critique brought against Kleinman's work

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[18] Kleinman (1978) maintains that most health care systems contain the three social arenas of popular (the family context of sickness and care along with the social network and community activities), folk (non-professional healing specialists), and professional (Western medicine and professionalized indigenous healing traditions). In each of these three arenas, explanatory models can be elicited from practitioners, clients, and family members regarding etiology, onset of symptoms, pathophysiology, course of sickness, and appropriate treatment. Once the explanatory models have been clearly expressed by both client and practitioner, the practitioner actively negotiates with the

is that it carries an emphasis on explanatory models without analysis of relations of power, and thus assumes that health care providers and recipients negotiate from similar positions (Lazarus, 1988; Pappas, 1990). As Lazarus (1988) notes, "Explanatory models writers cannot arrive at a clinical praxis when they study only beliefs that are brought to the clinical interaction and do not include the behavior of both clients and clinicians" (p. 44). Further criticism is that Kleinman's work does not explore those factors underlying supposed cultural differences; that is, through a focus on negotiating cultural differences, the emphasis is on the differences rather than on the structures that create and maintain such differences. However, drawing on more recent work by Kleinman, Tang and Anderson (1999) offer a counter interpretation, suggesting that Kleinman did "in fact, recognize the importance of structure and the interrelation between structure and agency in the complex intersection of multiple clinical realities" (p. 85).

Nursing scholars have applied Kleinman's explanatory model in various ways. The early work of Tripp-Reimer and Brink (1985) on cultural brokerage suggests that noncompliance by the client with medical protocol often alerts the nurse to the need for negotiation. The reference to noncompliance carries a strong message of the need to assimilate to the dominant health care system and overlooks any dynamics of power at work. However, Jezewski (1990, 1993) in her work on cultural brokerage acknowledges the power of the health care system and the integral role of policies and marginalization (e.g., through economic disadvantage). Her work, then, is an

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client, as a therapeutic ally, about treatment and expected outcomes. Kleinman, Eisenberg, and Good (1978, p. 256) suggest the following questions in exploring the explanatory model of the client:
1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you? How does it work?
4. How severe is your sickness? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your sickness has caused for you?
8. What do you fear most about your sickness?

example of critical perspectives gaining entry into nursing literature and moving the focus from the micro to the macro level. Likewise, the nurse-client negotiation model (Anderson, 1987, 1990) draws attention to the context of health care by examining the three structural domains of the professional sector, the popular sector, and the folk sector. West (1993) has developed the cultural bridge model that emphasizes bridging between interacting groups of people through assimilation, integration, education, and tolerance. The model is based on mutual respect and the goal of maintaining cultural differences and uniqueness while having meaningful relationships. The model, then, offers the nurse several strategies whereby to "bridge" cultural differences. In essence, the model places the responsibility for culturally sensitive care on the nurse and does not acknowledge the many other complicating influences inherent in a complex health care system.

Cultural Competence and Cultural Sensitivity

Another area of mid-range theory involves the skills or qualities of the nurse involved in intercultural care. Cultural sensitivity and cultural competence are two terms used widely in nursing literature to refer to this area. Both terms generally refer to the components of attitude, knowledge, and skill (Campinha-Bacote, 1994, 1995; Capers, 1994; Majumdar, 1996). Cultural competence as portrayed in the nursing literature has been heavily influenced by the multicultural competence movement in counseling psychology (e.g., the work of Derald Wing Sue, Gargi Sodowsky, Thomas Ottavi, and Donald Pope-Davis). The concepts of cultural sensitivity and cultural competence are grounded in the cultural pluralism ideology that affirms diversity. In keeping with this perspective, "nurses are required to be more culturally aware, knowledgeable, and skilled at working with culturally diverse individuals" (Pope-Davis, Eliason, & Ottavi, 1994, p. 31). Mid-range nursing theories regarding cultural competence/sensitivity, by

their micro focus, tend to overlooks the structural forces and everyday realities of *race* and racism. Further, implicit in the discussions is the idea that the nurse belongs to the dominant group (e.g., White) and that the client is non-White. That is, (White) nurses need to learn how to relate to non-White clients in order to provide care that takes the non-dominant culture into consideration. This assumption leaves the hegemony of the health care system unquestioned.

Cultural Safety

The concept of cultural safety is relatively new in the nursing literature, originating in the early 1990s in Aotearoa/New Zealand (Kearns & Dyck, 1996; Ramsden, 1993). In a response to Maori resistance to dominant western ways of thinking, the concept was formulated in the nursing education context with the aim of establishing biculturalism within education programs. As such, it is a nursing/health care application of postcolonialism and differs fundamentally from transcultural nursing (Coup, 1996; Ramsden). Behaviors, whether conscious or unconscious, of people in the dominant culture have the power to define health care policies and practices that may cause those from other cultural groups to feel powerlessness, anger, and humiliation often resulting in avoidance of health care services. Cultural risk in nursing describes a process whereby people from one culture believe that they are demeaned, diminished and disempowered by the actions and the delivery systems of people from another culture (Ramsden). In contrast, the result of cultural safety is "when the cultural 'looking glass' reflects a positive self" (Dowd & Eckermann, 1992, p. 11), suggesting that indigenous worth is recognized and reflected in health care provision.

The overall goal of cultural safety is to "take remedial action against the very conditions that prompted its formulation: deep-seated disadvantage and inadequate understandings of Maori models of health" (Kearns & Dyck, 1996). This goal is accomplished through nursing

education that has the following objectives: (1) to educate registered nurses to examine their own cultural realities and the attitudes they bring to each new person they encounter in their practice; (2) to educate registered nurses to be open minded and flexible in their attitudes toward people from differing cultures to whom nurses offer and deliver service; (3) to educate registered nurses not to blame the victims of historical and social processes for their current plight; and (4) to produce a workforce of well educated, self aware registered nurses who are culturally safe to practice (Ramsden, 1993). With its emphasis on biculturalism (Ramsden contends that all nursing interactions are bicultural), cultural safety aims at a critical understanding of the colonial structures and their ongoing influence on Maoris as well as the operation of power relations in health care, the intersectionality of racism with poverty, the need for revisionist history, and the ways in which social and political forces constitute everyday realities for Maoris.

Distinct from calls for "cultural sensitivity" based on token and uncritical support of multiculturalism, cultural safety involves real transfers of power to counteract legacies of subordination and disadvantage. In a more radical way, cultural safety represents an imperative to bring previously subjugated knowledge alongside that of established western biomedical discourse and practice, thereby legitimizing Maori knowledge and practices (Kearns & Dyck, 1996). Nevertheless, several concerns have been raised regarding this theoretical perspective that have to do with its exportability from what is described as a "bicultural" society (Ramsden, 1993) to multicultural societies (Dyck & Kearns, 1995; Polaschek, 1998), and the tendency to focus on the attitudes and knowledge of individual nurses rather than on nursing policies, settings of care, and the broader health care structures of which nursing is a part (Polaschek).

Nursing Research

Within nursing research, *race* has been dealt with in several ways. The first problematic representation of *race* within nursing research is that of silence, or not being present. Allman (1992) reports that a critical examination of most biomedical and nursing journals reveals a dismaying preponderance of studies that list "convenience" samples of 90 to 100 per cent "Caucasians". White European North Americans are represented as the norm: *race*less, cultureless, uniform, and homogeneous. A variety of reasons may be offered to explain the silence, including proficiency in English as a sample criterion and the challenge of recruiting from non-White populations. As a result, nursing science in general has remained thoroughly White in its orientation, yet has generalized its research findings to all populations. A second common operationalization of *race* within nursing research has been to objectify *race,* most often by using *race* as a discrete variable. By this approach, referred to by Ahmad (1993, p. 2) as "benign epidimiology", differences in health are compared across supposed racial groups (e.g., Lauver, 1992, 1994; Quackenbush, Brown, & Duchin, 1995) and *race*, in essence (often unconsciously), is used as a proxy for the influences of biological, cultural, socioeconomic, and political factors, and exposure to racism (Johnson et. al., 1995). Not surprisingly, much of nursing research's approach to issues of *race* has been shaped by a third approach, the culturalist perspective. By focusing on cultural differences, the adherents of this position overlook the centrality of *race* and racism in structuring the experiences of minority groups (Pearson, 1986; Stubbs, 1993). Instead, diversity and difference in languages, religions and cultural norms are seen to prevent effective communication/ interaction and create misunderstandings between the dominant and the "distinct" minorities. Any problems, therefore, are the result of mismatches between minority and majority cultures (i.e., the cultural differences themselves) that, according

to the culturalist view, meet on equal terms. There are a myriad of nursing research studies that examine health beliefs, practices, and illness responses of various ethnocultural groups (e.g., Brink, 1989; Chen, 1996; DeSantis, 1989; Kulig, 1995). The end result of such research may be a blaming of victims of racial, sexual, and class discrimination for their poor health status (Jackson, 1993). A final and more encouraging trend within nursing research is to approach *race* as a social construct. Studies proceeding from this stance, often informed by critical and feminist perspectives, are much more likely to focus on macro influencing structures as well as the everyday realities of racism.

In sum, the culturalist perspective, with its limitations, has had a widespread influence on nursing theory and research, and as a result, nursing, as a profession and science, has generally overlooked key matters of intergroup relations within health care such as inequities in health, marginalizing health care practices, racialization and racism. This is not to say that the extensive body of literature within this domain is worthless or that we should "throw out" as meaningless the concepts of *race* and culture. Rather, we are left with the challenge of re-thinking our scholarship. How might we theorize about culture in ways that account for the realities of shared meanings within groups while leaving an "openness" that allows for shifting identities and realities based on the intersectionality of other organizing features such as sexual orientation, class, gender, age, and so on? How do we make sense of difference in ways that do not succumb to racialization, othering, and reinforcement of existing power inequities? These questions served as important grounding points for me throughout the study, and I have concluded that we are in a position to move forward in our nursing scholarship, building on the foundation laid for us by those who first pointed to the importance of incorporating cultural aspects into nursing

care. Importantly, this review of nursing's approach to culture and *race* confirmed for me the importance of the critical interpretive framework from which this study proceeded.

I shift now to an overview of the contexts of Canadian society and health care. As will become evident, intergroup relations in health care are shaped by Canada's changing demographics, policies of multiculturalism, and ideologies of egalitarianism, individualism, and homogeneity.

The Canadian Context: A Pluralistic Society

Canadian society is becoming increasingly diverse in a number of ways. Perhaps the most obvious diversification is in its ethnocultural composition. According to Statistics Canada (1997), 54% of the population reported themselves as non-French, non-British[19] ethnic origin in the 1991 census. This is in comparison to the 37.5% of the population in the 1986 census who reported ethnic origin as other than French or British (Toumishey, 1991). In British Columbia, 71% of the province's population reported as non-French, non-British ethnic origin, with 40% having multiple ethnic origins. Of the remaining 29% (i.e., single origin, non-British, non-French), the two largest groups reporting as single origin were Chinese (6%) and East Indian (3%). Interestingly, while a majority of British Columbia's population is non-French, non-British, 79% name English as their mother tongue[20]. The number of immigrants coming to Canada has decreased from 265,405 in 1991-1992 to 219,183 in 1995-1996. Perhaps the most remarkable statistics are those regarding recent immigrant by country of last residence. While earlier immigrants came primarily from Europe, by the mid 1990s, 78.5% of immigrants to

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[19] Those who report their ethnic origin as other than French, English, Scottish, or Irish are included in this number. When those of Canadian ethnic origin are included, the number of non-French, non-British rises to 57%.

[20] After English, the largest groups by mother tongue are Chinese (5%), German (3%), and Punjabi (2%).

Canada came from non-European origins such as South and Southeast Asia, Central and South America, Africa, and China (Statistics Canada). In British Columbia, most immigrants come from Asia, with Hong Kong, Taiwan, India, Philippines, and China as the top five source countries. These statistics, then, reflect the growing ethnocultural and linguistic pluralism of Canada. Yet, these statistics cannot be viewed in isolation or as simple facts. It is instructive to look at the policies and underlying ideologies behind these numbers, and the consequences of these demographic shifts.

Generally, Canadian immigration policy and programs reflect three objectives: social (e.g., re-uniting families); economic (e.g., providing labour force); and humanitarian (e.g., protecting refugee claimants). State policies regarding immigration have fluctuated over time but have most often involved differential treatment based on *race* and ethnicity and typically exploited certain groups' labour power (Bolaria & Li, 1988; Fleras & Elliott, 1996; Henry et. al., 1995; Li, 1988). Stafford (1992) observes that the Canadian state always found ways to admit "undesirable elements" whenever capital so demanded them. Chinese were allowed in to build the railway, and Eastern Europeans were recruited to settle the prairies. Policies demonstrating the explicit preference for White immigrants continued into the 1950s with regulations that established a hierarchy of most to least welcome national origin (Whittaker, 1991). These overtly racist policies were replaced in the late 1960s with a series of radical reforms in immigration policy. A new Immigration Act in 1967 introduced a point system whereby immigrants, regardless of ethnic origin, were given points based on job training, experience, skills, level of education, knowledge of English or French, degree of demand for the applicant's occupation, and job offers. The point system, while appearing to make immigration policy more equitable, in effect continued to prevent poorer immigrants from gaining entry and thus

discriminated on the basis of class. In the late 1970s and early 1980s, immigration was limited

because of the federal government's concern with recession and unemployment. More recently,

there has been an increase in immigration to boost population numbers, in light of an aging

population and a declining birthrate (Frideres, 1992). Economic motivation is still present in

these policies:

> Ironically, the recent increase in the numbers of immigrants may be part of this...policy,
>
> designed to manipulate a market force, the supply of labour, in order to attain a "flexible"
>
> labour force at low wages. Supply-side economics is allowing more immigrants into the
>
> country, but it is also making it difficult for them to find and keep jobs. (Stafford, 1992,
>
> p. 87)

The business class immigration category[21] introduced in the 1980s brings an increasing flow of

capital and capitalists to Canada, augmenting the middle and upper-classes in this country (Wong

& Netting, 1992). The recently proposed requirement of English or French language fluency

(see *Vancouver Sun*, February 28, 1998) would similarly favor those with access to financial

resources as potential immigrants. What becomes quickly evident in reviewing Canadian

immigration policies are the complexities involved in deciphering the motivation for and effects

of the policies. Also striking is the long-standing construction of Canada as a White nation. The

very construction of Canada as a White nation has been, and is, dependent on simultaneously

constructing as Other those who are not of the so-called "mainstream" (Abu-Laban, 1996;

Anderson & Reimer Kirkham, 1998). Other is frequently racialized, poor, and unemployed.

According to Himani Bannerji (1996),

> Since...*race*-gendered class forms of criminalization, marginalization and exclusion

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[21] Most business immigrants come from Hong Kong, Taiwan, and South Korea to the cities of Vancouver, Toronto, and Montreal.

arise in present day Canada in the context of a liberal state (that claims to have parted company with a white settler colonial state), the situation we have to deal with becomes highly complex....The state here supposedly does not discriminate since it has a Charter of Rights with respect to *race*, gender, etc. But it is obvious that in its very organization of social communities in ethnic, *race* terms, in their differential positioning, they constantly create "Canadians" and "Others". This happens not only in the realm of a state constructed separated sphere of polity, but also in that of discursive representation in everyday life.... (p. 13)

As the Canadian population becomes increasingly diverse, racial tensions are becoming more apparent, and one can conclude with Omi & Winant (1994) that *race* has become a preeminently political phenomenon. The use of racial and ethnic symbols in political debate and conflict are common place today. For example, pre-election debate in 1997 repeatedly drew attention to the racist tendencies of members of the Reform party[22]. Immigration discourses of the day, heightened by the arrival of several boatloads of Chinese migrants off of the coast of British Columbia in the summer of 1999, are often marked by racist and exclusionary tendencies. There are more reports of and inquiries into discriminatory incidents and polls and surveys reveal that many Canadians feel negatively toward immigrants (Henry et al., 1995). A recent series in the *Vancouver Sun* on immigration reported that 49% of Greater Vancouver residents felt non-immigrants have become more tolerant but 45% believed they have become less tolerant. At the same time, the British Columbia Human Rights Commission has seen *race*-related complaints rise dramatically (*Vancouver Sun,* November 4, 1997*)*. Wong and Netting (1992) summarize the impact of Chinese business class immigrants, pointing out that

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[22] See, for example, Stephen Hume's column, entitled "Bigotry not new in Reform camp", in the *Vancouver Sun*, April 26, 1997 .

Chinese-Canadian tension in Vancouver has focused around four specific points:

real estate, education, criminal activity, and the media....racism appears to be rising,

as measured by the number of hate incidents and by the attitudes expressed in surveys.

Most of the apparent racism is in fact class antagonism wrapped in a racial envelope.

(p. 121)

Similarly, Grace, Strong-Boag, Anderson, and Eisenberg (1998) point out that stereotypes of

'rich Asians' constructed as 'taking over' and 'changing the face' of cities such as Vancouver

"operate insidiously to construct the 'other' as a threat to the 'white nation'" (p.10). While

generally on the periphery of society, the reappearance of White supremacist and hate groups

within the extreme right wing of Canada reiterates the racism embedded deep within society

(Cannon, 1995; Henry et al.; Kinsella, 1994; Wong & Netting, 1992). Barrett (1987) maintains

that the radical right is articulating what a significant proportion of the dominant community is

thinking and feeling, perhaps unconsciously. The activities of these groups are also increasingly

politicized and publicized, particularly after the conviction of five young White supremacists in

the murder of an elderly Sikh gentleman in Greater Vancouver. Therefore, it appears that *race*

continues to be a prominent feature in oppression and marginalization in Canada and that public

discourse regarding racism is becoming more commonplace.

As racial tensions appear to be rising, the shortcomings of Canada's multiculturalism

policies[23] are becoming more apparent. When first introduced in Canada in 1971, the three main

aspects of multiculturalism presented by Prime Minister Trudeau were that (1) there is no

official culture in Canada; (2) there must be creative exchanges or relationships among various

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[23] Multiculturalism in the Canadian context has been described as fact, policy, ideology, process (Fleras & Elliott, 1992, 1996) and discourse (Anderson & Reimer Kirkham, 1998; Cashmore, 1996). Here I am referring to multiculturalism as official state policy; in a later section I will discuss the ideological nature of multiculturalism.

cultural groups; and (3) all immigrants to Canada should have access to learning one of Canada's two official languages (McLeod, 1992). At that point, the government was concerned primarily with easing tensions between the two "founding nations"[24] but with rising concerns from a "third force" (non-British, non-French immigrants, especially in Western Canada), it extended government policy to endorse these groups. On July 21, 1988, the new *Multiculturalism Act* came into effect. The new law affirmed multiculturalism as a foundational characteristic of Canadian society with a central role in the decision-making process of the federal government (Fleras & Elliott, 1992). Although the early focus on cultural preservation and intercultural sharing has shifted to the current emphasis on *race* relations and the attainment of social and economic integration (Fleras & Elliott, 1992, 1996; McLeod, 1992), there is still a widespread belief that multiculturalism is "not working". Criticisms from the right, fueled by members of the Reform Party, denounce multiculturalism as a costly drain on resources (Cannon, 1995; Fleras & Elliott, 1996). Neil Bissondoth (1994), in his controversial and vocal condemnation of multiculturalism, argues that the obsessive preoccupation with accommodating diversity may empower minorities to demand that Canada adopt their customs and languages, rather than the other way around, with the result of increasing hatred and tribalism while undermining Canadian unity, identity, and culture. Reginald Bibby (1990), a sociologist from the University of Lethbridge, maintains that the virtue of pluralism portrayed in multiculturalism, when taken to excess, threatens to dismember Canada into isolated fragments, or "mosaic madness". On the other hand, critics on the left repudiate multiculturalism as an effort to co-opt and marginalize minorities and disguise racial inequities (Bannerji, 1995; Brand & Bhaggiyadatta, 1986; Carty, 1991). These critics point to the liberal tendencies of

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[24] This notion of two "founding nations" is being critiqued today for the ways in which it excludes First Nations peoples and other ethnocultural groups from the history of Canada (Anderson & Reimer Kirkham, 1998; Bliss,

multiculturalism to emphasize individualism and induce historical amnesia, both of which "occlude any awareness of and subsequent critique of historically trajected, mutually interdependent, and overlapping systems of oppressions" (Srivastava, Mathur, & Saldanha, 1996, p. 4). Bannerji (1996) argues that the state ideology of multiculturalism serves as political instrument that is a managing device for maintaining the hegemony of an anglo-american Canada, particularly in regard to the French and First Nations peoples. As such, multiculturalism policies reinforce the construction of Canada as White by emphasizing the notion of "two founding nations", marginalizing minorities as Other and ignoring the original presence of First Nations peoples.

Historically, many Canadians perceive their country as less racist because it does not share the United States' long record of extensive slavery, neither does it share Britain's legacy of colonial efforts outside its own borders. Yet, there are many illustrations of overt racism in Canada's legislation, policies, and practices over the years. The Canadian government with the Indian Act of 1876 and subsequent legislation and treaties initiated institutionalized racism that continues to prosper today (Frideres, 1993). Not a well known fact, the enslavement and racial segregation of Blacks in Canada existed for over two hundred years (Henry et al., 1995). The government-sanctioned racism against early Chinese, Japanese, and South Asian laborers is perhaps more widely acknowledged. Discriminatory laws such as the Head Tax, the internment of Japanese Canadians, and *Komagata Maru* incident are more blatant examples of racism in Canada's history.

There are fundamental contradictions within Canadian society: in a nation that espouses multiculturalism and tolerance, racism has long been embedded in the very fabric of society. As observed by Peter Li (1988), "despite a widely shared ideology of equality, which is best

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represented by the popular version of the mobility dream, social inequality remains well entrenched in Canadian society" (p. 129). This contradiction is captured in Henry et al.'s (1995) notion of democratic racism, described as the ideology that permits and sustains the ability to justify the maintaining of two apparently conflicting values. Egalitarian values of justice, fairness, and equality are held together with negative attitudes and behaviors against people of Colour. This then is the national context of this study.

The Health Care Context: Rhetoric and Reality

In response to Canada's pluralistic society, the government has enacted several policies. Through the *Multiculturalism Act* (Canada, 1988) and the *Charter of Human Rights and Freedoms* (Canada, 1984a), the federal government has established the expectation that the cultural contexts that determine and direct the ways of Canadians are to be respected and taken into account by those providing services. The federal health policies as outlined in the *Canada Health Act* (Canada, 1984b) and in *Achieving Health for All: A Framework for Health Promotion* (Canada, 1986) clearly state that all Canadians have the right to health care that is equitable, accessible, comprehensive, culturally sensitive, and appropriate (Toumishey, 1991). In British Columbia, *Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs* (1991) calls for a commitment to universal health care that pays attention to cultural and linguistic factors. These policies are intended to foster social justice[25] in the provision of health care.

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[25] The matter of social justice within health care can be interpreted as a matter of equality or equity. While there is some slippage between these two terms in the literature, it is important to understand that equality generally indicates sameness in treatment and equity refers to fairness in treatment. Stone (1988) observes the paradoxes that may arise around distributive issues of social justice: equality (i.e., sameness of treatment) may result in inequity (i.e., lack of fairness); whereas equity (i.e., fairness) may be linked to inequality (i.e., different treatment). It is generally agreed that social justice involves equity or fairness in health policy, although there is little agreement once again on what is meant by equity. For example, equity may refer to equal expenditure per capita, distribution

Health policies and legislation in Canada have focused on equal access to health care services. The principle of equal access has been entrenched in the *Canada Health Act* (1984), along with the principles of public administration, comprehensiveness, universality, and portability. While equal access is the most common interpretation of social justice in Canadian health policy, a careful reading of the 1984 Act reveals that two goals of social justice are encompassed in the policy statement: (1) equity in health; and (2) equal access to health care services. The primary objective of Canadian health policy, according to the 1984 Act, is to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (c.6, s.3), reflecting the larger ideal of equity of health. Rachlis and Kushner (1994) summarize five key policy directions for health and health care derived from the Canada Health Act:

1. Health policy is much more than health care services.

2. Achieving any health status objective requires a multi-sectoral approach.

3. The purpose of health care is to improve the health status of all Canadians.

4. Health care services should be available without undue barriers.

5. The federal government should continue to help the provinces fund their health care systems (p.8).

I would argue that the primary purpose established in the *Canada Health Act* (1984), namely health as the <u>end</u> goal of health care, has been widely subsumed by the secondary purpose (i.e., the <u>means</u> of achieving the end goal of health) of equal access to health care services. In essence, the means has become the end.

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of health care services according to need, equal access to services, equity in the quality of health care received, or equity in health outcomes. As Brown (1991) suggests, "the politics of policy are stalemated in part because no widely held agreement on the meaning and claims of equity has yet emerged" (p. 654). These differences in

This slippage in focus in Canadian health care coincides with a consequential grappling with values in tension, especially in the realm of health care reform. Janet Storch (1996) observes that values of health care as a humanistic and healing commitment are being challenged by a set of values that promote the business nature of the health care enterprise. This tension tends to boil down to choices between ethics and economics. The "closer to home" movement captures such tension between ethics and economics. Government reports like *Achieving Health for All: A Framework for Health Promotion* (Canada, 1986) and *The Report of The British Columbia Royal Commission on Health Care and Costs* (1991) draw attention to inequities in health and systemic inequities and issues of accessibility in the health system. *The Report of The British Columbia Royal Commission on Health Care and Costs* makes recommendations on how to address inequities in health and access to services, including recommendations to move health care services "closer to home". British Columbian health care reform has been built around the "closer to home" concept, along with regionalization, decentralization, and, in general, more efficient services. There is growing sentiment (and evidence) that the "closer to home" movement has further disadvantaged certain groups (Anderson, 1996; Armstrong, Armstrong, Choiniere, Feldberg, & White, 1994; Wuest, 1994). Lynn Smith, dean of the Faculty of Law University of British Columbia, was quoted in the *Vancouver Sun*, November 25th,

> Peter Seaton in his Royal Commission was not arguing that caregivers at home would take care of patients. He was arguing that services should move closer to home, but is has been translated as sending patients home. What's happened is the responsibility for care has shifted to women who are major care givers at home.

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interpretation can be traced back to different ideals of modern society -- those that derive from a libertarian ideal and those that derive from liberal egalitarianism (Stingl, 1996).

Current health care reform with its deinstitutionalization of health care services, privatization, and downsizing undoubtedly affects health care provision, particularly to marginalized groups. These shifts are shaped by trends of cost containment, aging of the population, the rise of new technology, an emphasis on determinants of health, and the consumer movement (Lefort, 1993), and are sweeping not only Canada but also many other developed nations (Evans, 1992; Inglehart, 1990; Organisation for Economic Co-operation and Development, 1994; Rachlis & Kushner, 1994). Although health care reforms across the country and around the world generally espouse values of equity, most of the attention of reform is directed toward the financing and delivery of health care and, in some cases, broader efficiency issues (Wagstaff & Van Doorslear, 1992). The reduction in federal transfer payments to the provinces is a macro-level policy matter carrying implications for social justice in health care. With these reduced payments, there has been increased attention to the principle of universality with practical consequences such as the return to debates regarding user fees, delisting services, and privatization. Each of these debates carries the overtones of health care services being distributed according to ability to pay rather than according to need and reflect the competing values within health care reform of equality and efficiency (Stingl, 1996).

With the current "health care crisis", nurses struggle to provide safe care to their clients (see, for example, the report in *Macleans*, April 28, 1997). Varcoe (1997a), in an critical ethnographic study in acute care hospitals in British Columbia, found that an "ideology of scarcity" perfused the work of nurses. As a result of constraints and restructuring, the importance of "emotional labour" in nursing has been reduced (Das Gupta, 1996a; Yyelland, 1994). In such conditions, culturally relevant care may quickly be perceived as a "frill". Nurses

in a pilot study[26] reported that they were much too busy to seek assistance from translators. Das Gupta, in her research with Black nurses in Ontario, learned that Black nurses, other nurses of Colour and in a few instances militant nurses are more affected by the current health care upheaval. The context of health care reform with its unending change certainly shapes the nature of intergroup relations in the provision of health care and, as is explained in the following chapters, was a continual theme in this study.

Thus, it appears that while policy statements communicate values of social justice, the actual implementation, particularly in an era of health care reform, may result in inequitable outcomes that perpetuate existing societal inequities. A closer look at the ideologies inherent within the policy statements and active in the health care system provides some insight into the gap between the rhetoric of policy and the reality of health care practices. Perhaps the foremost in ideologies influencing Canadian health care is the unspoken "preference for homogeneity and assimilation that runs deep in the institutions of Canadian society and clearly weaves its way into the human-services delivery system" (Henry et al., 1995, p. 167). As a result, most health care institutions are essentially monocultural, necessitating that people from outside mainstream Canadian culture adapt their ways and expectations to "fit" those of the health care system. In addition, the ideology of equality revealed in the claim that Medicare provides health care for all, regardless of ethnicity, overlooks the fact that many of our current health care services are inappropriate and inaccessible to people outside of the dominant group (British Columbia, 1991). The assumption of health care for all may, in fact, foster denial of inequities and racism within Canadian health care. Similarly, multiculturalism with its emphasis on diversity and cultural pluralism further reinforces the lack of awareness among mainstream health care policy makers

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[26] I conducted a pilot study in conjunction with a course in advanced methods in qualitative research (N624) in the School of Nursing, UBC in November 1996.

and providers regarding racism within the health care system. Sharing roots in the liberal tradition, the ideology of equality is closely linked to the ideology of individualism that is also pervasive within health care. As Joan Anderson (1996) notes,

> this ideology [of equality] forms the sub-stratum for health care theorizing, and even when it appears that the social context of health and illness is recognized, the ideology of individualism saturates the consciousness of those who are in positions of privilege; that is, there is a deep seated conviction that individuals have equal opportunities, and are equally able to take responsibility for their health. (p. 702)

The ideologies of equality and individualism lead to the assumption of an equal playing field, which is reinforced by Medicare's assertion of equal access to health care, and the understanding of individuals largely independent of their social context (Alonzo, 1993; Anderson & Reimer Kirkham, 1998).

The continued influence of biomedicine[27] within the Canadian health care system carries implications for intergroup dynamics in the provision of health care. Biomedicine has been critiqued for depoliticizing and individualizing ill health, treating the afflicted in isolation from their social, economic, and citizenship context, and thus legitimating structural inequalities and supporting status quo (Ahmad, 1993; Pearson, 1986). Lock (1993) draws our attention to the

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[27] The historical links between *race*, medicine, and ideologies of oppression have been explicated (Ahmad, 1993; Allman, 1992). Ahmad provides the illustration of medicine "naturalizing" slavery by coining diagnostic labels such as drapetomania (the "irrational" and pathological desire of slaves to run away). The notorious U.S. Tuskagee syphilis experiment provides a classic example of how a biological interpretation of *race* rationalized unethical and deleterious research (Allman). Ahmad also notes that biomedicine played a central role in colonialism as an integral tool of colonial foreign policy. Biomedicine kept colonizers healthy and benevolently brought medicines to the "natives". It undermined and often destroyed indigenous systems of health care, creating dependencies that still exist today. The "modernity" of many formerly colonized countries is measured, in part, by the degree to which their health care systems are westernized. Western biomedicine continues as a form of imperialism today, often resulting in inappropriate and expensive health care systems for the rich of these countries and minimal health care for the rest of the population. Similarly, pharmaceutical companies "test" new drugs in developing countries or "dump" outdated medications there.

tendency of health care providers to focus on disease and treatment apart from the personal and social aspects of illness:

> The terms "multiculturalism" and "ethnically sensitive health care" are buzz words in Canada today, and numerous health care providers have voiced concern about resources that are inadequate to deal adequately with the more than 100 ethnic groups represented in the country. However, this concern frequently masks a tendency to think of cultural beliefs as just the frills and trimmings which get in the way of the real business of modern health care, namely the repair of sick bodies....Paying attention to cultural difference can, therefore, be a thin disguise for obtaining compliance -- for learning how, in effect, to coerce patients into doing what one thinks is best for them, while at the same time conserving an intact analytical approach to the body. (p. 141)

In addition to this narrow focus, biomedicine typically maintains its dominance and hegemony by promoting ideologies of neutrality, objectivity and rationality. In so doing, alternative or complementary therapies are marginalized and discredited as "traditional", unscientific, or "folk" medicine. In essence, biomedicine's claim to being value-free and neutral must be replaced with the acknowledgment that it is indeed a political enterprise. A critical stance (as exemplified by critical medical anthropology; see Lock & Gordon, 1988) that reveals the taken-for-granted assumptions and hegemony of biomedicine was important in this study in order to understand the ways in which biomedicine continues to shape intergroup relations in the provision of health care.

In this discussion, I have attempted to demonstrate the demographic, social, political, and ideological context of Canadian health care. While Canada's health care policies state that all Canadians have the right to accessible and equitable health care, Canadians have different health

outcomes and health care experiences, depending on their ethnic, gender, and class identities. Legislation at both federal and provincial levels (e.g., Multiculturalism Act, Canadian Charter of Rights and Freedoms, British Columbia Human Rights Act) calls for the protection of the human rights and equal opportunity for all; yet, a gap exists between the legislated ideal and reality (Anderson & Reimer Kirkham, 1998). Ideologies of homogeneity, equality in health care, and individualism sustain the health care system as racialized, gendered, and classed. The current milieu of health care reform and the continued hegemony of biomedicine also contribute to a complex environment for intergroup health care. In the next section, I review literature that pertains most directly to the actual nature of intergroup relations in health care.

Intergroup Relations in Health Care

In this final section, I focus specifically on intergroup relations in health care and have organized this section around two topics that I believe reflect this topic. First, I review the growing evidence of differences in health outcomes along lines of gender, class, and *race*. Second, I present current literature regarding intergroup health care experiences from the perspectives of clients and nurses.

Health Outcomes

There is mounting evidence regarding differences in health (typically reflected in morbidity and mortality statistics) that fall along class, gender, and *race* lines. Despite the ideology that Medicare provides equal access to health care services and, by corollary, equitable health, the distribution of health and illness in Canada has not been significantly altered by Medicare. Bolaria and Dickinson (1994) explain:

Many of those groups with a history of heightened susceptibility to disease,

disability, and death before medicare was instituted remain in a highly vulnerable position today. In addition, the availability of medical services varies from region to region, and even in areas where medical care is easily available, equalizing health status remains an elusive goal. (p. 200)

In a similar vein, the British Columbia Provincial Health Officer's annual report, *A Report on the Health of British Columbians* (BC Ministry of Health and Ministry Responsible for Seniors, 1995a), acknowledges that although overall health status continues to improve, there are large inequities within the province, between regions and groups within the population.

In Canada, the most obvious example of inequity in health status is that of Aboriginals. The life expectancy of status Indians has always been much lower than that of Canadians in general. The life expectancy for an Indian male is 8.4 years less than a non-Native male and the Indian woman's life expectancy is 7.3 years less than her native counterparts (Health and Welfare Canada, cited in Shah & Dubeski, 1993). Cause-specific mortality rates are significantly higher in the Native population for infectious and parasitic diseases, diabetes mellitus, alcoholic psychosis and alcoholism, pneumonia, kidney disease, accidents and violence. Suicide rates continue to be much higher in Indian populations. Other health problems include anemia, hearing and vision impairment, mental health disorders, anxiety, depression and family violence. Obesity, poor nutrition, smoking, and hypertension are common and are important risk factors for disease (Frideres, 1994; Rootman, 1988; Shah & Dubeski).

Traditionally, victim-blaming has been common in explaining the health status of Aboriginals and health education has been identified as a primary response to deal with the problems. However, this is a simplistic and ineffective approach to the complexities of this issue. Barriers to equitable health range from poverty to inappropriate services to a shortage of

health care providers with cultural awareness and sensitivity toward Native circumstances (Shah & Dubeski, 1993). Shah and Dubeski suggest that

> the shocking differential in life expectancy between Natives and non-Natives
>
> reflects not only socio-economic conditions, lifestyle behaviors, geographical isolation
>
> (and thus lack of access to services), and cultural barriers, but also the impact of our
>
> "Indian" policies, which have created conditions of dependency and loss of cultural
>
> identity. (p. 84)

A problem of accountability exacerbates the entire matter; provision of health services to Aboriginal peoples has been described as a "jurisdictional quagmire between federal, provincial and municipal governments" (Markland & Turnball, 1993, p. 67). Frideres (1994), in a rich discussion of Native health, shows how socioeconomic status, poor living conditions, and political policies of colonialism interact with structures, relationships, and practices at institutional (i.e., a monocultural health care system in which dominant Western biomedicine dismisses traditional models of health) and individual (e.g., health care practitioners who do not understand Native ways) levels to decimate the health of Canada's First Nations people.

While the lesser health status of Aboriginal peoples is well established, the link between ethnicity and health is not as clear for immigrants and people of Colour in Canada. Chen, Ng, and Wilkins (1996), for example, observe that when immigrants arrive in Canada, they are a relatively healthy group. This first observation is not all that surprising, given that individuals in good health are more likely to emigrate and potential immigrants are subject to health screening. Chen, Ng, and Wilkins also found that recent immigrants (less than ten year since arrival), regardless of their country of birth, were healthier than those born in Canada. However, as time in Canada lengthened, the health of immigrants (e.g., the incidence of chronic conditions and

long term disabilities) became to resemble that of other Canadians. Thus, it would appear that the healthy immigrant effect accounted for the relative health of immigrants (D'Arcy, 1998).

However, research in other countries suggests correlations between ethnicity and health (Krieger et.al., 1993) as well as strong evidence regarding the links between class, ethnicity and health. Illness and impairment are positively correlated with low socioeconomic status[28] as confirmed by a substantial body of empirical evidence (Bollini & Siem, 1995; Evans, Barer, & Marmor, 1994; Krieger et. al., 1993; Johnson et. al., 1995; Lillie-Blanton & LaVeist, 1996). People from ethnic minorities are disproportionately represented in the lower socioeconomic status group and thus, we can conclude that their level of illness and impairment is higher than that of the majority population (Bollini & Siem; Funkhauser & Moser, 1990)[29]. Findings such as those by Bassett and Krieger (1986) of diminished black-white differences in breast cancer survival rates when social class, age and other medical predictors of survival were accounted for speak to the intersectionality of class with *race* in determining health outcomes. Nazroo (1998), in his research in Britain, also found ethnic differences in health that were linked to class inequalities.

However, more than biological impairment, common risk factors, and socioeconomic status must be taken into an equation of morbidity and mortality rates. Krieger et. al. (1993), present a study which found that among people 35 to 54 years old, the overall black mortality rate was 2.3 times higher than the white mortality rate. Only 31% of this excess mortality could be attributed to the six major risk factors linked to excess black mortality (smoking, blood

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[28] The widely used indicators of socioeconomic status, income, education, and occupation, are imperfect proxies for the general concept of social environment (Johnson et. al., 1995). These indicators are not equivalent across ethnic groups. For example, Whites receive higher income returns on education than do Chinese, Greeks, and Blacks (Li, 1988). A given level of income may provide less purchasing power for people of Colour.

[29] Women are also disproportionately represented in the lower income brackets. In 1991, 17% of women in British Columbia had incomes below the Statistics Canada low income cut-off point (referred to as the "poverty line")

pressure, cholesterol level, body mass index, alcohol consumption, and diabetes). Another 38%

was attributable to family income but the remaining 31% was unexplained. The authors

postulate that the everyday realities of racism, sexism, and social class help explain such poorly

understood racial/ethnic disparities in health. Recent research holds that the social relations of

race, gender, and class are determinants of health and disease through four principal pathways:

(1) by shaping exposure and susceptibility to risk factors, events, and processes;

(2) by shaping exposure and susceptibility to protective factors, events, and processes;

(3) by shaping access to, and type of, health care received; and

(4) by shaping health research and health policy. (Krieger et. al., p. 100)

Krieger et. al., go on to explain that factors that increase susceptibility stem from the interplay of

material, psychosocial, and biological conditions and "get into the body" by a variety of routes

such as direct physiologic or genetic damage and physiologic responses to stress (mediated by

immunologic, hormonal, or neurologic mechanisms). Examples are far ranging:

- exposure of migrant farm laborers to harmful chemicals while working long hours, living in

  poor, crowded conditions (e.g., without drinking water or toilet facilities), and not speaking

  English (Bolaria & Bolaria, 1994);

- phenylketonuria, a rare condition affecting Caucasians, is routinely screened for in all

  newborns (regardless of race), implying that diseases such as sickle cell anemia would be

  routinely screened if they affected the majority population (Anionwu, 1993; French, 1992);

- the higher incidence of schizophrenia among Afro-Caribbeans in England has been well

  documented (Farrington, 1993; French, 1992; Rasool, 1995; Vousden, 1987). While similar

  statistics are not available in Canada, western psychiatry has clearly developed as a highly

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compared to 14% men (BC Ministry of Health and Ministry Responsible for Seniors, 1995a). It follows that women
of Colour are especially vulnerable to poverty and therefore poorer health outcomes.

ethnocentric discipline with a very limited perspective that has successfully marginalized, and in some cases completely ignored, the presence of other types of culture, especially ethnic minorities (Farrington);

- health providers may discriminate against patients of Colour by treating them less aggressively, resulting in poorer health outcomes. Documented differences in treatment provided relate to ischemic heart disease (angiograms, coronary artery bypasses), bladder cancer, pneumonia, and kidney disease (King, 1996; Krieger, et. al., 1993; Kjellstrand, 1988; Mayer & McWorter, 1989; Wenneker & Epstein, 1989; Yergen, Flood, LoGerfo, & Diehr, 1987).

- poorer birth outcomes (reflected in infant mortality rates) for black women exist at every economic position and education level, suggesting that racism is a factor (Green, 1995; Krieger et. al., 1993).

- there is evidence of a positive association between the experience of racial discrimination and high blood pressure among Black women. Those who respond actively to unfair treatment were less likely to report high blood pressure than Black women who internalized their responses. (Krieger, 1990).

- perceived racism and reports of maltreatment due to race affect self-reports of mental and physical health (Jackson et. al., 1996).

From this overview, we can conclude that people of Colour tend to suffer poorer health outcomes than White people. Both structural forces (e.g., higher incidence of poverty among people of Colour; exposure to dangerous working conditions) and individual actions (e.g., racism by health care professionals prescribing treatment) contribute to these outcomes (LaVeist, 1996).

Moreover, though less documented, disadvantages on the basis of class and gender interact with those of *race* to amplify health differentials.

Health Care Experiences

This evidence of uneven health outcomes among ethnic/racial minorities is compounded by indictments of monocultural, disease-oriented, technology-driven health care institutions (e.g., hospitals and clinics) and marginalizing practices along the lines of *race*, class and gender by health care providers. A closer look at health care provision reveals a web of policies, procedures, and individual attitudes that result in less favorable treatment for patients of Colour.

While literature regarding racism in American, British, and Australian health care is readily available (Bowes & Domokos, 1993, 1996; Bowler, 1993; Connell, 1989; Curtin, 1994; Funkhauser & Moser, 1990; George, 1994; Howie, 1988; Keene, 1988; McGee, 1993; Murrell, Smith, Gill, & Oxley, 1996; Pearson, 1987, 1989; Todd, 1989; Torkington, 1986), less has been written about racism in Canadian health care settings. This silence is likely due to a combination of several factors: the subtle nature of Canadian racism that makes it less visible [i.e., what Henry et. al., (1995) refers to as "democratic racism"]; a general avoidance of this term in the literature (e.g., racism may be referred to as prejudice, stereotyping, or discrimination); and a colour-blind approach where *race* is conflated with cultural differences, and therefore inequities are never acknowledged. Nonetheless, there is a small but growing body of Canadian health care literature that deals with issues such as racialization and racism, marginalization, and oppressions.

The Institutional Context

The provision of intergroup care requires respect and flexibility; yet, our health care institutions are not known for their flexibility or adaptability. Instead, hospitals usually represent

values of efficiency and routinization (Kavanagh & Kennedy, 1992). Chrisman (1982) notes that nurses are less likely to deal with a patient's community and social life because of characteristics of hospital settings such as very sick patients, a highly technological environment, and the primacy of the biomedical physician-oriented subculture. Thus, while nurses may be less attuned to cultural issues in these settings, the very nature of the hospital itself with its bureaucracies, values of efficiency and routinization, and allegiance to biomedicine, contributes to the marginalization and racialization of clients of Colour. Susan Sherwin (1992) notes that health care institutions not only mirror the power and privilege structures of the larger society, but they also perpetuate them. She reminds us of the racialized stratification of most hospitals:

> working class and minority employees are concentrated in the nonprofessional
>
> ranks of cleaners, nurses' aides, orderlies, kitchen staff, and so forth....They have no
>
> opportunity to shape health care policy or voice their concerns about their own health
>
> needs or those of persons for whom they are responsible. (p. 229)

Sherwin also points to how services are designed to meet the typical needs of a White, middle-class community. For instance, hospital menus reflect the dietary preferences of the mainstream North American society. Child care facilities are seldom provided as health resources. French (1992) suggests that institutional racism exists when institutions are not geared to meet people's needs and when a uniform culture is assumed. Racism may operate by "default" where an institution adheres to traditional methods and ignores the multiracial and multicultural nature of the society it is called to serve. This "default" may be seen as an accidental by-product of administrative inertia associated with large organizations. However, Torkington (1986) maintains that when recognizing such inertia, administrative systems must not be seen as inhuman bureaucracies. They are run by individuals and therefore the rapidity or the

sluggishness with which those systems adapt is indicative of the attitude held by the administrators controlling them. If ethnic minorities are not regarded as an integrated and legitimate part of society, it is unlikely that administrators will adapt the systems to meet their needs. Therefore, at closer examination, what is initially seen as "default" or unintentional racism by institutions may indeed be informed and influenced by a prevalent collective consciousness (Torkington). Patel (1993) extends this discussion by identifying common expressions of institutional racism in health services: monoculturalism and the rigid application of rules; cultural accommodation/cultural pluralism where services such as interpreters are "add-ons" that continue to marginalize clients from linguistic backgrounds other than English or French; and direct racism in employment and services.

Inadequate and Inappropriate Services

Several Canadian examples can be cited as indicative of inadequate or inappropriate services. In Anderson's research program with immigrant women and families (Anderson, 1986, 1987, 1991a; Anderson, Blue, & Lau, 1991; Anderson, Elfert, & Lai, 1989), she relates how organizational practices of the health care system exclude immigrant families as participants in the caretaking process. These women are often in a low occupational status, without labour market protection. To seek out health care services during the hours when a clinic is open may mean taking time off work without pay; yet many cannot afford this loss of pay or may fear losing their jobs. Furthermore, they may be required to bring their own interpreter who must also take time off work. These experiences point to the monocultural nature of the health care system that excludes those who cannot communicate in English and are in the lower ranks of the workforce. In a study exploring refugee claimants' experiences accessing health care in British Columbia, Beaupre (1993) found that difficulties were encountered in response to social,

political, and economic factors. Situations perceived by participants as discriminatory, which occurred in a number of different settings, resulted in the participants feeling inferior and marginalized. The Report of the British Columbia Royal Commission on Health Care and Costs (*Closer to Home Report*, British Columbia, 1991) also points to difficulties in immigrants receiving satisfactory health care. Immigrants are not used to the kinds of services here and may have difficulty learning about them through their traditional networks of communication. Once they have access to a particular service, "their comfort level is usually low because of the way they are treated" (p.C-36). In considering the issue of access to health services, McGee (1993) states that clients from ethnocultural communities have less access because they are referred less frequently. Further, immigrants may have unique health care needs for which services are not readily available; for example, refugees may have a need for mental health support due to post-traumatic stress resulting from torture and persecution.

Several Canadian studies (Lo & Lee, 1993; Peters, 1993) revealed that, as in the United States, immigrants and refugees under-utilize mental health services, despite evidence that they experience a significant level of emotional distress. Lack of understanding or a fear of mental health issues and the health delivery system may discourage these clients from seeking help. When clients and their families encounter mental health professionals, linguistic and cultural barriers often interfere with the diagnosis and treatment, which may lead to poor compliance, treatment failure, and resistance to seeking help again (Lo & Lee). As specific mental health programs for immigrant populations have been developed in Toronto and Vancouver, there has been a significant increase in the utilization of mental health services by the groups they serve (Lo & Lee, Peters).

Seniors who are immigrants are particularly vulnerable to racism. Issues affecting the lives of immigrant seniors include socioeconomic status, resettlement, loss of independence, communication, and emotional or mental well-being (Masi & Disman, 1994). Masi and Disman also report immigrant seniors have more difficulties effectively accessing and using health care services. The report by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, *After the Door has Opened,* (1988) found that immigrant seniors utilized the services of general practitioners considerably more often and for a wider range of needs, including counseling needs. They were, however, less likely to complete a sequence of care. This pattern of utilization suggests that the health care services did not satisfy the needs of the immigrant seniors. Researchers studying communication patterns between nursing staff and the elderly in a British Columbia long-term care facility found that immigrant female residents were spoken to less than any other residents (Jones & Van Amelsvoort Jones, 1986). These examples point to the ethnic aged as likely victims of both individual and institutional racism.

From these illustrations, we see that racism may be subtly institutionalized in services that do not recognize non-dominant perspectives. Patients of Colour may be described as having "special needs" or "problems" that can be met by minor adaptations to the system (e.g., a slight revision of the weekly menu). However, as Pearson (1989) observes, such solutions marginalize patients of Colour and define their experience as "abnormal", outside the range of mainstream health care experience. Furthermore, deeply rooted power relations, inequitable structures, and sustaining ideologies remain uncovered by these superficial changes.

Racialized Provider-Patient Encounters

Canadian literature also speaks to the racialized nature of health care encounters at the provider-recipient level. In a qualitative study with recently graduated nurses, the influence of

the social construct of *race* on both clients and health care providers was obvious (Reimer, 1995;

Reimer Kirkham, 1998). Nurses recounted stories of racism at individual and institutional levels.

Nurses held varying degrees of commitment to cross-cultural nursing, ranging from being

resistant to competent to impassioned. The provision of culturally relevant care was dependent

on the nurse's level of commitment to cross-cultural nursing, as well as on contextual factors

such as the institutional setting, colleagues' support, and education. Browne (1995), in

qualitative study exploring the meaning of respect from the perspective of five Cree-Ojibway

participants, cited discriminatory attitudes, prejudice, and stereotyping that were expressed in

failure to consider the patient's perspective, failure to provide privacy, failure to provide

adequate explanations, and negative nonverbal behaviors. O'Neill (1989), in his research with

Inuits, reported assimilationist health care policies, and provider-recipient interactions where the

White health care providers maternalized and treated patients as children, trivialized those

aspects of patients' culture not easily understood (e.g., drum dances), and bracketed out

sociopolitical cues offered by patients (e.g., complaints about poor housing). In a study

conducted in Calgary, Chugh et. al. (1993) reported racism perceived by immigrants seeking

health care from their physicians. Varcoe (1997a), in her ethnographic study of nurses' response

to women who have been abused, found that nurses pauperized and racialized violence. Susan

Sherwin (1992) criticizes the paternalistic and patronizing attitudes often displayed by White

physicians and nurses toward minority patients:

> If patients do not follow "orders", then they are described as noncompliant and
>
> are treated with anger and hostility; even if the reason for failure was that there
>
> was a breakdown in communications, that the patient could not afford the drug
>
> prescribed, that the patient could not be excused from work for the follow-up tests,

that the patient had to skip an appointment to care for a sick child, or that the patient's exam was scheduled on a day that the patient's religion declares sacred. Without a more diverse group of health care providers at all levels of the system, such misunderstandings may be difficult to detect and will be virtually impossible to eradicate. (p. 233)

There is thus a growing body of Canadian literature that speaks to racialized encounters within health care settings.

The Standpoints of Nurses

A final aspect of understanding intergroup relations and health care experiences comes from the perspectives (or standpoints) of nurses. Most of the literature reviewed assumes that the recipient of health care is a person of Colour and that the health care providers are White. This, however, does not account for the experiences of nurses (and other health care providers) of Colour who endure marginalization and racialization within the health care system from both clients and colleagues. Once again, more has been written about racism within nursing in the United States (Barbee, 1993; Greer, 1995; Vaughan, 1997), England (Beishon, 1997; George, 1994; Pearson, 1987), and Australia (Jackson, D., 1996). However, several Canadian sources begin to document the experiences of nurses of Colour. In a report of a forum held by a small group of nurses in Ontario to address racism, Farr (1991) describes the participants' feelings:

the hurt that comes with overhearing racial slurs, even unintended ones, from patients and other staff in the workplace; the frustration of promotions denied for no apparent reason; the anger that inevitably builds with suspicions (difficult to prove but undeniable nevertheless) that in many complex ways, not having white skin, and speaking English with a foreign accent, can make it harder to get ahead. (p. 9)

Das Gupta (1996a, 1996b) draws on historical documents, anecdotal reports, and her own qualitative interviews to sketch consistent patterns of covert and overt forms of racism faced by Black nurses in Ontario. Everyday racism in the form of scapegoating, excessive monitoring, and infantalization (through condescension, belittling, etc.) accompanied the racism of the employment systems of hospitals. Nurses of Colour were less likely to be promoted and were over-represented in "heavier" units considered as less desirable places to work. These findings add to the picture of intergroup relations within health care settings.

Finally, the general descriptions of nurses (both White and nurses of Colour) regarding their experiences in providing intergroup care need to be considered. The limited number of research studies exploring nurses' perceptions of working with patients of Colour have revealed some valuable information. Nurses report a lack of confidence in caring for patients of Colour (Bernal & Froman, 1987, 1992) and frustration, often due to communication barriers (Bernal, Pardue, & Kramer, 1990; Kubricht & Clark, 1982; Murphy & Clark, 1993; Pauwels, 1990; Reimer, 1995). Several studies have cited the importance of contextual factors (e.g., the work environment, lack of resources, excessive bureaucracy, and negative stereotypes by others) in shaping the experience of caring for patients of Colour (Bernal, Pardue, & Kramer; Reimer). Furthermore, most studies note that nurses do not feel that their nursing education prepared them to meet the needs of patients of Colour (Bernal & Froman, 1987; Murphy & Clark; Reimer). The studies reviewed all focus on the interpersonal level of health care provision to patients of Colour. As a result, there is a profound gap in nursing knowledge pertaining to the ways in which intergroup health care provision is socially organized.

Summary of State of Knowledge

The problem providing general direction for this review of existing knowledge was that of uncovering the social processes and practices that structure intergroup relations in health care provision. Basically, this is a question of "how it works" (Smith, 1987), bringing together the local encounters between health care providers and patients of Colour with the social environment in which health care provision occurs. The theoretical and empirical literature reviewed suggests that there are larger structures, processes, and ideologies that work together to configure the day-to-day world of health care provision. One such a macro structure is the nation state of Canada, which has been constructed as a White nation. Through the nation's policies (e.g., immigration, multiculturalism), people of Colour, especially those in lower classes, are effectively marginalized and constructed as Other. Public discourses regarding the "problem of immigration" carry racist tones concerned with any disruption of status quo. Monocultural health care agencies, operating within a biomedical framework, reflect and maintain the interests of dominant groups. Processes such as health care reform succumb to the capitalist notion of efficiency at the expense of equitable health care services and contribute to the widespread impression that expansion of programs such as interpretive services are "frills" that cannot be afforded. Nurses are practicing in very difficult situations, working harder with fewer resources and little influence, leaving them little time or energy to attend to the distinct needs of patients of Colour. While they recognize some of the contextual constraints on their practice, nurses are more likely to see the challenge of intergroup health care provision at the individual, immediate level, concerned with cultural preferences, language barriers, and the like. Ideologies of homogeneity, individualism and egalitarianism operate in commonsense ways to leave current inequities invisible to those in dominant groups. Thus, inequities in health outcomes and

marginalizing health care practices continue, often unquestioned by nurses and other health care providers who most typically proceed from a culturalist stance.

I have "pieced together" this picture of intergroup relations in health care, drawing on a breadth of literature. As such, it provides a general map of the terrain with few details of how intergroup relations are actually organized. Based on this review, several conclusions can be reached and key gaps in our collective knowledge can be identified. First, from this piecing together of existing knowledge, it seems that marginalization, racialization, and racism are "everyday realities" that structure intergroup relations. Yet, most theoretical constructs and research methodologies within nursing and health care sciences do not access these everyday realities. I agree with Ahmad (1993) who, after reviewing inadequate approaches that either ignore *race*, take a culturalist perspective, or reify *race* as a measurable variable, concludes that "we need a radicalized and politicized field of *race* and health" (p. 31). Thus, the first directive I took from this literature review was the need for research employing critical theoretical frameworks and strategies that uncover everyday realities that have gone unseen for so long.

Second, there is now a consensus within existing scholarly work that an acontextual approach to the study of health and health care issues is no longer acceptable. The individualistic bent of health care policies, biomedicine, and nursing theories have made deep rooted inequities invisible. When social relations are understood as grounded in Western ideology built upon values that "encourage an aggressive exploitation of nature and the domination of women by men, of 'Orientals' by Westerners, and of the general citizenry by the values of a masculinist elite" (Grace et. al., 1998, p. 10), new understandings of health and health care issues become possible. Thus, research and theory must take into account the ways in which relations of power, ideologies, and societal structures shape health and health care

experiences. Specifically, research is needed in order to unravel the complex influence of such broader factors on the health care experiences of clients of Colour.

Third, while there are a growing number of references to racism in Canadian society in general and in health care in particular, the mechanisms of racism remain vague and unspecified. Here I cite Stubbs' (1993) caution against invoking "racism" as a catch-all category with no analytical value. Rather, the processes through which *race* is operationalized must be clearly demonstrated. In addition, the historical and social specificity of racisms means we need an ongoing investigation as they "mutate" (like bacteria disguising themselves to avoid extermination by the latest antibiotic) and a broad "take" that sees the social construction of *race* as ubiquitous, influencing all of health care provision. The need to study the processes whereby *race* is operationalized within health care encompasses several other gaps identified within this review. The construction of racial identities is a relatively new area of study and has not yet been addressed within health care settings. Also, it is clear that hospital settings shape intergroup relations in significant ways but, once again, the processes, policies, structures, and relationships that contribute to inequitable care have not been systematically studied in Canada. As Stubbs claims, "There is clearly a need for more research and published material examining institutional racism in health care provision" (1993, p. 37).

In the next chapter, I outline the theoretical and methodological perspectives that provided me with an interpretive lens for this study. The theoretical perspectives that were selected were influenced in large part by this review of the state of existing knowledge.

CHAPTER THREE:

THEORETICAL AND METHODOLOGICAL FRAMEWORK

Introduction

In the preceding chapters, I explained the background to the study and summarized the

current state of knowledge regarding the social organization of intergroup relations in health

care. In particular, the review of the state of knowledge prompted me to consider what

interpretive lens[30] might best inform me in this effort to explicate the social organization of

intergroup relations in health care provision. I maintain that much nursing (and health) research

to-date has been ill equipped to uncover processes of racialization, marginalization, privilege,

and oppression within pluralistic health care settings, often because of inadequate theoretical

foundations. To address these previous shortcomings, theoretical perspectives were needed that

contributed to an analysis of social relations in the larger sense. Specifically, I drew on the

traditions of postcolonialism, feminisms, intergroup relations, and standpoint theory in this study

because of their explanatory power. In this chapter, I outline the contribution of the theories

underpinning the research. This theoretical foundation shaped, to a considerable degree, the type

of methodological considerations[31] that preceded the study, and also arose in the process of

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[30] I use "interpretive lens" to refer to those intellectual perspectives that influence and collectively organize my approach to knowledge construction. Along with theoretical and empirical understandings, one's interpretive lens is also shaped by one's ontology, epistemology, and social identity. The ontology from which I proceed with this research project is that of critical, material realism, believing that while local meanings are important, they are ultimately embedded in larger societal meanings. Thus, reality is local and contextual but is shaped by social, political, cultural, economic, ethnic, and gender values (Guba & Lincoln, 1994). Epistemologically, I believe that intersubjectivity is inevitable in research and must be acknowledged. Both the researcher and the researched shape what knowledge is constructed. Further, multiple voices are important in knowledge construction in order to achieve accurate representations of the phenomenon under study. Yet, I do not believe that all knowledge is local or subjective -- there are certain shared realities and common meanings that transcend the individual and the context. My social identity as a White, Mennonite, middle-class, heterosexual, educated woman also contributed to how I framed this study.

[31] I understand the distinction between theory and methodology as primarily that of the level of abstraction one is working in. Methodology thus is the application of theory to research. Sandra Harding's (cited in Henderson, 1995) offers further clarification with her distinction between methodology and method. Methodology is defined as "a

research. Therefore, this chapter concludes with a discussion of these methodological issues in which I integrate examples regarding how my social identity contributed to my interpretive lens.

In outlining this interpretive lens, I acknowledge the dialectic between theory and research. Patti Lather (1991) speaks to this reciprocal relationship between data and theory, "data must be allowed to generate propositions in a dialectical manner that permits use of *a priori* theoretical frameworks, but which keeps a particular framework from becoming the container into which the data must be poured" (p. 62). My task was to use theory to bring a focus to this study, or an "angle of practice" as Thompson (1991, p. 34) says, while striving for an openness in my approach to the data. At the same time, I recognized that my interpretive lens might predispose me to look for certain aspects and away from others. To illustrate, while I reviewed theory regarding *race* and racism as part of the literature review for this study, and cited studies that describe racism within Canadian health care settings, I *backgrounded*, rather than *foregrounded* this theory, and drew upon it reflexively.

Theoretical Lens: Analyzing Social Relations

It is not uncommon for researchers within the critical paradigm to use a variety of theories that both complement and contradict each other, perhaps because of the interdisciplinary nature of traditions such as feminism and postcolonialism. In this study, I chose these theories deliberately for what each of them offered, aware of the ways in which the theories balance and challenge each other. In this sense, there was a certain pragmatism to my decision. Goldberg (1993) asserts the need for a "pragmatics of praxis", pulling on those theories that assist in resistance to oppression. Despite differences (e.g., in origins) between the theories of intergroup relations, feminisms, postcolonialism, and standpoint theory, I maintain that they are connected

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theory and analysis of how research does or should proceed", and method as "a technique for gathering evidence" (p. 59). Thus, methodology blends theoretical, philosophical, and practical matters.

in a larger sense as metatheory, in that they are all concerned with <u>analysis of social relations,</u>

particularly in understanding individual experience within the context of broader social relations.

In so doing, I draw on Jane Flax's (1990) idea of metatheory as inclusive categories that

transcend more specific theories.

Postcolonialism

Postcolonial theories offer insight into the processes and consequences of racialization.

Postcolonialism refers to the theoretical and empirical work that centralize the issues stemming

from colonial relations and their aftermath (Cashmore, 1996). Its concern extends to the

experiences of people descended from the inhabitants of those territories and their experiences

within "first world" colonial powers. The works of scholars such as Frantz Fanon, Gayatri

Spivak, Stuart Hall, Homi Bhabha, bell hooks, and Patricia Hill Collins were crucial in informing

my thinking in this study. These writers offer powerful analyses of *race* politics, critiquing

mainstream scholarship and practice. Black feminist intellectuals like bell hooks carry the joint

agenda of challenging racist and sexist oppressions. Drawing on the scholarship of people of

Colour offered a partial way of addressing the limitations of my own middle-class White

standpoint. Hurtado and Stewart (1997) explain: "One technique for addressing the limitations

of one's own standpoint is actively to seek out literature written from other standpoints" (p. 309).

They go on to encourage White scholars to "walk in others' shoes" by reading, taking seriously,

citing, and quoting the scholarship by people of Colour about *race*. By way of caveat, in

drawing on postcolonial works, I was also aware of the danger of appropriating postcolonialism

into Western, White academy and thereby participating in a trend that makes postcolonialism

less resistive.

Feminisms

Because of the intersectionality of oppressions, feminist theories provided me with further analytic tools to understand how gender oppressions interact with *race*. The many varieties of feminisms (e.g., material, social, cultural, liberal) share critique as their primary mode of scholarship (DeMarco, Campbell, & Wuest. 1993; Reinharz, 1992). As such, feminisms challenge prevailing power structures and patriarchal assumptions and seek to improve the lot of marginalized groups (most often women, but also extending to other groups such as disabled, gay and lesbians, people of Colour). Further, "one of the strengths of feminist critique is that it presents a model by which bias can be uncovered in a scholarly manner without rancor but with both urgency and compassion" (DeMarco et. al., 1993, p. 30). It is these characteristic features of feminisms that I drew on in this study. As well, I took direction from feminist research methodology (discussed in more detail later on) and aligned myself with the growing cadre of nurse scholars who are applying feminist theory to their work (e.g., Allen, 1996a; Anderson, 1989,1991b; Campbell & Bunting, 1991; DeMarco et. al., 1993; Hall & Stevens, 1991; Henderson, 1995; 1997; Wheeler & Chinn, 1991).

Intergroup Relations

I also drew on the construct of intergroup relations to stress that human behavior is contingent on more than interpersonal matters. Intergroup relations as theory has origins in social psychology[32], which is the study of individual behavior in social contexts. As explained by Taylor and Moghaddam (1987), "the unique perspective of social psychology in the intergroup context is that the perceptions, motivations, feelings, and overt actions of individuals

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[32] Social psychology began in the 1940s with the work of Kurt Lewin. Gordon Allport, with his book entitled *The Nature of Prejudice* published in 1954 was influential in the beginnings of theory on intergroup relations (Worchel & Austin, 1986).

are studied to identify how they influence, and are affected by, relations between groups" (p. 3).

These authors define intergroup relations as "any aspect of human interaction that involves

individuals perceiving themselves as members of a social category, or being perceived by others

as belonging to a social category" (Taylor & Moghaddam, p. 6). Other scholars in the area of

race and ethnic studies have drawn on this concept for the reason that its emphasis fixes attention

on the wider context in which developments in collective behavior take place (e.g., Elliott &

Fleras, 1992; Frideres, 1989). Neither the description of minority groups/cultures, nor the

examination of individual beliefs and actions are the primary focus of intergroup relations.

Elliott and Fleras explain the merits of an intergroup relations approach this way:

> Unlike approaches that deal with attitudes, beliefs, or intersubjective experiences,
>
> we prefer to emphasize human behavior as group activity embedded within political,
>
> economic, social, and cultural contexts. This allows us to zero in on the social forces
>
> of power, domination, and inequality that pervade and define intergroup processes. (p. 4)

In essence, such an approach recognizes that social life is a web of intergroup relations rather

than interpersonal relations. Importantly, while my primary interest in this study was grouping

according to *race*, intergroup theory accounted for the ways in which people may be grouped

along various axes (e.g., class, *race*, gender, age, sexual orientation, and so on), thus prompting

me to consider the intersectionality of oppressions. As well, drawing on intergroup theory in this

study facilitated bridging what might otherwise be two different levels of analysis: individual-

oriented positions (i.e., individual cognition, emotion, and behavior) and society-oriented

perspectives (i.e., group-based phenomena). This bridging occurred as I considered individuals

acting as <u>group members</u> rather than simply acting as <u>individuals</u> (Brown, 1995).

<u>Standpoint Theory</u>

This linking between the individual and the social was further expedited by the

application of Dorothy E. Smith's (1987) standpoint theory[33]. Smith explains,

> Beginning from the standpoint of women locates a subject who begins in a material
>
> and local world. It shows the different cognitive domains structuring our realities, not...
>
> as alternatives -- a paramount reality on the one hand and the scientific domain on the
>
> other -- but rather as a bifurcation of consciousness, with a world directly experienced
>
> from oneself as center (in the body) on the one hand and a world organized in the
>
> abstracted conceptual mode, external to the local and particular places of one's bodily
>
> existence. The abstracted mode of scientific province is always located in the local and
>
> material actualities. (p. 84)

In her critique of traditional sociology, Smith has developed a method of inquiry, known as

institutional ethnography, that has as its "fulcrum" the "standpoint of the subject" (1987, p. 105).

The point of entry in this type of inquiry becomes the everyday world and links the particular

setting and experiences "to the generalized and generalizing relations of the apparatus of ruling

and of the economy" (1987, p.147). To begin with the everyday world acknowledges the

socially constructed nature of knowledge and experience. "The only way of knowing a socially

constructed world is knowing it from within. We can never stand outside it" (Smith, 1990, p.

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[33] Other standpoint theorists include Nancy Hartsock (1983), Sandra Harding (1991), and Patricia Hill Collins (1990). All argue that one's positionality as a woman is crucial in gaining understanding of other women (Wolf, D., 1996). With the raised awareness of diversity within the category of 'woman' and due to criticisms of essentialism, "standpoint" has often been changed to "standpoints" since there is clearly no single standpoint for women of diverse class and ethnic backgrounds. Standpoint theory has been challenged for purporting epistemic privilege (e.g., "it takes one to know one") (Wolf, D., p. 13) with the possible outcome of implying that one group's perspective is more real or better than others and that "the greater the oppression, the greater one's potential knowledge (Wolf, M., 1996). Dorothy Smith distinguishes her conceptualization of standpoint from that of other theorists, and emphasizes that the standpoint of women "situates inquiry in the actualities of people's living, beginning with their experience of living, and understands that inquiry and its product are in and of the same

22). The entry point of research, thus, is the standpoint of study participants, including the organization of their work and practical reasoning. An explication of the rich details of the everyday world maintains the agency of people and avoids objectifying their experience. At the same time, Smith's notion of standpoint does not privilege the knower (as in epistemic privilege) but instead emphasizes the socially organized nature of knowledge. "Since knowledge is essentially socially organized, it can never be an act or an attribute of individual consciousness" (Smith, 1992, p. 91). Smith points out that such a beginning point in the everyday is in contrast to research practices beginning with concepts, theories, or text-mediated discourses that tend to obscure individuals as active agents. Yet, unlike traditional interpretive ethnographies, because social relations of the everyday extend beyond the boundaries of one's experience, analysis is not confined to the everyday[34]. Rather, everyday experiences are a source of questions (a "problematic") that focus and guide the inquiry to an analysis of how those experiences place participants into local social relations, and how they are shaped by social processes and practices happening beyond those immediate experiences. As explained by Marie Campbell,

> the intent is not to understand "experience" in a way that celebrates "subjectivity"
>
> (or claims to get at meaning and intentions of individuals), but rather to understand
>
> everyday experience....reflexively....we need to see how experience is (or is shaped
>
> up to be) inextricably bound to regimes of ruling. (Campbell & Manicom, 1995, p. 9)

Smith refers to this linkage between the everyday world and the larger social relations as "looking up" (Smith & Campbell, 1998). The analysis beginning from the standpoint of the

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actuality" (Smith, 1992, p. 90). [See Smith for a detailed discussion of the distinctiveness of her conception of "standpoint"].

[34] Traditional ethnography has been criticized for having a static, reified notion of culture (Whittaker, 1992, 1994) and a non-materialist approach that overlooks the larger material forces of society (e.g., patriarchy, racism, classism, sexism, capitalism) (Quantz, 1992; Thomas, 1993). As a result, the focus remains a narrow description of a particular culture, as if isolated from the broader socioeconomic and political context. Notably, critical ethnography

everyday and moving to larger social relations does not proceed by making "mystical connections" (Smith, 1990, p. 49) between the "micro" organization of the local to the "macro" organization of institutions. Instead, the pre-existing connections between the everyday and the broader social constructs are uncovered through careful analysis. Those relations that are present but not immediately visible because of ideological distortions or taken-for-grantedness of everyday experience. In sum, institutional ethnography aims to explicate the actual, though often invisible, social processes and practices that organize[35] people's everyday experience from a standpoint in the everyday world.

The terms "institutional" and "ethnography" are used deliberately by Smith. "Institutional" refers to a "complex of relations forming part of the ruling apparatus, organized around a distinctive function" (Smith, 1987, p. 160) such as education, health care, or law. Institutions are not a distinct social organization, but rather an intersection of various modes of social relations (e.g., state agencies, professional organizations, discourses, and bureaucracies) in a functional complex and mediated by ideologies. The term "ethnography" evidences a commitment to an in-depth exploration beginning with people's lived experiences. In short, "ethnography" directs us to show "how 'it' works" (Smith, p. 160). The combination of the terms "institutional" and "ethnography" implies the need to move beyond the particular to an

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has addressed many of these shortcomings as it aims to critically analyze and identify existing hegemony, and to act in response.

[35] Smith makes an important clarification regarding the <u>organizing</u> nature of these social processes and practices (i.e., the "apparatus of ruling") as opposed to seeing them as <u>determining</u> social processes and practices. This distinction maintains the agency of individuals.

explication of the intersection of local practices to practices beyond immediate experience (Travers, 1996). By constituting the everyday world as problematic, that is, by dispelling the "taken-for-granted" nature of experience, researchers gain access to the possibility of explicating how institutional processes are embodied in peoples' everyday experiences.

Summary

These theories worked together to assist me in the analysis of social relations, particularly in connecting individual experience to the larger context in order to understand how everyday life is organized. When viewed collectively, these theories offered insight into the conceptually difficult notion of intersectionality, showing how gender, *race*, and class operate simultaneously to marginalize some and privilege others. They also focused attention on concepts such as relations of power, *race,* and culture, intersubjective knowledge construction, and possibilities for social change. As the study progressed, I refined the theoretical framework somewhat, especially as I realized, in practice, the shortcomings of certain perspectives. For example, I raised for questioning the "fit" of the theory of intergroup relations when I realized how it pushed me to categorize participants into pre-existing and distinct groups. (This dilemma is discussed in more detail in Chapter Eight). I continue now with a consideration of several methodological matters raised by these theoretical perspectives that provided direction for this study.

Methodological Matters: Power, Knowledge, and Praxis

This study, an institutional ethnography, is situated within the realm of qualitative

research with its assumptions[36] and, more specifically, critical inquiry with its methodological

challenges. This section begins with an introduction of the methodological themes that pervaded

all aspects and phases of the research (and are reflected throughout this report). In the following

chapter, I translate these methodological principles into the practical domain of "how I did it", or

the research design. In preparing for this study, I anticipated what methodological themes might

most logically derive from the particular theoretical framework shaping the study and might be

most pertinent to this study. The themes I focused on were attention to relations of power,

intersubjective construction of knowledge, and a praxis orientation. Interestingly, these selected

themes proved foundational to this project, but not always in the ways I had anticipated!

Furthermore, my earlier thinking about these three themes was at a fairly theoretical level as I

drew on a variety of theoretical and empirical literature. Now, as I "write up" the project, my

understanding of these methodological issues has shifted to more of an applied level and, in

order to reflect how these methodological principles worked out in practice, I am integrating

some of the discussion regarding methodology in the following chapter on research design and

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[36] As qualitative research has gained acceptance and credibility in the scientific community, its assumptions have
become generally agreed upon and familiar. I outline them here briefly, drawing on Lincoln and Guba's (1985, p.
39) method of naturalistic inquiry:
- Research is carried out in natural settings.
- The researcher is the primary data-gathering instrument.
- Tacit knowledge is recognized.
- Qualitative methods are preferred.
- Purposive sampling is employed.
- Inductive analysis identifies multiple realities in the data.
- The guiding substantive theory is grounded in the data.
- The research design is allowed to emerge.
- Meanings and interpretations are negotiated with participants.
- Reports are often in case study format.
- Data tends to be interpreted in terms of particulars rather than generalizations.
- Findings are tentatively applied.
- The investigation is bounded by the emergent focus of the study.

methods. However, I briefly outline the themes of power, intersubjectivity, and praxis here in order to provide further introduction to the project.

Attending to Relations of Power

Attention to power dynamics within research is a central feature of critical inquiry. In response to the assumed neutrality of researcher-researched relationships within traditional paradigms, both critical and feminist researchers have problematized these relationships, alerting us to the ways in which the researched may be exploited or Othered. For example, Diane Wolf, in her introduction to Feminist Dilemmas in Fieldwork, notes that "the most central dilemma for contemporary feminists in fieldwork, from which other contradictions derive, is power and the unequal hierarchies or levels of control that are often maintained, perpetuated, created, and re-created during and after field research" (1996, p. 2). This study revealed, however, the shortcoming of conceptualizing power as fixed within the position of researcher or absent within the position of researched. Such constructions of power did not account for the resistances and agency of the researched, for the influence of the clinical settings of the research, and for the ways in which gender, *race*, and class shaped the research relationship. Foucault's (1980) analysis of the "mechanics of power"[37] offers an alternative understanding of power that does not see it as a commodity, something to be owned or centralized, but rather as operating in "micro" practices of all social relations. Aihwa Ong (1995), a postcolonial feminist, offers a similar theorization of power, considering it as "a decentralized, shifting, and productive force, animated in networks of relations rather than possessed by individuals" (p. 353). She applies this notion of power to the ethnographic relationship, speaking to the "complex and unexpected ways in which

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- Criteria for trustworthiness are applied.

[37] I also acknowledge the limitations of Foucault's theory on power, especially his lack of attention to the ways in which relations of power are gendered, raced, and classed (see Diamond & Quinby, 1988 and Sawicki, 1991 for this critique).

power can work" (p. 353). This relational and decentralized conceptualization of power is more in keeping with how relations of power evolved in this study.

Wolf (1996) suggests that power is discernible in the three interrelated dimensions of (1) power differentials stemming from the different positionalities of the researcher and the researched; (2) power exerted during research itself, such as in the relationship with the participants, unequal exchange, or exploitation; and (3) power enacted during the post fieldwork phase of writing and representing. I entered the study with a thoughtful explication of my positionality and the effects it might have on the research process and outcome, acknowledging my associations with academia and dominant Western biomedicine (as a nurse) and my alignment with dominant society as a middle-class, White researcher. One of the key motivations in explicating my positionality related to the debate over representation and "the right to speak" brought to our attention by feminist, postcolonial, subaltern, and postmodern researchers (Alcoff, 1991; Bannerji, 1995; Ong, 1995; Spivak, 1988). A basic question has been posed by these scholars of whether or not White researchers can truly understand the experiences of racialization and racism, and if so, what strategies should be followed to minimize the inevitable biases flowing from being reared in a different, dominant population (M. Anderson, 1993; Stanfield, 1993). As "outsiders" to the experience of racism, is it possible for White scholars to study those who have been historically subordinated without further producing accounts distorted by the current inequitable constructions of *race*, class and gender? Some have argued that studies in the field of *race* are best undertaken by minority scholars; others have argued that such matching of researchers with the researched results in marginalizing certain types of research, making, for example, racism only a concern for racialized groups (Rhodes, cited in Bowes & Domokos, 1996; Thorne & Varcoe, 1998). Rather than pursuing the

legitimacy of my role as researcher based on one aspect of my social identity (i.e., my Whiteness), I put forward the argument that my legitimacy as researcher was based not on my Colour, but rather on whether I was able to explicate the social organization of health care and recognize the ways in which marginalization and racialization operate. In the final analysis, my ability to do so was not dependent on my social identity, but rather on the interpretive lens with which I approached this project. At the same time, ongoing reflexive, critical evaluation of how matters such as relations of power and the privilege of Whiteness affected my work was critical to the final product.

Despite this reflexive preparation, there were still situations in which I caught myself constructing knowledge from a social position of privilege. An excerpt from my interview with a nurse of Colour demonstrates an instance of thoroughly "White" positionality on my part. The nurse says:

> Some people have just come from back home and they are just new. They probably have not seen a white person with blue eyes (*my laughter*). All they have seen is a person in a movie or something, you understand (*my laughter*). They might be shy or something, you know.

I laughed in these spots because I initially thought she was using exaggeration as a form of humor. However, when I realized that she was entirely serious, I was dismayed at how inappropriate my laughter was, how "White" my response was, to see as humorous the possibility that someone might not have seen a White person with blue eyes before and might be filled with what Fanon (1967) describes as "terror". Self-insights such as this one led me to understand the research process itself as inscribed with racialized constructions.

At other times, however, I felt distinctly disadvantaged, especially as a "visitor"[38] to the clinical settings. The process of recruiting nurse participants, for instance, was marked to a large extent by my dependence on a nurse's good will and sometimes by her/his interest in research. I also found myself negotiating between the position of insider (as an experienced nurse) and outsider (as a researcher and not an employee of the hospitals). As Jayai Lal observes, "In the actual practice of research...one is faced with the need to constantly negotiate *between* the positions of insider and outsider, rather than being fixedly assigned one or the other subject position" (1996, p. 193). The context was particularly important in these shifts between insider/outsider, influencing how power flowed between myself, participants, and non-participants in the hospital setting. For example, it was not unusual for the urgencies of the clinical setting to take precedence over my research agenda, meaning that I had to temporarily suspend my observations or postpone an interview appointment. Such situations left me feeling rather powerless, spoke to shifting re-alignments of power, and impressed upon me that while one's positionality is important in shaping the research process, a variety of other social and contextual factors come into play as well.

This research experience also highlighted for me that self-positioning by a researcher does not necessarily communicate clearly the impact of these categories. In my own case, while I introduced myself as a nurse researcher, it was not until I demonstrated a certain degree of clinical skills, knowledge, and judgment that I was perceived as a *bona fide* nurse. Furthermore,

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[38] There has been considerable reference made to the insider/outsider issue in ethnographic research with discussion regarding which role is more advantageous. The assumed dangers in taking on an insider role include that the researcher is likely to take more things for granted that on outsider would note immediately. Objectivity may be lost in the familiar setting (Bernard, 1994). Some have contended that this lack of objectivity results in researcher bias, to the extent that insiders will invariably present their culture in an unrealistically favorable light. Those arguing for the benefits of insider research claim that outsiders are inherently incapable of appreciating the true character of a group's life (Styles, cited in Hammersley & Atkinson, 1995). Insiders may also benefit from easier access to a research setting and, once in the setting, to various types of information. Finally, hooks (1988) points out that one is best equipped to talk for self, rather than Other.

on one unit my credibility seemed to be linked not only to my nursing experience, but also to my role as a mother. As I spoke about my daughter, nurses were much more likely to connect with me and include me as "one of them". These examples point to the dialectic nature of positionality, in which one simultaneously positions oneself and is positioned by others. Because of my physical appearance (e.g., White skin, blue eyes) I was typically positioned as a White woman and assumed to belong to dominant, mainstream Canadian culture. Yet, I perceive myself as distinctly different from the majority of White Canadians because of my Mennonite, rural origins. Participants were often surprised when I disclosed my own experiences as a minority, moving between several "realities", speaking another language while growing up. Visibility becomes an important analytic point here; because I was not seen as a "visible minority", I was positioned as part of mainstream society. The "differences" by which one is most likely "othered" are those associated with the superficial differences of the body and voice (skin colour, eye shape, hair texture, body shape, language, and accent) which are read as indelible signs of "natural" inferiority (Ashcroft, Griffiths, & Tiffin, 1995). The body then becomes a sign or metonym for "difference". Ultimately, the study in the relationships between positionality and power offered by this research experience has impressed upon me that while locating oneself as researcher is important, the dynamics of power within the research process are such that the exercise of locating oneself is inadequate when not accompanied by an ongoing and reflexive analysis of how one's position is constructed by others, and how this shapes knowledge generation (see Marcus, 1998, and Thorne and Varcoe, 1998, for a further discussion regarding the limits of situating oneself as researcher).

Perhaps because of my heightened awareness of potential effects of power differentials as I headed into this study and my constant guarding against hierarchical relationships during

fieldwork, my sense at the end of the study is that power was most problematic during the writing phase of this study. As I had less contact with participants and immersed myself in the task of translating "raw" data into theoretical constructs, the power differential seemed to shift significantly in favor of myself as author. As Judith Stacey observes, "Perhaps even more than ethnographic process, the published ethnography represents an intervention into the lives and relationships of its subjects. As author, an ethnographer cannot (and I believe, should not), escape tasks of interpretation, evaluation, and judgment" (1991, p. 114). My *angst* during the writing phases has been heightened by the repeated realization that I write from my positionality as a White, middle-class, professional woman. I concur with Carol Stack who, reflecting on her ethnographic studies with African Americans in the South, noted "I confronted my Whiteness more absolutely as a writer than as a researcher. I felt more alone and colour conscious as I began writing" (1996, p. 99). I have also been acutely aware of the possibility of participants reading the research report and have, in a figurative sense, felt them "reading over my shoulder" as I wrote. Brettell (1993) explains that self-censoring by researchers has been increasingly acknowledged as participants are seen as part of the audience one writes for[39]. I engaged in several strategies in an effort to account for the power differences inherent in the authorship/researcher role, including reflexivity, polyvocality, and a limited form of co-authorship. I engaged in reflexivity throughout the research process (e.g., facilitated by journalling) and did so with my participants with measured transparency[40]. For example, there were times when I shared with them some of the challenges of investigating such a disturbing

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[39] A collection of essays entitled *When They Read What We Write: The Politics of Ethnography* (Brettell, 1993) highlights the extent to which ethnographic writing has come under scrutiny and the tension and dis-ease this creates among most ethnographers.

[40] By "measured transparency" I mean that judgment is exercised in these disclosures. As well, I acknowledge that volunteering information may not always be welcomed and may be seen as a nuisance or as unloading a burden (Wolf, D., 1996).

topic, as well as the formidable task of completing an extended research project. Polyvocality is another strategy used to give "voice" to those who participated in this study. Liberal use of their (anonymous) narratives in this written research report help to balance their perspectives with mine. While co-authorship as such is not possible in this study, a version of it has involved member-checking in which participants were asked to comment on emerging conceptual structures (Lincoln & Guba, 1985; Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). I used any disagreements with my analysis heuristically, as advocated by Katherine Borland (1991), and in the process negotiated issues of interpretive authority[41]. Thus, I adhered to Stacey's (1991) methodological response to the predicament of writing:

> critical ethnographers... acknowledge fully and own up to the interpretive authorial self, and, second, experiment with dialogic forms of ethnographic representation that place more of the voices and perspectives of the researched into the narrative and that more authentically reflect the dissonance and particularity of the ethnographic research process. (p. 115)

In summary, attending to power relations in the research process has been no simple matter. This task was complicated by the realization that each strategy offered here (e.g., reflexivity, reciprocity, member checking) was only a partial solution with its own shortcomings. Nonetheless, I concur with Campbell and Bunting's (1991) observation that

> if one's epistemology involves belief that the purpose of knowledge is to release the individual from domination and to further autonomy and responsibility, as is the case in critical theory, then one would expect analysis to be designed to expose

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[41] I am not suggesting that all of my interpretations were validated by participants. To take their interpretations at face-value might not account for the socially constructed nature of their knowledge. When I "do" interpretation, I bring my own knowledge, experience, and concerns to the material, and the result will hopefully be a richer, more textured understanding of its meaning (Borland, 1991; Webb, 1993).

hidden power imbalances and enlighten agents about how they ought rationally to

act to realize their own best interests.... (p. 5)

The matter of relations of power is linked to the foundational conundrum of how knowledge is

constructed and how research is ultimately oriented toward praxis. It is toward these two

methodological challenges that I now turn my attention.

Accounting for Intersubjectivity in the Construction of Knowledge

The specific epistemological and methodological issue related to the intersubjective

construction of knowledge is that of exploring subjective experience while accounting for the

dialectic, intersubjective[42] influence of social structure. Katherine Borland (1991) refers to this

tension as the issue of "interpretive authority", noting the inherent contradiction faced,

particularly by feminist researchers. On the one hand, feminist and critical researchers seek to

empower participants by revaluing their perspectives and their lives, and acknowledging the

intensely subjective and local nature of their everyday reality. Yet, they hold an "explicitly

political vision of the structural conditions that lead to particular social behaviors" (Borland, p.

64). Notably, these political insights may not be shared by research participants.

Undoubtedly, the focus on the immediate experience (what phenomenologists call

lifeworld) contributes significantly to inquiry in the fields of social and health sciences as it shifts

attention to

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[42] In this discussion, I am using "subjectivity" in the phenomenological sense of a person's lived experience (i.e., human consciousness and its lived immediacy). By "intersubjectivity", I am drawing on Schutz's interpretation of the "'we-relation" in which persons in the same time and space are mutually aware of each other. Schutz saw intersubjectivity as the temporal meanings constituted in concrete social experiences and believed that intersubjectivity was the requisite for all immediate human experience in the life-world. He emphasized the historicity and cultural nature of meaning in commonsense thinking and posited that the world is not "my private world but an intersubjective one and that, therefore, my knowledge of it is not my private affair but from the outset intersubjective or socialized" (Schutz, 1967, p. 11). I am also extending Schutz's interpretation in light of his underlying apolitical stance toward the world that does not deal sufficiently with matters of domination (Lengermann & Niebrugge, 1995; Smith, 1987). I am therefore acknowledging the role of social (e.g., ideology,

the domain of everyday, immediate social existence and practical activity,

with all its habituality, its crises, its vernacular and idiomatic character, its

biographical particularities, its decisive events and indecisive strategies, which

theoretical knowledge addresses but does not determine, from which conceptual

understanding arises but on which it does not primarily depend. (Jackson, M., 1996, p.8)

With this focus on the everyday, the "truth" of realism is no longer sought as existing *a priori* in

the form of universal principles; instead, local and contextual meanings are explored within their

social setting and in regard to their consequences rather than their causes. Moreover, a focus on

everyday lives brings the experiences of embodiment into the realm of a researcher's

investigation. For Merleau-Ponty, "subjectivity is a bodily 'being-in-the-world' and

intersubjectivity is a modality of bodylife" (cited in Jackson, p. 32). Therefore, meaning cannot

be reduced to that of the mind, but must also take bodily experience into account.

While close attention to subjectivity offers new insights into lived experience, a singular

or unbalanced focus on subjectivity places one in jeopardy of essentializing experience and

accepting narrative accounts as representative of an unquestioned reality (Purkis, 1994). Joan

Scott, in her essay "The Evidence of Experience" (1991), comments "the evidence of experience,

whether conceived through a metaphor of visibility or in any other way that takes meaning as

transparent, reproduces rather than contests given ideological systems..." (p. 368). Thus,

experience may be regarded as an incontestable form of evidence to be accepted, recorded and

reported factually (Allen, 1996b). As such, it becomes a new form of absolute evidence,

replacing positivism's objectivity. When experience is taken as the origin of knowledge, the

vision of the individual subject becomes the foundation or evidence on which explanation is

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social norms and customs, institutions such as patriarchy, history) and material forces (e.g., economics, politics) in shaping knowledge.

built. For example, questions about the constructed nature of experience, about how subjects are constituted as different in the first place, are left aside. "The evidence of experience then becomes evidence for the fact of difference, rather than a way of exploring how difference is established, how it operates, how and in what ways it constitutes subjects who see and act in the world" (Scott, p. 367). Furthermore, a strict adherence to an interpretive paradigm, with its emphasis on subjectivity, is inadequate insofar as it is based on an assumption of fully rational action (Allen, 1985; Lather, 1991).

My reliance on Smith's (1987, 1990) standpoint theory provided direction in sorting through this tension between the micro level of everyday experiences and the macro influencing structures. When Smith argues for theoretical inquiry that begins with the standpoint of women, she is not referring to an essentialized common "female experience", but rather a focus on beginning in the material and local world. Locating the problematic in the everyday world does not mean *confining* the inquiry to that domain. Rather, it is essential that the everyday world be seen as organized by social relations not observable within it. The organizing "logic" of everyday experiences may indeed be located elsewhere than in an individual's own activity and experience -- in externalized and abstracted processes and relations of ruling. In effect, locating the knower (or subject) in the everyday world of experience pulls the "micro level" of everyday world and the macro level, observed as large concepts such as power elites, formal organization, social classes and the state, into a determinate relation. Experience then becomes a fulcrum or hinge from which inquiry can turn inward or outward (Bannerji, 1995).

The intersubjective construction of knowledge carried methodological implications for my own involvement in the construction of knowledge. As I have already indicated, my subjectivity and positionality shaped what I saw and heard, and what questions I asked.

However, the effect of intersubjectivity on the research process extended beyond the influence of my "preconceptualizations". Keeping in mind that all meanings are shaped intersubjectively, relationships between myself and the researched drew me into day-to-day intergroup relations as participant (Jackson, M., 1996). Therefore, I as researcher co-constructed knowledge with the participants as we actively influenced each other's experiences and understandings. By way of example, a nurse of Colour was talking about the importance of family upbringing to one's attitude toward diversity. She went on to ask me how I felt about the matter. I shared my own experiences regarding my own childhood experiences and we jointly concluded that family upbringing was very significant in shaping one's attitudes.

My commitment to the process of intersubjective knowledge construction, however, left me with several difficult questions. If knowledge is understood as shaped by one's abstract but real political and social situation, how do we account for and access that which is beyond the conscious reality of those participating in research? And how does one mediate between people's understandings and the need for ideology critique and transformative social action without becoming impositional (Lather, 1991, p. 64)? These questions took me squarely into the messy terrain of ideology and ideological mystification (also referred to by some as "false consciousness"[43]). I experienced tension between holding feminist ideals of attending to unequal power in research relationships while also holding final authority as researcher to interpret data in order to allow for that which may be outside the conscious realm of participants. Furthermore, I recognized that as a researcher drawing on critical theories, I came to the data with certain *a*

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[43] David Allen (1985) comments that ideology (the misrepresentation of social processes as being natural and hence inevitable rather than historic and subject to change) has been mislabeled as "false consciousness". Gorelick (1996) posits that the difficulty with the concept of false consciousness lies in the implication that (a) there is a true consciousness that is known and complete, and (b) the researcher-activist knows it, and the participant does not. Lather, on the other hand, uses the term "false consciousness" to refer to "the denial of how our common sense ways of looking at the world are permeated with meanings that sustain our disempowerment" (1991, p. 59).

priori theories and values that served as lenses for the interpretation of data[44]. For example, my interpretive lens included theory regarding the processes of racialization and racism. Because of this forestructure, there were situations in which I "saw" racism but participants did not. Drawing on her research with women, Katherine Borland summarizes this dilemma:

> On the one hand, we seek to empower the women we work with by revaluing
>
> their perspectives, their lives, and their art in a world that has systematically ignored
>
> or trivialized women's culture. On the other, we hold an explicitly political vision of
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> the structural conditions that lead to particular social behaviors, a vision that our field
>
> collaborators, many of whom do not consider themselves feminists, may not recognize
>
> as valid... (1991, p. 64).

The classic feminist dilemma of when to "enlighten" participants (e.g., to their gender oppression) stems from this tension. Because the fundamental goal of critical science is to "establish the conditions for open, unconstrained communication....[by] *exposing* hidden power imbalances that inhibit free discourse" (Allen, 1985), I could not sidestep this dilemma easily. I concluded that a solution, albeit open-ended, to these problematics of ideological mystification and theoretical imposition lay in a praxis-orientation toward research in which room is created within researcher-researched relationships for questioning taken-for-granted assumptions and practices. At the same time, I struggled with the judgments involved in deciding what equated ideological mystification and when and how to deal more directly with it. In the next section, I outline the methodology that undergirded my efforts toward praxis.

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[44] Critical research is no more or less value-driven than positivist or interpretive research, but is more explicit in making its interests known.

Orienting toward Praxis

By adopting an emancipatory research paradigm openly committed to critiquing the status quo and building a more just society, I held to the methodological stance of being praxis-oriented[45] (Henderson, 1995; Lather, 1991; Thorne, 1997). Nursing inquiry within this genre is committed to moving beyond the description of what "is" to providing prescription for what "ought" to be, and raises our level of investigation from matters of the individual to consideration of larger sociopolitical forces impacting on the common good (Starzomski & Rodney, 1997).

The notion of agency[46] underpinned my pursuit of praxis-oriented research. Although the nurses and patients in this study did not have an articulated awareness of all of what shaped their realities, I held the view that they were capable of participating in and co-constructing the exploration of intergroup relations. However, I also assumed that although participants thought and acted in meaningful ways, these thoughts and actions needed to be scrutinized and contested in order to uncover the taken-for-granted habitual actions and the contradictions between intent, meaning, and action (Street, 1992). Such a critique aimed to disclose the power relations at work that maintained oppressive and hierarchical structures in the provision of health care.

I carried a strong theoretical commitment to praxis throughout this study, but found that

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[45] The concept of praxis has been applied in various ways across disciplines and throughout history. Within nursing, two models have prevailed: one of reflection upon practice with the aim of improving both practice and theory (liberal use of the notion); the other of emancipatory research methodologies and educational practices (critical use of the term) (Thorne, 1997; Varcoe, 1997b). My use here falls within the second application of praxis. I also acknowledge the implications of the classic tradition of the term as shaped by Marx and carried on by neo-Marxists. By praxis, Marx referred to a synthesis of theory and practice for the purpose of de-alienation (Angeles, 1992; Holmes, 1993). Praxis is based on the Enlightenment assumption that people naturally strive to realize their optimal potentialities and are active agents with the ability to reflect and change their alienating conditions (Markovic, 1974; Schweitzer, personal communication, January 6, 1998). With this foundation, praxis provides a normative moral-practical direction for evaluation of the concrete ways in which existing societal conditions prevent or impede the full realization of human potential. Praxis thus facilitates freedom from that which blocks human potential (e.g., oppression) and freedom to realize one's potential (Schweitzer, 1992). Furthermore, Markovic also observes that praxis is rational and free of external coercion.

[46] I use the term agency in a relational sense, recognizing that relational persons shape and are shaped by others, rather than in an individualistic sense in which the self is autonomous and separate (see Joseph, 1996).

the implementation of praxis during the research process was not easy, in part because the "how-to" of praxis-oriented research is less developed in the literature, but more so because of the nature of the relationships I was establishing with participants. Therefore, while I envisioned praxis as part of both the process and outcome of the study, I found the former more difficult[47]. Nonetheless, in my efforts toward praxis, I drew on several strategies gleaned from researchers committed to praxis (e.g., Campbell & Bunting, 1991; Lather, 1991; Kobayashi, 1994; McCormick & Roussy, 1997; Opie, 1992; Staeheli & Lawson, 1994; Starzomski & Rodney, 1997; Thorne & Hayes, 1997). First, I contended that praxis began with my own critical reflection on my responses to the research process. Audrey Kobayashi posits that:

> ...It is this capacity for critical self-reflection, rather than their elite perspective, that provides academic researchers with a platen for social change as well as scholarly critique, and establishes a justification for combining the two. (1994, p. 78)

The questioning of my own positions and values, and other more widely held assumptions, allowed me new ways of conceptualizing intergroup relations in health care. Second, I strove to create environments between myself and the participants that allowed for questioning of commonly held assumptions. This involved a period of immersion in the field to ensure that I understood the everyday realities and the world views of participants (Lather). The creation of such environments depended on developing reciprocity and non-hierarchical relationships with participants. As researcher, I aimed to engage participants in respectful dialogues that included critical, self-reflexive analyses of the categories that shaped the research and the participants' lives. The method of dialogue was deliberately selected to allow for negotiation of meaning and exploration of relations of power, ideologies, and other structures shaping experience (Campbell

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[47] Leslie Roman (1993b) and Patti Lather (1991) provide examples of their efforts at integrating consciousness-raising into educative and research programs. They also experienced difficulty in achieving this goal because they

& Bunting, 1991; Staeheli & Lawson, 1994; Thompson, 1991). Essentially, what I was seeking

was a form of consciousness-raising within the research process itself[48]. However, I did not

carry any grand illusions of change but hoped for the possibility of some incremental changes in

participants' thinking in response to the questions I posed. For example, when 'buddying' with a

nurse who had made several discrediting comments about non-English speaking patients during

my time with her, I deliberately asked her what she thought the hospitalization experience was

like for these patients, hoping to shift her position to a more empathic one. About midway

through the project when I began hearing about the workload involved for nurses who interpreted

for patients on the unit, I began asking nurses who did not speak another language if there was

some form of reciprocation when their colleagues came to interpret for them, again desiring to

heighten their awareness of the extra work imposed on their co-workers. In other situations, I

took a more straight-forward approach (e.g., offering empirical information to a White

participant about the hospitalization experiences of patients of Colour).

Finally, a praxis-orientation led me to consider how I might connect this academic

research to political activism and social transformation in the multiple sites of praxis for nurses

and academics (i.e., practice settings, the classroom, publications, the university, communities

with which we identify, and those with whom we conduct research) (Staeheli & Lawson).

Toward that end, I have planned discussion forums in the three sites of this study to discuss these

findings with nurses in practice. I will be sending out "executive summaries" of the project to

participants (patients, nurses, and administrators) as well as to policy-writing organizations (e.g.,

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were faced with considerable resistance.

[48] Lather explains how important consciousness-raising is to critical inquiry: "...I propose that the goal of emancipatory research is to encourage self-reflection and deeper understanding on the part of the researched at least as much as it is to generate empirically grounded theoretical knowledge" (1991, p. 60). Dorothy Henderson (1995) also emphasizes the role of consciousness-raising in emancipatory inquiry, positing that it is the method of inquiry of participatory research in which social and individual change occurs, and also the goal of such research. On the

RNABC, Ministry of Health). I have presented preliminary findings at several conferences and will be following up with other formal conference presentations as well as published papers. I am also integrating the results of this study into informal and formal conversations in a range of places: with other academics, in the classroom, with friends, family, in my neighbourhood, and so forth. Notably, my concern for praxis was also shared by several of the participants who asked questions like "how will your research change things?" and "So, are you going to change the health care system?"

In conclusion, I envisioned praxis in two main ways:

(1) in the process of research itself, in which both researchers and participants see their worlds in new ways, realize they are able to relate to it in new ways, and then act in different ways (Henderson, 1995; 1997); and

(2) in the ways in which I disperse the research findings (e.g., to influence policy, in nursing education, to build on in further research).

I have come to understand that neither of these two vehicles of praxis come about easily, and also realize that there is a danger of assuming praxis and change have occurred when they may well not have. Therefore, I also see myself as committed to what Patti Lather refers to as "the long-term, broad-based ideological struggle to transform structural inequalities" (1991, p. 65).

Summary

The theoretical and methodological framework outlined in this chapter provided guidance throughout this research project and shaped the conclusions reached. Perhaps most importantly, the framework offered me the apparatus with which to make visible the ways in which intergroup relations are socially organized by a range of economic, ideological, political,

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other hand, Glucksmann (1994) argues for a realistic appraisal of the limits of research as a locus for authentic political activity.

historical, and social forces. In the next chapter, I outline how the theoretical and methodological framework, or "interpretive lens", was translated into the design and implementation of this study.

CHAPTER FOUR:

RESEARCH DESIGN AND IMPLEMENTATION

Having considered the background to the research problem, the current state of

knowledge regarding intergroup relations in health care in a pluralistic society, and the

theoretical and methodological lens with which I approached this research, I turn now to

elaborate in more detail the methods employed. Specifically, I explain how I conducted this

institutional ethnography, providing particularities of the method itself, and then describe how I

selected sites for the study, negotiated entry, and obtained participants. I go on to present the

"artful work" of fieldwork as the study was implemented, commenting on participant

observation, interviewing, writing field notes, and reviewing documents. The approach to data

analysis is outlined and I conclude with a discussion of considerations for ensuring scientific

quality and ethical standards.

Selecting a Design: Institutional Ethnography

In selecting a research design, foremost direction is that provided by the paradigm[49] held

by the researcher and the research question under consideration. To re-iterate, I proceeded

within the critical theory paradigm (Guba & Lincoln, 1994) that holds to a historical realism

(ontology), a subjectivist and value-mediated epistemology, and a dialogic methodology. I

selected institutional ethnography (Smith, 1987), informed by feminist, postcolonial, and

intergroup theories, as the most appropriate design to address the research questions. The nature

of the questions meant I needed to understand the everyday practices and worlds of nurses and

patients as located within the realm of institutional health care settings. Institutional ethnography

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[49] I am employing the much-used term "paradigm" in the sense explained by Guba and Lincoln (1994), to refer to a world view that "defines for inquirers what it is they are about, and what falls within and outside the limits of legitimate inquiry" (p. 108). It encompasses the "ultimates" of ontology, epistemology, and methodology.

enabled me to account for the influence of the institutional structure and its social relations on the day-to-day intergroup dynamics in the provision of health care by nurses.

As explained in Chapter Three, institutional ethnography is a method of inquiry, formulated by Dorothy E. Smith. It takes the everyday world as a point of entry for research and links the particular setting and experiences "to the generalized and generalizing relations of the apparatus of ruling and of the economy" (Smith, 1987, p. 147). In this study, I took as problematic the everyday world of nurses and patients in the provision of intergroup health care. I began by uncovering the character of the everyday world. From this vantage point, I explored how work processes and social practices are embedded in the social relations of extended social, economic, and political processes and are maintained in taken-for-granted ways by discourses and ideologies. In short, the method of institutional ethnography enabled me to show how intergroup relations in health care "work".

The design of the study involved ethnographic research on three surgical units in two acute-care hospitals (for a total of three research sites). Data was collected from multiple sources using the ethnographic techniques of in-depth interviewing, participant observation, and review of relevant texts. Data collection began in the primary hospital with a period of participant observation; interviews followed once I had a general sense of the units. I initially recruited nurses and patients/families as participants and focused on describing the everyday world of intergroup health care provision. Particular attention was paid to nurse-patient encounters and the ways in which the immediate setting shaped these encounters. As the study evolved, I took further direction from the actualities of the everyday world as I sought to connect the local traces of social organization with data from extra-local ruling practices (Smith & Campbell, 1998). In this second stage, I interviewed people from outside the immediate setting (e.g., hospital

managers, policy makers) and analyzed relevant documents (e.g., policies and procedures) as I made connections between the everyday and the social processes of the hospital that organized it. Finally, I took another step back to locate the hospital in the larger arena of the administrative relations of the state (e.g., at the regional, provincial, and federal levels) of which that hospital is a local agent (Smith, 1987). The drafting of a "design" (see Appendix B) at this point was useful in capturing the interrelationships between the influences on everyday experience. Thematic analyses of transcribed interviews, detailed field notes, and analyzed texts were completed by the constant comparative method to create a composite description of intergroup relations in health care within the larger social context.

The Process of Research: Constructing the Data

The "doing" of research is typically referred to as data collection, suggesting that data is pre-existing "out there", waiting to be gathered. As this project evolved, I came to see the "doing" of research somewhat differently. As suggested in Chapter Three, the construction of knowledge was an intersubjective process in which my own positionings and interactions with participants shaped what I interpreted as "data". For example, my own location as a White nurse researcher meant I was comfortable in pursuing certain kinds of data (e.g., what is it like to work on this unit?), but was more tentative in broaching other subjects (e.g., what are the experiences of nurses of Colour?). Through these types of realizations, I came to understand the process of "doing" research as constructive as I decided what might be data, and ultimately shaped what the data looked like. In this section, then, I show how data was constructed through the "doing" of research in the various phases of fieldwork.

The "Artful Work" of Fieldwork

Although I had read various accounts of fieldwork in preparation for this project, and had some limited fieldwork experience, I was nonetheless surprised by the intensity of the overall fieldwork experience. As fieldwork progressed, I came to understand it as "artful work". Although others have written about the art of fieldwork (e.g., Wolcott, 1995), my experience suggested that the art of fieldwork was closely connected with the art of nursing. Jenner (1997), in her concept analysis of the art of nursing, defined it as "the intentional creative use of oneself, based upon knowledge and expertise, to transmit emotion and meaning to another. It is subjective and requires interpretation, sensitivity, imagination, and active participation" (p.8). This definition is similar to the conclusion reached in a study by Johnson (1994) in which she determined that the art of nursing was characterized by a nurse's ability to a) establish a meaningful connection with a patient, b) grasp meaning in patient encounters, d) skillfully perform nursing activities, d) rationally determine an appropriate course of nursing action, and e) morally conduct nursing practice. The work of these two scholars has been helpful in elucidating my own experience. The "art" of fieldwork depended on my skill and expertise both as a nurse and as a researcher and occurred as I established points of connections with study participants, artfully negotiated my role as researcher, grasped the meanings embedded in clinical encounters, participated in nursing judgments, and morally conducted the research study.

An experience early on in this project alerted me to the artful nature of fieldwork. On a particularly hot Sunday afternoon, I was "buddying" with an experienced nurse for the second time. We had developed a friendly relationship and she teased me about why I would be here on such a day. Early in the shift, a patient problem developed that required close observation and problem-solving on the part of the nurse. Drawing upon my clinical background, I discerned

what the problem was, but because of my researcher, "visitor" role, was unsure of how to communicate my diagnosis without "showing up" this senior nurse. As I participated in the patient's care, and as this nurse "thought aloud" with me, I was able to direct her problem-solving in a non-threatening fashion by asking certain questions. Once the problem had been solved (with the patient thanking us profusely, saying she had not been this comfortable in days!), the nurse was quick to thank me and acknowledge my contributions to another experienced nurse. This exemplar demonstrates the benefit of my earlier connections with this nurse, my concurrent concern to maintain this level of rapport, my negotiation between the roles of clinical nurse and researcher, and participation in clinical judgments, while keeping this patient's comfort and safety at the forefront. My sense that day was also that what made this encounter "artful" was my careful reading of this nurse, and an intuitive sense of how I should respond.

The negotiation of researcher roles was central to the "artful work" of fieldwork. I continually found myself juggling the roles of visitor to the unit, nurse, nurse instructor, researcher, and learner. In essence, this negotiation between roles was one of balancing "engagement with detachment, familiarity with strangeness, closeness with distance" (Adler & Adler, 1994, p. 379). In the negotiation of researcher roles, there were some concrete decisions pertaining to how I represented myself as researcher, including what to wear (e.g., a lab coat over street clothes identified me with health care providers), how I identified myself (e.g., my name tag said "Sheryl Reimer Kirkham, Student Researcher, positioning myself in a certain way[50]), the language I used (e.g., using nursing "lingo" aligned me with nurses), and who I associated with

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[50] I think now that I should have had a nametag that simply identified myself as "Researcher". Two of the participants in the study (a nurse and a patient) commented that because of my clinical experience, I really should not present myself as a student. In other situations, it was this very association with the student role that opened doors for me.

(e.g., most often I took my breaks together with the staff nurses rather than with managers).

More specifically, my "insider" role as a nurse carried several implications that related, in part, to

my dual roles of researcher and clinician. By being present as "helper" and not just researcher, I

achieved more of an "insider's" view of intergroup relations, more quickly gained the trust of

study participants, and maintained a higher level of personal engagement in what could have

become tedious observation. This level of involvement, however, carried another type of

challenge, that of judging appropriate types of intervention. As Field (1991) points out, "nurses

do not find it easy to sit in a corner and do nothing, particularly in an area that is busy and one

they know well" (p. 94). While all researchers must struggle with the balance between

participation and observation, I agree with Lipson (1991) who explains that "in practice, clinical

and ethnographic roles can become highly intertwined....in an effort to separate those roles,

nurse-researchers probably have more difficulty with the issue of intervention than field-workers

trained purely in the social sciences" (p. 81). In my case, to participate meant active involvement

in nursing practice, particularly in a few situations that called for immediate response (e.g., a

patient fall in one case and a very restless, combative patient in another). However, I needed to

exercise clear judgment about when and how to intervene because I was not a hospital employee.

At the onset of each fieldwork episode, I clarified my role and negotiated some limited work

responsibilities with my "buddy".

The politics of the health care setting also influenced me as nurse-researcher in unique

ways. Considering the sensitive nature of the research question, I sensed at times that nurses

worried about being evaluated by me. I countered this evaluator role by emphasizing that I was

there to learn from them, and that I was really interested in how the context of their work enabled

or hindered them in providing intercultural care. Yet, I could not stop myself from evaluating

the quality of their nursing care (my tendency to evaluate was undoubtedly heightened by my years of carrying the evaluative role as a clinical instructor). My own discomfort around evaluating (even when only in my own mind) nursing care abated somewhat when I realized early on that all those I observed did some things as I would do, and others as I would not do, thereby reminding me that there are in most cases many ways to provide safe nursing care. Nonetheless, I experienced ambiguity and challenge as I negotiated these roles and recognized the centrality of reflexivity in the process of these negotiations.

In sum, the "art" of fieldwork did not materialize without considerable "work" or effort on my part. The "work" of fieldwork involved making persistent efforts to connect with people, even when I experienced what Street (1992) referred to as the "marginality" of being a fieldworker. The "work" of fieldwork also included my efforts to sustain enthusiasm for the project when I was physically and emotionally drained, participating in the embodied work of nursing, and straining to understand the "gestalt" of each setting I was in. The theme of the "artful work" of fieldwork is further illustrated throughout this section where I present the processes of negotiating access, engaging in participant observation, conducting interviews, writing field notes, reviewing texts, and managing data.

Negotiating Access: Sites, Sampling, and Entry

Negotiating access for this study was a multi-layered process as I identified possible sites for research, obtained agency and unit approval, and negotiated participant consents. At a certain level, negotiating access continued throughout the entire study, even as I returned to share study results with participants. As Goetz and LeCompte (1984) observe, the flexibility and adaptability of selection and sampling decisions, as well as their integration throughout the research process, are hallmarks of ethnographic research. My original plans were altered slightly

as the study progressed (e.g., I reduced the number of units from four to three because saturation was occurring for me while I was on the second and third units).

Site Selection. Selection of the sites of research was guided by certain criteria:

(1) the hospitals are situated in and serve a diverse community;

(2) entry is relatively straight forward (ideally, the sites will welcome nursing research); and

(3) I am likely able to build trusting relationships with the participants of the study.

I selected a community hospital as the primary site of research and a tertiary care hospital as a secondary site in which to compare and extend research findings. The first hospital was located in an urban community that is part of a large metropolitan city, and like other areas of this city, has had a significant influx of immigrants in the past ten to fifteen years. The second hospital was located in a cosmopolitan setting and serves as a tertiary care center for the province. While also having a large immigrant population, many of these immigrants are of European and American origin. The two sites complemented each other, allowing for confirmation and extension of research findings.

I selected two surgical units in the first hospital and one surgical unit in the second hospital on which to do my fieldwork, giving a total of three research sites. Each of these units represented a different type of surgical service. Surgical units are considered "typical" of most health care institutions and allowed for ongoing observations of intergroup relations. The selection of three units allowed me to capture the variability of intergroup dynamics in health care provision while also accounting for the peculiarities of the different hospitals and units. However, the nature of the research findings was no doubt shaped by the particular settings chosen (see Chapter Six for the influences of a surgical unit on intergroup relations).

Interestingly, it was suggested to me several times that I should be doing my research in the obstetrical and emergency areas of the hospital because this was where intergroup relations were often more contentious. However, I limited my research to surgical units in the interests of manageability and time, and because nursing research has typically not been completed on these units. While my main focus was on these specific units, I expanded my general investigation to reflect what was happening within the larger context (e.g., concurrent changes in health care reform, "news-making" events in the community, demographic shifts, etc.).

Gaining Entry. Entry to the research sites required both formal and informal negotiation and, as mentioned, access to certain groups and settings required ongoing negotiation throughout the research process. Therefore, I certainly concur with Zaharalick and Green (1991) who observe that access in an ethnographic study is never totally obtained. For example, even when I had obtained consent from certain participants and "buddied" with them during previous participant observation, I felt it necessary to re-negotiate their continued participation on each subsequent visit. Likewise, there were situations in which I had made arrangements to "buddy" with a certain nurse, but when I arrived on the unit, they were absent (e.g., sick, traded shifts, and so forth). Thus, the ongoing negotiation of entry required both persistence (e.g., not being discouraged by such "no shows") and sensitivity (e.g., reading nurses' agreements to participate carefully). Moreover, the nurses' job action that occurred midway through this project required careful "reading" of the field and close communication and collaboration with unit managers in order to establish, on a day-by-day, hour-by-hour basis the appropriateness of my presence.

Formally, I initiated contact with each agency with a letter of information (see Appendix C) and requested approval from the institution's research committee after receiving approval from the University of British Columbia Ethical Review Committee. This process of obtaining

agency approval was not straightforward in either site. For example, in the case of the first agency, contacting key stakeholders became critical to my success. However, identifying who these key stakeholders were was not either immediately apparent, due in part to the significant administrative restructuring occurring at the hospital. As Hammersley (cited in Street, 1992) reminds us, in formal bureaucratic organizations it is often not obvious whose permission needs to be obtained or whose support needs to be solicited. Ultimately, these stakeholders were able to facilitate my entry into the institution. Once agency approval was obtained, I negotiated entry at the unit level by contacting the nurse managers in charge of the surgical units. Bernard (1994) recommends that one go into the field with plenty of written documentation about oneself and one's project and therefore I kept letters of information and business cards handy at all times.

Informally, establishing credibility as researcher and nurse and gaining trust was critical to facilitating entry. This credibility and trust was achieved as I was visible on the unit (e.g., was present at a range of times, including weekends and shift), demonstrated my competence as a nurse (e.g., through the questions I asked and the tasks I assisted with), and allowed myself to be known (e.g., shared personal information about myself). Entry was also facilitated as I evidenced an interest in the nurses (e.g. their work, their personal lives) but also demonstrated sensitivity for nurses' and patients' reluctance to participate. Furthermore, thorough, respectful, and enthusiastic presentation of myself and my research was important in negotiating entry. In this regard, I agree with Marshall and Rossman (1995) who insightfully report that the energy that comes from high personal interest is useful for gaining access.

The Sample. Hoping for a true volunteer sample, I began the recruitment process at both hospitals by extending an open invitation to participate by posting a letter of information in the unit's communication book in one case, and on a poster in the second case (See Appendix

D). Those nurses interested in participating were asked to contact me. When this strategy was unsuccessful, I worked with the managers who identified potential participants. I realized after the first participant was recruited that her participation had not been unlike an "assignment" in which the manager told her that I would be "buddying" with her. I therefore "fine tuned" my plan by devising a brief invitation that the manager gave to potential participants. In this way, they communicated their consent to speak to me about the study to the manager, but knew they were not obligated to participate. Although I was still concerned that nurses understand their participation as entirely voluntary, the fact that nurses spoke positively of the experience, and encouraged others to participate, reassured me to a degree. As well, several nurses refused to participate, suggesting to me that my system of recruitment was working in keeping with the ethical standards I was committed to (i.e., they understood that their participation was voluntary). The criteria for participation in the study for nurses were:

(1) having registered nurse status (so that there is some homogeneity of the nature of care provided);

(2) regularly providing nursing care in an intergroup situation (nurses who work a regular schedule of shifts and who are employed as staff nurses or clinicians/nurse managers); and

(3) being employed on the unit for more than one year (so that they are qualified in terms of experience to represent the phenomenon under investigation).

Because of the high number of casuals working in all areas, I reconsidered this last criterion and included several casual nurses who had worked for less than one year in their respective areas.

Recruitment of patients occurred in a similar fashion. I worked together with the managers to identify possible participants, and the managers then approached the patients with a

brief explanation of the project and an invitation to participate. I then explained the project in more detail to those patients who voiced interest. The criteria for participation for patients were:

(1) being stable enough that the interview will not impinge on their health status;

(2) being over age 19 so that they can provide informed consent.

(3) speaking English[51].

The final sample consisted of twenty nurses, ten administrators, and five patients. I began with a core of eleven nurses and once I had developed an initial conceptual schema, extended the study to sixteen nurses (all at the first hospital). As the study progressed, I sought the perspectives of patients in order to gain a fuller understanding of the dynamics involved in intergroup health care provision. Further purposive sampling involved recruitment of ten people from outside the immediate setting (e.g., administrators, policy makers, and clinical educators) in order to obtain insight into the extralocal structures and processes that shaped everyday health care provision. The final phase of recruitment occurred at the second hospital where I validated and extended the conceptual schema derived from fieldwork on the first two units. Sampling was purposive throughout these phases in the sense that I sought participants who represented a range of nursing experience, age, and ethnocultural backgrounds. Although I had anticipated that careful consideration and extra effort would be required to recruit participants of Colour, I found that they participated enthusiastically when the purpose of my research was clearly explained. Twenty-one of the 35 participants were White, the remaining fourteen were persons of Colour. Eleven of the twenty nurses, nine of the ten administrators, and two of the five patients were Canadian-born. Reflecting the demographic profile of nurses in Canada, nine of

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[51] I gave considerable thought to this criteria and decided, that since the primary focus of this study was not the experiences of patients per se, but rather intergroup dynamics, English-speaking patients/families would be sought. This was also a pragmatic decision, in light of the added time and resources needed to translate letters of

the twenty nurses were over the age of fifty. Sixteen of the twenty nurses had diplomas, four

were baccalaureate-prepared. Three of the administrators had graduate education, four had

degrees, and two had diplomas. The patient participants also represented a range in age and

education. All of the nurses and administrators in the sample were female, not by design, but

because few males worked on the units in my study. One of the patient participants was a male,

and a husband joined half way through an interview with another female patient. See Appendix

E for a demographic profile of the study participants.

Engaging in Participant Observation

Whereas a research design based on interviews alone tends to emphasize the subjective

(e.g., personal experience) and decontextualize nursing practice, participant observation offers a

form of triangulation to complement or challenge interview data in a heuristic fashion and

thereby begins to account for the problem of privileging narrative accounts of experience in

qualitative research (Allen, 1996b; Purkis, 1994). The immersion of participant observation

enables the researcher to directly and forcibly experience for him/herself both the ordinary

routines and conditions under which people live their lives, and the constraints and pressures to

which such living is subject (Emerson, Fretz, & Shaw, 1995). It was therefore a method of data

collection particularly suited to the aims of this project. Participant observation offered a holistic

approach to research whereby I as participant observer used my senses and intellect to compare

events, actions, and behaviors against a background knowledge of the "known" history of the

setting/community (based on written documents and other factual information). Participant

observation also provided important context to the interviews.

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information, consent forms, and interviews (both written and verbal translation), especially because I could not
predict in advance what languages would require translation.

Fieldwork is often described as occurring in a number of stages or phases (Adler &

Adler, 1994; Bernard, 1994; Lincoln & Guba, 1985; Spradley, 1980; Street, 1992). For example,

Adler and Adler describe how participant observation generally shifts from an initial descriptive

phase of general and unfocused observations to more focused observations to a final stage of

theoretical saturation where new findings consistently replicate earlier ones. In this study, after a

two month period of gaining access, I spent an initial seven months primarily in participant

observation (and other modes of data generation such as interviewing and reviewing texts),

followed by a two-month period focused on data analysis. I then re-entered the field for another

three months in which fieldwork was used to clarify and expand conceptual structures emerging

from the data analysis process. Most recently, I have been immersed in analysis and writing but

have had brief periods of re-visiting the research sites in order to clarify and expand specific

points. Having said this, this entire research process could be characterized as iterative as I

alternated between data generation and data analysis (See Appendix F for Research Timeline).

Participant observation sessions varied in nature; most of them involved "buddying" with

a RN, at other times I attended orientation sessions, seminars, or unit meetings. My goals during

these experiences were to a) observe intergroup interactions, b) understand the nature of nurses'

work, and c) understand the larger context of health care. In essence, I shadowed the RN while

"buddying", observing her provide care (following her consent and cues and those of the patients

regarding the appropriateness of my presence), assisting with simple nursing tasks (e.g., such as

making beds, providing water, fetching supplies, etc.), and attending breaks with the participant

(in a few instances participants preferred to take their breaks alone). The participation aspect of

these episodes (i.e., my "being useful") was often what assisted in gaining trust and credibility

with these nurses. Typically, at the end of each "buddying" session they thanked me sincerely for my "help" and said they enjoyed having me with them.

I commonly "buddied" with each RN participant on two occasions (I spent three episodes with three RNs, and only one episode with seven other RNs). I also "buddied" with three of the administrative participants. Most of these observation periods occurred in the morning and lasted for three to four hours. This pattern developed for several reasons. First, nurses are most likely to interact with patients during these morning hours as they complete initial assessments, provide "a.m." care, and perform important treatments. Second, this allowed for a realistic schedule for myself in which I could write up my field notes in the afternoon and then be ready for more fieldwork the next day. Third, although I also stayed in the field for more extended periods (i.e., up to eight hours), I found that the three to four hour time period allowed me to stay alert and observant. It was more difficult to write up detailed field notes once I had been in the field for more than four hours. In order to bring more representativeness to my observations, I also spent six afternoons, six evenings, and one night on the units for a total of sixty-five episodes of fieldwork.

Making explicit observations, especially after I was acquainted on a unit, took effort on my part as I worked consciously to make the familiar strange. Without deliberate and careful attention to observation, it was difficult for me to describe, in detail, the exchanges between nurses and clients, for example, or to describe their work. From my nursing perspective, they were simply "providing a.m. care". Clearly, participant observation was a selective enterprise, involving active processes of interpretation and sense-making, noting some things as significant, others as insignificant, and even missing other possibly significant things altogether (Emerson et. al., 1995). The missing of certain significant things was likely, not just because of my own

familiarity with clinical settings, but because certain events or occurrences were "second nature" or transparent to participants themselves. Kobayashi (1994) states that

> One of the greatest challenges to the researcher in a field situation is to untangle
>
> what people take to be essential and unequivocal and what is challenged and
>
> therefore subject to change. The former are usually unequivocal because they are
>
> assumed to be part of an unquestioned "natural" order; the most difficult concepts,
>
> however, are those which are so naturalized that no one, including the researcher
>
> has even thought to question them. (p. 77)

Writing field notes was the one of the most helpful strategies for seeing the field in a less taken-for-granted way. Regular meetings with my supervisor were also important in helping me make visible that which was taken-for-granted.

Participant observation was usually my first contact with RN participants, followed by an interview at a later date that was convenient for both of us (in a few cases, interviews were conducted on the same day as participant observation). As I "worked" alongside them, trust developed quickly and by the end of the first episode, most nurses spoke freely with me. As Bernard (1994) observes, participant observation involves getting close to people and making them feel comfortable enough with your presence so that you can observe and record information about their lives. I paid careful attention to rapport with nurses during these episodes of "buddying" as I strove to establish comfortable relationships by emphasizing "sameness" between us (e.g., that as a nurse I understood much of their practice and the challenges they faced), using humor, and seeking other points of connection. I also worked at approaching each episode with a sense of "naturalness", trying to blend into the clinical environment and not draw undue attention to myself. Thus, while concern with reactivity, or the Hawthorne affect, stems

largely from the positivist paradigm of seeking objectivity, it also played a certain role in my

research as I aimed for non-threatening relationships with participants. Importantly, I did not

consider the effect of my presence as "contaminating" but rather saw these effects as another

source of learning (Emerson et. al., 1995; Paterson, 1994).

Conducting Interviews

Interviews were an important method of data generation and complemented participant

observation. Participant observation, for example, helped me formulate sensible questions

during the formal interviews, allowed for the establishment of a level of trust and therefore more

open rapport during interviews, and allowed for informal conversations as extensions of the

formal interviews. Notably, interviews were considered as "windows" into the world of

intergroup dynamics, rather than as unquestioned, factual reports of reality. Discrepancies and

ambiguities that arose between verbal accounts and my observations were used heuristically, and

often offered me deeper insight into the dynamics at work.

I conducted formal interviews with all but one of the study participants, and also had

many informal conversations with nurses, administrators, and patients. Formal interviews were

arranged in environments convenient and preferred by participants. Most often these occurred in

quiet areas of the unit (e.g., the manager's office, the staff lounge) during a lull in the nurses'

workday, or immediately before or after their shift. Two interviews were conducted in

participants' homes, one in a coffee shop. Interviews with administrators were typically

conducted in their offices. Four of the five patient interviews were conducted in the hospital

(two at their bedsides, two in a patient lounge) and one was conducted in a participant's

downtown office following discharge. Generally, interviews conducted off of the unit were less

likely to be interrupted and occurred at a more relaxed pace. When interviews occurred during a

nurse's workday, both myself and the participant tended to "watch the clock" more closely. However, because of the nature of the relationships that had been established during participant observation prior to these interviews, even these shorter interviews flowed easily and were "rich" in detail. Interview procedures evolved in response to ongoing data collection and analysis (May, 1991). For instance, interviews in the later phases of the research were often directed by more specific questions as I aimed to clarify emerging conceptual structures.

Formal interviews varied from thirty minutes to two hours in length. All of the first interviews were in-person, many of the second interviews were phone interviews. Second interviews were arranged for clarification and validation as data analysis proceeded (Thorne et. al, 1997). Most of the interviews were audio recorded and transcribed with permission from participants. Several of the participants preferred not to have our conversations taped, so in these cases I took more detailed notes which I "fleshed out" immediately following the interview. After explaining the purpose of the interview and obtaining signed consent, I initiated the conversation with a general or "grand tour" question (e.g., "What is it like to work on your unit?") that give the participant "practice in talking to the researcher in a relaxed atmosphere while at the same time providing valuable information about how the participant views the general characteristics of the context" (Lincoln & Guba, 1985, p. 270). As the interview progressed, several open-ended questions provided guidance to me and minimal structure for the interview (see Appendix G). This loose structure was in keeping with my concern regarding the exercise of power in my researcher role. As well, I used clarifying questions that followed the story of the participant as necessary. Interestingly, it was not unusual for nurses and patients to question whether they were qualified to be interviewed, to which I assured them that their perspectives were worthwhile in assisting me to understand the issues of providing intercultural

care and the nature of nurses' work. I found I was tentative in raising issues of discrimination and racism, and also perceived that participants were hesitant to tell stories of discrimination experiences. In order to get at this type of information, I asked nurses if they ever felt they had been treated differently because of their ethnic background, allowing them to choose how and to what extent they disclosed such information. There were also times when participants asked to have the tape recorder turned off, and the conversations that followed were often emotional and less reserved. At the end of these "off the record" comments, I asked if they would mind if I took notes on our conversations and included them in the data if they agreed.

The interview was terminated when it was no longer productive, or when the agreed upon time had elapsed. At this point, I briefly summarized the discussion and invited any final comments. The concluding minutes of the interviews often generated "rich" data and I was always interested in these final comments as they often reflected what the core issues were for each nurse. Thereafter, I thanked the participant for her cooperation. As part of the interview, I also collected biographic information from each participant (See Appendix H for Biographic Forms).

Informal interviews occurred as I "buddied" with nurses (e.g., during coffee breaks). These interviews were unstructured and were not be audio taped. Instead, I recorded them (as my memory allowed) in my field notes. These informal conversations were invaluable in enriching my understanding of intergroup relations as nurses often spoke in dialogue with each other and me, and tended to speak more freely.

Writing Field Notes

Writing field notes was an integral form of data generation in this study. Emerson et. al. (1995) emphasize the close relationship between fieldwork and field notes:

It is easy to draw a sharp contrast between these activities, between doing fieldwork and writing field notes. After all, while in the field, ethnographers must frequently choose between joining conversations in unfamiliar places and withdrawing to some more private place to write about these conversations and witnessed events. By locating 'real ethnography' in the time spent talking with and listening to those studied, many ethnographers not only polarize but also discount writing notes as a central component of fieldwork. "Doing" and "writing" should not be seen as separate and distinct activities, but as dialectically related and interdependent activities....writing field notes helps the field researcher to understand what he has been observing in the first place and, thus, enables him to participate in new ways, to hear with greater acuteness, and to observe with a new lens. (p. 15)

Field notes, then, were a vehicle for deeper insight into what was observed in the field, an important mnemonic device (Sanjek, 1990) to remind me of what happened during participant observation, and an instrument for researcher reflexivity.

I maintained three forms of field notes: (a) a small notebook for "jottings" in the field; (b) a theoretical journal; and (c) field notes "proper". The first form, the "jottings", were a precursor to full field notes. I developed the habit of jotting in the field, although taking time out of the unit's routine to do this was always difficult. I attempted to jot notes at the nursing station or in a nearby classroom without drawing undue attention to myself. Most often, I tried to follow the flow of my "buddy's" work. When she sat down to chart, I would sit down to expand on my jottings. Several nurses joked about what I was writing, but generally paid little heed. These jottings were most often scanty, with a few trigger words recorded chronologically (i.e., timed) to help me reconstruct the events of the day later. The second form of field notes, the

theoretical journal, traveled with me wherever I went (e.g., to seminars, lectures). In it, I recorded new insights, thoughtful comments, and an ongoing reference list of sources I wanted to pursue. This form of notes has been particularly useful in the latter stages of this project as I have sorted through various analytical issues.

The formal field notes were computer-based, and consisted of three columns of observational, reflexive, and analytic notes. In the first category, observation notes, I wrote descriptive narratives of what happened and what I saw in a chronological fashion in as much detail as I could remember. Admittedly, the narratives I wrote were selected and interpreted through my own lens of observation; that is, I wrote about what struck me as important. As such, the narrative reflected only one "take" on the events of the day. This category held verbatim quotes, reflecting my commitment to capturing multiple perspectives and building polyvocality into the ethnography. The second category, personal notes offer a place for reflexivity in which I recorded what I was thinking and feeling in the situation (in keeping with the intersubjective nature of knowledge construction). The final category, analytic notes, included notes in which I offered beginning interpretations and coding. The formal field notes, then, portrayed the unfolding of the research project. To facilitate tracking of the project, I printed these notes immediately and kept them in a binder for quick reference. I also designed a chart that documented each research episode, its time and length, the nature of it, and kept a running tally of the number of episodes and hours of fieldwork.

I wrote the field notes, constructed from my "jottings" and my head notes (what I remembered), as soon as possible after each fieldwork episode. As noted by Emerson et. al. (1995),

Writing field notes immediately after leaving the setting produces fresher, more

detailed recollections that harness the ethnographer's involvement with and excitement about the day's events. Indeed, writing notes immediately on leaving the field offers a way of releasing the weight of what the researcher has just experienced. (p. 40)

Even when I was exhausted, I found writing field notes an important form of "catharsis" and a vehicle for deeper insights. As I wrote about my experiences, I understood them with greater clarity. However, I soon recognized the time-consuming nature of writing field notes and began to set aside blocks of time immediately after fieldwork in order to capture the happenings. I decided early in the project that if I was unable to set aside such a block of time within 24 hours of fieldwork, I would postpone the next episode. As well, I followed Emerson et. al.'s recommendation to spend shorter lengths of time in the field (e.g., three to four hours) in order to allow more time to write field notes.

Reviewing Texts

Reviewing texts also contributed to my analysis of the broader context of the study. Textual analysis is an important technique within institutional ethnography. As explained by Campbell and Manicom (1995), textually mediated knowledge production leaves behind "what people know" and becomes authoritative, taking on a transpersonal and objective character. As these texts are applied (e.g., by a professional), local experience is subordinated to an authorized objectified account of it, ultimately contributing to relations of ruling. We see then, that language is a social phenomenon and part of a socio-historical context.

I sought texts in the meso context (e.g., hospital policies and procedures, memos, patient teaching aids) and in the macro context (e.g., newspaper clippings, popular magazine articles, government policies and statements). These collateral materials provided a useful testing ground for the conceptualizations that evolved from data analysis (Thorne et. al., 1997).

Managing Data

I gathered a large amount of data in the form of field notes, interview transcripts, and various texts. The management of these data, aside from analysis, presented its own challenge. Field notes were stored both on the computer (hard drive with back-up on zip disc) and in hard copy (chronologically in a binder). Interview transcripts were handled similarly with copies on the computer as well as hard copies used for coding. Texts were kept in file folders organized by type and/or topic (e.g., a file of hospital policies; a file of newspaper clippings related to immigration issues; another regarding reports of racism and inequities). All of the printed materials, discs, and audio cassettes were stored in a secured filing cabinet.

Constructing Meaning and Knowledge: Data Analysis

Sandelowski (1995) observes that the most daunting challenge confronting anyone conducting qualitative research is what to do with the data that have been collected. Themes, categories, or codes do not magically emerge without the researcher's hard work and creative conceptualization. In the case of ethnography, data analysis most often is referred to as interpretation and is accomplished through writing. In keeping with the constant comparative method, data analysis in this study was ongoing, beginning with the first fieldwork in order to facilitate the "emergent design, grounding of theory, and emergent structure of later data collection phases" (Lincoln & Guba, 1985, p. 242). In this way, each interview and participant observation built on the preceding ones. Understanding data analysis as beginning with the initiation of the project generally made the task of analysis more manageable. Sandelowski's approach to data analysis, with the stages of data preparation, data analysis, and data

interpretation, was helpful in providing an organizing structure to the overall process of data analysis and I adopt it here to sequence my discussion.

Data Preparation

According to Sandelowski (1995), data preparation and analysis may be viewed as "operations that (re)present and (re)organize the data into forms that will permit interpretation" (p. 372). In this project, data preparation consisted of the writing of field notes (described above), transcribing interviews, and organizing texts. Transcripts were double-spaced with a 3 1/2 inch right margin. I initially carried out transcriptions myself, on the same day as the interview when possible, in order to begin a rudimentary form of analysis as I got a sense of the interview as a whole. However, in the interests of time, I employed a transcriptionist as the project progressed. I then listened to the tapes as I "checked" the transcription. This replay reminded me of the nuances of each interview (e.g., tone of voice, pauses, and laughter) and assisted me in my initial analysis. Merrit-Gray and Wuest (1995) similarly found that listening to the participants' voices during coding greatly enhanced their ability to identify conceptual indicators in the data.

Data Analysis

Although data analysis was an ongoing and cyclical process, I followed three steps in my approach to the interview transcripts. First, I read and reread these documents to get a sense of the whole. During this step, I jotted notes in the margins that occurred to me -- some of these notes became "codes", others were more reflexive in nature where I considered how I influenced the flow of the interview. Sandelowski (1995) suggests that scribbles and doodles on transcripts and freedom in notation are preferable to constraining intellectual activities according to some *a priori* rules. Second, I wrote point form abstracts (what I called "story lines") of each interview,

summarizing the key points and the interactional flow of the interview. During this step I also reviewed corresponding field notes from my participant observation (i.e., reading the field notes from my participant observation with the nurse I had interviewed). Third, I reread each transcript again with the purpose of developing a systematic method of coding and recording the data. I then transferred these coded sections, together with their locations in the transcripts, into a computer file. That is, in order to facilitate data analysis, I worked initially with hard copies of transcripts and field notes and then used a word processing software package (Microsoft Word for Windows)[52] to group coded sections into files (e.g., when using the code "translation services", I started a file by that name and cut and pasted coded transcript sections into that file). These code files became a way of comparing and synthesizing data across interviews and facilitated the aggregation of like data (Morse, 1994). I also read and reread my field notes, coded them, and included these coded sections in the variously coded computer files.

Data Interpretation

Interpretation was the end-product of qualitative analysis where I rebuilt data into something new that was different from, yet faithful to, data in its original form. This new conceptual structure allowed me to communicate the phenomenon under study in a meaningful and illuminating way. Part of the interpretation phase of institutional ethnography was the construction of a schematic "design" that captured the relevant relations implicated in the everyday experiences of nurses providing intergroup health care (See Appendix B) and the sketching of this "design" itself contributed to a deeper understanding of the "whole picture".

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[52] As the study progressed, I realized the limitations of using this particular software in this fashion. The time I gained up front by not learning a new software program seemed to be lost in the analysis phase as I struggled to keep the data organized. Data retrieval, for example, was cumbersome with the method I chose, and it was difficult to "cut through" the data in different ways when I wanted to check a new analytic idea.

Thematic analysis involved initial description and proceeded to evolving levels of abstraction. Early analysis resulted in a conceptual framework with six major themes, with multiple subthemes, that were predominantly descriptive in nature. As I focused more closely on analysis, I reworked these themes into an analytic structure that mirrored the micro, meso, and macro contexts of intergroup relations. The final stages of analysis involved the development of theoretical arguments that linked various themes together around a main theme of "Making Sense of Difference". Notably, analytical work in the final stages centered on writing, rather than conceptualizing per se or reading and organizing data. Another mark of data interpretation was its dialectical nature, as I moved between field notes and transcripts, evolving data analysis, and theoretical and research literature. Re-immersion in the literature, for example, allowed me to "try out" different explanations for the patterns I had identified, and also helped me stay within the critical interpretive framework I was committed to, making the analytical phase both inductive and deductive.

Denzin and Lincoln (1994) speak to the art of interpretation, suggesting that the "interpretive practice of making sense of one's findings is both artful and political" (p. 15). In this case, I found that the links I made between data seemed intuitive at times, and creativity contributed to the process of conceptualizing how various themes might be interrelated. Certainly data analysis was political, as I was well aware that the interpretive lens through which I approached the project meant I was more likely to identify certain themes. For example, because I was interested in the social organization of intergroup relations, I interpreted comments such as "we only like to care for English-speaking patients" as indicative of a personal stance, but also reflective of larger societal discourses and ideologies that construct Canada as a White, homogeneous nation.

In summary, data analysis began in the initial stages of this project and evolved throughout the study into a multi-layered conceptual framework portraying the social organization of intergroup relations in health care provision. Careful preparation of the data, detailed analysis (i.e., breaking up the data), and thorough interpretation that reconstructed the data into a meaningful whole facilitated thematic analysis.

Ensuring Scientific Quality

The basic issue at the heart of concerns about scientific quality (typically referred to as rigor[53] within quantitative methods and trustworthiness within qualitative studies) is this: How can a researcher convince her audiences that the findings of an inquiry are worth paying attention to (Lincoln & Guba, 1985)? Traditionally, scientific quality has been established by researchers' attention to reliability and validity. By these measures, qualitative research has often been denounced as "sloppy", "undisciplined", "subjective" and generally lacking scientific adequacy. These criticisms, along with a shift away from a realist ontology, have led qualitative researchers to look at new criteria to ensure scientific quality emphasizing integrity in the process of research rather than the "truthfulness" of research findings. As explained by Sandelowski (1993), "trustworthiness becomes a matter of persuasion whereby the scientist is viewed as having made...practices visible and, therefore, auditable; it is less a matter of claiming to be right about a phenomenon than of having practiced good science" (p. 2). However, this emphasis on the *process* of research has also been scrutinized, and critiqued for its preoccupation with procedure and lack of allowance for intersubjectivity in the process of making meaning (Hart, 1998).

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[53] I am intentionally avoiding the term "rigor" because of its association with positivist research. Sandelowski (1993), in her insightful discussion of ensuring scientific quality in qualitative research, comments that "there is an inflexibility and an uncompromising harshness and rigidity implied in the term 'rigor' that threaten to take us too far

Qualitative researchers within critical traditions are beginning to refocus criteria for ensuring scientific quality. Whereas earlier sets of criteria were most likely to focus on the process (i.e., procedures) of research, Lincoln (1995) points out that emerging criteria are *relational*, recognizing and validating relationships between the researcher and those who participate in the inquiry. She also makes the astute observation that specific criteria apply to specific kinds or classes of research, making uniform criteria across studies less likely. She calls for individual researchers to exercise professional judgement in determining what criteria are most relevant for a particular study.

This discussion of the evolving conceptions of criteria for ensuring scientific quality leads me to select standards that "fit" with this particular study. First and foremost, Smith (1987) contends that validity within institutional ethnography "involves reference back to those processes themselves as issues of 'does it indeed work in that way?' 'is it indeed so?'" (p. 160). This calls for an interpretation of validity that is closer to the idea of "truthfulness" than "trustworthiness" and is echoed in Lather's (1991) notions of construct and face validity and Denzin's (1997) portrayal of verisimilitude. Second, to account for the critical theories informing this research and the associated emphases on relationality, positionality, and praxis, I also considered the criteria of triangulation, catalytic validity, reflexivity, rapport, and voice. Together, the selected criteria directed me to evaluate this study in terms of its accuracy in uncovering the social relations shaping everyday experience and its faithfulness to the tenets of critical inquiry.

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from the artfulness, versatility, and sensitivity to meaning and context that mark qualitative works of distinction" (p. 1).

Construct Validity

I use the term construct validity to reflect Smith's (1987) concern for accurate explication of the extralocal forces shaping everyday experience. Although she does not explain the "how-to" of ascertaining such accuracy, I suggest that the heuristic contribution and explanatory power of the research findings serve to meet this criterion. Patti Lather (1991) observes that "determining that constructs are actually occurring rather than mere inventions of the researcher's perspective requires a self-critical attitude toward how one's own preconceptions affect the research" (p. 67). Therefore, in keeping with the dialectic between theory and research, the findings presented here are grounded in certain theoretical perspectives to keep in check any tendency to impose my own preconceptions on the data. According to Lather, construct validity is also enhanced by a continual immersion into and respect for people's daily lives to avoid theoretical imposition. In this study, extensive fieldwork (participant observation and interviews) provided such continual immersion and guarded against the simple imposition of *a priori* theory. In the following chapters, several findings are presented that challenge commonly held theoretical ideas. Systematic reflexivity incorporated throughout the study (and reflected in this report) further revealed how *a priori* theory was changed by the logic of the data.

Catalytic Validity

If one of the goals of critical inquiry is political or social action to change inequities, the scientific quality of the research is reflected, in part, by the degree to which such change occurs. Lather (1991) is one of the proponents of this less known measure of validity, termed catalytic validity, and describes it as "the degree to which the research process re-orients, focuses and energizes participants toward knowing reality in order to transform it" (p. 68). Earlier in Chapter Three, I explained that praxis was sought through the researcher-researched relationship (e.g.,

both researcher and participants were changed) and also in the dispersal of research findings (e.g., policy recommendations, presentation of research findings). The evaluation of this criterion can only be partial at this time, because the dispersal of research findings in any formal sense has just begun, however, there was evidence of changed participant perspectives as the project progressed, and I am certainly aware of significant shifts in my own perspectives due to immersion in this study.

Triangulation

Patti Lather (1991) also includes triangulation as a critical indicator in establishing the trustworthiness of research and extends triangulation to include multiple data sources, methods, and theoretical schemes. Triangulation in this study was achieved by collecting data from thirty-five participants from three different units. Various methods were used in order to collect this data: participant observation, interviews, writing field notes, and reviewing documents. Moreover, the theoretical framework informing this study drew on feminist, postcolonial, intergroup, and standpoint theories. Throughout the project, I consciously considered both converging and contradictory patterns of data.

Reflexivity

In order to achieve scientific quality, scholars (especially critical scholars) emphasize the need to check that researchers have not simply verified their own preconceptions or imposed *a priori* theory on the data (Hall & Stevens, 1991; Lather, 1991; Acker et al., 1983) but have located themselves within the research project. Anderson (1991b) proposes that "fieldwork is inherently dialectical -- the researcher affects and is affected by the phenomena (s)he seeks to understand" (p. 117). Reflexivity, the "critical thinking that reflects the dynamic interaction and exchange between the investigator and the total research environment" (Lamb & Huttlinger,

1989, p. 766), is a means of ensuring scientific quality. Reflexivity infused all of the research project as I continually examined my own values, assumptions, characteristics and motivations to see how they affected my theoretical framework, review of the literature, research design, data generation and interpretation. Reflexivity was facilitated through writing field notes, conversations with colleagues, and guidance from my supervisory committee.

Rapport

As alluded to throughout this report, the influence of feminist theories on this study meant that I valued engagement with, rather than detachment from, the participants and phenomenon investigated. Hall and Stevens (1991) explain that a researcher must be involved with participants in order to achieve the detailed data collection and analysis required to present a credible description of the everyday realities of the participants. The quality of relationships with participants becomes a criterion of scientific quality indicating how well that reality has been accessed. In this study, rapport was evidenced by the nature of information shared, verbal and nonverbal indications of participants' comfort and openness, their willingness to be involved over a period of time, and their inclination to recruit other participants.

Voice

Because of the undergirding theme of attention to relations of power in the study, a final criterion of scientific quality is that the active voices of participants must be 'heard' in the research account (Acker, et al., 1983; Alcoff, 1991; Hall & Stevens, 1991). Polyvocality was sought by (a) purposive sampling for a diverse group of participants with a range of experiences, (b) listening carefully to the accounts of participants, and (c) liberal use of their verbatim stories in written reports.

__Considering Ethics__

While all researchers attend to ethics, it seems to me that researchers informed by critical theories and working with marginalized groups must operate from a "maximalist" ethic. That is to say, with consciousness of relations of power and commitment to address social inequities, critical researchers carry a heightened awareness of ethical issues in research. We are concerned not only with ethics *within* a research project, but with the ethics of research itself. Daphne Patai (1991) captures this concern with the question: "Is it possible -- not in theory, but in the actual conditions of the real world today -- to write about the oppressed without becoming one of the oppressors?" (p. 139). She concludes that in an unethical world, truly ethical research is not possible. Judith Stacey (1991), in her essay "Can There be a Feminist Ethnography" comes to a similar conclusion:

> ...the irony I now perceive is that ethnographic method exposes subjects to far
> greater danger and exploitation than do more positivist, abstract, and 'masculinist'
> research methods. And the greater the intimacy -- the greater the apparent mutuality
> of the researcher/researched relationship -- the greater is the danger. (p. 114)

With this sobering picture of potential ethical pitfalls in my mind, I want to highlight several areas in this discussion: exploitation and reciprocity; informed consent; confidentiality and privacy; and intervention.

I was cognizant of the possibility of exploitation occurring in this study. I was especially aware of the possible perception by participants of exploitation once I left the primary unit where I had developed closest ties with participants. Toward that end, I revisited the unit periodically to re-connect with participants and left general notes regarding the ongoing status of my research in the communication book to be read by participants who might be off duty. I have also

planned educational forums on each of the three units and have offered to serve as informal consultant to participants in the future. While I sensed that participants typically benefited from their involvement in the research (e.g., from having someone listen to them during an interview), I wanted to extend reciprocity in this study in more tangible ways. I looked for ways of giving back to the participants, such as assisting in simple nursing tasks, providing them with relevant resource materials, and offering them summaries of research findings. I am certainly indebted to the participants in this study who agreed to work with me.

Informed consent was obtained prior to first interviews and/or participant observation. Participants were informed verbally and in writing of the nature and purpose of the study, their involvement, how the data would be collected, handled, and dispersed. (See Appendix I for consent forms.) I conceptualized consent as process consent, to be continually obtained because the emergent design of qualitative researcher makes it difficult to predict the direction of the project (Lipson, 1994; Munhall, 1988; Ramos, 1989). Therefore, even though I gained initial written consent from nurses, I remained alert to any indications that they were hesitant about my observation of any aspects of their nursing care. As well, along with the written consent from each of the nurse participants, I provided other health team members with documentation about my project and told them that I would not take notes on my observations of them against their wishes. Most of these "periphery" health care providers responded positively to my presence; however, several asked that I not include them in my notes. I also sought verbal permission from each of the patients my "buddy" nurse was caring for by introducing myself and explaining my purpose in "buddying" with the nurse. I interpreted their nods, smiles, and greetings as informal consent for my presence. Most patients gave consent freely and were interested in my project. Because of the social status inherent in the nurse researcher role (Robinson & Thorne, 1988), I

continually emphasized and clarified my researcher role (e.g., through introductions, and the use of my name tag) and exercised judgment in suspending the researcher role in situations where it was clear that a patient was responding to me primarily as nurse or when they were unable to consent to my participant observation. Further, there were situations in which I did not observe nurses performing personal care for patients because I did not feel free to invade privacy to that degree without specific written consent from the patient.

Confidentiality was assured by the use of code names (in numeric form) in written reports. I have also altered circumstances in some instances in order to protect the identity of participants. Access to the data was limited to myself, my supervisor, and the transciptionist (who signed an agreement to confidentiality; see Appendix J). Audio tapes, written field notes, and transcripts were kept in a secured filing cabinet. Documents that identify individuals or agencies (e.g., consent forms) were kept separate from the data itself. I obtained consent from participants to retain the data for possible secondary analysis by myself.

A final issue that relates directly to ethics in qualitative research is that of intervention, in the form of providing nursing care, or in the case of witnessing unethical conduct. From a traditional research perspective, intervention is of concern because of the risk of "contaminating" data, but from a critical stance with an acknowledgment of the intersubjective nature of knowledge construction, intervention becomes part of the data itself to be analyzed (Anderson, 1991b; Robinson & Thorne, 1988). The dilemma, then, is one more of negotiating between nurse researcher and nurse clinician roles. As a nurse, and therefore a client advocate, I was clear that I could not place the research imperative above the therapeutic imperative (Lipson, 1991; Munhall, 1988). Therefore, there were situations in which I suspended my researcher role and participated as an assistant or "gopher" for the nurse. In another instance, I delayed

beginning my "buddying" episode until well after an emergency situation had been dealt with by the participant. I also had concerns regarding the witnessing of unethical or illegal actions going into the study. Although I did not witness any major infractions, there were times when I was uncomfortable with the care a patient received (e.g., not having their privacy assured by pulling curtains, how a patient was spoken to, or not spoken to). In these cases, my interventions were non-confrontational in that I "modeled" more appropriate care by quietly pulling the curtains, or starting up a conversation with the patient. I felt more discomfort regarding what my intervention should be when participants made comments that I perceived as classist, racist, or otherwise discriminatory. Depending on the circumstance and my relationship with the participant, I tried to present a counter perspective in a diplomatic fashion and, in so doing, portray a demeanor open to dialogue, but also averse to such comments. Because of my praxis orientation, my ultimate goal in these situations was to promote a degree of self-reflection among participants.

In conclusion, the ethical issues arising in this study were not always clear-cut nor anticipated. Because of this, I appreciated Lipson's (1994) advice that emphasizes the centrality of respect in guiding ethical decisions. She also suggests that

> we inform ethical decisions with cultural sensitivity, awareness of our own ethical values and how strongly we need to impose them, and trust in our own gut feelings about what is right in the immediate situation and whether there will be later repercussions. (p. 353)

Summary

I have outlined the research methodology and methods employed in this study.

Institutional ethnography, with its aim of unmasking and challenging oppression and its multiple

methods of data generation, was well suited to the objective of studying the social organization

of intergroup relations in health care provision. The experience of conducting this research study

has been a remarkable experience for me as I have come to understand the "artful work" of

fieldwork and have "lived" with the study data in an intimate fashion for some time. The

meanings and knowledge constructed from this study are presented in the next four chapters.

CHAPTER FIVE:

INTERGROUP RELATIONS IN HEALTH CARE PROVISION:

NURSE-PATIENT ENCOUNTERS

The remaining chapters of this dissertation contain the "findings" of this research. I begin here from the standpoints of nurses in a portrayal of day-to-day intergroup encounters and then expand this discussion in the following chapters to make visible how these day-to-day encounters are socially organized by the context of nurses' work (meso level; chapter Six) and organizational and community settings (macro level; chapter Seven).

The enterprise of health care provision in intergroup situations is complex, involving the intersection of a myriad of factors: the identities, values, personalities and health care needs of patients and their families; the disposition, competencies, identities, and commitment of the individual nurse; the nature of nurses' work; the organization of health care institutions and the larger priorities of the health care system; the community setting; societal values and ideologies; the histories of various groups within society; and so on. The aim of this research was to contribute to the unraveling of these complexities in order to enhance our understanding of intergroup relations in health care provision and to thereby influence the quality of care provided to patients, especially those in marginalized groups. This dissertation then is an interpretation of how it all "hangs together". While attempting to capture a "whole" and present a coherent story, this particular representation contains variations, nuances, and even contradictions. I have reconciled myself to this multiplicity, believing that the world of health care itself is incredibly complicated and all the more so when viewed through the lens of culture.

As noted earlier, this story is in many ways a continuation of my masters' thesis, picking up on that description of nurses' experiences in caring for clients with diverse ethnocultural

backgrounds (Reimer, 1995; Reimer Kirkham, 1998). That study revealed, among other things, how nurses vary in their commitment to caring for patients with diverse backgrounds from being resistant to neutral to impassioned. This current research brings further light to the processes and reasons behind such variations, while locating intergroup care in its larger context to show how this context shapes day-to-day health care encounters. Additionally, the 1995 study alerted me to the ways in which health care is influenced by the social construct of *race*. In this study, it has become increasingly clear that many of the processes and structures that mark interethnic/interracial health care spill over into other situations in which nurses provided care across "difference"[54] and that the construct of *race* rarely operates in isolation, but rather teams up with other signifying categories such as gender and class to create boundaries and distinctions.

By beginning with the standpoints of nurses in this chapter, the project of explicating intergroup relations is entered into through nurses' experiences of intergroup care provision. The perspectives of the five patient participants are also incorporated throughout the report to extend understanding of the negotiation of intergroup relations. Participants' constructions of intergroup health care provision are instructive in providing initial understandings that serve as the basis for the rest of the study. Specifically, this first section deals with how difference is constructed, common sources of challenge in intergroup health care provision, and the concern of a lesser quality of care for marginalized patients. It also became quickly apparent that nurses

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[54] I use the term "difference" in a politicized sense in this study, realizing the dangers of reifying and essentializing difference in a culturalist sense. Ahmad (1993) describes the culturalist perspective as one in which realities are constructed and explained in terms of 'cultural differences', with difference equated with deviance and pathology. Racialized inequalities are then explained as the outcome or result of cultural differences and deficits. Likewise, Anderson, Tang, and Blue (1999) tell us that "the notion of 'difference', embedded in the assumption that some people's beliefs are located in their 'ethnic heritage,' solidifies ethnic boundaries and treats beliefs as frozen in time and history" (p. 9). Postcolonial scholars like Stuart Hall (1997) and Homi Bhabha (1994), while employing the term in a political sense, avoid a necessarily pejorative tone, indicating that "difference" can be something viewed as positive and empowering or as negative and exclusionary. It is along these lines that I use the term.

constructed intergroup relations in various ways as they approached intergroup health care provision through their own ways of understanding the world. Thus, their interpretive lenses provided a framework for the work of making sense of difference and were shaped by their past experiences, identity(ies), education, and values and beliefs. The second section builds on the foregoing interpretations to explore the ways in which intergroup relations are negotiated in health care settings, explicating the themes of seeking points of connection, working through language differences, accommodating "difference", and acknowledging the racialized experiences of nurses of Colour.

An Entry Point: The Standpoints of Nurses

According to Smith (1987), a standpoint "cannot be equated with a perspective or worldview. It does not universalize a particular experience" (p. 107). Rather, Smith explains that "the standpoint of women …directs us to an "embodied" subject located in a particular actual local historical setting" (p. 108). This presentation of the standpoints of nurses therefore does not attempt to capture one cohesive experience; rather individual standpoints are understood for their uniqueness. On the other hand, this inquiry varies from what could be criticized as a subjective, phenomenological project by extending to uncover how everyday experiences are coordinated and penetrated by discourses, structures, and other extralocal forces.

In order to understand intergroup relations, I began by asking nurses to talk about situations in which they cared for people from ethnocultural groups different from their own[55]. Thus, the notion of intergroup health care provision (i.e., health care provision in which nurses and patients did not share common ethnicity) served as an *entrée* into the larger research

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[55] Importantly, I entered the study with the assumption that intergroup relations were multidirectional, meaning that I was examining interactions between White nurses and patients of Colour as well as those between nurses of Colour and White patients. This early assumption, with its corresponding methodological decisions (e.g., to include nurses

investigation of intergroup relations in health care provision. These early descriptions of how intergroup care was constructed by nurses and patients revealed a number of key themes that are foundational to the entire project.

Descriptions of Intergroup Care

When first asked about their experiences with intergroup care, nurses were often fairly nonchalant about the whole matter. They would reply "that's interesting" when I explained my project but gave the impression that there were certainly more pressing issues facing them in their clinical practice. Receiving these sorts of responses as a novice researcher, committed to my research question, was somewhat unsettling. However, as the study progressed, I realized the "truth" in their responses. Because of the intensity of the demands on their practice (e.g., heavy workloads, threatening job action, increasing technology with its demands), intergroup care often became less of a priority for them. They were frequently in a sort of "survival mode", "just doing the basics" as they told me. Now as I come to the data, I see that intergroup care was always a challenge at a certain level, yet most nurses "took it in stride" much of the time. However, it was when some part of the equation intensified – that is, when a cultural preference became a conflict, when the need for interpretation prevented the provision of a minimal standard of care, or when workload demands accelerated – that intergroup care became a "big issue" from the standpoints of nurses.

Additionally, from the initial phases of research, nurses' interpretations of what constituted an intergroup encounter pointed out to me that nurses were more in-tune to "difficult" patients than "different" patients. When I asked nurses to talk about providing care "to patients different from themselves", conversations invariably centered on who "difficult" patients were,

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of Colour and White patients in my study), brought a richness to the data and offered unexpected insights into the complexities and intersectionalities inherent in intergroup relations.

with typical representations of these patients as outside the normative standard of what is expected and appreciated in illness behaviour as well as societal involvement. Thus, those with histories of substance abuse; those from impoverished groups, especially when on some form of social assistance; those who were confused, restless, or demented; those who were extremely ill (e.g., multi-system failure) or categorized as "off-service" patients; those who could not speak English; and those who participated in cultural practices considerably outside the "norm" were constructed as "different". Analyzing the commonalities across these groupings of "difficult" patients, I concluded that difference is most likely to become an issue when it

a) interferes with efficient care (e.g., requiring extra time to communicate); b) raises moral dilemmas for nurses (e.g., raising a conflict between the culture of the hospital and the culture of the patient/family or evoking judgments regarding deservedness of health care); or c) challenges the status quo of the dominant culture of the health care system (e.g., pushing the limits of visiting hours). These insights into how "difference" is constructed and when it is interpreted as problematic are central to understanding intergroup relations in health care provision[56].

Although these commonalities around the construction of "difference" could be identified, there was also considerable variation in how nurses constructed intergroup care. Some described it as difficult and challenging, others described it as "no big deal" if the patients could communicate in English, others emphasized the importance of looking beyond "cultural differences" to common, shared humanity. Some nurses indicated that intergroup care only became an issue when there was a language barrier. Other nurses voiced resentment toward patients who did not speak English, with one nurse telling me that "we only like to look after patients who speak English". Evidencing a perspective that acknowledged the challenge of

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[56] Although this categorization of who is "difficult" will be drawn upon throughout this study, I will focus on the sources of difference related most directly to the issues of culture and *race*.

intergroup care, one nurse commented, "We are also getting a lot of multicultural people. Like, people of Chinese background, East Indian background, others are mostly European background. Those three groups. But I think sometimes it's hard to deal with"[57]. She went on to elaborate on the challenges of dealing with language barriers and family expectations for certain approaches to care. Her comments captured the two most commonly cited sources of challenge: language and "cultural differences". (These two themes are developed in more detail later in this chapter).

Concerns Regarding Quality of Care

A prevalent theme involved nurses' reflections on the decreased quality of care received by patients outside the "norm" or dominant majority, particularly those who could not speak English. One nurse observed that minority groups in general

> do not receive the same amount of care as, you know, if you are in the, if you are English speaking because the unit is so hectic, the nurses do not have time really to stop and try to figure out what the client is trying to say in her, his language....I don't find minority patients really receive the care that should be because of that.

More specifically, nurses identified the areas of clinical assessment, pain management, informed consent, and patient education as those in which care might be compromised for patients who did not speak English. Notably, they did not include emotional support as an area of potential neglect, perhaps because this was an aspect of care that was slipping for all of their patients (see Chapter Six).

Nurses observed that they often had difficulty completing accurate assessments and therefore had trouble planning and implementing appropriate interventions. One example

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[57] As outlined, both White nurses and nurses of Colour participated in this study. As well, nurses in a variety of positions were interviewed (front-line nurses, administrators, clinicians, regional level managers). In the interests of confidentiality, I am not indicating the backgrounds or job positions of nurses here unless immediately relevant to the interpretation of the data.

involves the assessment of pain and administration of analgesia. As explained by one participant, "It is hard. Because you don't know whether they have pain or where their pain is or what they want or if they need to go to the bathroom or if they are hungry". It was my observation that patients who could not communicate tended to receive less analgesia. Several nurses also suggested that people who did not speak English were not good candidates for patient controlled analgesia (PCAs), although they noted they did have patient education pamphlets regarding this intervention in a range of languages. One nurse informed me that non-English speaking patients, even when taught about PCAs did not "comply" and gave the example of a patient who had 129 requests on his PCA in 12 hours because family were entering the requests and at one point the patient mistook the PCA as the call bell. Interestingly, this issue was not constructed as one that required careful attention to patient education in situations where the patient did not speak English. Rather, the solution was seen to be withholding PCAs from these patients.

Some nurses also questioned whether informed consent happened for patients who did not speak English:

> I know from one instance in the past where we're trying to explain a consent to someone and we wanted the family member to read the consent to the patient. Well, he said something to the patient but he wasn't even looking at the piece of paper so we know that it was his version of what he wanted because he wanted the mom to sign the consent form. What was said, who knows. And you really felt bad about that.

Others raised the challenge of incorporating patient teaching across language barriers. In one of my observations, a nurse was providing a young Asian woman with discharge teaching late one evening.

When she takes the discharge information in to the patient, she explains the main points (take it easy for 24 hours, drink lots of fluids). It is not clear by the patient's responses or by the responses of her husband whether they understand this. The nurse repeats the question about whether the patient will be alone. She puts the paper in front of the patient to sign. As the nurse leaves the room, she looks at me, raises her eyebrows, and says "it is hard to know if they understand, he says "yes "yes" but I don't know if he understands". (Field Notes October 1998)

This nurse, while making an effort to provide discharge teaching, questioned whether the patient and her husband understood. Further, because she was offering explanations in simplified language, even if the patient did understand, she would have received only the most rudimentary instructions and would not have been supported in the traumatic life event she had experienced (i.e., ectopic pregnancy).

The move to early discharges typically places extra burden on family. In the case of patients who did not speak English, there was a suggestion that it was assumed that family would care for these patients. When I asked about how a language barrier influenced her ability to engage in discharge planning, one participant explained,

P: Well, lots of times with those cultures they have huge families anyway so they aren't going home alone.

R: So discharge planning has a different focus?

P: It's not like "Who's going to look after them?" It's more like the wound care or something like that, more that than the details of who is actually going to be with this person.

Such comments suggest certain assumptions being made about the availability of family, based on cultural stereotypes of extended family housing.

The common concerns regarding language, "cultural differences", and quality of care are reminiscent of those found in my earlier study (Reimer, 1995; Reimer Kirkham, 1998) and also by other researchers (Bernal, Pardue, & Kramer, 1990; Bhimani & Acorn, 1998; Burner, Cunningham, & Hattar, 1990; Murphy & Clark, 1993). Thus far I have provided a general "picture" of the different positions and perspectives of nurses. In the next section, influences on how participants understood intergroup relations, that is, how they "made sense of difference", are looked at more closely.

Making Sense of Intergroup Encounters

During my conversations with nurses, they often explained why they approached intergroup care the way they did. These stories typically revealed several strategies that nurses employed in order to understand certain nurse-patient encounters. They also provided insight into what shaped nurses' interpretations of intergroup relations.

Sense-Making Strategies

Nurses carried on a form of reflection that I have entitled "internal dialogues" or "self talk" as they sought insight into particular behaviours or experiences. An experienced nurse described it as follows:

P: There are a few things in different cultures, that men seem to be catered to a lot, we find that a lot. Where women come in and feed some one that is perfectly capable. And sometimes I have said things in joking, "oh, you know, you must let so and so", especially if it is a young, I say "it is very good for them". But in the back of my mind, I'm thinking, I should be thinking, "that is what they do" but on the other hand, I'm

thinking, "oh my goodness, he is only 25 years old and he has just had an appey - [appendectomy]". But you know, that is what they feel is their role, so that is fine. And I know I have to respect that, but on the other hand I'm thinking, I'm just thinking about the rehabilitation of the patient. You know?

R: You are coming at it from your nursing perspective.

P: Exactly.

R: So it sounds like, even within yourself, you are sort of having this conversation about what is going on here? That sort of thing?

P: Exactly (laughs).

The internal dialogue here involved her effort at making sense of the interaction between a son and his mother with its gender tones, while sorting out the conflict this represented to her from both her own cultural location as well as her professional value of self-care. As in this case, the internal dialogues of nurses were often marked by indecision, frustration, and even judgment, suggesting a degree of moral ambivalence and in some situations, moral distress. This process of sense-making is also reflected in the following interview excerpt:

P: And then, you know, the language barriers for cultures, I have had some really bad experiences. Like, you know, "what am I?" You know, like, for example, I had an East Indian man. Totally, I can't remember what he was here for, like COPD or something. Got up off the commode, bent over the bed, and pointed. He wanted me to wipe his bottom. And I handed him the cloth and said "it will be a frosty day in hell', like, I didn't say that, but you can do it yourself at home, you can do it yourself here. Pointing, like, "no".

R: So what were you thinking?

P: I was blown away first of all. Did I miss something? Did I not read, has this guy broken both arms? (Laughter) You know, I thought, "well, OK, well maybe it is a cultural thing". I'm thinking, "I'm sure his wife doesn't do this at home". "Is it a female thing? That can't be that". I was just, I stood there for a second. Then I gave him the cloth and "no, you do it". And I didn't, I wasn't sure if I was missing something, you know, you second-guess yourself. But than I thought, "no this isn't right". And now people have told me that in their culture nurses are second hookers. I don't know how true that is. Like women a) are subservient, and b) nurses, but like I say, I don't know.

R: Have you felt that at other times?

P: Well, it seems like, yeah, they spit on the floor and point. Like they expect us to be their servant. Again I don't understand. Is it the cultural thing or what? Then again I have had other ladies of that culture that are totally sweet. You know, you get both. That is like any culture. But that one just blew me away. I was, "oh", (laughter). And when I mentioned it to other nurses, they said "I'VE HEARD..." (with emphasis) like, you know, what they think of nurses. But the language barrier, I could have asked him, but I couldn't ask him "why are you asking me to do this?"

At one level, these examples illustrate the conflicts that may face nurses as they provide care to patients from across a range of diversity. The examples also speak to the gender issues that operate, sometimes overtly, at other times covertly, in many nursing interactions. The last case also refers to the construction of nurses as subservient, portraying that what could be interpreted as simply an intercultural encounter on the basis of varying ethnicity is further shaped by social positioning of nurses and gender constructions. As well, the difficulties of communicating

without a shared language are highlighted in this example. At another level, these two cases also provide insight into the sense-making processes of nurses, how they draw on their own personal and professional values, "hearsay" stereotypical knowledge, as well as on past experiences and bring these to bear on intergroup encounters as interpretive lenses. The nurse in the latter example is drawing on her interpretive lens to construct this exchange as a matter of "culture" and language, thus inferring a stable, homogeneous representation of "culture". In my interpretation of the data, then, I "read" the variations in the descriptions of intergroup care and the sense-making internal dialogues as reflective of the range of interpretive lenses brought by individuals to intergroup encounters.

Associated with internal dialogues, participants also used story-telling as a way of sense-making. Interestingly, of all the topics nurses talked to me about, they were most likely to present a "story", complete with detail, to describe the situations they interpreted as a "cultural conflict" and often these stories dealt with the care of a patient and their family at the time of death. It was also in this realm of what was constructed as "cultural conflict" that I heard one story so frequently (about a nurse cutting a Sikh man's hair) that I began to code it as "unit folklore". Scholars working within the tradition of narrative analysis tell us that story-telling serves as a form of "empowering persons through more subtle understandings of their life situations" (Manning & Cullum-Swan, 1994, p.465). Therefore, I took these stories as evidence that nurses were still "making sense" of these particular events, and that what were perceived as conflicts perhaps required more "sense-making" on the part of nurses than some other aspects of intergroup relations.

Along with these stories and internal dialogues, the strategies of reductionism and classification were also used as forms of "sense-making" when dealing with the complexities of

intergroup care in demanding and changing environments. As already introduced, reductionism most often occurred as nurses distilled matters of ethnocultural "difference" and intergroup care to one of language. In discussions regarding intergroup care, language was often the focus of our conversations. This reductionism, however, is not surprising in light of the earlier observation that "difference" became a "problem" when it interfered with efficiency.

Classifications according to mental encoding systems were also evident in my conversations with nurses and in my observation of nurse-patient encounters. Both nurses and patients categorized individuals on the basis of accent, language, appearance, and skin colour. One patient, for example, asked me what nationality the nurse I was buddying with was, saying that she had "such a striking appearance". She continued "I would ask her but that is not considered polite". Later she did ask the nurse this question, doing so in a fairly relaxed manner, saying that she had adopted foster children and that one had the same beautiful face. The nurse replied that her parents were Filipino, that her father was Spanish. She also added that she considered herself "Canadian". (Field Notes November 1998). I noted that this patient had an intense interest in this nurse's "difference", but was hesitant to pursue this, reflecting a widespread hesitation and carefulness around matters of *race* and "difference". Yet, the classification by appearance occurred. Classification also operated as a cognitive "sense-making" process through the application of stereotypes. For example, the stereotype of South Asian women as wanting to be pampered during hospitalization was frequently referred to as nurses explained that they had to "get after" these women to mobilize after surgery.

Reductionism and the related strategy of classification were also illustrated in the heavy reliance on "culture" as an explanatory device for "difference". This reliance reflected an essentialized conception of culture as a cohesive and relatively unchanging set of beliefs and

practices "belonging" to particular cultural groups. It was not unusual for participants to understand encounters with patients as representative of interactions they might engage in with others who shared what was constructed as a homogeneous "cultural group". Several participants, however, challenged such essentialized views of culture. An important point in the study came when two participants, both women of Colour, by their responses to my interview questions, queried the validity of using the concept of culture as located in or attached to discrete groups. In the first situation, a nurse of Colour put little emphasis on the importance of culture, but rather shaped the fundamental issue facing nurses as that of connecting with patients as human beings.

> R: So when I say a cross-cultural situation between you and a patient, what comes to mind in that what do you consider to be a cross-cultural interaction?

> P: Yeah, see, this is what, personally for me I understand human nature so whatever the person is doesn't bother me. If you understand human nature and basic needs of the human being, the color of the skin, the language really shouldn't be an issue....I think if everyone understands human nature and looks beyond culture and look, and that is important, I'm not saying it isn't, but that is important, but if you understand human nature basically, if you were that person what would you feel or whatever and understand it I don't think it could be so difficult understanding.

This nurse, by her emphatic response to my question, was resisting the easy categorization of people into cultural groups that would dictate certain types of behaviours. In the second case, a patient of Colour also challenged the assumptions underlying my questions:

R: I'm interested in intercultural care, and how the hospital might take your cultural needs into account.

P: I didn't know there was anything about my culture to take into account.

These two excerpts point to the ambiguities and limitations involved in using the concept of culture both in research and in practice. While many participants constructed group identities and distinctives as part of culture, these two participants contested any reified or essentialist notions of culture and, in so doing, confronted me with the imperative of maintaining a certain "openness" in my thinking about culture. Throughout the project, I myself sensed a pull toward concretizing culture – for example, while participating in the clinical settings it was not unusual to refer to the practices of various "cultural groups". Yet, at the same time, the vast variations within these "groups" reminded me of the fluid nature of culture, shifting across time and place. The tensions inherent in theorizing culture thus became an important analytic challenge for the entire project.

In sum, the strategies of sense-making internal dialogues, story-telling, reductionism, and classification were applied to counter the complexities of intergroup care. Intertwined with these strategies, culture was used as a powerful explanatory device to account for what were perceived as "differences". When taken together, these strategies point to the interpretive frames nurses draw upon in "making sense" of intergroup relations.

Understanding "Difference" Through Interpretive Lenses

As mentioned, it was not uncommon for nurses to explain to me why they understood intergroup encounters the way they did. In other cases, however, nurses seemed quite oblivious to the assumptions and identities they were bringing to health care provision. There were also situations in which I heard (and observed) contradictions that initially baffled me. For example,

nurses on one unit told me on several occasions that intergroup care was "no big deal" on that unit because there were few patients from non-European backgrounds, yet I had observed quite a few patients of Colour on this unit (e.g., Chinese, Iranian, Aboriginal). When I interviewed the manager for this area, she thoughtfully countered this construction of culture as not being a salient factor.

> R: My interest is in issues of culture and ethnicity in health and for a lot of nurses they just say ethnicity isn't much of an issue up here.
>
> P: Sometimes it is. Uhm…Certainly there are all sorts of levels. I mean if you scratch the problem I think it is [an issue]. I think that is true because my observation of problems or difficult patients and I'm going by as a manager is when the nurses walk in the door and they need help with this….So ethnicity doesn't always come up by I tell you when the chips are down that's where it's at.

This manager is suggesting that issues of culture and ethnicity may not be in the forefront of many nurses' minds but that these issues operate as subtexts. As she goes on, the role of interpretive lenses becomes clearer – nurses who have not had racialized experiences of discrimination, for example, are less likely to construct culture and *race* as an issue. On the other hand, because she herself had had the experience of being a "minority", she was more likely to "hear" nurses of Colour when they came to her with stories of discrimination. Further, the nurses themselves when faced with derogatory comments were reminded of past discriminatory experiences.

> Knowing, I think that that's true because my observation of problems, or difficult patients and I'm going by as a manager is when the nurses walk in the door and they need help with this. "I hate to bother you but it's come to this" and I will get a Filipino nurse here

who might start to cry and, uh, and it has to, or that patient may have used some derogatory terms toward her at some time or way back when this person, uh, brings up other past experiences where she has been degraded for her being Filipino or Chinese or whatever and so I think it is of race.

The notion of interpretive lenses that are used to make sense of day-to-day intergroup encounters is useful in reconciling apparent contradictions as the one just described. There were several situations, for example, when an individual interpreted an event as "racist" but the other party denied that racism was an issue. For example, one administrator noted that *race* was sometimes appealed to as the explanation for being treated differently, when this really was not the case.

> P: We've had allegations of racial discrimination come up and at a very low level. They never go very high because that's not usually the problem, uhm, whether it be nurse to other nurses or, uhm, patients' families involved in it. Like I say, that's almost never the problem. The problem is usually an inadequacy or an inflexibility somewhere and...

> R: So it sounds like race becomes an explanation?

> P: Well, it's something easy for people to feel as though, but what's at the bottom of it you know? They are being treated differently, so if they can't see or feel anything different it must be because of their background. And some have been personality challenges that have been nothing to do with culture, race, anything that has to do with their personalities and we're able to work with it you know. Once we sat down and really talked it out and, you know, had face-to-faces with the other people.

The task of data analysis here is not to decide whether racism was perceived or intended; instead my interpretation here is that individuals bring their own interpretive lenses to each intergroup encounter and that these lenses mediate how these encounters are understood.

Influences on Interpretive Lenses

As has already been alluded to, interpretive lenses derive from a range of influences and are shaped over time. According to the study data, one's past experiences, identity(ies), education, and values and beliefs come together most commonly in the formation of one's interpretive lens. Several nurses talked about how their upbringing and early childhood experiences shaped how they viewed intergroup care. One nurse, born in Asia, talked at length about what has influenced her view of intergroup encounters, explaining that she did not find it difficult to communicate with someone who did not speak English, citing how travelling and being in the minority position of not knowing a language now helped her. She expanded by saying

> It all goes back to your upbringing. Some families, South American, Asians, Chinese, whatever, they group together, socialize together, you know. And some parents don't encourage kids to bring their friends home, that type of thing, so consequently they only bring their own nationality home. So they are not so flexible. Their whole mentality, their lifestyle is limited. It all brings back to your upbringing, how adaptable your parents are....your upbringing dates back to your young days....So I think it is very essential for the younger generation to go through this process of college and university. So they can mingle with, rather than being sheltered.

Another participant explained that her own minority experiences as a child allowed her to "hear" nurses who came to her, telling of their discriminatory experiences.

P: Because my ethnic background, and living where we did, the French kids, if I could talk that way, would tease us and so there are some roots there which take away your confidence. I think it's a confidence thing, uhm, ethnic, being out of your country you lose your confidence. Being out of your group you lose your confidence. I think that my success (with these nurses), I know you haven't asked that question, but it's that when I respond to Asian staff in that manner they respond it's healing for them.

R: Your response being that you're listening to them.

P: Yah, that I can identify with them even though I'm white.

Along with the exposure to difference and experiencing a "minority" position, previous experiences of discrimination typically sensitized nurses, leaving them more likely to interpret future situations as racist. One nurse described that while living in another part of the country, she and her husband experienced both institutionalized (justice system) and individual racism. She now confided that she was experiencing "some discrimination that doesn't feel good" in her work setting. Another younger nurse explained that she had grown up experiencing racism as the only visible minority in her school,

Well, I have grown up with this (racism). I was the only kid like this (gesturing to her skin) in my school, so I got it all the time. Also in university. But I learned to be assertive, almost aggressive, like "keep those comments to yourself, OK?" Otherwise they trample all over you.

Only a few nurses mentioned the influence of education on their approach to intergroup care, and this was in the context of suggesting that the hospital organize more continuing education to assist nurses. One nurse commented,

Honestly, I don't know about the hospital. It would help us if they had Continuing Education on this cross-cultural things, how people live in the East, like myself I know because I have been there, I was born in the jungle and I live in the city, right. But not everyone was born in the jungle, you know. So it wouldn't hurt to have Continuing Education, so we would understand them.

A few managers mentioned that when the hospital had organized educational sessions around "cross-cultural caring", they were not well attended. One manager speculated that this was due to nurses being defensive around the issue, "my sense from the staff was that, "well we're insensitive and they're going to tell us how to be tolerant, you know, that type of thing". She went on to explain that with the workforce becoming more diverse, nurses would benefit from some type of forum in which they could deal openly with matters such as intergroup communication. Thus, while education was not seen to play a significant role currently, it was seen as an important missing piece.

The social identities of participants, as marked by their culture, ethnicity, gender, and class, was a stronger influence on interpretive lenses. Most remarkable was the strong pattern that emerged as I asked nurses to comment on how their cultural identity influenced their experiences with intergroup health care encounters. White nurses were most often surprised by this question, and often said so. Several White nurses responded with comments such as "well that's not an issue for me because I'm Caucasian", reflecting a construction of Whiteness as natural and without "culture" (Such constructions of Whiteness are discussed in Chapter Eight). Several other White nurses, however, who described their heritage as being from other than the dominant Anglo-Canadian majority, were quite thoughtful about the influence of their identity. One nurse, for example, reflected on how her heritage shaped her work ethic:

R: I'm asking all the nurses this, do you think there are any ways in which your own ethnicity or nationality shapes the way you provide care?

P: Oh, absolutely.

R: So what would be some of the ways?

P: I think that Japanese nurses, they have a way of dealing with things, the Chinese, the East Indian nurses have a different way. And I think how you were brought up, how things were sort of ingrained. That doesn't just leave.

R: What are some examples for you?

P: For me, uhh, I work hard.

R: Yeah, the work ethic, eh?

P: I think that has been bred because of my nationality? People were very hard workers. Yeah, I will not lie back from any hard work or anything.

This nurse's reflections begin with the observation that culture is significant to how Japanese, Chinese, and South Asian nurses function, and upon further reflection (and my prompting) was quite moved in telling me that her work ethic was directly linked to her Eastern European roots. Another White nurse drew on the experiences of her immigrant grandparents:

I think what I probably recognize is that my mother's family was labeled, treated in a certain way. They were called DPs and treated in a different way. I think that has kind of sensitized me to some of the issues, you don't have to be a different colour, you don't have to look that different to feel like you don't fit in and feel like you are treated like you don't fit in. It is interesting, what it makes me realize is that everyone needs to be given a fair chance to have things like interpreter services which my grandparents never had when they came to this country. It was very difficult for them to get assistance. And

I think that in some respects that people coming to this country, yes they have barriers,

but they have far more resources than my family ever had coming to Canada. So I feel

that a lot of people coming into our facility -- although they don't have as many resources

as I would like them have, that is still a challenge for us, mostly from a monetary

perspective, not that is an excuse -- but I feel we are more resource-rich than we were. It

also makes me realize people have fears. What else. It makes me more aware there are

issues, needing someone to be there for you. Understanding people feel better when there

is family around the bedside, when they speak English or not. That we do have to

consistently stay open to different cultures, not only to their dress but that different things

mean different things to them, like we might like ice water, they might like warm water.

We have to take into consideration.

Several points are raised in this narrative: the participant reflects on how the experiences of her

grandparents have sensitized her to the experiences of immigrants and minorities today, and

suggests that visibility was not part of being labeled as different historically. Several nurses with

"mixed backgrounds" and several who had immigrated to Canada had some difficulty in

describing their cultural identity, explaining how they drew on the multiple aspects of their

identity, and how their sense of self shifted over time and place. Nurses of Colour were

generally more likely than White nurses to talk about their experiences, with specific examples

of how they negotiated their cultural identity. One younger nurse told me she sometimes was not

recognized as South Asian and would choose when to "reveal" her ethnicity:

Which is maybe… but I've also had times where the patients are East Indian and they're

not too sure if I'm East Indian so they will be speaking in Punjabi, you know, "is she…"

And then I'll say back in Punjabi, "yes I am." (laughter) Also I've found sometimes I

don't want them to know I speak Punjabi because they really want to monopolize my

time and really want me to do favors for them.

This story speaks to the visibility of "difference" as being linked to how one is classified or

signified as Other, or in this case, as one of "us" in the minority sense. It also shows how one's

identity is not stable, but rather shifts in certain contexts as individuals choose which identity to

foreground and which to background and speak to some of the complexities related to intragroup

relations. A Chinese nurse described how she felt "in-between" Western and Eastern cultures,

drawing on the best of each culture, and therefore was "not a typical Chinese nurse". The

experiences of these nurses give us insight into how identities are negotiated in order to bridge

differences and connect with people.

Another influence on interpretive lenses was that of people's values and beliefs. Several

nurses, for example, explained how their spiritual beliefs influenced how they approached

intergroup care. One participant explained the influence of her faith as follows:

R: Can you help me understand, for yourself, let's say you're caring for somebody that

you feel is quite different from you, what are the things that you do to help you?

P: Um, what I do is I must say I do have a background of Christianity too so that makes

a difference in how I care for my clients, you know, regardless what colour, what race,

what creed they are, you know, I see them as an individual themselves, created by God.

Another person of Colour similarly commented,

I really wish to advocate for people who are not getting their service, whether it's because

they can't speak the language or they just don't have the information or they really don't

know how to make the decisions or so on. So I think it's [her commitment to diversity issues] more shaped by that [this desire to advocate] plus my background. I was really brought up strongly in the church environment and so I think I'm influenced much more by that than my ethnicity....So I really want to demonstrate what it means, you know....what does it mean to "love your neighbour".

These nurses are drawing on moral principles, derived from their faith backgrounds, that significantly shape their interpretive lenses.

As evidenced in several of the foregoing excerpts, participants also drew on notions of nationhood in "making sense" of intergroup relations. These notions were rooted in constructions of Canada as "resource-rich" as cited above, or as tolerant as illustrated in the following comments by a participant who had immigrated to Canada some time ago:

But you know I don't see difference. I don't see you as White, I don't notice colour. We don't really have problems here. I had a friend who was studying here from Bahrain, and he said that he had a hard time getting used to the difference. There HIV patients would be segregated and treated really badly. Here they are treated with respect. This is Canada, everyone is treated the same. We are more open here. This makes it easier for us and easier for the patients.

This nurse is attributing her openness to a variety of patients, in part, to the Canadian setting where "everyone is treated the same" and "treated with respect". Other participants were influenced by societal discourses and ideologies that construct Canada as a White, English-speaking nation, as revealed in comments such as "they [immigrants] should learn English. This is Canada." Thus, past experience, education, identity(ies), values and beliefs, and societal discourses and ideologies seem to play an important role in how nurses make sense of intergroup

care. Importantly, interpretive lenses were as influential to how people of Colour make sense of "Other" (be it White people or people from other groups of Colour) as to White participants.

My earlier research (Reimer, 1995) suggested that nurses differ in their commitment to caring for patients with diverse backgrounds. The notion of interpretive lenses begins to account for underlying reasons for such differing approaches. Along similar lines, Dyck (1998) in a study with occupational health students, found that participants constructed interpretations of Canada's cultural diversity "from their particular subject positionings in ongoing processes of social and cultural transformation" (p.30). As she notes, identity has not been given much attention in health and health care research. The findings of this current research regarding interpretive lenses also extends other studies, mostly in the psychological domain, that seek to account for differing attitudes toward culturally different patients and cultural competencies by examining family upbringing (Eliason, 1998) and racial identity and racial consciousness (Eliason, 1998; Ottavi, Pope-Davis, & Dings, 1994; Pope-Davis & Ottavi, 1992).

Negotiating Intergroup Relations

I now want to build on the foregoing interpretations and examples of data and demonstrate the ways in which intergroup relations are negotiated in health care settings. Thus, I am shifting my gaze slightly from the standpoints of nurses and intergroup <u>care provision</u> to the actual <u>relations</u> that are negotiated in health care settings. In this discussion, I draw on four exemplars that came up repeatedly in my conversations and observations with nurses and patients: a) seeking points of connection; b) working through language differences; c) accommodating "difference"; and d) acknowledging the experiences of nurses of Colour.

Seeking Points of Connection

The seeking of common ground as a strategy for negotiating intergroup relations is a strong theme throughout this study. In my conversations with nurses and in my observations of intergroup interactions, nurses described how they looked for connections, and demonstrated through face-to-face encounters with patients and each other what connections involved. One nurse paused to thoughtfully ask how a patient's name was pronounced, communicating that she was caring for this patient of Colour as an individual both in her words, and in her attentive body language. Another nurse explained that when she treated her patients (drug addicts) as individuals and "got to know them and their preferences", they responded positively,

> If they know you are trying to be nice to them, like you're not treating them like garbage, or if they are an ethnic group, like you know they are not secondary, they will stay calmer. If a drug addict likes lots of orange juice, I'll bring them two big orange juices, just to help them settle so they don't feel excluded or looked down upon".

I witnessed two nurses approach a frail elderly woman who spoke only Ukrainian. They explained to me that they had been getting this woman up out of bed with a mechanical lift and when done at her pace, she did well. From my field notes: "The RN puts her face near the patient and pats her arm. As the patient awakes, she smiles at the nurse and reaches to take her hand." What struck me in this interaction was the communication of gentleness and caring through the simple but artful enactment of physical touch. I recognized this same type of caring approach with many other nurses as they communicated with patients who spoke little English as they lightly touched a patient's arm or reached for his or her hand.

One manager told of how she worked at connecting with the nurses of Colour on her unit, "I will say, 'how's your family', this sort of thing so that there's some kind of connection with the staff. Now that's hard to do. I do it by waving, non-verbal, like on the fly and that's because I'm very social". This manager also offered the insight that a certain humility was necessary to transcend difference. One nurse made a strong link between understanding and empathizing with a patient's experience and connecting with the patient. In this excerpt, she is describing a form of negotiation pertaining to visiting hours that is based on understanding and empathizing with a patient's experience:

P: So you have to give and take on some situations, you can't just say yes or no.

R: And there what you're talking about is to be able to empathize about what is that like to be that patient....

P: Yah, you have to. You have to. You just put yourself in the place where you don't speak the language and you don't understand and you're frightened, you know. Some people have just come from back home and they are just new. They probably have not seen a White person with blue eyes. All they have seen is a person in a movie or something, you understand. They might be shy or something, you know. Shy, or backwards talk or whatever. It's just being a little more understanding, you know. And I think it can go a long way rather than just saying, "yes", "no", you cannot just tell anybody. Some of the nurses are trying to show empathy.

These efforts at connecting are rather elementary in a sense, as though they reflect the core of interpersonal relationships, namely, respect. It is respect at the level of one human to another human, as noted by nurses who repeatedly referred to shared, basic humanity. When this

connection was made, they could "click on to exactly what this person needs, whatever the culture that person is". This nurse emphasized the importance of looking past culture to focus on shared humanity:

> I think if everyone understands human nature and looks beyond culture and look, and that is important, I'm not saying culture isn't, but if you understand human nature basically, if you were that person what would you feel or whatever and understand it I don't think it could be so difficult understanding.

Another nurse used the word picture of "we all have red blood flowing through our veins" to similarly emphasize a shared humanity that transcends culture and ethnicity. Importantly, this call to respect based on inherent worth and shared humanity needs to be "read" within the frame of justice, meaning that respect does not imply we condone actions or attitudes that are inherently unjust[58]. Yet, regard for each individual, regardless of their actions and attitudes, remains as the core of human relations.

This fundamental level of connection did not discount the variances represented by different individuals. This same nurse mused, "we are created with such variance, I think God intends for us to be good to each other, to give value to each other". Several participants stressed the centrality of good communication and caring relationships in bridging "difference" and countering illness experiences. As one participant observed, "sometimes horrendous things can happen to people but if they feel the staff has been communicating with them, that they're getting lots of support, you know, you don't hear about it". It seems, then, that seeking points of

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[58] I am grateful to Dr. Joan Anderson who has drawn to my attention that the very notion of respect itself is not "transparent", but rather requires problematization.

connection is a foundational strategy that precedes all other aspects of intergroup care.

Browne's (1995) study with five Cree-Ojibway women similarly pointed to the centrality of respect in intercultural nurse-patient encounters. Characteristics of respect identified by these women were: capacity to treat people as inherently worthy and equal in principle; acceptance of others; willingness to listen actively to patients; genuine attempts to understand patients and the unique situation of each; attempt to provide adequate explanations; and sincerity during interactions. In contrast, disrespect was described as: lack of respect stemming from discriminatory attitudes; failure to consider the patient's perspective; failure to provide privacy for patients; failure to provide adequate explanations; negative nonverbal behaviours. Other scholars have emphasized common humanity in conceptualizing intercultural relationships. Tripp-Reimer and Fox (cited in Baker, 1997), for example, invoke the universalism of a shared humanity that transcends diversity in their criticism of the undue stress placed on cultural differences in nursing theorizations of transcultural care. They argue that the emphasis on categories of difference results in a failure to address that which is essentially human and independent of form. I believe such a call to focus on shared humanity requires some qualification, for the danger in such an approach is to gloss over differentials of power and experiences of racialization and discrimination.

Working Through Language Differences

A predominant source of challenge for nurses in intergroup encounters was language differences, especially the complete absence of English, to the extent that "cultural issues" were commonly equated with language differences. The following notation from my field notes illustrates this conflation:

As I leave the room, I introduce myself to the 2 White nurses who are making this patient's bed. I explain my project briefly, saying I am interested in intercultural encounters and issues for nurses when they provide intercultural care. One nurse quickly responds, "oh, that's interesting. You are studying what it is like for us nurses who are not bilingual to care for someone who does not speak English". (Field Notes, Nov. 24, 1998)

Several reasons became evident for why language difference (especially the absence of English) is such a source of challenge for nurses. The "issue" of language was certainly a matter of communication and many nurses empathized with the experience of being in a health care setting where patients did not understand the language of business. One nurse mused, "I don't know what they must be thinking when we go to sponge them that they don't understand what we are doing to them. I'm sure this must raise some fear for them". Another nurse put it this way,

> The patient comes in here. Very often I think you have to put yourself in their bed. If I was to go, for instance to India, and land up in a hospital there, with the hustle and bustle going on in Hindi or Punjabi, not understanding the health care system, not having someone there to interpret on a daily basis or in the morning. All I know how to say is, the only think I can get across is "pee pee" maybe, that would drive me nuts. It would scare me. I would see these strange faces with white coats on, the doctors, what do they do, what are they going to do?

While nurses empathized with the experience of being a non-English speaking patient, the difficulty in communication was also presented as a source of frustration for them.

If you can't communicate effectively because of the language barrier, you get the frustrations that are taken out in terms of, you know, "I can't seem to make the family understand this. The patient just won't do this". You know, that type of thing and frustration because you can't make yourself understood.

Another nurse echoed this frustration,

Well, one day I had 4 patients in one room, and one lady was so confused, she didn't speak, and the other 3 didn't speak any English. They were all in the same room, no one I could talk to. And I go, well you try….but it is just, you feel like you should talk to them, but you can't say a word. You say something and they all laugh. And you think, "are they laughing at me or with me?" And they are chatting around the room. They all understand each other…. But one knew a few words, and she said, "you learn Punjabi", and I'm "no, I don't think so". It is frustrating. You just feel like you are not doing your job when you can't talk to someone.

This nurse's story reflects a degree of moral distress[59] (Rodney, 1997) because she is not able to provide nursing care according to accepted standards that involve communication. Interestingly, part of her frustration also stems from the minority experience of not being able to communicate that is forced upon her as she, a member of the dominant White group, is a minority in this room of South Asian women.

Frequently, the reason why language was an issue in intergroup care provision seemed to be the matter of efficiency. Language barriers "add a layer of complexity" to an already complex work environment and effect a nurse's ability to "get the job done".

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[59] Rodney (1997), in her ethnographic study on how nurses enact their moral agency, describes moral distress as feelings of anger, frustration, guilt, and powerless that result when contextual constraints made it difficult to translate a moral choice into moral action.

The nurse comes on and says "oh my god, they speak no English. They are going for surgery. The family was in last night, why didn't someone get the consent from the family?" There may have been very good reasons but that is OK. What you do is just get on with it. You try to phone family. Very often there is no one that speaks English, "no speakea English" (in feigned accent). Click.

One nurse who had spoken candidly about difficulties she encountered in caring for South Asian patients (citing gender relations and language differences) also noted the extra workload involved.

R: And do nurses in general perceive caring for someone, let's say who doesn't speak English or has beliefs and customs that are quite different, do nurses perceive that as extra workload?

P: It is an extra baggage, you know. It is really hard because you have to deal with that, and also your feelings, like you may not be comfortable doing it, like you want, you want it your way cause this is the way I have learnt, "I have to do this".

Interestingly, even for nurses of Colour who shared language with non-English speaking patients, added workload stemming from language issues became problematic as they became involved in interpretation. A nurse who spoke Cantonese described it this way: "It (interpreting for others) does take away your time from your own clients....I think sometimes people know that you are on duty and you can be taken for granted". Unfortunately, it seemed other nurses had little awareness of this added workload and rarely offered to help the interpreting nurse in exchange. In the following excerpt from my field notes, a Punjabi-speaking nurse seemed to be hinting at this lack of acknowledgment,

She says they need 2 to 3 South Asian nurses on the ward to deal with all the translation. She was the first on this unit and is happy for several others now that work part-time and casual. She says she translates a lot *"but gets paid just the same"*. She says this with a bit of a smile, then adds, "well I don't mind". I ask her about some form of reciprocity, she says "no". (Field Notes, November, 1998).

A third reason, along with difficulty in communication and lessened efficiency, for language being interpreted as the main "issue" around intergroup care, while not as overt, is the political and ideological issues raised. At this level, the lack of English in immigrants "irked" some care givers, who would say things like, "why don't they learn English? This is Canada", or "we only like English speaking patients". English thus became a marker for who was truly Canadian, and who was an outsider or Other. These sorts of comments, although not common, indicate an underlying preference for assimilation and a construction of Canada as an English-speaking nation.

Having described the general "work" related to language differences within both communicative and political/ideological domains, I continue now with a more explicit analysis of how nurses dealt with these differences. Nurses pursued two main strategies in seeking to bridge language barriers: a) "Muddling Through", and b) Seeking Interpretation.

"Muddling Through"

While the majority of nurses preferred to negotiate language barriers with an interpreter, they were often left without this option. In these situations, they did the best they could and "muddled through", as one nurse put it, evidencing both creativity and persistence. Various strategies were employed to communicate with non-English speaking patients. Gestures,

"charades" and simplified "sign language" were most common as nurses, for example, pointed to the bathroom to see if this is what the patient was requesting. Nurses also used a few simple words that were considered "universal".

> Like you use "pee pee, pooh pooh". Pretty basic. Pretty crude. Like whatever (gesturing toward her bottom). You do that a lot. I'm sure there are other people in the room looking and going "what?" Like you go "ouw" "pain". You do a little charade type of thing.

A few nurses had learned a small number of words in the most common languages of patients although others seemed to make no effort to do this or even resisted the idea. Nurses repeated themselves, spoke slowly, often leaned toward the patient, and deliberately tried to simplify their language as they communicated with non-English speaking patients. I observed a nurse asking a young South Asian woman who spoke little English: "Do you need to have a BM?" She then realized she was using nursing lingo and said out loud, "Hmm, how do I say that, do you have to use the toilet?" Informal translation sheets, usually made up by the family, were sometimes used to allow nurses to point to key words such as "pain" or "hungry". They also followed the nonverbal cues of the patient, noting that many expressions, such as suffering, are, as one nurse put it, "multicultural". One nurse commented that she could communicate a lot even without an interpreter because "sign language is quite universal". Another nurse qualified this conclusion by adding that nurses needed to employ heightened observation and analysis when not having the benefit of shared communication.

> It is good to communicate in the same language but it need not be a big hindrance because I do find gestures really help, but just use your mind to analyze. Let's say, you

have given a client an enema, then you would know that very likely when she asks for something it's the bed pan....So it is a matter of looking at the whole picture, what have you done for the patient, what procedure has she gone through.....Analyze totally what you have seen, what has been done and what could it be.

Along with this clinical judgment, the importance of communicating caring across language barriers was also noted. One nurse explained that "a little touching, and shaking hands and just the nodding shows that you understand and you care and you are trying to make them feel comfortable. I think this goes a long way". According to this nurse, caring can be communicated regardless of language barrier. These examples illustrate the importance of seeking connections when faced with language differences and, while demonstrating the resourcefulness of nurses, also suggest that "muddling through" is not the ideal way of dealing with language differences.

<u>Seeking Interpretation</u>

Nurses on all three units had access to some form of hospital interpretation services[60] and yet they rarely used these services. This was likely due to a number of factors. There was a general lack of awareness both of the nature of the service itself, as well as the limitations of the informal interpretation they tended toward. Further, the services were seen as not readily available, especially on nights. Nurses explained that they often needed interpretation on short notice, like when a patient suddenly became distraught or had a change in condition. Formal interpretive services were thus constructed as useful in particular circumstances such as

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[60] Here I am presenting interpretive services as understood from nurses' standpoints. In chapter Six, I present the organizational aspect of interpretive services.

obtaining informed consent, explaining surgical and diagnostic procedures, and providing

discharge instructions. Most often, nurses used whatever forms of interpretation that were most

convenient, be it family, other visitors, or staff. Indeed, they spoke highly of the benefit of

frequent family visits and of the increasing number of nurses who spoke a range of languages.

However, one Chinese nurse who was quite thoughtful about the issues inherent in informal

interpretation summarized what concerned her when she interpreted for patients:

> P: I think the main thing is to know how to translate particular terms, medical terms into
>
> the Chinese language at an understandable level to the client because there is no perfect
>
> translation from one language to the next one.

> R: Exactly.

> P: Especially for medical terminology that occurs so I find that when I do translation, I
>
> tend to be really nervous because I want them to understand fully what they are in for,
>
> what procedures are going to take place….and I do not want them to be going for
>
> something not fully understanding. And it might put the hospital into liability later for
>
> that and I also feel equally responsible as well.

> R: When you take on interpretation.

> P: So every time I have to do that I really try to be careful. If I can't explain then I tell
>
> the doctor I couldn't say to be honest what I can tell.

This nurse then was well aware of the intricacies and pitfalls involved in "informal"

interpretation. Yet, on the whole, informal interpretation was rarely problematized regarding the

issues involved (e.g., the complexity of interpreting medical terms; limited confidentiality; and

the legal implications of providing insufficient explanation). This common acceptance of informal interpretation is concerning and is certainly not supported by the literature (see, for instance, Hatton, 1992, and Hartog and Hartog, 1983 for discussions regarding the shortcomings of informal translation).

Although many nurses voiced concern about the negative effects of language barriers on quality of care, I was struck during some of my observations by what seemed to be a rather casual approach to the whole matter of meeting the language needs of patients. In some situations, interpretation services tended not to be seen as something useful on a day-to-day basis and there were several situations when I was surprised that nurses were not taking advantage of families who visited or phoned to discuss the general care of a non-English speaking patient. Analysis of these particular situations left me with the understanding that because the nurses were not immediately concerned with efficiency, interpretation seemed less urgent (i.e., they had "gotten the job done" for these patients and did not have any obvious need for further communication). However, as explained earlier, there were many other nurses who voiced clear concern about the lack of shared language and the concomitant inability to satisfactorily communicate with patients. Therefore, to leave the impression that the lack of utilization of interpretive services is primarily a matter of indifference or even ignorance on the part of nurses would be misleading. Another step in analysis must be taken to consider what organizational and/or structural factors come into play to facilitate or discourage the employment of interpretive services (this task is undertaken in Chapters Six and Seven), and what societal constructions and ideologies mediate the whole matter of language differences (discussed in Chapter Eight).

<u>Accommodating "Difference"</u>

Participants relayed a range of examples about how they worked at accommodating the preferences of patients from diverse backgrounds. Included in these narratives were references to those times when the preferences and practices of patients conflicted with those of their providers or with the routines and values, in essence the status quo, of the dominant culture of the health care system. In this section I explain how these preferences, often shaped around notions of "cultural difference", were constructed and accommodated. I then describe how the negotiation of "difference" was contested and resisted in certain situations. However, before proceeding with such an explication, I unpack how "difference" requiring accommodation is perceived, or constructed.

The accommodation of "difference" is dependent, of course, on the noting or constructing of "difference". In this study, "difference" was constructed in two distinct ways: as that which was indicative in a political sense of something inferior, Other, "foreign" to Canadian ways, to the extent of being "incompatible" in some situations; and that which was much less nefarious, a more neutral observation of diversity. Woodward (1997) speaks to these various interpretations of "difference":

> Difference can be construed negatively as the exclusion and marginalization of those who are defined as 'other' or as outsiders. On the other hand, it can be celebrated as a source of diversity, heterogeneity and hybridity, where the recognition of change and difference is seen as enriching; as in the case of social movements which sought to reclaim sexual identities and celebrate difference from the constraints of the norm (for example, by asserting that they were 'Glad to be gay'). (p. 35)

When "difference" was constructed as representative of a radical, unbridgeable separation, there was less effort to accommodate the preferences of these patients, and considerably more judgment passed on them, with comments such as "This is Canada, They should learn our ways". Exclusionary practices were not always overt, but the language of everyday discourse marked a "setting apart" because of some type of divergence from what was considered the "norm".

"Difference" often became attached to culture or ethnicity, resulting in the application of stereotypical assumptions and the construction of beliefs and practices as essentially "cultural", static and relatively unchanging. For example, differing opinions, values, and practices might be constructed as just that; however, in certain situations they were much more likely to be constructed as cultural in nature. Thus, if a White woman was slow to mobilize after surgery, this would likely be interpreted as a personal preference. On the other hand, when South Asian women were hesitant to mobilize, this was seen as a cultural matter that involved gender roles and a cultural pattern of unrealistic expectations ("they like to be pampered"). As discussed below, the matter of visiting hours serves as an example in which "difference" was interpreted as attached primarily to certain bounded homogeneous ethnocultural groups, and as representing group values that conflicted directly with "Canadian" ways.

In the construction of "difference" as concrete, essentialized, and characteristic of particular groups, there was also a tendency to conflate culture with gender, ethnicity, and religion. As a result, what were constructed as "cultural problems" were better understood at the intersection of culture and gender. The following comment illustrates this equating of culture and gender:

> I find it very difficult to deal with (speaking slowly) the fact that a lot of the
>
> IndoCanadians expect the same kind of, uhmm, expert service from me, who is used to a

different type of culture, a different way of doing things, as they do from their own

people. And frankly, it irritates me a lot.

Here culture is drawn upon as an explanation to make sense of an uncomfortable situation for

this nurse. When stereotypical assumptions were applied to groups of people with shared

ethnicity (e.g., by suggesting that all South Asian men act in certain ways), the presumption was

that they also shared a coherent culture. Thus, when culture is drawn upon so extensively in

"making sense" of "difference", other intersecting categories that organize social relations, often

in oppressive fashions, are effectively overlooked.

Certainly many examples in this study illustrated the tendency to view "difference" as

that which does not fit with mainstream society and health care delivery, leaving the "gaze" on

those who were "different" from White culture and, in so doing, obscuring the hegemony of

mainstream culture. However, to leave the constructing of "difference" as something engaged in

by only White people does not fit with the interpretations of this study either. For example,

those in minority positions also participated in constructing "difference". A Chinese woman

identified several "cultural differences" she had noticed with her South Asian roommate: a large

number of visitors who were noisy and brought in young children; "they smell of garlic"; and a

"different sanitary standard". In naming these differences, she at the same time said that she

understood the value placed on family visitation in the South Asian culture and that, although she

wished the visitors did not use the patient bathroom, felt it would be inconvenient for them to

have to go downstairs to use the public washrooms. This patient, then, was accommodating

herself to these "differences". Similarly, several nurses of Colour described how they acted as

"cultural brokers", speaking on behalf of patients with whom they shared a common heritage. In

some of these cases, it was the nurses of Colour themselves who pointed out what they perceived

as "difference". For example, during one of my observation periods, a nurse of Colour volunteered that

> Our community expects a certain kind of care while here. They believe they should rest and stay in bed and they would not like such a suggestion to have a shower. They are not happy if they do not get this type of care, they feel they have not been well cared for when they are encouraged to do things for themselves. (Field Notes, November 24, 1998)

This participant is constructing her "community" as a homogeneous group and in so doing draws on an essentialized view of culture. Furthermore, although the act of identifying "difference" is by a person of Colour, "difference" is still being ascribed to those not belonging to the White community.

In other situations, the notation of "difference" was directed toward White culture, as exemplified by an immigrant nurse of Colour who remarked on the "difference" she perceived between Chinese patients in her "home" country and patients here in Canada:

> Chinese patients at home are very contented, they are easily satisfied, they will not question too much of what pills you give them, what medical treatment they are given, they trust the doctor, they trust the nurses. But the clients here [in Canada] are different. They question more, they want to know more what the available resources are, and they question why and how and the dosage of medicine and so on....Here the patients want a lot of autonomy.

This nurse is constructing "difference" as that what falls outside of her norm, based on her Chinese positioning. Although her language suggests a preference for "contented" patients who are "easily satisfied", the exclusionary tone is not present. In several of the examples that follow in the next section, "difference" is constructed as something to be accommodated, but not judged as inferior. Other participants spoke of "difference" as enriching and positive:

> We are created in different colours. Obviously there must be good in this. In Genesis, everything is created good, this is mentioned so many times. It reflects on me, human beings are forgetful of this and need to be reminded all the time. It is good, it is good.

Thus, the narratives in this study exemplify both interpretations of "difference": "difference" that excludes, and "difference" seen in a positive light. Moreover, constructions of "difference" are notably multidirectionality, not limited to the exclusionary practices of White individuals representing people of Colour as Other, but also extending to a more general construction of "difference" from a variety of social locations and identities. With these varying constructions of "difference" in mind, I turn now to an examination of how caregivers accommodate "difference".

The Process of Accommodation

Early in this chapter, I suggested that "difference" became an issue in health care settings when it interfered with efficient care, raised moral dilemmas, or challenged the status quo of the dominant culture of the health care system. One nurse's commentary evidences the ways in which "difference" is seen to interrupt preferred routines.

> They have the custom, some people, like when you do a.m. care, they have to when they wake up in the morning, they do some sort of routine or ritual or something like that. They don't eat first, maybe go to the bathroom first or whatever. It doesn't suit your

schedule, your plan for the day, "I want to do this at that time", so that would interfere. And also some think hot is good for them when they are sick, some foods are, you know, not good, cold water is not good.

In this example, the nurse is constructing "difference" as that which interferes with the status quo of the hospital. Other examples of "difference" that raised a degree of dilemma and judgment and challenged hospital routines included patients spitting in the hospital, patients preferring to squat on the floor rather than lie in their beds[61], and family members going barefoot during a healing ceremony. Additional sources of "difference" that called for accommodation included patterns of gender relations interpreted as "cultural", food preferences, patterns of visiting, expectations regarding care provision, beliefs about illness, and religious patterns at the time of death. In these situations, nurses were faced with the challenge of accommodating "difference".

Typically, the process of accommodation involved efforts to understand the nature of the dilemma represented by "difference", suspension of personal judgment, diversion from commonly held institutional practices, and negotiation to come to a mutually agreeable solution. Nurses' internal dialogues presented earlier in this chapter carried evidence of their efforts to understand the nature of the dilemma represented by what was perceived as "difference", as they often looked for an underlying reason for this "difference". By way of example, one nurse explained how she "made sense" of the illness behaviours of South Asian women:

At home they are always caring for others, so they think it is their turn to be waited on. We had a 40-year old who had had a MVA (motor vehicle accident), a broken arm and broken hip. But she wouldn't do anything. Someone told us that this is their way, that it is now their turn to be taken care of. So this is different, it is interesting.

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[61] These examples of spitting and squatting on the floor can be understood not only as cultural conflicts, but also as conflicts stemming from class and urban:rural differences.

This participant is drawing on the commonly held assumption that South Asian women like to be pampered when hospitalized. Another participant explained how crucial it was that nurses understand the meaning of "cultural values" around family visiting:

> Visitors are expected in that community and if they don't visit it's considered rude. So of course, everyone is going to want to come and visit. If you don't realize that that's why so many people are coming, you just get annoyed. These people are doing it for a different reason, and you can't get angry with them for that reason.

Although understandings of the nature of various values and preferences were often based on stereotypical knowledge and static views of culture, as in the two foregoing examples, caregivers were more likely to accommodate preferences that varied from the "norm" when they held to some type of explanatory schema that accounted for the "difference" in a more-or-less positive fashion.

The suspension of personal judgment was another important element of the process of accommodation. One participant described eloquently how to suspend judgment in cases of "difference",

> ...The phrase, "When in Rome, do as the Romans" doesn't come in with this kind of thing because you have to be exceptionally tolerant. To lifestyles, cultures, even expression of pain, you have to be very tolerant. That is what I find is different. Of course there are habits, I find East Indian, older patients spit a lot, they are messy, downright unhygienic. To them, if they come from the farm, there is ground everywhere you can spit wherever you want. A free country. But as disgusted as I could be, you just have to pretend you are not, because if you do, you are interpreted as discriminating. You have to be psychologically strong. If you are a nurse, it would be good if you are

> psychologically strong. No body can control your mind. You could be looking at cow
> dung and think it is perfume, you can convert it if you don't want to look at it, to survive,
> you know? (laughter).

This excerpt provides a strong illustration of the suspension of judgment that may be involved in accommodating "difference" and the sense-making involved in this accommodation process[62]. The participant making this statement was a Chinese nurse, and we see again from this example that intergroup relations must be constructed to account for more than "differences" between the dominant White community and other groups of Colour. Rather, the complexities of intergroup relations extend to the interactions between various groups of Colour, as well as to interactions between various White groups.

In situations where caregivers did not suspend personal judgment or did not understand the importance of certain practices, accommodation was less likely to be marked by respect and connectedness. One participant provided insight into the responses of some nurses in allowing their personal perspectives to influence how they responded to visitors:

> I find some older nurses very upset with visitors. Like if they come before two o'clock in
> afternoon, they become very upset. I'm not saying it isn't good to be upset. What I'm
> saying is that it should not affect your performance, you should not suddenly become less
> professional in your manners. You cannot actually loose your cool. The visitors will
> never understand.

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[62] As with the notion of respect, the ideas of tolerance and suspension of judgment also need to be viewed through a lens of justice (e.g., not all actions and attitudes are tolerated). Also, as pointed out to me by Dr. Joan Anderson, the idea of tolerance is embedded in relations of power, often with the implication that a morally "superior" group those may "tolerate" or not "tolerate" the shortcomings of those in "inferior" groups.

Obviously, when nurses resented the presence of visitors, they were less likely to offer any flexibility from "official" visiting hour policy. While the suspension of personal values and judgment was not always easy for nurses, it was critical to the accommodation process.

Accommodation often involved diversion from commonly held institutional practices, with flexibility being key. For example, there were instances in which considerable effort was made in order to accommodate the presence of family at the time of death. Patients were often moved into private rooms or semiprivate rooms and families were allowed to stay after the death as part of the mourning. In one situation, a patient's body was kept on the ward waiting for the family to arrive from out of town. The manager described the situation,

> ....The patient died at 8:00 in the morning and at 2:00 in the afternoon the family still had not arrived. I just happened to say, "how are you guys doing?" And they said "we're still waiting for that family". I get the look on my face because first of all the other patients in the room. I mean, the nurses did a hell of a job because the other patients in the room, they were respecting this patient's ethnic background. I was concerned about the body being there that long. I was trying to honor everybody's decision but finally I made the decision that I think we'll take this body down....And so it worked out okay. I felt we honored the ethnic to a point and then we had to take action.

From this illustration, we see the importance of the physical environment in accommodating cultural preferences and also see that there are limits to accommodation. In order to accommodate this family, nurses certainly pushed the common practice of removing a body from a patient care area before the onset of rigor mortis in, to the extent that the resulting demands placed on both nurses and patients in the room seem almost incredible. This then is an example of accommodation taken to considerable length and it raises a range of questions such as, "To

what extent should health care providers accommodate practices divergent from commonly held practices?"

Because of the need to flex commonly held practices, negotiation became central in order to achieve a mutually acceptable solution. The negotiations that occurred around the presence of visitors serves as a prime example of the give-and-take required. Nurses spoke of "bartering" in order to come to an agreement, suggesting that both parties might have to compromise from their preferred positions. This negotiation around visiting hours might involve the time of the visit (often discouraged before noon), the number of visitors, or the place of the visit (visitors might be asked to use the lounge area). The following quote captures the need for negotiation:

> We are really trying to work around cultural issues. For instance, when there are four patients in a room, but 8 family members want to be around one bed. There is a cultural tug-of-war going on often because they don't understand why we can't have 8 people around that bed at once. We often have to say, "7 a.m. is not a good time to come and visit your family member and here are the reasons why". We talk about privacy, and ask that patients be allowed to rest. We are very flexible, we are a public institution and basically have an open door policy.

Here the matter of visiting hours is clearly constructed as a "cultural issue" in which the values of discrete "cultural groups" come into conflict, to the extent of being characterized as a "cultural tug-of-war". Humor was used at times in negotiations, sometimes to suggest that a patient's preference might not be a nurse's preference, as exemplified in the earlier-mentioned exchange where a nurse joked with a mother about allowing her son to do more for himself. In such cases, humor served as a conduit for a message that might not be welcomed if not "softened" by humor.

In some situations, resistance to what was interpreted as a "cultural difference" also occurred. Some nurses, for example, spoke of how they resisted male domination from South Asian men,

> Men do not like to be commanded, to be told by a woman, like "you do your care". They do not like that, you know? Like taking them to the bathroom, I have encountered quite a few men that don't like you to be ahead, you have to follow them. But that is quite hard, right? You have to lead the way, especially if they have an IV pole. Then the family explains, "you just go behind him". Then I say, "You know, I will try, but you know I have to lead the way". Especially if there is some equipment. You have to explain.

This nurse describes her approach as one of "meeting them halfway", evidencing accommodation to the point of what was practical. Also relating to gender relations and setting limits, one nurse explained,

> P: I don't allow myself to feel I am in a subservient position. I mean, there have been instances, where, you know, like "pull up my blanket" or "get". And I'll just bring the table over and say "you can reach it", or say "here is the blanket, you can pull it up". Because that is not me, and I wouldn't treat any one else any different.
>
> R: So that is interesting. While there are times you go, for the most part, with their cultural traditions, beliefs, and practices, there are some times that you draw the line when it starts to make you not feel good or it is not respectful of you?
>
> P: Exactly. I just sort of feel like I won't change my ways for people. I will certainly respect your wishes as far as what your family members do for you, and what your beliefs are, the foods you eat, and whatever. But I'm not going to cater to you like your family caters to you. But if it is for a medical reason, yes I will.

These last two examples raise the issue of relations of power in the nurse-patient encounter in which nurses in their professional roles are able to exert considerable autonomy in the extent to which they chose to accommodate patients' preferences. In other situations, power operated in other directions with nurses feeling subordinated on the basis of their gender, profession, or ethnicity. Overall, there was a general pattern of nurses accommodating patients' preferences, but in certain situations, such as the one described above, limits were set.

The Negotiation of Contested Terrain

At other times, however, conflict ensued in the negotiation of "difference". In offering an analysis of the contested terrain that resulted from conflict deriving from perceived "differences", I draw on two examples: visiting hours, and discourses regarding political correctness. Situated in the realm of the day-to-day, visiting hours were represented most often by both nurses and patients as a "cultural problem" and as a point of contention with little consensus. There was a wide range of interpretations of visiting hour policy among the nurses themselves, as observed by this participant, "Well if you ask 20 people they'd give you 20 different interpretations of what the policy actually is. And how they enforce it." These variations in interpretation were demonstrated as nurses enacted policy contextually, taking into account such factors as the immediate setting, the ways in which the visitors conducted themselves, and their own interpretive lenses and personal experiences.

Even with such careful judgment, visiting hours seemed to be a "flash point" for intergroup relations, with nurses often caught in the middle. They found themselves negotiating with visitors, "bartering" and "dickering" about what hour a visit might begin or when it should end. In some of these situations, nurses felt like they were not being "listened to" by the family, which heightened the feeling of conflict. One participant recounted, "But with some visitors, it

just doesn't register, and they ignore your requests when you ask for just one or two visitors at a time. You may say 'just two or three visitors' but they ignore you". Another participant drew on similar experiences, "I mean, you try to tell the family once, if they don't understand, what can you do? You know, you can't just keep badgering because often you are so busy you can't be bothered with it". Difficulties in communication sometimes escalated to the point of threats being made and security officers called onto the scene. As one participant told me,

> The patient is perfectly fine, they don't need to have anybody to stay in overnight but they will insist that and make a big fuss and threaten the hospital and their staff….like, "we will sue the hospital….if you don't let us stay".

Further friction arose when other patients complained to nurses about the visitors. One administrator said,

> It's not easy sometimes. People have different attitudes too and some get right down to being racially, you know, slanderous almost and I've had other patients do that too. "I only have my wife come in, how come he has six visitors?" "All day I get no rest and these people…" And, it's like, "whoa, you know, we're not having this conversation". Like, "we'll control the visitors but I'm not going to talk to you in that". But that's something that staff have to deal with too, is the other patients in the room who give them grief and some of that is racially motivated and so that's not easy for them to deal with.

> With these types of charged exchanges, it is not all that remarkable that nurses responded with resentment at times. Yet, most nurses were clear about the need to remain in a mediator role and advocate for the general well being of all patients. Because nurses had such differing views regarding visiting hours, nurses with more flexible approaches were also caught in conflict with other staff members at times. As described by this nurse,

> There are other situations where I will say "it's okay, you can visit this patient" and I
>
> have gone off duty and the person after me comes and says I don't want you to be here"
>
> So now you're a good nurse while this person is a bad nurse and it shouldn't be because
>
> we are all there to help this patient out so where do you draw the line. We do have
>
> conflicts on that sometimes we do have because, you know. I may say it's okay but the
>
> person after me says no so these are conflicts.

With all of these sources of dissention around visiting hours, nurses felt they were in a "PR" role

for the hospital, trying to keep "everyone happy".

How might we make sense of such a conflictual issue? One approach is to understand

this as an example of racist attitudes expressed in public ways by White patients and nurses.

While this interpretation captures part of the picture, the exemplar of visiting hours brings to

light some alternative insights that differ from traditional constructions of intergroup relations.

First, the influence of the contexts in which negotiations around visiting hours are negotiated

must not be under estimated. A participant drew attention to the importance of the context of

nurses' work, suggesting that

> when the staff are exercised, if you will, about visiting hours there's usually other issues
>
> going on for them, issues going on for their patients and that may be work load, it may
>
> be, you know, a patient that's out of control somewhere else.

Thus, nurses were in the position of balancing the presence of visitors with the constant demands

represented by their work responsibilities. Visitors then interfered with "efficiency" and became

the impetus for an interpretation of "difference" as problematic or an issue.

Moreover, tensions associated with visiting hours point to the great difficulty of

negotiating a range of preferences in the public domain of health care institutions. The needs

and wants of patients vary considerably, and often conflict with the routines of an institution. In light of the size and complexity of today's health care institutions, increased diversity represents enormous challenges to the operation of such large institutions that are not flexible or responsive to change by their very nature. One of the managers in the study observed, "Well I think that with visiting hours have traditionally been very much a control issue for institutions". Here the image of a hegemonic institution is elicited, in which the status quo of mainstream ways is not easily challenged and relations of power are institutionalized to a considerable extent. However, considering the aggressive attitudes that nurses faced, conflicts surrounding visiting hours need to be understood as something more than a case in which the dominant majority imposes its status quo on powerless, marginalized groups. Rather, the exemplar of visiting hours brings to light the dynamic and shifting nature of power relations in health care settings.

Finally, despite the representation of visiting hours as a "cultural problem" most often associated with a particular ethnocultural group, there are reminders in the data that "violations" of visiting hours are not unique to any group, nor do all patients belonging to a particular group prefer large numbers of visitors. For example, a South Asian patient told me that "These are my people, but I don't agree with all the visitors coming in". She went on to say that when her husband was admitted for major surgery at another hospital, they had discouraged visitors. Upon closer reading, the issue of visiting hours brings new insights into intragroup variations and intergroup relations in health care.

The contested terrain of negotiating "difference" was also visible in the everyday realm of how political correctness[63] was enacted and perceived. Dorothy Smith (1999), in her essay

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[63] Cashmore (1996) describes political correctness as a "much-derided set of guiding principles and directives that became a virtual orthodoxy at many U.S. universities in the early 1990s. While it was based on sound academic concepts, its enactment was quickly interpreted as a form of censorship and a threat to academic freedom. Political

entitled "'Politically Correct': An Organizer of Public Discourse", outlines how political

correctness as an ideological code operates to structure text or talk. In this study, political

correctness functioned to restrict what could be safely said, and also to discount or discredit what

was said. I sensed a widespread uneasiness in discussing matters of *race* and culture with any

degree of openness. Participants often spoke hesitantly and with carefully guarded speech,

sometimes catching themselves as they said things that might be construed as "politically

incorrect". In the following excerpt, a participant begins in a less guarded fashion, but then

seems to "hear herself" and offers some censorship to her own comments:

> Another thing there culture does, and I have to understand that, but I don't, it doesn't sit
>
> too well on this ward. They like to visit 24 hours a day. And here it is not possible, the
>
> rooms are too dingy and small. And in their culture, if they don't visit every day, it is
>
> considered an insult to the family. Friends included, children, babies, you name it. And
>
> they don't discipline their children while they are here. That is another problem.
>
> *(Hesitates). Mind you, there are White folk that don't discipline their children either.*

In this case, self-censorship may have resulted in this participant re-thinking some of her

opinions and, in this way, the notion of political correctness provided some boundaries to what

might be considered socially appropriate commentary. In other situations, the hesitation and

self-censorship evident in this study worked against the open address of racialization and

discrimination when it did occur. Managers were hesitant to deal openly with charges of

discrimination (whether at the hand of patients/families, or administration itself), likely afraid of

antagonistic union responses, but also unwilling to admit anything but an unprejudiced

workplace. In essence, while offering general guidance to what might be considered within the

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correctness aimed to redress the balance of North American academies, which were understood to be mired in the same racism and sexism that existed in and was promoted by much American culture." (p. 281)

realm of socially condoned speech, the common concern with political correctness inhibited open discourse on matters that require careful examination and thoughtful dialogue. The contested terrain of intergroup relations was therefore sidestepped, or "whitewashed" as one participant put it.

On the other hand, some participants railed against what they interpreted as political correctness on the part of administration. One example, told to me by several participants at one site, involved the instruction from a well-meaning senior administrator who requested all staff to abstain from wishing patients "Merry Christmas" because this might "be offensive to some our non-Christian friends". One nurse recounting this incident to me stated,

> Well that really offended me. Now, I mean, that offends me, because we are a Christian
> community, a Christian country essentially. Why should we worry that it offends
> someone of a non-Christian culture? That is really too bad. You know? So it has been a
> big issue with me.....I think he (the administrator) was hoping to be, I hate this, but
> politically correct. And it happened to offend a lot of people.

Here an administrative effort to stem exclusionary greetings is discredited as "political correctness". In this case, political correctness is also read as a "regulator of the social relations of public discourse" (Smith, 1999, p. 194) but in rather different sense -- that of threatening the established "norms" of what is perceived to be a homogeneous nation, and therefore something to be resisted.

Concern for political correctness, operating in these two apparently contradictory fashions, acted to silence and censor that which was said. In the first sense, political correctness, while providing a format for bringing "private behaviour into line with political principle" (Smith, p. 179), effectively silenced open dialogue that might begin to acknowledge and address

the racialized discourses and practices present in today's health care settings. In the second case, political correctness discredited the voices of those wishing to bring about transformative change. The concern regarding political correctness from both camps draws attention to the social domains in which intergroup care is provided as non-neutral territory, charged with competing struggles for power and influence.

These two examples regarding visiting hours and the interpretations of political correctness point to the frequently contested nature of intergroup relations in health care settings. They begin to show how constructions and negotiations of "difference" are embedded in relations of power and are mediated by larger societal discourses and ideologies that are exclusionary and silencing in practice (I provide further discussion of societal discourses and ideologies in Chapter Eight). The next section builds on this idea of contestation by drawing on the racialized experiences of nurses of Colour.

Acknowledging the Experiences of Nurses of Colour

As we have already seen, the dynamics of intergroup relations are not always as one would expect, nor as they are represented in academic literature. The stories told by nurses of Colour stand as testament to this fact. While much health care literature focuses on encounters between White health care providers and recipients of Colour, there are a whole range of other relations, often along various intersecting axes of power differentials, that illustrate the nefarious and shifting ways in which *race* is constructed and negotiated in health care settings. I have found the stories illustrating the experiences of nurses of Colour depressing, shocking, and yet encouraging at the same time[64]. The lessons in their experiences are not only about the ways in

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[64] I have also considered how my social positioning as a White researcher shaped how these stories were relayed to me. Perhaps some nurses of Colour were hesitant to speak of racialized experiences in an open fashion for fear I might become defensive or simply might not understand their perspectives. On the other hand, perhaps they told me of certain circumstances they might not readily admit to another nurse of Colour. As I spent more time with these

which all of health care is organized by racialized discourses and practices, but also about resistance, agency, and transformative action. The description that follows serves as a collection of the range of experiences told to me by these nurses; it is not a depiction of "one standpoint" or unitary experience representative of all nurses of Colour. I must also note that during my many hours of fieldwork, I observed predominantly positive, affirming relationships between nurses of Colour and those they came in contact with. Nonetheless, because the similarities between many of their experiences, there are conclusions that can be drawn about the ways in which their professional lives are socially organized.

Racialized Encounters

In encounters with patients, colleagues, and managers, nurses of Colour felt that they were, at times, treated in certain (i.e., "different") ways because of their ethnicity/*race*. A question that stayed with me during this study was, "How can I attribute these experiences to *race*?" Certainly there were situations when White nurses had conflicted relationships with White patients, for example, that one would simply credit to "personality differences". Not wanting to misinterpret the data, I have drawn primarily on the cases in which *race* was obviously an issue (i.e., when the encounters included blatant *race* language and when nurses of Colour realized that it was only them having "problems" with certain patients). Many of these nurses were also hesitant to share their stories with me, perhaps sensing risk in talking about such matters.

I heard numerous stories of situations in which White patients treated nurses of Colour with disrespect and rudeness. For example, one nurse told of the following episode:

R: Have you ever felt you were treated differently because of your ethnicity?

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nurses, I sense they became more open in what they shared with me. This interpretation thus becomes one "take" on intergroup relations and the experiences of nurses of Colour.

P: Oh yes, sometimes you feel it. Like they treat you different.

R: In what way?

P: They are rude. One [White] patient said, "well, that is what I am paying you for". That made me so angry, I said, "well I am paid by the government and I imagine I pay more taxes than you do". I just won't take that.

This patient's comments communicate a sense of ownership over this nurse of Colour, and the implication of being "paid help" rather than a professional offering a specialized service. In some situations, participants noted that it was only the nurses of Colour who were treated this way. One nurse observed, "there was this old man, he was really rude. He was rude to all of us non-Caucasians. He didn't overtly use words like race, but he was really rude." In the more extreme cases, White patients would say that they didn't want a nurse of Colour to care for them[65]. An administrator commented

Because we have had patients on our unit that are very, uhm, against having someone of non-White skin look after them. One fellow I'm thinking of in particular was an older man and that… And I have spoken with some elderly women who have a bit of a problem around people of different color looking after them. And just the comments they make. You know, when they refer to them as "the Chinaman" and that kind of stuff. And so I think we get that in the patient population for sure. I'm not sure, the staff don't pick up on it always until there's a confrontation.

As reflected in these examples, a consistent theme that emerged from early on in the project was the identification of elderly patients as most likely to be racist. One participant, in recounting

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[65] To demonstrate the multidirectional nature of intergroup relations, I heard of a similar story in which a patient of Colour requested not to have White nurses caring for him.

two situations in which a direct approach had been taken to deal with racist comments from patients, referred to the age of these patients, "Both of these people were of the older generation where tolerance or the ability to tolerate changes in life was not part of their repertoire in life." Although such a claim has some commonsense appeal to it[66], the assertion needs to be held up for critical analysis. First, when old age is used as an explanation for racism, the words, actions, and underlying attitudes tend to be "excused" or at least diffused. However, if discrimination-free work environments are a goal, racialized comments from all quarters must be taken seriously. Second, the recurrent association between age and racism illustrates the need for theoretical approaches to intergroup relations that capture the range of intersecting lines along which experiences are socially organized. The question must also be raised whether this increased likelihood to identify the elderly as prejudiced is a reflection of negative attitudes held about the aged themselves.

In the foregoing excerpt, this White administrator also felt that the staff did not notice such racialized comments, however, I questioned whether the staff noticed but chose to "put up" with many of these comments, or chose not to draw such comments to the attention of management. In one case, a nurse of Colour herself asked to have her assignment changed to end the harassment she was experiencing.

> The participant tells of a nurse of Colour who was hassled all day by an older White man who told her that "what did she know, she wasn't Canadian". The nurse, by the end of the day, was exhausted by this and asked to have the assignment changed. The participant pointed out that to change the assignment isn't really dealing with the

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[66] This claim holds some commonsense appeal for several reasons. Generally, the first half of this century was marked by more public beliefs about White superiority and related assumptions that people of Colour were backward, savage, depraved, and so forth. Many of these older people have lived during the colonialist expansionist

problem. She also wonders how other patients were responding in this room, stating,

"you are either part of the problem or part of the solution".

This last comment introduces the idea that each individual within health care settings (whether

nurse or patient) participates in racialized social relations by either reproducing them or

challenging them.

The nurses of Colour I spoke to felt strongly, as the participant in the above example, that

changing the assignment was not the proper way to deal with situations in which patients

harassed nurses of Colour. They looked to administration to take a stance against such behaviour

and, at the very least, involve the nurse in such a decision.

> P: And I think that's [changing assignments to please patients] totally wrong. And we
>
> have done this in the nursing but I totally disagree with.

> R: So better to just sort of gently confront them?
>
> P: Yah, confront. And say "I am your nurse through the day". You can like it or lump
>
> it. I mean not in that sense but, you know, because this is how people get away with
>
> things.

They also acknowledged, however, that it might be difficult to for nurses to provide care after

this type of confrontation. An administrator explained how this might affect the nature of the

nurse-patient relationship,

> Another experience I've had with that where you won't change the experience the nurses
>
> say "that's okay, I will take that assignment". Or the patients will say, "yah". I'm sure
>
> there's a distancing but there's still care.

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phase and have also witnessed the often-violent decolonization that followed. See Robert Miles (1989), for example, for an of the history of *race* and racialization.

Another nurse of Colour told of her experience, "but I have had incidences with patients who've said "I don't want you looking after me". Or "go back to your country". Ironically, this nurse was born in Britain and the suggestion that she "go back to her country" serves as an example of classification according to physical appearance, as well as the common conflation between nation and *race*. While she did not agree with changing assignments in such instances, she also went on to say,

> But sometimes I feel when you're in that situation it's really hard to provide that patient with the type of care that you give to everyone because you feel so offended and attacked personally that you're not going to give them the same type of care that they would have got if that hadn't happened.

These cases of overt and covert aggression from White patients caused these nurses of Colour considerable anguish.

They also told of difficulties when they cared for patients from similar backgrounds. One Filipino nurse explained,

> There is sometimes an issue when we care for people from our own race. Especially the older women, they are more demanding if you are the same race. I talked to (names 2 Filipina nurses) and they said the same thing. They can be very fussy, I say it is because they are Filipina. But you have to be careful, because they will go back to the community and say you are not a good nurse, so you have to make an extra effort.

An administrator made a similar observation,

> I think one of the challenges that face some of our staff that come from different cultures is the expectation of the castes within their culture. Sometimes they feel they are not treated very well because they care from another caste level. So I have had staff come to

me quite upset to tell me they have been tested by some patients. The comments they get is that "you are lucky your mother doesn't come to my temple or I would tell them what a terrible nurse you really are" or there will be a lot of testing that will go on. I must reassure the staff that I know they give good care, that I don't want them to be threatened from the cultural perspective….That came to light a few months ago. I didn't realize that was an issue, but two separate staff members brought it to my attention. So there can cultural issues even within their own community. They wanted me to realize that there were two separate issues, the level of care they were giving and the challenge from the caste level and that they were not seen as being in the same caste because of their job.

These two excerpts draw our attention to the intersection of class in shaping intragroup relations, showing how the dynamics of a relationship are changed by power operating along another axis.

To further illustrate the nature of intragroup dynamics and the intersectionality of oppressions, a young South Asian nurse told of how she challenged a South Asian man,

I remember one fellow who really spoke to me in a demeaning way and I just said to him, "you know, you might talk to people at home that way but don't talk to me that way, you know, I don't like it when you speak to me in that manner" so… but overall they've been quite respectful and appreciative.

Here, gender is acting as a confounding feature, adding another dimension to intragroup relations, and this nurse is actively resisting gender subordination. In sum, intergroup and intragroup patient experiences for nurses of Colour, while most often rewarding and respectful, were also characterized at times by hostility and conflict.

Nurses of Colour generally constructed their relationships with colleagues in positive lights, although several of them cited certain instances when they were not sure if colleagues were acting in racially-motivated ways. One nurse, for example, observed that

There are pleasant colleagues who are helpful, willing to help and teach, so that makes it OK. This has changed, though, with some of the newer staff, they do not have the same team approach. They talk against you, not in a nice way, behind your back, so that makes it very difficult. Now I am just waiting for retirement, at 55, so I can get out of here.

One nurse of Colour, while not labeling her experience as discrimination, reflected on how she dealt with stereotypical comments made by her colleagues. "So many people need me to interpret for them but I do find a lot of stereotyping going on and I try and always educate co-workers". She went on to describe how she, in essence, functioned as a "cultural broker" on the floor, explaining cultural behaviours and preferences to her colleagues.

R: So how do you do that? Like what would be an example?

P: One typical thing is, uhm, how the men don't want to do anything for themselves and how the women are catering to the men. And, you know, "how can these women stand to act that way?" And I'll try and explain, you know, it's not everybody and, uhm, you have to look at circumstances at home, where this woman's come from, does she have any other support and if she doesn't, uhm, act in the way the family expects her to act who does she have to turn to if they say "fine, you don't want to do it, we will then", you know, so it's, and then sometimes I will also say it's a woman's choice. I mean, she could say "I'm not going to act this way" but there's a lot of pressure to conform kind of thing and it's not everybody. Like there's so many families who aren't that way....And it's not just East Indian people who are acting this way, so... I mean whenever something comes up that I can, then I try and give them my point of view on it.

During this cultural brokerage, she felt uncomfortable with the attitudes of her colleagues at times.

> R: You must be comfortable as a staff member here in order to do that. Like that feels safe for you to do that?
>
> P: Mmh. Yah. But, you know, sometimes too things, issues come up and, uhm, it's kind of, you don't want it to reflect on yourself so you try and make light of the situation and use, you know...
>
> R: You use humor?
>
> P: To kind of brush it off and not make it seem so, that it's kind of offending you or something, you kind of make light of it.
>
> R: So that would be like if you were to hear other people talking negatively about...
>
> P: Yah, try and make a joke about it to make it a little lighter subject kind of thing. Or to make it that you're accepting.
>
> R: To sort of fit in that way.
>
> P: Yah. Or to say, yah, "I'm not like that". I can laugh at this and whatever kind of thing, so.

This nurse used humor to position herself in certain ways to deal with the discomfort of hearing negative judgments passed on her ethnocultural group. The use of humor in this way was a common strategy to deflect conflict that might arise from racialized comments.

These nurses told of situations with administrators where they did not feel supported and perceived they were not treated fairly. One nurse told of an incident that involved a confrontation with someone in another department that stemmed from her feeling that she was being made to wait for an unreasonable length of time because of her Colour. She looked for support from her supervisor, who instead dealt with the situation in an insensitive fashion (e.g., conducting the conversation in the hallway) and reproached her for the confrontation. After this incident, the nurse was no longer given charge duties, which she ultimately interpreted, after corroboration with other colleagues of Colour, as a form of further reprimand. As a group, these nurses of Colour also had the impression that others with less experience and who were coming in after days off were put in charge rather than a nurse of Colour who had more seniority and had been on for a few days. Another nurse reflected that she did not feel all that supported by her managers and would likely not go to them if she had been racially harassed.

> P: And I've been finding overall too patient's demands are, uhm, they're really high. Like, their expectation of their hospital stay seems to be, I don't know, like a hotel or something, you know. And then you don't have the backup from you're higher ups and the unit manager said, "this is their home", this is, it's patient care, patient rights first. But you feel like you're standing there on your own, you don't have anyone backing you up if something happens….So, you know, when you're working your day to day things and you have a patient who says whatever about Indians or something, like, what are you going to do or what are you going to say because you have to be really careful because you're always afraid this person is going to call back and say you treated him shoddily or something, you know.
>
> R: So you would be hesitant to…

P: Say anything to them [management].

These examples, thus, point to what could be interpreted as a lack of awareness and/or a lack of support on the part of management of the experiences of nurses of Colour.

The Racialized Workplace

It was my observation that nurses of Colour, especially on one unit, worked in settings that were, at times, permeated with racialized discourses. In a public area of this unit, I observed on several occasions White health care personnel feigning the accents of visitors and other health care personnel. Although this appeared to be done as a form of humor, it portrayed a message of debasing those who spoke with an accent. Considering that there were numerous health care providers on this unit who spoke with accents, it seemed inevitable to me that they would have overheard these feigned accents at some point. Days on which several Filipino nurses were scheduled to work were referred to as "Filipino Day". Another example of workplace dis-ease occurred during coffee breaks. While White nurses and nurses of Colour routinely took coffee breaks together, I observed that the conversation was most often dominated by White nurses. During one coffee break, derogatory comments were made by a White nurse about the First Nations displays at a local museum, with the remark that these were "so boring". On another occasion, two White nurses talked at length about the Christmas displays up at the mall, directing their comments to all at the table, despite the fact that three of the nurses at the table, sitting in polite silence, did not celebrate Christmas. This example suggests that in some situations, dominant culture is assumed to be shared by all. Moreover, they provide insight into the ways in which a work setting may condone racism that is systematic and institutionalized.

The administrative profiles of the hospitals reflected a certain hierarchy, and in this way, maintained the workplace as racialized. While none of the nurses of Colour in this study felt they had been overlooked for a promotion or were not considered for other jobs, there was an obvious lack of people of Colour in management positions at both hospitals. In one conversation with a White administrator, she commented on how "White the management is at this hospital". She then went on to muse why this was, wondering if people from certain ethnic groups stay away from particular types of positions because they do not enjoy that type of work, referring to her experience of encouraging nurses of Colour to apply for certain positions but being told, "oh no, I could never do that". Interestingly, at this point she asked for my opinion on the representation of people of Colour in management positions. She then went on to speculate that some people of Colour did not get the jobs that they applied for, noting barriers such as a lack of orientation and skill upgrading provided by the hospital that kept "Filipino nurses in extended care settings". She continued,

> The hospital can't offer them the training that would be required to put them on to some of the med/surg units and, therefore these people are sort of locked into extended care positions. And because the hospital does not provide them with the support they need, they are basically set up to fail.

This participant clearly recognized the important contributions that these nurses would bring to the hospital, citing their language skills and cultural knowledge. The insights of this participant point to a degree of systemic discrimination present in the health care system where nurses of Colour are not admitted into certain positions and are faced with barriers that prevent them from moving up the professional ladder.

Although the nurses did not construct these types of racialized workplaces and encounters with patients, colleagues, and administrators as commonplace, these stories nevertheless suggest that the construct of *race* is mobilized in damaging ways. This report of the racialized experiences of nurses of Colour is not complete without further analysis of how they interpreted and responded to these occurrences. To end without such explication would leave an inaccurate construction of these nurses as relatively passive, as victims without agency.

Reframing and Resisting

The nurses dealt with these experiences by reframing them in certain ways, by resisting racialization, and by taking action. Reframing could be understood as the application of one's interpretive lens to the particular situation to make sense of it in less threatening ways. One nurse was cautious in interpreting patient behaviour as racist,

> P: But I do find some clients react, they can react very sharply and rudely but I cannot, I cannot conclude that it is because a culture thing or because they are resentful because I am a Chinese person. I cannot because there is no other facts or data to support me to come to that conclusion so it could be because they had a bad day.
>
> R: Like they're grumpy?
>
> P: And then they become grumpy. The only time, the only thing I could come to a conclusion is, you know, that clients treat all the other nurses well and that I being the Chinese is not treated well, then I can say for sure that its the main reason.

This nurse, then, was hesitant to label rude behaviour as racist. Other nurses echoed this hesitation. One nurse admitted that there might be some patients who acted in discriminating fashions, but stated that these needed "to be seen as the one rotten apple" rather than as part of a larger problem. This nurse was the same nurse who had recently concluded that there was

indeed a pattern of discrimination against nurses of Colour occurring on her unit. Thus, she seemed to be in the midst of shifting her interpretive lens to account for discrimination; she said it was only recently that she thought this might be the case. Another example illustrates the influence of a nurse's interpretive lens:

> R: Have you ever felt you were treated differently because of your ethnicity?
>
> P: You know, I have been waiting for something like this to happen to me, but it hasn't, perhaps I am blind but I really can't say. Once, when I was young, 20 years old, naïve, a young guy in traction said something. I asked my girlfriends what this meant, and they said, "he said this to you?" I went back and told him I didn't like this word, and asked if he had said it because I wasn't White. He said, no, he said it because he liked me and wanted to go out with me, he didn't even think I was different.

It may well be, then, that this early experience assured this nurse that she was not seen as "different" and therefore subsequent encounters were interpreted through this lens. She went on to comment, "Maybe I am blind, but I just treat everyone the same. I don't notice colour. I treat everyone the same, with respect, and my patients like me" (laughs softly). Our conversation moved on to reveal more details about the formation and influence of her interpretive lens.

> R: I have noticed that the staff is quite diverse on this unit. Do you talk about cultural stuff amongst yourselves?
>
> P: No, we don't think of that, maybe because I am married to a White man, my husband is white, my kids are white and Filipino, I don't think of myself as inferior or superior. I treat doctors like this too. They are an employee like me, if they do something wrong, I tell them. If they don't like it, well that is OK. I think it is up to each person to make it work, to treat everyone the same. Maybe it also depends on your self esteem, if you can

present yourself well. *We all have red blood flowing through our veins.* That means you have to respect everyone. You have to respect street people too.

This nurse's interpretive lens is grounded in her multiracial marriage and day-to-day intergroup interactions in the most intimate aspects of her life. She appeals to common humanity as a way to move beyond "noticing Colour" and also speculates that a strong sense of self is important in negotiating intergroup relations.

This nurse's reference to having a strong self esteem was picked up by another nurse who emphasized that the way she presents herself influences how others respond to her.

> R: Have you ever, you can answer this how ever you want, have you ever been in situations, either with staff, family, or patients, that you thought you were treated in a certain way because of your Colour?
>
> P: (Pause). Not that I, I don't think so. Maybe they are unfriendly, but I don't think they are discriminating. Not really (pause). Because I don't give them a chance, you know what I mean? (laughter).
>
> R: You are extending yourself?
>
> P: Right, I don't give them a chance (hesitation). Umm, and the other thing that helps me is how I conduct myself, how I dress myself, how I, I feel that it doesn't necessarily have to be beautiful, but if you dress neatly and dress, you know, decent, you get respected.
>
> R: Right.
>
> P: You know, that would be my number one. Presentation. The other thing is that I always approach with "good morning". That is how I was trained. That helps. Whatever the time, I always say "good morning", good evening". Something.

R: A friendly approach.

P: Right. I find that through travelling, if they are a minority group I always

acknowledge their visitors. For myself, that helps.

R: That is a very respectful thing to do.

P: Yeah, So that gives them belonging, welcome. As minority, they feel they are

different, they want to belong in a sense.

This nurse is emphasizing the importance of presenting herself in friendly, caring ways and

seeking to connect with patients and families. Care must be taken here to avoid mis-

interpretation: the point is not that the onus is on nurses of Colour to prevent racism through

positive presentation of self. Yet, this nurse (along with the previous nurse cited) clearly

constructs this type of presentation as the claiming of agency in intergroup interactions.

Agency is also reflected in nurses' active resistance to behaviours they find demeaning,

as illustrated in some of the earlier examples (e.g., the nurse responding with the comment about

paying taxes; another nurse challenging a man's demeaning comments). Obviously, there is

some risk for nurses in confronting patients, especially when they do not feel supported by their

managers, as in the pre-mentioned illustration of the nurse who was hesitant to challenge a

patient for fear that they would "report her". There were several accounts where a more formal

approach was taken to harassment by patients:

We recently had 2 situations where we had patients making ill comments, rude remarks

about other cultures. We actually had to very nicely sit down with them and have a

conference with their GP, the charge nurse and the staff to let them know we are a

multicultural setting, we provide care to a multicultural group and that if they can not

tolerate this, we cannot have belligerent comments in a 4-bed room. So we basically let them know this is not tolerated.

This more formal approach takes the burden off of the individual nurse to deal with the situation. Another nurse appealed to administration to deal with such situations, saying, "people with power are morally responsible to do what is fair". She noted, however, a tendency in the organization to downplay racialized encounters, "This is the reality, but we want to whitewash what happens". This nurse clearly put forward the idea that all are involved in the reproduction and/or challenge of racialized social relations. In what was one of the earlier interviews in this study, this nurse by her responses to my questions, also challenged what I realized was a limiting question. As she concluded that the distribution of charge duties on her unit really was about discrimination, I asked if she dealt with this by talking to the other nurses of Colour. She gave a clear response, "we do not need a support group, we need different practices". To that end, she agreed to have me share her experiences through research "if it helps someone else".

In summary, while nurses of Colour in this study did not construct these types of racialized encounters with patients, colleagues, and administrators as commonplace, these stories nonetheless suggest that the construct of *race* is mobilized in damaging ways. In seeking an understanding of the standpoints of nurses of Colour, it is important to acknowledge racialized experiences and to make sense of these in light of their own interpretations and responses. Furthermore, these narratives shed further light on the complexities of intergroup relations, the multidirectionality of creating Other, for example, and the intersectionality of other signifying categories. Although the focus of this study was not specifically the experiences of nurses of Colour, these suggestions of racialized experiences and workplaces, fewer opportunities, and less advancement are supported by a small but growing body of Canadian research (e.g., Bhimani &

Acorn, 1998; Das Gupta, 1996a, 1996b; Farr, 1991; Head, cited in Henry et. al., 1995; Neysmith & Aronson, 1997).

Summary

By starting from the standpoints of nurses in this chapter, the groundwork has been laid for the further explication of the social organization of intergroup relations that follows in the next chapters. The constructions of intergroup health care provision presented in this chapter have provided insight into how "difference" is constructed and when it matters. Intergroup care typically becomes an "issue" when efficient care is interfered with, when moral dilemmas are raised for nurses, or when the status quo of the health care system is challenged. (The interpretation that "difference" is most likely to become an issue when it interferes with efficient care is a theme that is picked up in the next chapter where the context of nurses' work is examined.) More specifically, the primary sources of challenge for nurses in intergroup care were described as language differences and cultural preferences. Throughout this discussion, the contextual nature of making sense of "difference" has also come to light as participants worked hard at "making sense" of "difference", engaging in strategies such as internal dialogues, story telling, reductionism, classifying, and framing intergroup relations through their own interpretive lenses. These interpretive lenses derive from a range of influences (i.e., past experiences, identity(ies), education, and values and beliefs), are shaped over time, and are therefore not static. (The constitution of these interpretive lenses, particularly the role of identity formation, will be developed in more depth in Chapter Eight). The negotiation of intergroup relations occurred in varying contexts such as language barriers, accommodation of "difference", and the experiences of nurses of Colour. Throughout the foregoing narratives, we have seen how, in some cases, cultural and linguistic differences are bridged as nurses and patients develop points

of connection. In other cases, we have seen something that looks different, where individuals and sometimes entire groups, on the basis of their appearance, beliefs, or practices, are constructed as "Other". Moreover, we have been alerted to the complexities inherent in understanding intergroup and intragroup relations and the corresponding challenge of negotiating "cultural differences". My next task is to situate these interpretations of nurse-patient encounters in the meso context of nurses' work.

CHAPTER SIX:

THE CONTEXT OF INTERGROUP HEALTH CARE PROVISION:

NURSES' WORK

Introduction

I have described intergroup health care provision from the standpoints of nurses and patients in the preceding chapter. Yet, to focus on nurse-patient encounters may not be all that unusual; much has been written elsewhere about the nature of intercultural nurse-patient relationships, for example. The important contribution I want to make here is to situate these nurse-patient encounters in the contexts in which they occur, and thereby demonstrate that these interactions are, in large part, mediated by much more than the actual dispositions and skills of individual care providers. Some of this situating has already occurred inevitably in the previous chapter as the context of care was frequently alluded to, demonstrating that the day-to-day is indeed organized by the social; intergroup encounters occur in complex domains that directly shape how care is provided. In this chapter and the next, I aim to unpack that complexity and show how it affects day-to-day nurse-patient encounters.

The focus of this chapter is an analysis of the meso level context, the immediate settings in which intergroup nurse-patient encounters occur, revealing how the nature of nurses' work and the organizational setting of nurses' work come together to influence intergroup health care provision. Specifically, my aim is to explicate how the nature of resources and particular contexts organize nurses' work, which in turn shape intergroup relations. The two hospitals, one community and one tertiary, in which I conducted fieldwork are located in two distinct geographic areas and in two different health regions. Both hospitals, like other hospitals in the province, are undergoing significant and ongoing administrative changes associated with the

move toward regionalization. While my discussion here and in the next chapter points to both similarities and differences between the two sites used in this study, my purpose is not to engage in a comparative analysis of these two sites, but rather to explore how various organizational characteristics or factors mediate intergroup relations.

I begin with an explication of nurses' work as I understand it, based on my extended period of research. Intergroup care, by its very nature, has to do with connected care, seeing the entire picture, spending time to make interpersonal connections. Yet, there is much within the context of nurses' work that mitigates connected care – disjunctured care is a more natural outcome of the way in which the delivery of care is structured. Furthermore, the workload of nurses is such that they can do little more than "the basics", leaving them with minimal time or energy to focus on matters such as language differences and cultural preferences. I conclude that the outcomes of disjunctured care and heavy workloads are reduced quality of worklife for nurses and reduced quality of care for patients, especially marginalized patients. Furthermore, these characteristics of disjunctured care and heavy workloads need to be situated within discourses of efficiency and downsizing associated with health care reform.

The Context of Nurses' Work

The demands facing nurses on an hour-to-hour basis are remarkable – not only are they faced by the diversity and complexity represented by their clientele, they are also in the situation of having to constantly prioritize a raft of demands, and do so within the context of limited resources. When the complexities inherent in intergroup care (e.g., dealing with language differences and cultural preferences) are added to this formulation, nurses are faced with a formidable task as they strive to provide acceptable care to all patients. In Chapter Five, I concluded that seeking points of connection is integral to bridging the "differences" associated

with intergroup care provision. The ideal, not just in intergroup care, but in all health encounters, is what I have termed "connected care". In this study, I frequently observed nurses providing connected care, interacting with patients in caring ways. While they were "doing a.m. care", for example, they were also connecting with the patient, communicating concern, and seeking an understanding of the experience of illness from the standpoint of the patient. The real art of connected care occurred as nurses achieved this connectedness in the absence of shared language. Thus, in my fieldwork observations and concurrent analyses, I mapped out what connected care looked like, drawing on those instances when I perceived that care was provided in a mutually satisfying way (i.e., both nurse and patient were satisfied with care provision), as well as those times when I observed what I deemed was not connected care. While I observed many nurses working diligently to provide connected care, I also noticed numerous situations in which connected care did not materialize, resulting in what I named "body care". Generally, body care was typified by nurses attending to tasks and caring for the body, without obvious acknowledgment of the person to whom this body belonged. This type of care, then, seemed to occur isolated from the "lived experience" of illness and apart from a holistic picture of a patient's health care needs.

I was both disgruntled and puzzled by the gap between the *ideal* of connected care and the *reality* of body care, and found that it pushed me to identify in more detail just what it was that I myself considered excellent nursing care. However, more important than this exercise in self-reflection was the coexistent impetus to analyze the contextual impediments to connected care. When I shifted my attention to contextual influences, I saw that nurses were most often putting extraordinary effort into their work, but were constrained by a myriad of interruptions and demands. Thus, although the provision of body care could be attributed simply to a lack of

commitment on the part of individual nurses, I argue here that it needs to be understood as part of the larger context of nurses' work and the delivery of health care in general. At least two interrelated trends within health care mitigate against connected care: a) disjunctured care delivery, and b) increasing workloads. In these next sections, I discuss these characteristics of nurses' work with the goal of showing how they mediate intergroup care.

Disjunctured Care Delivery

Key qualities of connected care are those of "seeing the whole" in regard to the overall health/illness experience of each patient, understanding the lived experience of illness from the patient's perspective, and connecting at the human level through caring interpersonal relationships. Yet, much of how the delivery of care is constructed and structured hinders these three intertwined aspects of connected care from developing, particularly in intergroup situations. In contrast to "seeing the whole", a functional orientation breaks down the overall plan of care for a patient into tasks to be completed by individual practitioners. A range of critiques have been offered against functional approaches; common to most critiques are the concern that some aspect of the overall human experience (e.g., psychosocial components of health) is overlooked, and an associated call for "holistic care" or "patient centered care". Likewise, interpersonal connections are less likely to develop in the absence of ongoing relationships with patients and their families. Based on my fieldwork observations, I have concluded that there is much in realm of "surgical nursing" that facilitates functional approaches and/or prohibits interpersonal connections.

The Substance of Surgical Nursing

A first factor contributing to discontinuities in care is the very substance of nurses' work on surgical units. Nurses' work on these units has to do mainly with providing actual, hands-on

care – what is euphemistically referred to as "bedside nursing" -- to patients who have undergone, or will undergo, a variety of surgical procedures. Although not unique to such settings, the substance of nurses' work on surgical units tends toward an emphasis on physical care and a de-emphasis on the psychosocial and educative aspects of nursing care[67]. This provision of physical care was very consuming for nurses in this study, although they were constantly pulled away from this mission by a host of other demands, most of which related to the care of the patient but in a more indirect fashion. The centrality of this physical care in the overall picture of nurses' work was reflected in how nurses talked about patient care. They would say they "were done" once they had completed "a.m. care[68]" and "treatments[69]", thereby constructing the core of their work as the provision of such physical care. The following exchange in which I am negotiating access with a nurse demonstrates this emphasis on physical care:

> When I approach the nurse about buddying with her, she hesitates and says that there is not much happening in her end, adding that most of her patients are self-care, and that she has some empty beds. I explain that the number of tasks to be done are not the important thing, but that I'm looking to understand nurses' work. She says *"I won't be doing any nursing work"*. (Field Notes, August 1998)

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[67] I noted a profound shift in this regard since my own days of general practice in the 1980s. During that era, for example, there was a trend toward integrating more patient education into day-to-day care. As patient stays have gotten shorter and as pre-operative teaching has been re-located to outpatient departments, nurses on surgical units now do little formalized patient teaching, although at an informal level they are incorporating teaching around issues such as deep breathing and coughing, body mechanics during transfers, and so on. Another reason for less teaching by staff nurses is the number of specialized professionals who are now involved (e.g., enterostomal therapists, intravenous nurses or diabetes educators teach patients about the specifics of their care). Discharge teaching, still an important responsibility of the nurse, is often completed by distributing prepared materials (e.g., handouts).
[68] "A.m. care" is a widely used term by nurses to refer to attending to the hygienic needs of patients: mouth care, showers and baths, and changing linens.
[69] On surgical units, "treatments" most typically refers to completing assessments (e.g., vital signs, serum glucose monitoring) and attending to surgical incisions (e.g., changing dressings, removing sutures and drains, emptying drainage bags). With the increasing incorporation of technology into health care, treatments have become more

While this nurse was engaging in a variety of nursing activities (e.g., documentation, coordination, medication administration), she was not constructing these as "nursing work", reflecting this overriding attention to "hands-on" care.

Embedded within nurses' concern to complete physical care was a commitment to efficiency and "getting the job done", often heightened by the workloads facing them. This then is what nurses "do" on these surgical units, and it is easy to see that the importance placed on the physical aspects of patient care lends itself to a disjunctured, functional approach to care provision.

The Delivery of Nurses' Work

The very organization of how care is delivered may reinforce a task-focused style of care delivery and thereby contribute to fragmented care. The delivery of nurses' work can be characterized by a combination of factors: how care is delivered (i.e., team nursing or primary care, length of shifts), and who delivers care (i.e., Registered Nurses [RNs] or Licensed Practical Nurses [LPNs], casual or regular staff). Care was organized by team nursing on the first unit and by modified modes of primary care on the two secondary units in this study[70]. Modifications to primary care on the two units involved LPNs assisting RNs in comprehensive patient care. On two of the units (one primary care and one team nursing), a clinical resource nurse coordinated the care of all patients. My purpose here is not to make a decisive statement about the desirability of one mode of patient care delivery over the other, but rather to uncover how these systems of care in and of themselves contributed to a task orientation with a resultant

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complex, requiring closer monitoring (e.g., patients with PCAs or epidurals as modes of analgesia require close monitoring that includes frequently assessing vital signs, level of consciousness, and other such indicators).

[70] MacPhail (1996) tells us that the focus of team nursing is the team which includes professional nurses and nonprofessional staff with the idea that patient care is improved by using the diverse skills of team members to their full potential. In contrast, primary care focuses on comprehensive patient care, with autonomous nurses providing all care to the patients within their assignment.

fragmentation of patient care. In fact, nurses on all three units told me that the particular mode of delivery of care on their unit was "best" or most suitable considering the nature of patient needs on that specific unit (for example, nurses on an orthopedic unit were unanimous in their approval of team nursing as the most efficient way of dealing with the "heavy" demands of their work that included turning, lifting, and transferring patients). Although less obvious on the modified primary care units, each of these delivery systems contributed to disjunctures in patient care because nurses rarely had "the whole picture" regarding any one patient. To illustrate, an RN might be coordinating the discharge of a patient without having seen the patient mobilize or without assessing the patient's incision. Part of what prevented this "whole picture" was the division of work between LPNs and RNs.

The RNs I interviewed repeatedly drew attention to how the mix of LPNs and RNs on a unit dictated that the more functional tasks were left to LPNs while RNs took responsibility for the coordination of care. I did not interpret their frustration about this mix as indicative of a lack of respect for their LPN colleagues, but rather as a reflection of a) the overall demands on a unit that required the more in-depth knowledge and skill level of a registered nurse, and b) the overall quality of care that resulted. One nurse explained it this way:

> On our ward LPNs are helpful, but not as helpful. Because for most of the things, RNs are needed. If you have a night shift LPN work load then they can do vitals, and they can empty foleys[71], and do in and outs, but a lot of the things that you end up having the problems with are RN issues and not LPN issues.

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[71] "Doing vitals" refers to the assessment of key vital signs indicative of cardiovascular status and general wellbeing (including measurements of heart rate, blood pressure, respiratory rate, and temperature). "Emptying foleys" refers to emptying urinary drainage systems (i.e., urinary catheters).

This nurse is pointing out that LPNs can relieve an RN of certain "tasks", but cannot deal with the more complex patient care issues that arise. Many nurses echoed this concern that LPNs were limited in the degree to which they could provide care (e.g., they are not qualified to care for patients with many of today's technology-based interventions such as epidurals, PCAs, TPN or to coordinate multidisciplinary decisions around discharge planning) and, as a result, the imposed division of labour was such that LPNs handled much of the less "complicated" care (e.g., providing for hygiene, monitoring vital signs). Holistic care became less likely as the care needs for each patient were divided into "LPN duties" and "RN responsibilities". The delegation of certain patient care to LPNs was a source of anxiety for some nurses, because as RNs they still carried the ultimate responsibility for ensuring an acceptable standard of care. On the other hand, the LPNs often felt like they were left with the more menial aspects of patient care with RNs busy "at the desk". One participant described it this way:

> P: And so generally what I'm doing, and the LPNs even said to me when they work with me, the day seems busier and it seems less, but they take longer to get stuff done and it's because I generally ask them to come and get me when they're doing stuff. Like I find it's quite chaotic too but I just can't feel, I don't know what they're up to when they're doing all that stuff. And, to be honest, my observations of their abilities are not great so it does provide opportunity for me then to do some education with them as well and to identify problems with my manager which is what I'm finding is quite valuable. Like even just equipment, ways that we operate...

> R: And so that's actually, feet on the ground, you know, brings that to light.

P: But, so there is resistance. In the end they [the LPNs] resist in that they complain and say "why can't I get more help?" But I know, as an RN working on the unit, you are so busy, by giving out some medication, checking on their different technical stuff, like the pumps, like the PCA, doing that monitoring, doing the IV care, checking the physician's orders, checking with the physicians, attending the discharge planning rounds...

Despite the fragmentation that resulted, the general trend in both institutions (as elsewhere) was toward further deskilling of the nursing workforce. For example, one manager explained at a staff meeting that if the workload justified it, more staff would be hired on the particular unit, but that LPNs would definitely be hired, not RNs "like they used to in the 80s". Thus, in keeping with organizational discourses regarding cost-containment, the move toward deskilling was justified without any apparent regard for the associated outcome of increased responsibility (perceived as increased workload) for RNs and increased fragmentation in patient care.

Continuity of care was further interrupted by the shift work of nurses, most notably, by 12 hour shifts[72]. On one unit, the clinician observed that LPNs, who worked 8-hour shifts, were perhaps the more obvious care providers to be involved in discharge rounds because, unlike the RNs (who worked 12-hour shifts) on this unit, they had much more continuity with patients and therefore understood patient needs and resources more completely. Nurses spoke openly of the fragmentation that occurred because of 12-hour shiftwork, noting for example, that their first day on was "terrible" because they "didn't know anyone". One nurse explained,

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[72] 12 hour shift schedules typically mean a nurse works a rotation of two 12 hour days (e.g., 7 a.m. to 7 p.m.) followed immediately by two 12 hour nights (e.g., 7 p.m. to 7 a.m.) with four to five days off between these rotations. Thus, a nurse might care for a patient during daytime hours for two out of every ten days and then might well be switched to another set of patients for the next rotation.

R: What is a typical day like for you up here?

P: It is busy, quite heavy. The first day is usually worse, I don't know the people. Like today, I have to follow up whether Mr. R. has been followed by an endocrinologist with these high blood sugars. Also this patient is having purulent drainage and I need to know who is following this up. A pink slip has been left on the front of this patient's chart but I'm not sure anyone has looked at it. Things are usually calmer after this first day.

The casualization of nurses also contributes to disjunctures in care, where nurses are continually in the position of "not knowing" the patient. Casualization is a widespread cost cutting measure of the 1990s in which full-time nursing positions are filled by nurses who work casual or "on-call". Casual nurses usually worked on several different units and hospitals, which meant they were often not familiar with the routines of a unit, never mind the specifics of each individual patient. Casual nurses also replaced sick call and provided vacation relief. One day I observed that five out of eight nurses on one unit were casuals called in that day for either sick or vacation replacement. While most nurses deplored this trend toward casualization, two participants in this study with considerable seniority chose to work casual, explaining that it gave them greater flexibility in choosing when they worked and when they took their vacations. Nonetheless, the general trend toward casualization contributed significantly to disjunctured care. Current patterns in patient care delivery rooted in discourses of health care reform, including functional approaches to patient care, deskilling, delegation of nursing duties, and casualization, all contribute to disjunctured care and make connected care less likely.

Biomedical Dominance: Absent Presence, Present Absence

One of the surprises for me in fieldwork was the near invisibility of physician presence on the first two units in this study. I rarely observed physicians at the bedside or in the desk area, even though I was in the hospital at all times of the day and night. When they were present, physicians typically flipped through the patient's chart, made a brief visit to the patient's room, and then left the ward, often without speaking in any detail with the nurses[73]. I understood this lack of consultation with nursing staff as reflective of a shift in the professional role of nurses (i.e., away from the "handmaiden to the physician" image) but also as indicative of the demands placed on nurses where they often were not accessible to physicians because they were tied up with patient care. This lack of interdisciplinary communication carried considerable implications for the ways in which care was provided to the patient. During my fieldwork observations at Hospital A one morning, the RN I was buddying with was concerned about the deteriorating status of a post-operative patient whom she described as "dopey", "vague", and generally less alert than the previous day. She reported her concerns to the charge nurse who paged the physician but was told he had "gone upstairs for an hour to sleep". Careful monitoring of this patient (assessing vital signs, oxygenation, and blood glucose levels frequently) became the prime focus of the RN's morning. Several hours later, the charge nurse finally reached the surgeon who informed her that the patient had a low hemoglobin (83mmol/L) the previous day and that he might need a blood transfusion. In this case, the nurses spent considerable time monitoring the patient and seeking an explanation for his apparent shift in condition, while the patient himself was frightened by his own drowsiness, yet, had there been a conversation

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[73] This lack of consultation stood in contrast to my clinical experience in the 80s and early 90s when nurses spent considerable amounts of time in face-to-face discussions regarding patient care, often in the format of "rounds".

between the physician and nurse, this problem could have been dealt with earlier[74]. Nurses, in the position of providing "watchful care", were often the ones worrying about the patient while physicians were either inaccessible or minimally involved. I witnessed, on numerous occasions, nurses driven by their immediate concern for a patient's well-being seeking physician input – phoning physicians' offices, leaving urgent messages, paging physicians on the overhead paging system – but not able to locate or contact the physician (amazing in this day of advanced communication technologies). This finding is similar to that of Allen (1997) who explored boundaries between nurses and doctors and observed that a common nursing complaint in her study was that of the difficulties in getting doctors to come to the ward.

In other situations, the search for physician input was stymied not by lack of accessibility per se, but by confusion regarding who was taking primary responsibility for the medical treatment of the patient. For example, when a patient developed a complication not directly related to his abdominal surgery, the surgeon, commenting that this was beyond his expertise, suggested a consult to an internist. The nurse was left scrambling to contact the on-call internist and explained to me "each specialist has a piece of the body and doesn't pay attention to the rest".

The lack of accessibility to physician care is structured, in part, by the nature of the institution. As I extended my fieldwork to the second hospital to "test" the study findings, several organizing features came to light. First, in contrast to the physically absent physicians in the first setting, physicians were more visible in the second site, often travelling in pairs or groups. Yet, I was struck by the lack of interaction between the nurses and physicians. My interpretation here was that the focus of these specialists (general and family practitioners visit

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[74] To be fair, other characteristics of nurses' work (heavy workloads) and the delivery of nursing care (team nursing in this case) also came into play in this scenario. For example, presumably the lab result was also filed on the

but do not leave orders in this hospital) was on the medical students and residents, more so than the nurses. However, I observed friendly and extended exchanges between the residents and nurses on this unit. Second, nurses in the community hospital were more likely to have difficulty in tracking down a physician. Their counterparts in tertiary care hospitals reported less difficulty in accessing physicians (in part because of the system of on-call residents in surgical specialties) but were more often "caught in the cracks" between specialties. For example, I observed one nurse spend at least ten minutes trying to find out who was on call (starting with an out-of-date call-list). Despite the existence of considerably more medical coverage at this site, it took extra time to contact the appropriate service and this was also a reflection of fragmentation in the system.

Obviously, the care of patients was fragmented by this absence, this lack of accessibility to physician care. However, with more observation and analysis, I realized that this lack of physical presence did not translate into a lack of biomedical influence. Despite some re-alignment of power, the biomedical model in general, and physicians as individual practitioners, continued to exert considerable influence over the enterprise of patient care. First, nurses, especially at the first site, spent hours facilitating the work of physicians, making phone calls to inform them of admissions, discharges, diagnostic results, and so forth. Fax machines on each unit were used to fax diagnostic results to physicians' offices. I understood these tactics as nurses expending effort organizing doctors' work, as it were, in a collegial endeavor, based on a concern for their busy schedules, as well as on a certain professional deference. Nurses at both sites had systems of deferring non-urgent calls by placing notes (pink slips) on patients' charts and on "doctors' boards" (a clipboard with a list of questions for various doctors). On two units, a form of charge nurse had been re-instated after the head nurse position was deleted, largely for

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patient's chart and would have been accessible to the nurses through this avenue.

the purpose of facilitating communication and coordinating care with physicians. Once again my observations at the second hospital proved instructive. On the unit there, which adhered to a primary care model, the manager noted the resistance of physicians to the lack of a front-line manager: "The doctors don't like it, they want…somebody there to do some of their leg work, but I strongly disagree with that". However, even on this unit, the RNs spent much time "at the desk" communicating patient concerns and coordinating the care of patients.

Nurses also facilitated medical work when, in the absence of physicians, they were asked by patients to explain or interpret the medical regime of care. Often this positioned nurses in an uncomfortable conflict between "doctors orders" and patients' resistance to these directives (i.e., the handmaiden role conflicted with the advocacy role). Several nurses raised this issue in relation to caring for chemically dependent patients. As one nurse explained,

> P: There is little respect for us. Swearing at us, calling us every name in the book if we don't give them their medication on time. Well, it is not our fault that the doctor ordered it that way. And I find that the doctors don't support us a lot either.
>
> R: So you are caught in the middle?
>
> P: The doctor changes the guy's drug dose but doesn't tell the guy and then it is 2 in the morning, we take a lot of shit.
>
> R: You are then the bad guy?
>
> P: Yeah. You know, it is hard.

Another nurse described how she facilitated the preferences of the gynecologists who wanted patients who had had hysterectomies to have a shower on the first post-operative day. Yet, there were situations in which a woman's preference conflicted with this medical mandate to have a shower. In such situations, the nurse enacted general principle or intent of the physician's order

by having the patient wash at the sink, "The gynecologists are really strict with that [shower on day one]. But you have to meet halfway, you know, so if they don't want to have a shower, what we can do is take them to the bathroom and have a good wash."

Second, physicians have by and large maintained their role and dominance as "team leader" of the multidisciplinary team involved in a patient's care, even in domains that fall outside their expertise. For example, while physicians rarely attended multidisciplinary discharge planning meetings, they were the ones to officially discharge the patient from the hospital. In one case, a social worker, a community liaison nurse, and a charge nurse concerned with a patient's decision to remain in her own home had been counseling this patient to enter more supervised care. When the physician arrived on the scene, he spoke briefly with the patient, then strode by the other team members at the desk announcing "we have a signature" and left the ward without any further explanation or consultation. In this example, we see the primacy of the physician role accented by the lack of consultation and collaboration on the part of the physician, leaving the liaison nurse in the position of having to seek him out in order to achieve a coordinated plan for the patient.[75] Several nurses recounted situations in which physicians served as final mediators in what were constructed as cultural disputes.

> There was one example, uhm, I forget which nationality, something to do with hot and cold and they wanted to keep the patient hot, the room in darkness and that became a real problem. That was the only time that I've ever run into that problem and that was, uhm, we ended up having to tell the doctor, or having to get the doctor to explain and write a specific order, and that was the way we dealt with it in the end because, uh, we couldn't

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[75] Drawing on an ethnographic study on an acute medical ward in Britain, Latimer (1998) describes a similar process in which a decision to discharge a patient appeared to be arrived at through a due clinical process (rounds). However, while the decision was based on the "mundane work of nursing assessment...is temporarily effaced" (p. 53) suggesting that nurses' work became less visible in the guise of multidisciplinary teamwork.

come to grips with what was going on and it was so completely opposite to the way we

did think about it and just didn't think it was, as far as we were concerned, we didn't

consider it healthy.

These examples, then, speak to the continued influence of physicians in the overall provision of

care to hospitalized patients.

The presence of biomedical influence was observed in a third way in the biomedical

agenda that dominated patient care in hospital settings, often in taken-for-granted ways. One of

the managers I spoke to noted this strong presence in this way: "...In many areas of the hospital,

physicians of course are dominant in terms of social organization. It is frequently the moderating

demeanors of physicians and they will either give permission to or support certain ways that

things are handled". The dominance of medicine, with its alignment with technology and

science, was reflected, for instance, in how acuity was constructed. Informal workload

indicators had been formulated on several of the units and were used when justifying "workload"

(extra staff to help out because of heavy workload). Forms were used to document

measurements such as the number of patients in the immediate post-operative period, the number

of epidurals and PCAs on the unit, and the number of confused patients. Yet, it was my

observation that these categories did not necessarily reflect what contributed to "workload" for

nurses. For example, they repeatedly told me that language barriers and patient education were

time consuming, yet these were not calculated in the overall workload instrument, suggesting

that the "objective, technological" interventions were more likely to be valued as legitimate

workload. This valuing of the larger biomedical agenda was also evidenced in discourses around

discharge, when physical readiness for discharge took precedence over emotional readiness:

...The medical care system has pushed us to that point of discharge planning, turnover, let's get shorter length of stay and so, you know, as soon as we see people coming off of their IV's and tubes, okay, it must be time to go now. Where do they go next, let's move on, let's get the next one in the door....But there are also people you can't push and you have to realize when that is. When those people do need that extra time. Are we dealing strictly from a turnover in a physical perspective and saying, yes, physically they may be ready to go home but mentally they might not be. Psychologically they have not adapted to their big radical surgery that they've had and whose following them on the other end in terms of dealing with that after effect?

Thus, when the biomedical agenda intersected with the organizational agenda of fiscal restraint and restructuring, disjunctured care was all the more likely.

In summary, the extended time spent in the first hospital with further extension and validation of research findings in the second hospital revealed that disjunctured care results from current patterns of health care delivery. These findings are supported by earlier studies such as the one by Rodney (1997) who described fragmented communication and decision-making that detracted from the moral agency of nurses. While a concern for all patients, disjunctured care is especially worrisome in intergroup care situations, where communication is already challenged by linguistic and cultural differences. The interrelated matter of the workloads carried by nurses is another obvious theme in this study that poses further threat to connected care.

Increasing Workload

Nurses in this study were often frustrated when they were prevented or "pulled away" from providing connected care, to the extent of experiencing moral distress. Most commonly,

nurses in my study lamented that "workload"[76] was the overriding factor that "pulled them away" from connected care. When I asked nurses to comment on what their work was like in general, the most frequent response at all sites was that it was "heavy".

R: How would you describe your work?

P: Work wise it's very heavy.

R: And by heavy, what do you mean?

P: It's very heavy. Heavy in a sense like, it seems that patients are so complex and so much more needy now for the ratio of the staff. Sometimes you don't have that quality time to spend with your patients so basically you really want to get your work done – necessary work for the patients.

Because of the heavy workload, nurses said they "just do the basics now". If the results of a heavy workload are such that nurses have trouble achieving minimal standards of care, it is essential to look more closely at what is meant by a heavy workload. In the following explication of this workload factor, I describe the general nature of nurses' work and then look to more specific factors (nature of patients, priorities, and resources) that contribute to a heavy workload for nurses.

The Nature of Nurses' Work

In my observations, I witnessed the immediacy of nurses' work in which they juggled numerous demands simultaneously, making ongoing assessments and keeping track of a multitude of details in their minds. As I explained earlier, the "work" on surgical units is characterized by fairly routine care, focusing on the physical needs of patients (e.g., routine assessments, medication administration). However, an element of unpredictability is common to

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[76] A discourse has developed around "workload". The term itself has become a code word for nurses signifying unreasonable responsibilities. Interestingly, the term also refers to the staff who is called in as "extra" help during

this routine care, meaning that at any moment something could arise that demanded the nurse's complete attention, such as the sudden deterioration in patient condition. More often, these unexpected demands were rather mundane, but still required time from nurses and pulled them away from the other tasks awaiting completion. For example, during routine medication administration[77], several inconvenient matters largely beyond her control delayed a nurse, yet still demanded her attention. What would have been a five to ten minute job expanded into 45 minutes:

At 1030, she says it is time to do her 1000 medications. There are several glitches in giving these medications:

- First, she cannot find the prescribed lomotil (later a RN reminds her that it is locked up with the narcotics).

- An antibiotic is not in the drawer where it should be. She phones pharmacy about this, and they say they do not have any more in stock and are not sure when it will be available. She passes this on to the charge nurse.

- Next, she finds that the vented administration set she needs for a particular medication is not on the ward. She fills out a form from the stores department and passes this on to the charge nurse.

- When she goes to administer 30 mg. of MS Contin, the patient says she can only take 15 mg. The nurse negotiates with the patient, but the patient stands firm. The nurse then goes to call a MD who changes the order. She discards the 30 mg. tablet and administers a 15 mg. tablet. Because she is discarding a controlled substance another

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these periods of increased work.

[77] Scheduled medications are administered at "routine", predetermined times of the day. In this case, the nurse was administering the 0900 medications.

RN must witness this action and it takes a minute to find another nurse to do this.

- While she is at the narcotic cupboard, a student nurse comes by and asks for the keys, saying she also needs supervision. This takes another 2 minutes…

- When she goes to discontinue a PCA, the tubing is so tight that she cannot get it apart. She tries using forceps, but still is unable to remove the tubing so she has to change all of the tubing which involves getting another IV pole, flushing the tubing, and reprogramming the PCA pumps. All of this takes another eight minutes. (Field Notes, October 1998)

Nurses on this particular unit tended to distribute medications from a centralized medication area, which undoubtedly added "travel time" to this nurse's work (although they had the option of rolling the medication carts to the patient rooms). Nurses on the third unit most often distributed medications from a well-supplied, portable medication cart that they moved from room to room. However, I use this example not to suggest that the nurse might have anticipated some of these problems, or to speculate where the system of medication administration failed (obviously various oversights and errors had occurred in the prescribing medications, the stocking of supplies and medications, and so forth), but rather to point to the "hassles" that are part and parcel of nurses' work.

Another aspect contributing to the overall workload perceived by nurses was the constancy of nurses' work. There is a deep undertone of vigilance to nurses' work in which they constantly observe the wellbeing of patients, watching for responses to interventions or ominous changes in condition. The 24-hour presence of nurses underlines this "watchful presence". One manager pointed out that it was this watchful presence that distinguished nurses from doctors who had the more straightforward "notion of diagnosing". In contrast, the nurse's constant

presence meant he/she was "unraveling other circumstantial problems through ongoing interaction" that affect other health team members.

Adding to the picture of nurses' work as "heavy", along with the immediacy, unpredictability, and constancy of nurses' work, was the very physical, embodied nature of nurses' work as they walked, stood, lifted, and moved in cramped quarters. Nurses told me that they went home exhausted, often covered with bruises. One nurse described the physical demands of the job this way:

P: The work is very heavy, taking more of your physical strength including your mental strength but it is physical because being an orthopedic floor. We do a lot of lifting, and you know, getting patients up and they have to get up before break, er, lunch and they have to get back before we leave and so we are doing a lot of heavy lifting.

R: yah!

P: Some of them are so heavy that you, you don't get extra help to help you and so we have to rather do it than make the patients sort of wait and wait and wait and so sometimes we do it without thinking so it is physically exhausting sometimes. There are two people working on one side and you have post-op orthopedic patients that need to be turned every two hours or sometimes get up, and then one of you are on a break and you are basically left alone to help that person. If someone's vomiting or whatever and you are all alone…

R: And they need to be turned on their side…

P: …then you just go out there and do it, you know, you can't just wait for extra help. Sometimes you get it and the nurses on this floor, especially, are pretty good at coming

running to help you but the fact is you are all alone here you have to just go ahead and do it without thinking and then get the strains afterwards...

The physical environment of nurses' work accented this embodiment as nurses worked in tight spaces, often battling with furniture and technology (e.g., IV poles, monitors) for limited space. As one nurse put it,

> Yeah, you go home with lots of bruises, frustrations. You can't even get the bed in the room, you put down the siderails, and especially getting the patient back from the OR or PAR, there are 4, or 3 people in there waiting, you are banging the bed. Like the guy in the next bed had traction, we wacked him every time we came in and out of the room. And I know the families find it very depressing when they come on the ward, "Oh, my god this floor is so ugly, I don't want my family to stay here, we are taxpayers, we pay money". I've heard that so many times.

One morning, I was dismayed to observe a not-so-young nurse trip and fall over a commode as she tried to squeeze by. Her joking response was "I knew I couldn't get through there but I thought I would try". The embodied nature of nurses' work was particularly apparent on this nurse's unit located on an older wing of Hospital A where temperatures fluctuated significantly (during the summer time nurses carried squirt bottles to cool themselves down) and noise was often a factor making conversation and any nursing action depending on auscultation, such as taking blood pressures, rather difficult. The physical environment of the third unit (Hospital B) was much more pleasant, with many windows and adequate space around the bedsides. The size and lay-out of this unit eased nurses' work, with all of the rooms within a short distance from the main desk, compared to rooms removed from the main desk down long hallways in Hospital A.

We see from this discussion how a range of factors worked together to contribute to or ease the general "heaviness" of nurses' work on these units. For the most part, the constancy, immediacy, and embodiment of nurses' work pushed nurses to buy into the "efficiency" discourses rife in current health care. This explication has also revealed how the availability of resources and pleasant physical settings can contribute to a sense of reduced workload.

The Nature of Patients

Many nurses commented that the acuity of patients on surgical units was much greater than even several years ago, noting that the patients now on the general ward would have been in intensive care units several years ago. One participant commented, "Having gone into critical care nursing and now coming back out 15 years later, I see a major change in what the workload and acuity is like on the ward. So everything you've been reading about future hospitals turning into intensive care units has happened". Nurses pointed to the complexity of patients' needs, often referring to "multi-system failure" as a way of describing patients who were suffering from more than one ailment. Most often, these sick patients had highly sophisticated technological interventions (e.g., total parenteral nutrition, central venous catheters, numerous drainage tubes) that demanded close nursing attention. These acutely ill patients added significantly to the "workload" of nurses. However, as one nurse pointed out, acuity in and of itself was less of an issue for nurses than the staffing level.

> A lot of people don't mind the high acuity, like I don't mind the high acuity, I don't mind looking after sicker patients, that's not an issue to me. The issue to me is the staffing issue and that if I need extra help then I want to have it. I don't want to have to beg for it.

Although not typically as acutely ill, patients referred to as "off-service"[78] were also frequently named as adding to the overall workload for nurses. These patients, often requiring a different type of nursing (e.g., rehabilitative focus, or supportive care), were described as "frustrating", "time consuming", and even "stupid". Some of this resistance to "off-service" patients can be understood as nurses preferring to care for patients undergoing procedures familiar to them, as well as reflecting the frustration of caring for confused, disoriented patients. However, the real crux to off-service patients seemed to be the added demands on a nurse as she was required to "shift" her focus to accommodate the needs of each patient. One manager described it this way:

> That nurse may be having a really bad day....she may have had someone in the other
> room who just passed away or an alcoholic going through DTs and now she's in this
> room dealing with your pregnancy loss. Those are difficult matters and sometimes, uhm,
> you know, they're not always in the frame that you want them to be and you gotta think
> this nurse has 8 or 10 patients that she's looking after and has to switch gears every time
> to accommodate the personalities in that bed and the family and the this and the that so,
> uhm, those are not easy skills and sometimes I think, you know, but this nurse was really
> nice, well yah, but we're not all the same. We don't all react the same and we're not
> always having the exact same kind of a day.

This excerpt, then, illustrates the "layered" care that nurses provide, in which they provide physical care to patients, but also need to consider the range of complex psychosocial needs represented by patients (e.g., supporting patients who are facing life threatening illnesses or who

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[78] Off-service patients on a surgical unit might be someone admitted for palliative care, observation, respite, or diagnostics. While off-service patients were more of an issue at Hospital A, I observed several situations in which off-service patients added considerably to the workload of nurses at Hospital B.

have sustained profound losses, sorting out social problems, to the extent of screening who visits patients, etc.).

While nurses worked diligently to cope with the workload issues represented by rising acuity and "off-service" patients, what was not as apparent in my conversations with nurses was insight into what had contributed to this escalation in the number of these types of patients. I sensed a general absence of political awareness regarding health care reform among the nurses in the study. For example, when I asked them how health care restructuring affected their work, they almost unanimously said it had no effect on their day-to-day work. Yet, many of the factors contributing to increased workloads relate to health care reform. Increasing acuity, for example, is certainly brought about by changing medical technology and an aging population, however, the fact that these patients are on general duty units suggests that resources have not been sufficiently allocated to deal with this shift (e.g., by increasing the number of intensive care beds, or increasing the number of nurses on surgical units to deal with acuity). Likewise, bed closures in hospitals resulted in amalgamation of units, meaning that the "mix" of patient care needs on these units is very diverse, and therefore there are more patients who are deemed "off-service", although there may be no other place for them to go. Therefore, the priorities and discourses of health care reform "reach in" to organize day-to-day nurses' work and patient care.

The Nature of Priorities

Health care restructuring has further ramifications on nurses' workload, particularly in shaping the nature of what is constituted as "priority" in day-to-day health care settings. A key component of health care reform, the "closer to home" shift means that discharge planning has taken on a very high profile in many patient care areas (Sochalski, 1999; Wells, 1995). At one level, this has meant that patients spend shorter times in the hospital, going home as soon as they

are considered physically stable. At another level, early discharges add considerably to nurses' workload: nurses in this study focused on preparing patients for discharge, assessing home environments, and dealing with any "fall-out" related to early discharge. Furthermore, the move to early discharge and same-day admission for surgical procedures has considerably raised the acuity level of hospitalized patients[79]. The decision to discharge is often a complex one. From the biomedical viewpoint, patients are ready to go home when they are physically stable, leaving nurses and other multidisciplinary team members to assess patients' home environments and make a judgment regarding their ability to cope at home given family resources and supports. This judgment often left participants in a position of moral distress, as they balanced the organization's endless demand to "create beds" with concern for an individual patient's well being. The following dialogue captures these dilemmas:

> Now there are some patients, usually the older population because they can't go back to their previous living situation, that end up waiting either for placement or for extended sort of convalescence. I think at some point you see the focus shift to "why isn't this patient getting home?", you know, that wanting to see a turn over. "Okay, we've done our thing now, you know, it's time for them to move on. What's next in the care plan." And I don't know whether, uhm, if that's a result of the fact that we, the hospital or the medical care system has pushed us to that point of discharge planning, turnover, let's get shorter length of stay and so, you know, as soon as we see people coming off of their IV's and tubes, okay, it must be time to go now. Where do they go next, let's move on, let's get the next one in the door. That turnover mentality has become so emphasized to make maximum use of resources that, you know, we're sort of pushed to think that

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[79] Patients waiting for surgery and patients recuperating from surgery meant that the overall workload on a unit was less. With these types of patients no longer hospitalized, these beds are now filled with sicker patients.

way…You know, …whose decision is it? Do we listen to the patient to say, yes, we'll

keep them in that extra day because then they'll be ready and they'll feel much better

about their discharge or when emergency is, you know, stacked to the hilt do we really

push this person to the limit and say you must go today? I don't think there's any easy

answers. I think we kind of weigh the balance. Sometimes we accommodate them,

sometimes they push a little bit harder and those are judgement calls.

In this study, organizational priorities, often around maximizing the use of resources, drove

much of nursing's agenda and heightened the workload for nurses. When biomedical priorities

(discussed earlier) were added to organizational priorities, nurses were often strained to the point

of breaking.

The Nature of Resources

Nurses in this study faced daunting work environments as their workloads increased.

Contributing to the problem was a striking lack of resources. The most obvious lack frequently

identified by nurses at both hospitals was the matter of staffing. While patient acuity had

increased, the ratio of nurse-to-patient had stayed the same, for the most part, on the units in this

study[80]. Moreover, as this research progressed, the looming nursing shortage became more

tangible. Administrators scrambled to find nurses, most often with little experience, to fill

positions. The story of a nurse with five years of experience (she did not consider herself among

the senior staff on the unit[81]) points to the stress and added workload for more senior nurses

associated with working with inexperienced staff:

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[80] On the primary unit, a LPN had been added to the night shift. Staffing on the other units had not been increased, although managers were collecting "statistics" to make a case for increased staffing.

[81] I noted a frequent distinction made between nurses who were "experienced" and those who were "inexperienced". In some exchanges, there was a certain impatience with "inexperienced" nurses, suggesting that senior nurses would prefer to work with senior nurses. This is not all that surprising, considering the stress of the

P: I was working night shift with myself and all new people, so, myself being the senior staff and I've really only been here for 6 years. So, you know, it's not as if I've been here for 20 years with 20 years experience and then I'm working with all people who have maybe between 80 and 800 or 1000 hours. That's nothing. It's not experience. So, when you're working on a ward with one person and four other temporary people on the floor...

R: So how did that night go?

P: Terrible, It was terrible, you know, you have things, people are just not as experienced as they should be for the ward. Like, you know, a particular example was someone said to me that night we had an active upper GI bleed, he was vomiting blood and, you know, she came to me and so many problems so of course I had to drop all my patients and take on her problem and, you know, call the in-house, do all the things people do. And then I said to her "we have to give him blood and I've ordered the blood and it's on its way so could you get the tubing started". And her comeback was "why are we giving more blood if he's just going to throw it up again?" So people don't have the knowledge base...

R: Oh, wow!

P: So then you start questioning people's, uh, assessment skills and their knowledge base totally. You know if somebody said like that to you then you are working with them and you're relying on this person to look after their 10 patients and if that is their response for

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workload and the added responsibility that comes with working with junior nurses. In an era of few nursing positions, this nurse with six years experience was still a junior nurse on the unit. However, with the escalating

one of their 10 patients then, and I can't cover everybody's patients. You know, you can only barely be responsible for your own patients. If you have a particularly good night then you can help other people but normally on a night shift you don't have that much time to answer questions...

R: Because it's pretty steady?

P: Yah, and then you know they have all their questions about checking charts. If you're just not familiar with it you always question everything and so....

R: And so there were 4 people that were asking you questions?

P: Plus a couple of emergencies cause there was 2 or 3 emergencies that night which we had the in-house [physician] up for... I mean, I think everybody has to learn but I think you should learn on a less acute ward. Or with more support. If you're with one extra new person or two new people it's not so bad but I would say three of the senior staff should be spread out.

This excerpt illustrates how an already heavy workload is magnified for a more experienced nurse when she/he is called upon to assist less experienced nurses. Her observation about the need for more support for these inexperienced RNs was echoed by other participants who noted that orientation programs were generally inadequate in assisting nurses in the transition to a new work setting.

The lack of staffing resources also meant that nurses often worked overtime. On one unit in particular, nurses were often asked to work during their days off because of the difficulty in

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nursing shortage, it can be projected that those with two years of experience may soon be the senior nurses on a unit, for example.

filling positions on this unit. A nurse who worked full-time on this unit explained that she was routinely called at least two or three times on her days off to come in to work. Other nurses talked about being asked to work "double shifts"[82] and did so at times. Importantly, the matter of staffing, including overtime, was a major concern at both hospitals. What was different was that nurses in the second hospital were more likely to call in workload, evidencing a degree of autonomy I did not witness at the first hospital.

Downsizing and health care restructuring has also seen a profound cut in the level of clinical resources available to nurses. Nurse educators in this study (both sites) carried huge portfolios, and readily admitted that their availability for clinical problem solving was greatly diminished. While educators, managers, and nurses alike valued ongoing education in the form of inservices, a strong theme in this study was that there just were not resources or time for inservicing. One clinician commented,

> P: But in fact it's frustrating to have an inservice. It must not be great for a physician to do an inservice because there's only one or two people in there because the reality of it is that the staff aren't replaced to come to these inservices.

> R: So they can't even get away.

> P: They can't get away. It's just too busy on the unit.

Exacerbating this lack of clinical support and education, trends in hospital administration have seen the deletion of immediate supervision (formerly a role completed by head nurses and shift supervisors). At the primary site, head nurses had been replaced by less present managers, but after several years of what was described as "chaos", clinical resource nurses were installed

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[82] A double shift involves working two shifts back-to-back, either two eight-hour shifts, or a twelve-hour and a four-hour shift, for a total of 16 hours.

to oversee the day-to-day functioning of the unit. Shift supervisors had been deleted. At the secondary site, nurses worked without direct supervision and were expected to be autonomous practitioners, making decisions and coordinating care. While this is a realistic role for experienced nurses comfortable with clinical judgments and familiar with available multidisciplinary and community resources, it is a much more difficult expectation to place onto inexperienced nurses, particularly when they are left with few clinical supports. I was struck that nurses were by and large, left to fend for themselves, particularly on night shift. As this recent graduate nurse told me,

> P: Here, if it is busy, you just have to manage.
>
> R: Is there anyone you can call if things are really crazy?
>
> P: I suppose we could call the unit manager, but she would say, "well just do your best". I really don't know what we would do if we just couldn't manage. You could call another ward, but they would also be busy. That's where the supervisor used to help – at least she would know who might be able to come and help. There used to also be a hospital float nurse at night, but not anymore....Management doesn't have a clue about what our work is like. They should work several shifts each year in order to have a sense of what the work is like. That's why we are having job action now.

This perception of a profound gap between management and nursing staff was a common and disturbing theme at both sites in this research. While certainly accentuated during a time of labour negotiation, this rift must be understood as part of the corporatization of health care (to be

discussed in more detail in chapter Eight) where management holds a distinct mandate from clinical practice[83].

As a result of the lack of clinical support, nurses generally become reliant on each other, and more resourceful in meeting their learning needs. A clinical educator observed that nurses asked their practice questions of "whoever is around" because while they were good at problem-solving, the pace of their work also required them to "go for the quick fix" when they had a question. In tandem to a discussion regarding workload, nurses often added that it was the collegiality and support among staff that made their work life bearable. On two units where there had been significant staff turnover, and in one case in particular, the suggestion of nurse "burn-out", nurses bemoaned the resultant effect on their work. One experienced nurse explained that that because of staff turnover and low morale among that staff that remained, the quality of patient care as well as her work life was effected. She contrasted her present work environment with another unit:

> On the other unit, there are a lot of senior nurses and when I worked there I can see the difference because people are comfortable with their work so they are able to make an effort to look out for each other. And also help when they see you are running off your feet....I think it's a matter of making an effort to look out for each other, to understand that nursing is a team work, we do the best that we can to help each other, to make it a better environment to work in.

Nurses, thus, were clear in communicating the importance of staffing resources, especially as they related to support for inexperienced nurses, requests for overtime, clinical support, and support and teamwork with colleagues.

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[83] This rift between management and staff was obvious during rest breaks. I was struck by a lack of collegiality between these groups, with joint breaks a rare thing on both sites. I interpreted this as a shift from 10 years ago

A final element in the theme of limited resources is that of reduced physical resources. Nurses often spent what I termed "empty time" searching the unit for basic supplies that one would anticipate would be readily available (e.g., linens, pillows, commodes, wheelchairs) and worked with equipment that did not function properly. This was particularly so in the first site, leaving me with the not unfounded impression that community hospitals tend to be less resourced than tertiary care hospitals. Therefore, I was surprised when I observed nurses in the Hospital B work with outdated technology (e.g., serum glucose monitoring occurred with chemstrips, rather than glucometers that are considered much more accurate). Certainly the time of apparently endless resources is a thing of the past and not in keeping with a publicly funded health care system, but the question must be asked, "how much deterioration in availability of resources is acceptable?" "At what point is patient care seriously jeopardized?"

In this chapter thus far, I have presented impediments to connected care that are embedded in the nature of nurses' work. Data analysis has revealed how a functional orientation, the organization of how nursing care is delivered, and biomedical dominance work together to bring about disjunctured care. Furthermore, analysis of the context of nurses' work has also made visible how the immediate, constant, and embodied nature of nurses' work, patient acuity and "off-service" patients, the nature of current priorities (e.g., the "turnover mentality" associated with early discharge philosophy), and the availability of resources (e.g., staffing, clinical support and ongoing education, physical resources) contribute to what nurses call "increased workload". As a correlate, also apparent were the ways certain conditions such as improved resources and increased nurse autonomy (associated with Hospital B) enhanced work conditions for nurses. Yet, there were more similarities between the nature of nurses' work at the two sites than dissimilarities. Nurses in this study were well aware of the realities and

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when I was in practice.

problems associated with disjunctured care and increased workload, but the underlying reasons for these two factors were not always visible to them. Yet, larger influences such as health care reform are instrumental in structuring nurses' work, both through the structural changes it has ordained, and through discourses of scarcity (Varcoe, 1997a) and efficiency that have sustained the restructuring (this theme will be developed in more detail in Chapter Eight). I turn now to an examination of the results associated with the nature of nurses' work.

Outcomes: Quality of Life, Quality of Care

In the preceding sections, I have outlined two of the major themes of this study pertaining to the context of nurses' work: disjunctured care, and increasing workloads. Not surprisingly, taken together, these two characteristics of nurses' work contribute negatively to a) quality of life for nurses, and b) quality of care for patients.

Quality of Life for Nurses: Dissatisfaction

At both the personal and professional levels, nurses in this study expressed dissatisfaction with their lives because of the nature of their work. They were frustrated and disappointed when they could not provide the type of care they wanted to provide. I sensed a prevailing level of discouragement and poor morale among nurses related to their work situations. Nurses described dropping morale on the units they worked on that resulted in less teamwork, more sick leaves, and a lesser standard of patient care.

> I think on this unit nursing practice really has gone down...Some senior nurses have left, some have taken part time positions, and some senior nurses, they don't work as well as they used to, I do not know whether its because the morale is down or they have things in their own lives that take a lot of energy. So they could not put much focus and do their

best on the unit. They just do what is pertinent, important….With no head nurse around,

I think the morale on this unit is pretty bad.

She went on to add, "If the morale is not great, it does affect patient care because we have to work as a team". Contributing to the lack of morale was the perception that the nursing profession was not respected anymore. One nurse explained,

P: Yeah, I like it. Well, nursing I think as a whole is going down the tubes. I don't know.

R: Why do you say that?

P: Umm, Just the way we get treated. People have no respect for us.

R: Like the public you mean?

P: The patients. A lot of them too are confused, they don't know what they are saying. People, just say, you know like "the staff here", or people are just super demanding. They expect so much. And don't realize that we give our all to 10 patients or more in a day. Plus the people you work with, you support your fellow nurses. Like we give a lot and they don't realize that? They expect number 1 treatment for their family members, which we all expect. But they have to realize that, you know, we are doing the best we can.

The high level of stress carried by nurses at work carried over into their personal lives. It was not unusual for nurses to worry about work during their time off. The RN quoted earlier regarding her discomfort working with inexperienced staff during night shift offered the following commentary:

R: If you know you're coming on to a night and you are working with lots of junior staff or if you come off a night with that, do you sort of find yourself stressing about it when you're at home? Like, how do you deal with it?

P: Oh yeah! I mean you stress about it. It's always on your mind like what, you know, yah, of course you stress about it so it affects you. It affects you on your time off so then when you come back you're not rested.

R: And it makes you less likely to be able to work overtime?

P: Oh yeah, definitely. Cause you're spent on your 4 days, your 2 days and 2 nights. You don't want to come back for more.

Another nurse explained that she tried to leave work behind when she headed home at the end of a shift.

I sometimes come home and sort of vent my feelings at home. And then I never, sort of, try to mix work and home. I try not to do that. Keep it separate. But I sort of go over it in my head, you know, what I could do. For example, I am here for the next few days so what could I do to plan it, maybe, you know, to have more time to do something different. I would think of those things in my head or else, like sometimes, it's so busy then I say, "did I do this? Did I do that?" You know. Like it sort of worries me, you know. So that's why I try to make sure always before leaving to check, especially my MAR, to see if everything was given and everything was signed before.

Several nurses told me they chose to work part-time because full-time would be "too much" for them to handle. Many of the nurses in the study carried considerable responsibilities outside of work, providing care to their children or to other family members.

The demands placed on nurses as they worked in contexts with little organizational support took their toll.

R: So if you really feel like you're, I don't know, I'll choose the word drowning, it's just crazy on nights, is there anybody you can call for extra help or what do you guys do as a group if things are just like, they're not going to get any better?

P: *We just, uh, carry on,* because there's, uh, if you were in a really crisis situation you can try to another unit, but often they're busy too. They can't, they don't have time to free anybody up and I guess, you know, there's really no others. I mean if it was a terrible, terrible crisis situation we could phone ICU and ask an ICU nurse to come but often they're too busy anyway and they're all short staffed so I mean you can always try and transfer someone off the ward.

R: Which that takes time too, right, just to be able to do that?

P: And lots of times there are no beds, so... I think the biggest problem with this unit is that issue...the workload problem....and that's the reason why there is a staff problem because of the workload and a lot of the senior staff are worn out or tired or taking four sick days, lots of compos [Workers Compensation Leave].

This nurse is describing the outcomes of working under what are essentially unsafe working conditions as burn-out, extra sick time, and disability leave. Along with sick leaves and absenteeism from work, nurses also dealt with the stress of the current context of health care

provision by taking early retirement and seeking employment elsewhere[84]. The manager of this unit explained that surgical units have traditionally "fed the system", meaning that nurses who have gained experience in surgical areas tend to specialize and transfer to areas such emergency, renal dialysis, and critical care.

Thus, nurses in this study were feeling the strain of increasing workloads and disjunctured delivery of care in both professional and personal realms. Other researchers have reported similar findings. Rodney (1997), in her ethnographic study with nurses in acute care hospitals, concluded that personal costs associated with nurses fulfilling their work obligations were substantial and included fatigue, guilt, and personal risk. She situated these personal responses against the current context of health care restructuring with its climate of (dis)valuing nurses' work. Boon (1998) in a hermeneutic study with nurses in the Okanagan, reports that downsizing and financial restraints brought overwhelming workloads, lack of equipment, a sense of disjointed unit operation, and feelings of powerlessness and isolation. A survey conducted by the polling firm McIntyre & Mustel for the British Columbia Nurses Union (BCNU, 1998) showed that 74% of nurses reported an increase in workload over the last five years with 89% of hospital-based nurses responding that they felt overwhelmed by this workload. Forty-seven per cent of nurses surveyed reported that, given the opportunity, they would leave nursing. In Nova Scotia, nurses described feelings of hopelessness, anger, anxiety, uncertainty about the future, financial and family worries and low self-esteem which the researchers linked to changes associated with healthcare reform (Keddy, Gregor, Foster, & Denney, 1999). Marie Campbell

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[84] During the period of this study, several nurses left one unit to take specialization courses, and another two left for positions in the USA and England. Nurses spoke enviously of the nurse who had gone to the States, saying that her workload was lighter, her pay was higher, and that she had opportunities for ongoing education financed by the hospital.

(1994) similarly accounts for the burnout experienced by nurses through an analysis of "cost-efficient" organization of the nursing labour process.

In an era of nursing shortages, the general level of discontent among nurses does not bode well. In a recent statement, the Registered Nurses Association of British Columbia (RNABC, 1999) pointed out the importance of retention of nurses as well as recruitment of students entering nursing programs. Based on a review of one of Canada's "magnet hospitals"[85], Mount Sinai Hospital in Toronto, the Canadian Nurses Association (1998) named the following characteristics as contributing to better recruitment and retention of nurses: autonomous practice, recognition of clinical expertise, nursing leadership, support for continuing education, supporting beginning practice, use of a primary nursing care model, flexible scheduling, and nursing staff development. In this study, nurses at both sites identified many of these characteristics as lacking in their own professional practice, and thus the strain felt by these nurses is not all that surprising. Nurses in the first site, while benefiting from more direct nursing leadership, identified a lack of support for continuing education, inadequate support for beginning practice, and inflexible and overly demanding work schedules. Nurses at the second site were generally more autonomous in their practice but pointed to a lack of leadership and also decried the lack of continuing education and support for beginning practitioners. The findings of this study, then, suggest that the current characteristics of nurses' work and health care in general (disjunctured care, increasing workloads) are placing considerable burden on nurses.

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[85] Magnet hospitals, known as the "gold standard", are institutions where nurses are recognized for their professional value, quality of work and excellence in nursing services. Magnet hospitals are known for their ability to recruit highly qualified health care providers and improve staff retention (CNA, 1998; RNABC, 1999; Scott, Sochalski, & Aiken, 1999).

Quality of Care for Patients

It was my observation, and also the testimony of nurses from both sites in this study, that while nurses worked diligently, there was an overall decrease in the quality of care provided to patients. I noted that there were fewer interactions between patients and nurses, less teaching, and generally less holistic care being provided than mandated by current professional standards of practice. Nurses typically did not have the time, nor did the delivery of care allow for an overall sense of patients' experiences of and responses to illness and medical intervention. As mentioned earlier, many nurses told me that they "just did the basics now", suggesting that they are having a difficulty meeting standards of care. A recent graduate explained,

> R: We know it is important to understand the personal meaning of illness, for example. Can you get into that here?
>
> P: No, we don't have the time, we really just do the basics. I might ask a few questions while I do a bath or a dressing, like "how has this affected your work?" or about their family and how they are coping.

We see then that the emotional labour of nursing (Yyelland, 1994), connecting with patients, taking emotional needs into account, is the aspect of nursing that is the first to go when nurses "just do the basics". It is not all that surprising then that complaints about communication were among the most frequent patient complaints.

During my observations, I also noted situations when even "the basics" did not appear to be met. For example, the following scenario captured for me the worst of patient care, in the realm of the inhumane. It was just after midnight on a busy surgical unit when an elderly,

restless woman was placed in her bed out in the hall so that she would not disturb her roommates, and also so she could be observed more closely. She was restrained (leather wrist restraints) and was lying in bed linens completely saturated with urine. I have seen many wet beds in my day, but never one as wet as this one. My immediate response was anger with the nurse who was assigned to her. How could this happen? Yet, this example really illustrates how contextual factors work together to prevent quality care. First, the nurse assigned to her was inexperienced, to the point that she was truly overwhelmed – she did not know where to start with this patient. Further, she was working casual, just beginning her shift, and was not familiar with this patient. Second, the evening shift had been particularly busy for all nurses on this unit. When I had arrived at midnight, there was a general feeling of disarray and unsettledness on the unit. Thus, the previous shift likely felt they did not have time to care for this patient and the nurse now on duty was having difficulty finding someone to help her. Finally, this patient was in that category of "off-service", restless, confused, admitted without a solid diagnosis, yet clearly very ill. While this patient would require much nursing care throughout the night, the young nurse also had many other ill patients demanding her attention. When viewed as a whole, this patient was at the nexus of many intersecting factors that contributed to the abysmal care she received.

In light of this generalized threat to quality patient care, it behooves us to return to the focus of intergroup care. If patient care in general is suffering, what is the quality of care to patients from marginalized populations? One nurse put it this way:

> I do find minority groups sometimes do not receive the same amount of care as, you know, if you are in the, if your English speaking at all because, you know, maybe because the unit is so hectic, the nurses do not have time really to stop and try to figure

out what the client is trying to say in her, whatever, his language or if the client tries to

speak English it doesn't come out quite the same so it takes awhile to understand what

she's saying so they are neglected in the sense that, you know, nurses don't make enough

time for them. They have to rush onto the next client or the next things.

The example provided in Chapter Five of a nurse assuming that elderly patients from certain

groups (Chinese in this case) would be cared for at home and therefore not taking the same

approach to careful discharge planning speaks to a lesser standard of care for those who do not

speak English. When coupled together with the prevailing emphasis on early discharges, non-

English speaking patients and their families may be placed under particular strain. As explained

in Chapter Five, the particular challenges of intergroup care (e.g., understanding cultural

meanings of illness, seeking interpretation) are often overlooked in times of busyness.

Moreover, disjunctured health care delivery that affects the quality of all care may

disproportionately affect intergroup care, especially when the importance of connections and

connected care is understood.

As with decreases in nurses' quality of professional and personal life, the decline in

quality of care exposed in this study can be understood as shaped by health care restructuring.

Although nurses in this study typically did not use the language of professional standards, their

descriptions revealed that in many situations, they were unable to meet standards for nursing

practice, as laid out by the professional association. The BCNU (1998) survey cited above found

that 54% of nurses felt they were not able to provide quality care that met RNABC professional

standards. Other Canadian research has made links between health care restructuring and patient

satisfaction (Beardwood, Walters, Eyles, & French, 1999). Beardwood et. al. conclude that the

increase in patient complaints regarding nursing care over the past few years can be accounted to

the increase in public power and consumerism with a concomitant decrease in nursing power due to the process of the restructuring of health care. In an ethnographic study with emergency room nurses, Varcoe (1997a) reached the conclusion that the ideology of scarcity, with its images of sparse, insufficient and shrinking resources, influences practice to the extent that it resembles the "efficient physiological processing of patients" (p. 355), and that the overall health of patients is not served by this pattern of practice. Importantly, the fact that these findings regarding nurses' quality of life and quality of patient care are not unique to Canada with similar outcomes reported internationally (e.g., Sochalski, 1999; Tovey & Adams, 1999) can be understood as a reflection of the widespread health care reform movement.

Summary: Agency and the Context of Nurses' Work

This discussion of the nature of nurses' work, the quality of nurses' lives, and the quality of patient care raises the pressing question of agency. What are nurses, individually and collectively, as staff nurses and as administrators, doing when faced with the present nature of nurses' work? At one level, individual nurses in this study were too wrapped up in struggling from hour to hour to meet demands placed on them to actively resist the trends in care delivery. There was also a certain apathy apparent in which nurses just wanted to get the job done, and then go home. For example, one nurse told me that they were too busy to fill out the forms reporting unsafe practice and that she did not even know how to go about doing this. Nurses often worked overtime in order to complete the tasks of their shift, but rarely completed overtime forms. When I asked one nurse if she had filed for overtime on the previous shift, she said "No, the charge nurse had not put out the forms and I just wanted to get home". I also noted earlier in this chapter that there was not a high level of political awareness among practicing nurses. These findings are not unlike those of Keddy, Gregor, Foster, and Denney (1999) who found that

nurses demoralized and exhausted by the quality of their work lives in the aftermath of health care reform did not resist or revolt as they were "too exhausted or stressed to do much else but keep going from day to day" (p. 63).

Collectively, however, nurses during the period of this study gained considerable voice through labour negotiations. The job action that occurred through the fall months of 1998 could be understood as the collective voice of nurses saying, "we won't take these working conditions any longer". The key issue in this negotiation was workload and quality of care, with nurses demanding more staff to meet an increased workload (Cathy Ferguson, president of British Columbia Nurses' Union, cited on BCTV News, October 21, 1998). Other issues included unequal benefits for nurses across the province and financial reimbursement (especially on-call and shift premiums). The settlement included the establishment of 1000 new nursing positions across the province. Along with these terms of settlement, a less overt outcome of the labour negotiations was a renewed sense of agency for nurses. One nurse, for instance, told me that since the job action, they were much less likely to put up with heavy workloads. "We just don't put up with it anymore". She went on to say that if "the manager puts up a fuss, we would file a union grievance about unsafe work conditions." (Field Notes, March, 1999).

Importantly, the clinicians and managers interviewed for this study were also concerned about matters such as disjunctured care, increasing workload, poor staff morale, and standards of patient care. They were often caught in a difficult spot between the priorities of corporate health care (i.e., responsible fiscal management) and the realities of nurses' work and patient care. Reflecting this tension between priorities, one participant explained the process involved in seeking more staffing:

What the manager is trying to do is compile enough information and give Finances some hard data to justify the bringing in, you know, the addition of extra staff. Not just calling in workload but actually adding a permanent position. And this has been going on for, well, since I came up here so it's been a couple of years now... So, you know, that type of staffing level [reduced staff at night] just doesn't fit anymore and in terms of trying to get the numbers to talk to the finance people who aren't nurses who need to understand this has been a challenge. So that's why the manager is collecting this information and trying to get it together to justify the addition of staff. And we're getting there, we are because I've talked to both the director and to the COO [Chief Operating Officer] who, she also has a nursing background and they're listening.

Clinicians and managers also spoke of the need to provide better clinical support and initial orientation to nurses, especially inexperienced nurses. It seems then that clinicians and managers were attempting to counter the trends that left nurses so dissatisfied, but were themselves constrained by the priorities and philosophies of these large health care institutions.

In this chapter, I have begun the project of making visible the organizational features that mediate intergroup relations in health care settings. Disjunctured care and increasing workload were two identified features that characterized and structured nurses' work and mitigated the connected care characteristic of sound intergroup health care provision. The nature of nurses' work also left nurses dissatisfied and demoralized. Labour negotiations, a key event during the tenure of this project, brought some agency and resistance to nurses. An important theme running throughout this chapter has been the influence of health care restructuring on nurses' work. In the next chapter, I offer further analysis of the institutional or organizational structures that shape nurses' work and their ability to provide intergroup health care.

CHAPTER SEVEN:

THE ORGANIZATIONAL AND COMMUNITY CONTEXTS OF INTERGROUP

HEALTH CARE PROVISION

Introduction

In this chapter I bring the organizational and community contexts to bear on nurses' work

and nurse-patient intergroup encounters. Specifically, my interests are along the lines of

administrative structures, institutional practices, organizational philosophies, policies, and

resources, and how these shape intergroup relations in general and nurses' abilities to provide

intercultural care in particular. Most notably, analysis of the research data revealed a gap

between well-intentioned hospital policies pertaining to multiculturalism and their

implementation into practice at the "bedside" level, and careful reading of the data provided

several explanations for this "gap". In the second section of this chapter, I explore the influences

of community contexts on intergroup relations, concluding that they are a profound mediator of

the ways in which difference is constructed and negotiated in health care settings.

The Organizational Context

Back in 1979, Melia observed that hospital wards constituted "turbulent" work

environments. Twenty years later, this observation seems all the more accurate, with change a

seemingly constant feature of health care delivery. As noted by Allen (1997) and evidenced in

the data of this study, hospitals are sites of varying fluctuations in the pace of work where the

unexpected can occur at any moment. The descriptions of nurses' work as constant, immediate,

unpredictable offered in Chapter Six can be applied to most areas of the hospital. Allen also

explains that at another level, hospitals are essentially public spaces in which complex, internally

controlled patient care is coordinated on a 24 hour per day basis. The diversity represented within the communities in which the research hospitals were located reinforced the notion of a public space, as people from all walks of life were brought together in "artificial" but intimate ways. The large numbers of staff and practitioners employed also marks the unique and complex settings of hospitals (e.g., in many communities, hospitals are the largest employer). Finally, this decade has seen hospitals further complicated by the importation of what is often referred to as the "business model" of health care and by wide ranging changes derived from health care reform. At the same time, the reduction of funding to hospitals without significant simultaneous alteration to the dominance of the medical model has resulted in an increased "curative approach to body parts treated by experts who assume mainly biological causes" (Armstrong & Armstrong, 1996, p. 66). These two shifts have resulted in an increased bureaucratization of hospitals as the focus has subtly shifted from the health of patients to "the bottom line". As we have seen in Chapter Six, current trends in health care have significant influence on the day-to-day provision of care.

In this section, I shift the focus slightly from nurse-patient encounters and nurses' work to administrative structures, institutional practices, and organizational philosophies and polices in an effort to make visible how these features, removed in a sense from bedside encounters, do enter into the day-to-day construction of intergroup relations. That is, I am pursuing the analytic task of examining the administrative structures and organizational policies that govern everyday practice with the goal of uncovering the fundamental social processes and structures that mediate intergroup relations in health care provision.

Administrative Structures

While an organizational analysis of the two hospitals was not a goal of this research, several themes derived from participant accounts and my observations regarding the administrative structures of the hospitals emerged that have direct relevance to intergroup relations. Both hospitals in this study were undergoing significant and ongoing changes in administrative structures associated with health care reform and the move toward regionalization. When viewed over the period of the last three years or so, the degree of change that had occurred and was still being planned in these institutions was remarkable. Administrative structures had changed significantly (e.g., both hospitals had shifted from traditional departments organized by profession to versions of program management), and the corresponding vocabularies were still strange to most front-line nurses[86]. For example, when I asked about the impact of the shift to program management, several nurses did not realize this had occurred, and another asked what program management was. My sense was that while administrative structures had changed, nurses were, for the most part, unaware of how they were affecting their day-to-day lives, saying that "we still do the same thing we did before". Other changes involved changing titles for positions, changing personnel within these positions, and changing portfolios associated with positions. Several participants told of how their own portfolios had expanded incredibly recently. Aside from the obvious increases in workload and responsibilities, these nurses were also unhappy about how such increases in responsibility had come about without their input. Thus, changes had occurred that affected these participants directly but left them feeling without "voice". Another nurse commented how her position had changed over the years on account of

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[86] I found myself experiencing a huge learning curve as I struggled to understand terms such as health services areas, program management, quality initiatives, continuous quality improvement (referred to as CQI), clinical pathways, care maps, risk management, and so on.

the amalgamation, on several occasions, of her original unit with other units. She now worked on a surgical unit that looked very different than the one that she originally worked on and therefore was one that she "did not apply for". At the time of these changes, she had been informed that she could apply for jobs elsewhere, but she said that in reality, there had not been opportunities elsewhere, and "I need the money". These types of changes left nurses feeling estranged and disconnected from those in positions of authority, with talk of "us" and "them" and derisive comments about all the "power suits" in the cafeteria. My conclusion was that the nature and degree of change over the last few years left participants demoralized and overworked, with less loyalty to the agencies they worked in.

Further, I understood the ways in which decisions were made and communications accomplished as reflective of the bureaucratic nature of hospitals. Several of the participants who were in administrative positions mentioned that they felt "far away" from where the decisions were occurring and therefore "didn't know what was going on". This perceived distance was expressed more strongly in the larger hospital and, according to the participants, had been exacerbated by regionalization that added "an extra layer of bureaucracy". One participant told of the difficulty she had providing consistent information to all units regarding AT&T language services:

> I've recently asked; I'm going to put some more information on the units about the AT&T service. I think one of the pamphlets about the service should be at every telephone, but I was sent just four of them. I really need 100, one for every bedside. It makes me think they don't want people to use the service when they send me four pamphlets....And there's no place for it to live. They have never established room for this in the interpretive service. It needs to be in the administration manual, or if I go to

any one of the units I'm looking for this information. I need to know where to find it. A lot of it's in the telephone book but because the telephone book changes regularly, sometimes it inadvertently gets discarded. It needs to be in one manual and so I have talked to the language coordinator about that.

This quotation suggests that because of inadequate initial direction about where to keep this key information, consistency is now lacking in where the pamphlets are stored on each unit. Her reference to "they" suggests a distance from where decisions are made, with an associated lack of accountability for follow-through. The fact that so few staff nurses knew about or used the existing interpretive services also speaks to inadequate communication regarding available services. On the other hand, coordinated efforts between departments often brought about the potential for significant change. In one example, all patient complaints were handled by one person who could then work with all the involved parties. As a result, this hospital had an overall sense of what key issues of concern were arising and were able to link these to their quality initiatives program.

Regionalization was one of the changes that had the most apparent effect on how intergroup relations were managed and was viewed in different ways. Participants explained that they were "still learning" regionalization and were testing out the relationships between the regional board and the agency. Several participants, especially those in management positions, tended to express more positive views about regionalization, emphasizing the opportunity to share resources and "deepen problem-solving abilities". After a region-wide conference on diversity, one participant commented on the wealth of expertise and knowledge represented by the conference participants. In the other case of regionalization, the study hospital was, according to a spokesperson, benefiting from the amalgamation process by drawing on resources

established at other sites in the region. Another participant noted the increased opportunities to liaise with community resources brought about by regionalization. However, one participant expressed pessimism regarding the process, stating that

P: I think we are going to suffer even worse cuts due to regionalization before we are going to feel any kind of relief.

R: Right, we are not in a stabilization period yet.

P: The impact hasn't hit yet. By the time they think we are on the mend, we are really going to be in a downfall. So, I don't know, I am not too hopeful, as you can probably understand. I don't know if regionalization is going to work. It never worked in Australia or New Zealand. Wherever they tried it before, it was just a process that was unsuccessful. And why they didn't pay attention. Real expensive.

This participant was dubious about the success of regionalization and evidenced a distrust in governmental planning. She also predicted a loss in beds and services offered at the hospital and worried that patients would have to travel further in order to access services. Another participant observed that regionalization was not all that popular, and that it was seen as a fad.

Paradoxically, with one of the goals of regionalization being decentralized services offered with more community input (Burgess, 1996), an outcome at the agency level was a decrease in autonomous decision-making. This shift to regional-level decision-making and policy-setting had ramifications for the implementation of a multicultural program in one site. Left without a clear vision of their mandate or influence, the previously-active diversity committee went into near dormancy. An action plan that had been drawn up "went nowhere" because of changes in the line of reporting. An expansion of the interpretive services program was also delayed as the official endorsement of the program shifted from the hospital level to the

regional level. Interestingly, the message perceived at the regional level from this particular hospital was "just let us be, the region is holding us up". While these delays and loss of momentum were likely temporary (i.e., until regionalization was "up and running"), they still had significant impact on the day-to-day provision of intercultural care.

Administrative structures, marked by change and bureaucracy, and heightened by regionalization, were important in this study in influencing the ease with which policies and programs (e.g., language services) were implemented. As well, the perception that decisions were made "elsewhere" left individual practitioners with less commitment toward these decisions.

Institutional Practices

There was a range of institutional practices that spoke to the hospitals' overall commitment to diversity issues. Some practices were highly visible, either by their presence or absence. Others were less noticeable but still influenced how intergroup relations played out in the provision of health care. One of the more visible institutional practices involved multilingual signage of the hospital. Both of the hospitals had made some effort at providing multilingual signage (one used mostly universal symbols), although signage was not consistent at either site (for example, both sites had hospital mission statements posted on each unit, but in each case they were posted only in English). Temporary and/or informal signage also varied. At one site, public notices regarding job action by nurses was posted in several languages, at the other site such notices were posted in English only. One participant, referring to a facility map in three or four languages at another hospital, observed that this agency had carried out some key initiatives that "don't have to cost a whole lot". Positive efforts were also being made to translate annual

reports into high usage languages and public announcements were posted in community papers representing the second language of the surrounding area.

The availability of interpretive services is another institutional practice or resource central to providing intergroup care. At both sites, language services involved use of hospital staff from a centralized roster. Hospital A had initiated a formal interpretive service two years ago (with professionally trained interpreters), while Hospital B was using the AT&T phone interpretive service but was also planning a more formalized service. Both sites were in the process of hiring a language services coordinator. Related to language services is the matter of patient educational resources offered in various languages. One participant spoke of the difficulty in obtaining such resources:

> We have some pamphlets [in various languages], that are from outside. We have some pamphlets from cancer prevention and breast health. It has actually been hard for me finding pamphlets on my areas, on arthritis, different orthopedic illnesses. They are not necessarily translated. And I think we will see more of that thing as we request more, they will become more available. And hopefully free of charge, so that has been a challenge.

During the interim of this study, a multi-agency web site was launched with the purpose of "sharing" patient education resources. During my observations, I did not notice non-English speaking patients receive any educational resources in other than English.

Another tangible institutional practice relates to nutrition services, and the range of dietary choices offered. One hospital offered a diverse menu that included items such as curries, samosas, and congee, while a participant at the second site said that "ethnic foods" were not offered there because they were likely not in demand. She added that "if family members are

bringing in a thermos of congee for this person, I don't mind. If they're going to eat then that's fine".

Both hospitals, thus, had implemented some important practices to serve their clientele with diverse backgrounds. My sense was that significant progress had occurred since my 1995 study (Reimer, 1995). Yet, the question that arose for me was, "are these services indicative of an integrated approach to diversity and culture, or are they 'add-ons' to a system that continues to be predominantly monocultural?" One participant, during a conversation about visiting hours, suggested that the latter was the case,

> We are eventually going to get so much pressure from our community that that's
> [controlled visiting hours] unacceptable that they will have to make some changes on the
> institutional level. Because it is such a North American model. I mean, when I went
> down to Mexico and had my accident and surgery, there was a couch in there and I could
> have a friend come and stay with me.

Although all of the units in this study had cots available for family members, many times the rooms were so crowded with equipment that it was impossible to use a cot. The conflicts and negotiations involved around visiting hours (described in Chapter Five) point to the difficulty of shifting away from a monocultural position. Generally, my conclusion was that while both hospitals were moving toward an integrated approach to diversity, they had not arrived at this goal yet. Interestingly, Stubbs (1993) posits that an emphasis on language and diversity, when in a vacuum, is partial and inadequate, especially because such a focus is unlikely to identify racist practices and uneven power relationships. As discussed in more detail in the next section, both facilities had incorporated diversity as key to their organizational philosophies and did not carry overt anti-racist positions. Furthermore, certain values visible in this study as driving health care

(e.g., efficiency, self-care, biomedical, allopathic dominance) were more likely to disadvantage those not from dominant mainstream groups. For example, while participants made several references to the use of alternative modalities, I saw little evidence of them being incorporated into health care provision. The strong biomedical curative focus (with the underlying belief that disease is physical in nature) represents a Western notion of health and illness not shared by all users of health care services. Thus, while not deliberate, the values informing institutional health care practices contributed to a system that favored those from mainstream groups.

Organizational Philosophies and Policies

Dorothy Smith (1987) tells us that "texts are the primary medium (though not substance) of power. The work of administration, of management, of government is communicative work (p. 17). She posits, then, that relations of ruling are textually based, "text-mediated relations are the forms in which power is generated and held in contemporary societies" (1999, p. 79). Keeping in mind the centrality of texts as a medium of power, I turn now to examine how texts, taken here as organizational philosophies and policies, operate in the organization of intergroup relations.

Each of the institutions in which this research took place had formulated clear organizational policies at both regional and agency levels outlining that diversity and multiculturalism were key features of the organization[87]. For example, in one region, diversity is one of the five core values along with accountability, fairness and equity, innovation, and respect. At the agency level, one institutional policy stated that "all people from the Hospital's

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[87] In both hospitals, mission statements were prominently displayed on the clinical areas. Interestingly, one statement emphasized efficient and cost-effective care, the other statement focused on the sacredness of life, spirituality, justice, and seeking to be a place of healing.

community should experience equal, safe, appropriate and caring hospital treatment as needed regardless of demographic characteristics, socioeconomic status, ethnic and cultural heritage." Both institutions had participated in the Multicultural Change in Health Services Delivery Project[88] (referred to as the "22 Hospitals Project") and had conducted staff and patient surveys regarding the hospital's response to diversity issues[89] in 1996/1997 as part of this project. The results of these surveys were now being used in establishing priorities within the general domain of diversity. As with most hospitals who participated in the "22 Hospitals Project", both sites had multiculturalism/diversity committees and reported a range of actions and initiatives taken to "improve cultural sensitivity and accessibility" (e.g., interpreter services initiatives, multi-faith initiatives and specific clinical programs), although one agency had made more formalized progress in this regard. The assignment of responsibility for the "diversity portfolio" also differed in the two sites. In one situation, the primary role of one manager was diversity initiatives with less direction from the regional level. In the other site, one of the clinical managers held the diversity portfolio along with several other major responsibilities, however, she was supported at the regional level by a director responsible for diversity initiatives throughout the region.

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[88] Funded by Multiculturalism BC, 22 health care agencies came together under the umbrella purposes of a) creating an environment where cultural sensitivity is an inherent factor, b) improving the ability to provide culturally appropriate health care, c) promoting collaboration between health care and community agencies and other key stakeholders, d) aligning with the province's strategic initiatives in multiculturalism and New Directions, Ministry of Health; and e) developing a resource to be shared with other non-participating agencies.
[89] Both agencies had shifted to use the broader term of "diversity" rather than "multiculturalism" in their organizational policies and terminology. The regional director who carried the diversity portfolio explained the benefits and limitations of this wider focus, citing inclusiveness, increased accountability and relevance, strength in

A Policy-Practice Gap

Both agencies had clear organizational policies affirming multiculturalism and diversity. However, the integration of diversity as a core value throughout the agencies, as reflected in programs and day-to-day practice, was a struggle in both sites. The overarching question that quickly became evident was, "how is policy translated into practice?" One participant noted, "At the board level [regional], diversity is very much an integrated thing as one of the five core values, you know, in everything we do needs to reflect these values. It has been very much woven through everything." But she went on to observe that at an operational level, this integration still had far to go,

> We have all these noble statements about diversity. But how does this translate into action? How is it going to impact the people that we work with? That is where the importance of education, skill development, and tools, come to play and where there are some excellent bits and pieces but we haven't quite pulled it all together.

As my research progressed, this gap between policy and practice became more visible to me. For example, early on in the project, I assumed that the policies of the organization might not communicate a strong commitment to matters of multiculturalism. However, when I realized this was not the case, I turned to a more careful analysis of the reasons behind this gap between the ideals represented by policy and the realities of clinical practice. In this analysis, some of the issues highlighted in regard to the administrative structures and institutional practices are re-visited here to show how they too influence the implementation of policy.

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numbers, less backlash and less stereotyping as advantages. However, she also acknowledged that this broad term meant that the focus tended to be somewhat nebulous, and that the agendas and issues of smaller groups might get lost.

Time, Coordination, And Energy

At one level, the gap between policy and practice could be understood as a matter of
time, coordination, and energy. Drawing on the example of language services, one manager
mused about the time and energy it takes for changes to become adopted throughout an agency,

> The thing about this cultural competency is that it is a continuous learning process so you
> can't move to the level of professional interpreters before you've used staff and
> volunteers....I see all of those policies becoming more inclusive if you will, over time,
> and it takes a great deal of work and it just is a building process.

Another director outlined the importance of coordinated efforts throughout the region, in which
policy direction was provided by the region and implemented through specific programs at the
agency-level, drawing on services such as the education and the quality initiatives divisions.
Certainly, much had been accomplished in these two hospitals by the vision and effort of key
players. For example, one manager talked of a previous manager who had "championed" the
cause of diversity in that agency, "building community, building the diversity committee, and
leading in an action plan". This committee, struck in 1994, facilitated the staff and patient
surveys linked to the Multicultural Change Project, organized an annual Multicultural Week, and
drew up practical actions plans directed to more inclusive patient care and working
environments. This hospital had also implemented a range of other initiatives designed to serve
its diverse clientele. This manager noted, however, that since the previous manager had left, the
agency needed another "champion" to take on the cause,

> Well, I think somebody needs to have the energy to bring, like there's lots of people here
> who are very keen in one aspect of this or another but it needs somebody to nurture that

process. To be able to come in and make sure that they get information to get them off to conferences and stuff like that and to provide them with the support to lead...

Well-coordinated efforts with strong leadership, thus, were influential in implementing hospital-wide diversity policies. Several other important factors were also identified as important in bridging the policy-practice gap.

Staff Awareness and Education

Participants also stressed that staff members need to be provided with educational opportunities in regard to resources and policies such as interpretation services and anti-harassment policies. As described earlier, awareness on the part of nurses regarding the nature of interpretive services (e.g., availability) provided by the hospital was generally not high. Most nurses believed that the interpretive services were not readily available, but because of limited resources, little was being done presently to raise this awareness. One of the participants noted that education would be the role of a language services coordinator who was to be hired shortly so that staff would know when and how to use interpretation.

Another participant outlined a possible action plan for implementing an organization-wide anti-harassment policy,

P: Wouldn't it be wonderful to do some skill development around our staff and, and supply them with a tool that they could easily interject so if they see one of their colleagues demonstrating unacceptable behaviour that they would only have a simple statement like, "we don't do that here", or some kind of a simple thing that has the power of the organization behind it and then the person knows exactly what message is being

transmitted. At the same time it can be, uhm, handled somewhat delicate so it doesn't create conflict then between those two.

R: Exactly, for down the road.

P: Because people, they value their relationships with their co-workers and so to try and tell a co-worker that, you know, unless you have a really good relationship and if a power situation is in it then it becomes even more awkward, uhm, that's what I mean in terms of tools. You know, like, even to have a poster campaign or something like that, you know, tapping into that, and it sounds a little bit trite but at the same time it's like the Participaction Campaign, you know, "Just do it!". You know, it can have, you know, quite a lot of power behind it so I think that that's the trick in terms of making policies come more alive is. I guess education and awareness are number one.

The comments of this participant suggest the need for creative educational programming, and also indicate the responsibility of the organization in providing educational opportunities. This view was echoed by another participant, "you can't blame the staff if they really are not knowledgeable and we haven't done anything about pointing out what some of the areas are that they should be looking at".

However, the identification of staff awareness and education in relation to policy implementation requires closer examination. As alluded to in the above examples, resource allocation has been a key influence in the availability of education programs for staff members. The lack of resources has been coupled with agency and professional discourses (e.g., RNABC's Continuing Competence requirements) emphasizing self-learning. These discourses, in effect, remove the obligation to provide resources and opportunities from the employer and place the

responsibility for seeking educational opportunities on individual nurses. This tendency to "off-load" is reflected in the following excerpt:

> It is hard to get staff to take that extra step and walk to the library...We are really encouraging at this facility from our education department, we are encouraging staff to be self-directed and self-motivated with their education. We will support them but we also want them to recognize that it is their responsibility to keep their knowledge base up.

The discourse of self-learning stands in contrast to current recommendations from RNABC (1999) regarding the importance of educational opportunities for nurse retention. They recommend that "nurses should receive assistance to obtain/access post RN clinical education. Assistance includes financial support, time off work, or access during work time" (RNABC, 1999, p. 4).

> However, the availability of educational opportunities, according to the participants in this study, is not necessarily sufficient. One nurse told of in-servicing set up several years ago by the education department regarding cross-cultural caring that was poorly attended.

> P: My sense from the staff was that, well we're insensitive and they're going to tell us how to...

> R: Oh, exactly, be tolerant.

> P: ...you know, and that type of thing. So it was a real "get the hair sticking up on the back of your neck", you know. You know, "why isn't that population integrating with us as opposed to us having to accommodate them?" All of those things were sort of going around in circles. They [the in-services] were not well attended. I think they were

thought of as, uhm, "we're in the wrong. You're going to be taught how to do this right" and so it wasn't very successful. I think it's a real challenge to get staff to attend, to be able to openly talk about what their issues are without being seen as the bad guys but also to see both sides of the picture. I'm not sure how, what the answer is for that....but I think the advertising wasn't coming out in a good way so they weren't well attended at all. And that's too bad because I think there's a big need for it.

From this exchange we see some of the difficulties inherent in providing safe opportunities for staff to explore issues relevant to them in the provision of intercultural care. The participant also refers to resistances that communicated racialized, assimilationist thinking. Clearly, careful planning and packaging of educational opportunities are necessary in order for them to be "received" by nurses. Overall, while these examples speak to the potential contribution of increased staff awareness and education in bridging the policy-practice gap, they also impress upon us the complexities of such an endeavor.

The Institution's Commitment: Resource Allocation

Undoubtedly, educational opportunities and the vision of individual leaders within a health care institution are needed in order to fulfill organizational policies regarding diversity. However, as one participant pointed out, it is the *commitment* of an organization, not just its policy statements, that determines how intergroup health care provision comes about. When one of the organizations communicated a renewed commitment to diversity in its corporate priorities, a manager commented how pleased she was to share this with the diversity committees,

They [diversity committees] ask, "where is the organizational support?" And I say, "Well, they tell me we have it", but it has never come out in a formal way. I say to the

directors, "If you want people to do something and really feel that they are part of working together they need to see that the organization is valuing this in a very visible way". Now I can make copies of this plan and show it to the committee.

Participants, both those in management positions and in staff nurse positions, were continually "reading" the commitment of the agency to matters such as diversity programming, anti-harassment and human resources policy, and resource allocation. This assessment of the agency's commitment is illustrated by a nurse who wanted to take a language course:

> I wanted to take a language night course. I mean personally, $75.00, right it would have cost. And I figured it is important for me to learn some things, I know some words, but I certainly cannot converse. I was turned down because the hospital didn't want to fork the money. There were a few of us willing to do this night school thing; we were willing to invest the time….That really sat like bile in a lot of peoples' throats. And it sat in mine the same way, and I'm no different than anyone else in how I react to things. I kind of thought that might be important.

These nurses felt they would be improving their ability to provide care to non-English speaking patients by taking the night course but were also looking for the tangible support of the hospital in this commitment.

Resource allocation offers an indication of an institution's priorities and commitments. In an era of fiscal restraint and cutbacks, language services, for example, joins many health care services and programs competing for a limited dollar. In my conversation with one manager, we talked at length about funding for language services, "We are kind of dependent on the organization's view of language services". She went on to explain that "we're putting ourselves

at a lot of risk by having family members interpret, by not offering an interpretation service. I've said the budget we have now is still minimal but we will likely go over our budget." She made the observation that many American hospitals have allocated large budgets to language services because "they have had real court action to spur them on". She, along with several other participants, speculated that Canadian health care institutions would require similar motivation before allocating significant funds to language services. She did note, however, that current accreditation standards have incorporated a criterion regarding language services.

The matter of resource allocation regarding language services has profound implications for the provision of intergroup health care. I noted earlier in Chapter Five that nurses typically did not access formal language services. Various reasons were cited, ranging from the convenience of using family, to the perception that these services were not accessible or convenient. When I discussed these findings with a manager who coordinated language services, she concurred that these services were typically underutilized in the medical-surgical in-patient areas. Yet, she was constrained in promoting the language services program because of the limited budget, "I'm not out there beating the bushes for business because we don't have the budget". Recognizing the potentially large budget demand of language services, health care agencies are proceeding with apparent caution. Several participants told of how they repeatedly advocated for language services in the budgetary process. One explanation for the caution in allocating significant funds to language services offered by participants was the need to clarify the mandate regarding language services. One participant explained, "What we need to do as an executive, we need to really hash through what is going to be the policy. Is our policy in this region that people will be able to be communicated with wherever possible in the language they

feel comfortable with?" Resource allocation decisions, thus, challenge an organization to clarify its mandate and commitment to programs such as language services.

Competing Priorities

As noted, resource allocation is a difficult task during this era of fiscal restraint. Competing priorities and visions, extending beyond the budgetary realm, may draw institutions and individuals away from the challenge of implementing their "noble" policy statements of intent regarding diversity and multiculturalism. As one manager who carried several portfolios explained, "because it's not crisis, the diversity portfolio doesn't get the attention it requires. You know, we're quite open about that. And everybody thinks it's really important but it's really hard to find another champion." Another participant commented that those involved in diversity programming "typically do it off the side of their desk", suggesting that while they were committed to it, it was not their primary focus. These comments reflect the demanding positions held by managers today. They also reflect an era of change, restructuring and even chaos within health care in which something has to be of "crisis" proportions before it is attended to.

Participants also sensed competing priorities on the part of the organization within the realm of anti-harassment policy. While these organizations had adopted a "zero tolerance" policy regarding harassment, a concurrent commitment to the patient (i.e., a consumer focus) could place the organization in a place of competing priorities.

P: The organization has to protect the staff. Irregardless of whether they're hassled because of their race or because of something else, we have to protect them.

R: That's where that culturally safe work environment is a very strong statement from an organization.

P: Mmmh, oh, yes! Because I think we went through it ourselves, when our staff have gone through a stage where they thought they could say not anything, that they would not be protected by the organization and that the patient was always right.

This excerpt suggests that a strong consumer focus on the part of a hospital may threaten work environments for employees. In Chapter Five, I cited the experiences of several nurses of Colour who did not feel they could count on the support of their managers in situations of harassment because of the ideal that the "patient always comes first". These illustrations of competing priorities suggest that structural and philosophical blocks may hinder the implementation of diversity policies.

Resistances

Thus far, the reasons explicated here underlying the policy-practice gap are relatively benign: the coordination, energy, and awareness needed to implement policies are generally not constructed as particularly political. The notion of resource allocation is certainly more political, obviously representing competing interests and demands, yet, it too can be represented as a matter of equal, well-deserving choices that must be prioritized in some fashion. However, closer reading of the data in this study suggests that there are deep-rooted resistances at play in some situations that furtively sabotage the implementation of well-intentioned organizational philosophies and policies. These resistances occurred at various levels throughout health care organizations and typically operated in relatively unarticulated ways. At other times, this resistance was more obvious. One participant noted, "It takes a great deal of work to build

policies that are inclusive. I mean, there was a time, there still are, you know, blatant racists walking around here at every level in the organization".

Health care providers at the "bedside" level perhaps most obviously subvert the implementation of policy into practice for it is at this level that policy implementation is particularly tangible. The example provided in Chapter Five of the administrative instruction to abstain from wishing patients "Merry Christmas" illustrated how individual staff members might resist the implementation of policies they did not agree with. The nurse quoted in Chapter Five was offended by this notification because of its challenge to her own perceptions of Canada as a homogeneous, Christian nation. Another nurse telling of this incident took a more moderate stance but pointed out that

> some staff had a very hard time with it. I mean, I can see both sides. I can see patients being offended by it because they may not be of Christian background...and they may feel that the dominant culture is being forced upon them, you know?"

In this example, then, the first nurse resisted administration's advisement and continued her practice of wishing people "Merry Christmas" rather than "Happy Holidays" or "Season's Greetings" while the second nurse followed the suggested practice.

By way of further example, the earlier discussion regarding visiting hours (see Chapter Five) demonstrated how nurses enacted policy in a contextual fashion, choosing when to enforce visiting hours strictly and when to take a more lenient approach. One nurse's description of visiting hours policy as "invisible policy" captures this idea of selective, individualized implementation. Yet, what might be interpreted as basic resistance (and perhaps discrimination)

on the part of individual nurses must also be understood in the overall context of the demands placed on each nurse by her/his work obligations and the range of patient needs and wishes.

Thus, apparent in this study was the phenomenon of some front-line health care providers resisting the implementation of certain diversity-related policies. Less apparent but equally effective was resistance at administrative levels to the implementation of certain organizational policies that speak to the valuing of diversity. At both agencies, for example, managers described the "pushing" required in order to influence the allocation of more resources to language services. One participant questioned whether there was not still a very deep-seated resistance to change within the organization, especially resistance to any really significant widespread change. She observed that it is relatively easy to offer "surface acknowledgements" or "lip service" to diversity policies, but quite another thing to actually implement policies that would bring about interpretive services programs.

Participants also described resistance from community members to certain initiatives undertaken by the hospitals. One participant observed, "Occasionally we get letters from patients and so on that say, you know, 'How come no one is paying any attention to the White people? You know all your signage and TV programs and stuff are in a language other than English." Public discourses regarding visiting hours also contained the message of resistance from the dominant community to initiatives undertaken to make the health care agency more inclusive. These resistances, occurring throughout all levels of health care organizations, provide us with insights into the highly politicized, racialized domain of intergroup relations in health care.

In conclusion, both agencies in this study had clear organizational policies affirming multiculturalism and diversity. Yet, the integration of diversity as a core value throughout the agencies and the implementation of related policies were not occurring easily in either site. Policy-practice gaps existed as the result of a complex interplay between factors such as time, energy, education, commitment, and the balancing of competing priorities. Notably, this interplay occurs in political, contested, and racialized contexts. In sum, although text-mediated relations (Smith, 1987, 1999) were important in this study, the competing priorities and complexities common to today's health care environments introduced other variables that diffused the influences of the organizational philosophies and policies.

Summary: Understanding Organizational Contexts

This analysis of the organizational contexts of intergroup care has alerted me to the theoretical challenges inherent in understanding health care institutions. How one conceptualizes institutions carries implications for how one imagines praxis. If institutions are seen as large, inanimate bureaucracies imposing power from "on top", the route to change is rather different than if institutions are seen, for example, as social constructions, composed of individuals. This latter view is more in keeping with Tulin's (1997) description of an institution: "…institutions exist in the interactions of their members, which are in turn shaped by the institutions they produce" (p. 105). Tulin, drawing on Gidden's theory of structuration, suggests that the structures that characterize an institution are the rules and resources people use in interaction. Dorothy Smith offers a slightly different conception of institutions, suggesting they are a complex of relations forming part of the ruling apparatus, organized around distinctive functions, such as health care or education.

In contrast to such concepts as bureaucracy, "institution" does not identify a determinate form of social organization, but rather the intersection and coordination of more than one relational mode of the ruling apparatus. Characteristically, state agencies are tied in with professional forms of organization, and both are interpenetrated by relations of discourse of more than one order. We might imagine institutions as nodes or knots in the relations of the ruling apparatus to class, coordinating multiple strands of action into a functional complex. Integral to the coordinating process are ideologies systematically developed to provide categories and concepts expressing the relation of local courses of action to the institutional function. (1987, p. 160)

Smith's explication helps me in understanding the composition of the institutions in this study. First, the hospitals were influenced by state interests, as evidenced by the imposition of fiscal limitations on them by regional and provincial governments. They were also constituted by official state policies regarding human rights and multiculturalism. Second, professional forms of organization participated in the construction of each hospital, as management, physicians, and nurses negotiated how patient care was delivered. Third, various discourses informed each institution. Corporate discourses heralded total quality management, continuous quality improvement, quality initiatives, patient focused care, and so forth. Health care discourses favored self-care, equal access, and community partnerships; and education discourses lauded self-learning. My interpretation then is that all of these relations ultimately operated to serve the interests of dominant society. However, the resistances cited in the above discussion prompt me to incorporate in my understanding of institutions the notion that they are constituted and managed by individuals (albeit influential individuals). Torkington (1986) asserts that when institutions are understood as run by individuals, the rapidity or sluggishness with which they

adapt is indicative of the attitude held by the administrators controlling them. Hence, slowness in responding to the pluralistic nature of Canadian society (e.g., in implementing language services) can be understood as informed and influenced by a prevalent collective consciousness. Hospitals can therefore not be understood as institutions independent of community and societal influence. In the following section, I explore the dialectic relationships between hospitals and the communities in which they are situated in order to uncover how influences such as demographic changes and societal ideologies and constructions "reach into" a hospital to shape day-to-day health care provision.

Community Contexts

Thus far, we have looked at how nurse-patient encounters are shaped by the interpretive frames brought to bare on interactions and by contextual influences such as the nature of nurses' work, and the organizational context. There is another layer of influence to be examined, namely the effect of the larger community in which health care agencies are located. This effect is not necessarily unidirectional; rather communities and hospitals operate in mutual fashions, where hospitals shape communities to an extent (e.g., civic authorities tend to cite hospitals and health care agencies as part of what makes their community appealing or "livable") and communities, in turn, influence a hospital's philosophy, policies, programs, and so forth. Here, I am especially interested in the influence of the community on the hospital, and more specifically, on intergroup relations in hospitals[90].

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[90] While my focus is on how the community influences intergroup relations in hospital settings, several participants also spoke about how the hospital might influence the community, especially in "educating the public" about what they might reasonably expect during hospitalization and at discharge. Other participants talked about how the public needed to be educated about visiting hours.

Some of the impact of the community on intergroup, hospital-based health care provision is in direct, tangible and formally acknowledged ways. For example, an organization may mount a population-specific program because of an obvious need. In the hospitals in this study, a variety of programs had been established to meet the needs of particular groups (e.g., group-specific diabetes education programs and prenatal classes). Along with the population-specific programs mounted at both hospitals, administrators at regional and hospital levels were also seeking strategic linkages with community groups, and in particular with minority community groups. It is widely held, particularly within the current emphasis on primary health care, that community partnerships are vital to the success of any health care agency. These partnerships take on different forms, often with extensive community advisory boards and consulting groups. This emphasis on community partnerships derives from the belief that health care agencies are to reflect the communities they serve and provide care in a seamless fashion (e.g., as indicated in the notion of a "hospital without walls"). However, for the agencies in this study, these linkages did not always come about easily and were described as political mine fields. A first concern was the perception that certain groups were consulted extensively but not necessarily with resultant action. One participant told of her experience as a regional health board spokesperson to a collaborative project regarding diversity issues initiated by the civic government involving various public institutions. The suggestion had been made that the group poll various communities to see what the issues were. Her immediate response to this suggestion was,

> Oh no, we can't possibly do that yet again. I can't possibly go in front of some of these communities yet another time and ask them more questions. It looks like we're not carrying through on anything that they've told us. That we're not valuing what they've told us.

Other participants spoke of the difficulty in making connections with certain ethnocultural groups, citing the factions within any one group. One participant explained that as the senior administration team of the hospital was seeking linkages in the community, they came to realize the

> many different kinds of members of the Sikh community alone....There are lots of dilemmas and you don't want to make things worse...there are people here who have had their lives threatened because of their religious affiliations so you really don't want to bring that into this [health care] environment but it's hard to understand. So we've resorted to connections through the Seniors' Center rather than through the temples.

This participant, in citing the "politics of religion", is highlighting the ways in which community linkages are unavoidably political. Anderson and Rodney (1998) tell us that "we need to recognize that communities are not homogeneous entities with common interests; intra-group divisiveness and relations of power are usually the reality within any given community" (p.259). There is also the suggestion here that the tensions within any community may "enter" a hospital, although clearly this is something that this participant sees as undesirable.

Interestingly, several participants were hesitant to make connections between the community and the hospital, especially in regard to ethnic tensions occurring in the community[91]. The following excerpt reveals this hesitancy:

> R: How does the community environment, so what goes on outside the walls of the hospital, how does the community environment effect how you give care in the hospital?

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[91] I found this construction of the hospital as removed from community tensions fascinating, especially in light of the frequent race-related news stories during the period of research.

P: You mean what goes on in the community affects how we give care?

R: Yes. Let's say situations where there have been racial tensions in the community. Does that filter through to the hospital? Do nurses talk about it? Do patients talk about it? Does it enter your mind when you are at work?

P: Never entered mine.

R: So it is quite separate?

P: Yeah, like I like to go to work, try to treat everyone the same. Don't think about "well this guy might…" I have even had patients with ceremonial knives in their beds with them and it is like, you kind of look at it, oh OK, you look at it and think "oh OK, it is their religion". Try not to piss them off. (laughs).

This nurse's commitment to treat each patient "the same" meant that she was less likely to account for the tensions that were inevitably carried into the hospital. Such a commitment to egalitarianism is deeply embedded in the humanist philosophy of nursing, is reflected in professional standards of practice and codes of ethics, and is typically reinforced in nursing education programs. The scientific tradition so influential in health care also reinforces the notion of objectivity and viewing the patient apart from his/her social position and political alliances. At a more practical level, it may be that the ongoing, immediate demands of providing patient care left this nurse with little time to contemplate linkages between the hospital environment and the community setting. While it is not my intention here to disagree with this nurse's commitment to care for all clients regardless of class, race, gender, or religious affiliations, the matter of how the interface between hospital and community is constructed

seems critical. When a mutual influence is denied, it seems more likely that health care providers and recipients will overlook racially motivated comments and actions. Domicelli (1989) refers to the construction of this type of separation of an institution from its community as "decontextualization", observing that discrimination is constructed as "out there" but not "in here".

In my observations in surgical settings[92], the most obvious example of the community "entering into" the hospital was that of visiting hours. In Chapter Five, I described the discourses and conflicts surrounding visiting hours, often constructed as conflict between the preferences of mainstream (White) society and the preferences the ethnocultural communities. This conflict then was constructed in large part as an Us:Them dichotomy, which was also evident in other situations. One strategy employed by senior hospital administration at one site to counter bad press following several incidents involving patients from minority groups was to encourage staff to defend the hospital. One participant in explaining this request commented that "the community" was "up in arms" and that there was a "backlash" against the hospital. This was one of several instances when "the community" was used as apparent code to refer to members of an ethnocultural community in the area. This denotation as "the community" suggests a homogeneous, well-delineated group distinct from the rest of the population served by the hospital. This setting apart is also evident in the observations of another participant who depicted members of this group as aggressive in seeking health care as opposed to the more passive style of Caucasians.

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[92] Several participants emphasized that Emergency Departments (not part of my study) were the areas in which community tensions were most likely to be apparent in the hospital. They explained to me that nurses in Emergency were often in dangerous positions, dealing with volatile situations.

P: Their culture, which is their normal culture, is good at manipulating the system and that's just because of what they're used to. That's their normal role in their own country is that way so, I mean, they are just doing their normal thing but that's....Sometimes I think that sometimes they think they might get better treatment because of it and that doesn't sit well with me because everyone should have equal treatment, so...(pause) It's not really their fault, it's the other people's fault because they're not pushy enough.

R: Sorry, other people being?

P: Like, uh, Caucasian people.

R: So one group knows how to make themselves be heard?

P: Right. And to force their issue and to make sure they're getting proper care and to bring their family into emergency it goes to waiting for their member to come up on the waiting list for the OR, they are here with the pain, which isn't really as severe as they say and then they are getting rushed through the system a lot quicker but it's not their fault that the other people are more passive.....The squeaky wheel gets the, right. But as a group, people of certain cultures that are aggressive will benefit from that.

With an Us:Them dichotomy established, comparisons are made between the dominant group seeking health care and the second group that is constructed as demanding, aggressive, and even dishonest. Further, these characteristics are cited as stemming from patterns of interaction in their country of origin and are thus attributed to their "culture" deriving from nationality. During this conversation, I did not sense an accusatory tone in the participant, but rather she was recounting for me a commonly-agreed upon explanation (i.e., part of the sense-making process described in Chapter Five). Her commonsense approach suggests that she is buying into racialized discourses that construct immigrants as threatening the smooth functioning of

Canada's institutions. Thus, there is another layer of complexity and politicized community influence that is added when we look at how minority groups are constructed in health care settings through everyday discourses.

While I did not perceive antagonism or particular judgment in the above example, there were certainly other situations in which I observed directly or heard indirectly about degrading, discriminatory comments. Perhaps the most blatant Us:Them distinction was the comment cited earlier regarding the suggestion that immigrants have "their own hospital". In Chapter Five, I told of racialized work environments where accents were feigned. As in many other arenas of society, hospital settings are not exempt from day-to-day discourses regarding immigration. One participant captured the gist of such discourse, describing comments she had heard in the past, "Or, or the, you know, the immigrants are coming in and they're taking our services and we're having to do with less and we're getting kicked out of the hospital, whereas the immigrants come and...". Another sentiment I heard expressed several times was the idea that immigrants should learn English, "after all, this is Canada". Also in Chapter Five, I outlined the experiences of nurses of Colour, many of whom had been at the receiving end of degrading comments because of their ethnicity, with suggestions such as "you are not really Canadian". These racialized discourses are located in widely-adhered to constructions of Canada that purport the superiority of Whiteness and the English language. The discourses, ideologies, and constructions that support racialized practices in health care setting are analyzed in depth in Chapter Eight.

An important further analytic point here is that although racialized discourses occurred at both sites, the Us:Them dichotomy was more pronounced at Hospital A. There were several variations between the two hospitals that might account for this difference. Hospital A was a large regional hospital but not a teaching hospital. On the other hand, Hospital B was a large

tertiary care, teaching institution[93]. One of the participants, who had worked in a range of

settings, mused about the difference between community and teaching hospitals, commenting

that,

> P: There is a great difference between teaching hospitals and non-teaching hospitals. I
>
> find that the non-teaching hospitals, although they are professional in all other ways,
>
> communication-wise they are not professional.
>
> R: Do you mean communication with the patients?
>
> P: No, amongst the nurses.
>
> R: So why do you think that is?
>
> P: I think it is because there are no rounds, no student rounds, no staff rounds, you get
>
> forgotten along the way, you know? It becomes like a family, a very frustrating family
>
> unit, like you and your kids. You know, sometimes as parents, yelling at the kids and
>
> they don't even know. In a non-teaching hospital, things are slower, other things, are less
>
> demanding, you don't have to do a careplan everyday, in a sense the work load it is less
>
> stressful. People, the older ones, usually don't like sitting down and doing all this
>
> writing, changing all these things, don't like changing formats.
>
> R: Let's do it like we always did.
>
> P: Right. So they stay in non-teaching hospitals. After about 10 years, they forgot.
>
> Their mentality is like their home.

While I concur to an extent with her differentiation between teaching and non-teaching hospitals,

the difference in community demographics is also notable. The changing demographic profile of

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[93] Hospital A, as a non-teaching hospital, is more representative of hospitals in Canada. Statistics Canada (cited in Armstrong & Armstrong, 1996, p. 55) report that in 1990, there were 783 non-teaching hospitals in Canada, compared to 57 teaching hospitals.

the community surrounding Hospital A has meant that the hospital has gone from serving a predominantly White, English-speaking community fifteen years ago to serving an ethnically and linguistically diverse community today. Hospital B is also situated in a diverse community, but the population it serves carries a somewhat different profile. While also having a large immigrant population, many of these immigrants are of European and American origin or have arrived more than fifteen years ago. Participants describing the population served by the hospital tended not to mention specific ethnic groups but referred to other marginalized populations that represented "difficult" care to them.

A recent Immigration Canada study (reported in *The Vancouver Sun*, October 12, 1999) stated that negative feelings toward immigrants were more common in Vancouver than the rest of Canada. The study concluded that "Nowhere is this [cool attitude toward immigrants] more the case than in Vancouver where the rapid rate of social change due to recent immigration appears to have had marked effects on attitudes and perceptions". It may be, then, that the influx of immigrants into the community around Hospital A over the last decade has brought about a rate and degree of social change that has been difficult for the dominant culture to adapt to. This speculation is supported by the observations of one nurse:

> I think it's a lot different today than it was when I first started here. When I first started here in 1989 there was such a struggle for everybody because it was just at the time we were making this switch from all Canadian type people, you know, white Caucasian Canadians sitting in this nice, to having more people from another ethnic background and oh, I can remember, you know, if we had this conversation then, it would be a totally different conversation (with emphasis). Now with these immigrants here for awhile, they

have adapted to the Canadian way (gestures for quotation marks) and we adapted with,

"well that's the way they do this", so you don't even pay attention to it anymore.

This participant points out that the changes faced by the hospital and the community due to

increased immigration were significant, but she also suggests that a state of equilibrium and

mutual accommodation has been achieved. My own observations would suggest that the process

of negotiation is not complete and that intergroup tensions continue to surface within the realm

of health care.

Summary: Understanding Community Contexts

This discussion has drawn upon study findings to demonstrate how community settings,

characterized by certain demographic features and societal attitudes, "reach into" a hospital to

mediate intergroup relations in powerful ways. Some of the links between the hospital and

community were tangible and sought after; others were less apparent. Although there was

considerable evidence in this study of how racialized tensions in the community supported by

dominant ideologies were also at play in the hospital, many participants decontextualized the

hospital from the community, denying or choosing not to "see" conflicts. I have surmised that

such positionings are less a deliberate denial of racial conflict than they are an expression of the

ideal of tolerance and equality within health care. Henry et. al. (1995, p. 21) label such a

phenomenon as "democratic racism" in which conflicting values -- those of commitment to the

democratic principles of justice and equity and those of negative feelings toward minority groups

-- are made to be congruent with each other.

Overall, this chapter has added another layer of complexity to this exploration of

intergroup relations in health care. In the next chapter, I pull together the discussions of

Chapters Five, Six, and Seven to present a synthesis of the research findings in an overview of "how it works" and a more theoretical discussion of key themes, including an analysis of how racialized encounters and discourses are sustained by dominant structures and ideologies.

CHAPTER EIGHT:

DISCUSSION: THE COMPLEXITIES OF CONSTRUCTING AND NEGOTIATING "DIFFERENCE"

In this chapter, I bring together the interpretations of this project to explicate the complexities inherent in constructing and negotiating "difference" in the context of intergroup relations. As explained in Chapter Five, I use the term "difference" in a problematized, or critical fashion, not suggesting that it is a neutral or "real" entity, but rather a social construction that carries ramifications central to the social organization of intergroup relations. I begin the chapter with an introduction of a "design" or visual depiction that illustrates how the various influences discussed in the preceding chapters come together to shape intergroup relations. In this discussion, several key themes are emphasized: the multidirectionality and intersectionality of "difference" in intergroup provider-recipient encounters; the role of social identity in the formation of interpretive lenses; the mediating influence of health care reform on the contexts of health care provision; and the discourses, ideologies, and constructions of Canada that shape intergroup relations in health care settings. I conclude with a discussion that highlights the macrosocial context of health care in order to demonstrate how the everyday realities of intergroup relations within health care settings reflect and re-constitute wider social relations.

Explicating the Social Organization of Intergroup Relations

The distinctive outcome of institutional ethnography, according to Smith (1987), is the making visible of how social processes and practices organize everyday experience. My task in this chapter, then, is to draw together the interpretations of the preceding chapters into a coherent representation of "how it works". Intergroup relations are embedded in particular social contexts and constructions. By examining nurses' and patients' perspectives as entry points into these

contexts and constructions, it became possible to develop a clearer view of how intergroup relations in health care are socially constructed and organized. The social organization of intergroup relations in health care provision can be summarized schematically with a "design" (See Appendix B). This design is not meant to be interpreted as an unchanging depiction of reality, but rather as a heuristic, conceptual device organizing the central themes of this research. Furthermore, the following explication of key themes in sequential order is not intended to suggest that these themes are layered in such an order (i.e., with each influencing the next in turn) but is rather a pragmatic approach to presenting this information. As evidenced in the following discussion, key themes are enmeshed within each other to socially organize intergroup relations in an everyday sense.

Nurse-Patient Encounters: The Intricacies of Connected Care

Intergroup nurse-patient encounters ideally illustrated connected care, which was characterized by profound interpersonal connection, an understanding of the illness experience from the patient's perspective, and a holistic picture of the patient's health care needs. At the core of connected care was the communication of respect and empathy, as nurses recognized shared, common humanity. There were, however, many intergroup interactions in which connected care did not materialize, either because the context of care precluded the establishments of connections, or because nurses themselves were not "in-tune" with their patients. A nurse's interpretive lens, the framework through which she/he made sense of "difference" and approached intergroup care, was critical to her/his ability and motivation to provide connected care. Nurses constructed intergroup care provision in various ways, but were most likely to see intergroup care as an "issue" when it interfered with efficient care, raised moral dilemmas for them, or challenged the status quo of the health care system. Common

sources of challenge, deriving from language differences and cultural preferences, were often the impetus for negotiating intergroup relations, where nurses and patients practically worked out the implications of "difference". However, these negotiations did not occur in isolation from contextual constraints or social constructions, but rather were intertwined, and intimately shaped by them.

A striking interpretation in this study was the multidirectionality of intergroup relations, with power operating in unexpected ways in many nurse-patient encounters. As evidenced in many health care and nursing theories, intergroup health care provision has traditionally been framed by the supposition that White professional caregivers, in relative positions of power, provide care to patients of Colour who hold disadvantaged positions in society. Furthermore, patients of Colour have been "placed" into discrete cultural groups that are assumed to share predictable patterns of beliefs and practices that influence their health and illness experiences. While the White caregiver-recipient of Colour configuration is still fairly common in our health care system, this study suggests that this constricted view does not capture the complexities involved in intergroup and intragroup relations in the realm of health care provision.

This study revealed the range of combinations in nurse-patient relationships that occur in today's health settings, and that challenge nurses and patients alike. Although not commonly acknowledged in Canadian health care and nursing literature, encounters between White nurses and patients of Colour described in this study (Chapters Five and Seven) were at times marked by exclusionary comments and racializing practices on the part of White nurses. Yet, although there were certainly such situations in which a nurse's positionality within the dominant White culture of Canada influenced how she or he related to patients of Colour, the common postulate that correlates Whiteness with power and dominance and Colour with subordination and

powerless was challenged in this study. For example, the accounts of nurses being threatened if visitors of Colour were not allowed demonstrated a reconfiguration of power. Further, relationships between White nurses and patients of Colour were characterized by more than their respective ethnic identities. White nurses told of degrading comments made to them by some men of Colour, evidence of the intersecting oppression of gender discourses. Other White nurses felt demeaned on account of how some patients of Colour constructed the nursing profession (e.g., as "second class hookers", or as a low ranking job). In short, relations of power operated in unexpected ways at times in exchanges between White nurses and patients of Colour.

Second, along with the White nurse-patient of Colour relationship, encounters between nurses of Colour and White patients in this study also disclosed much about intergroup relations. The descriptions in Chapter Five of the encounters between nurses of Colour and White patients brought to light some of the issues faced by nurses of Colour as they were treated rudely and were faced with derogatory comments (e.g., "Chinaman"). While these exchanges were not portrayed as everyday experiences, they do represent another aspect of intergroup relations in health care that requires closer attention by managers, educators, theorists, and researchers alike. Clearly, the nature of the encounters between nurses of Colour and White patients described by the participants in this study challenges the stereotype of the powerful professional and the subordinate patient. Although it is not my intention to discount the power and influence associated with professional roles in general [see for example, O'Neill (1991) for a critique of professionalism within nursing], the point here is that the construct of *race* is powerfully deployed in health care settings to counter traditional nurse-patient roles by subordinating nurses of Colour.

Finally, relationships between nurses and patients of Colour in this study brought further insight into both intergroup and intragroup relations. A reductionistic approach to intergroup relations might assume that all nurses of Colour and patients of Colour, regardless of ethnic origin, share a common experience (i.e., that of subordination within Canadian society) and therefore discrimination or conflicts between them would not be expected. Interestingly, many nurses of Colour in this study constructed intergroup care as difficult, acknowledging, for example, the types of cultural differences that they found particularly annoying or challenging. Similarly, in one exchange, a Chinese patient spoke about the behaviours that she found offensive in her South Asian roommates. By way of further example, one nurse of Colour described how she had also received threats from visitors of Colour regarding visiting hours even though she shared an Asian heritage:

> Families will make threats like, you know, "we will sue the hospital, but you know, if you don't let us stay…." Or they come, like, 7 o'clock, before you start your shift and be there in the morning. I mean, I can understand their point of view because coming from the Asian background I am where somebody sick is really given a lot of importance in this culture and everybody tries to do their best and help them and being there and make them comfortable but sometimes I guess we [health care providers] go overboard culturally [in what we accommodate].

An important and recurring theme in the study related to the tensions that arose in certain intragroup encounters between patients and nurses of Colour who shared a common ethnic origin. Chinese, Filipino, and South Asian nurses all spoke of situations in which they were not comfortable providing care to patients from their own ethnic group, citing a range of reasons for this. Several nurses felt that patients from their own ethnic group were much more demanding

and had higher expectations of the type of care (referred to as "pampering") they received. Others cited class differences as a source of friction. Gender issues were also a concern, as in the example cited earlier where a South Asian nurse challenged the sexist and demeaning comments made by a South Asian man. Some nurses were demeaned by patients who shared similar cultural backgrounds but held to a low view of the nursing profession. Based on such experiences, these nurses of Colour held the consensus that it was better not to attempt "matching" between nurses and patients. This consensus is an important finding that challenges what has been recommended in some health care literature in which "ethnic matching" has been called upon as a solution to intercultural health care provision. The assumption is that by matching professionals with immigrants and/or minorities of the same origin, there will be an automatic increase in the level of empathy, an absence of prejudice, and more effective service (Weinfeld and Wilkinson, 1999). The interpretations of this study, then, uncover complexities inherent in intergroup relations that challenge existing assumptions regarding the nature of intergroup nurse-patient encounters. Clearly intergroup relations, with the ascription of "difference", operate in multidirectional fashions and demonstrate the influence of intersecting axes of social categorization in the exercise of power and domination.

I provided a brief overview of intersectionality in Chapter Two concluding that an acknowledgment of the interrelatedness of *race*, class, and gender guards against incomplete and reductionistic analyses. This study has shown how gender, class, and *race* operate together, often masking the effects of each other. This study revealed how some men may act as oppressors in some situations, drawing on gender discourses to demean nurses irrespective of ethnicity; but these same men were also in oppressed positions within a health care system that favours those of the dominant majority. As insightfully noted by other scholars (Collins, 1990;

Lorde, 1984) the phenomenon of being oppressor and oppressed at the same time points to the

intersectionality of these organizing constructs and to the co-existence of multiple identities. I

also noted in Chapter Five how "difference" was often constructed as meaning "difficult" and

how patients falling outside societal norms, especially those relying on some form of social

assistance, were constructed as different and "difficult", suggesting the importance of class

issues in understanding the social organization of intergroup relations. However, the narratives

described in the foregoing chapters also suggest that intersectionality of oppressions may not be

limited to these three structuring forces of *race*, class, and gender (what have been referred to as

the "mantra" of critical studies). Rather, religion, notions of Canadian nationhood, age, and

constructions of nursing were also layered onto *race* discourses as axes of social organization.

What were essentially religious differences and preferences were most often constructed

as "cultural" in this study[94]. For instance, when I asked one participant about conflicts between

the culture of the hospital and the culture of the patient, she responded with the following

narrative:

> We've had a couple incidents where there has been a death. One was a Muslim that I
>
> remember, and another one was, now was it a Sikh, the Muslim I remember much better.
>
> But lucky enough, we had them both in private rooms. And they, there were people that
>
> came and came and came. And there were certain things about moving the bed to
>
> whatever side. What I found interesting, they have to be, I can't remember, facing the
>
> moon or whatever. But it was interesting enough that some people said "they have been

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[94] This slippage between religion and culture is not all that unusual, as religion is often named as a component of culture. However, I would argue that this is not a particularly accurate conceptualization as religious groups more and more often are not equivalent to ethnocultural groups, and within any one ethnocultural group, various religious traditions may be adhered to.

here all day, and da ta da ta da ta" (in whispering voice). So, you know, that was very important for them, they were waiting for someone in their faith to come. There was a whole different, And it was really quite interesting, the family was appreciative afterwards that that was allowed. It went on for 5 or 6 hours....Everyone has their own beliefs, so I, it is not a problem for me.

This participant's story shows how religious practices are accommodated within the hospital setting (although not without some "murmurings") and are essentially equated with culture. Other participants noted strong religious differences among the South Asian community that challenged a view of the community as unified or homogeneous as they described difficulty in obtaining spokespersons for this community because of these religious differences that stratified the group. In so doing, they simultaneously pointed to the distinctions between religion, culture, and ethnicity, but also the connections between the three. It seems then that in order to understand the nature of intergroup and intragroup relations in health care, intersectionality needs to be understood as extending beyond *race*, class, and gender to include the differentiating category of religion.

Similarly, the notion of nation also surfaced as an organizing construct in this study. Participants constructed Canada in different ways, but one recurrent construction was that of a cohesive, English-speaking, Christian nation that required assimilation into it by minority groups. The ideologies associated with such constructions are discussed in more detail later in this chapter, and here the point is that representations of Canadian nationhood create hierarchies of belonging that draw on certain intersecting social relations (e.g., class, religious affiliation, language groups). As explained in Chapter Five, age too became an intersecting signifying category as the elderly were reported to be more likely to be racist. In a pattern of apparent

deference, their discriminatory comments were more likely to be excused with the assumption that they were simply reflecting the widely held attitudes of their day. A final important categorization that structured intergroup relations was that of how the profession of nursing was constructed. Several examples have been offered in Chapter Five demonstrating how negative images of nursing held by patients mediate how power is played out in clinical settings.

Thus, the need for more textured intersectional analyses that extend beyond the triad of *race*, gender, and class are needed to understand intergroup relations in health care provision. A handful of feminist scholars are beginning to acknowledge the

> challenges in capturing social relations that have material force and meaning in women's lives have stretched intersectional theorizing beyond the triadic formulation of race, gender, and class. Diverse intersectional frameworks reflect the complex and contradictory relations women have with ethnic tradition, religion, nations, and other forms of social differentiation. (Stasiulis, p. 379, 1999)

Yet, when the intersecting forces of domination are understood as extending beyond *race*, class, and gender, we see an almost endless listing of possible categories that might account for the structuring of social relations. As Stasiulis puts it, "Which social relations in the seemingly dizzying array of differences should be accorded particular salience or significance in any given theoretical framework is impossible to predict a priori" (p. 378). She points us in the direction of seeking contextual lenses rather than one blanket general theory of intersectionality and argues that rich forms of intersectional theorizing can result from analyzing a range of axes of oppression.

The further stratification of conceptualizations of intersectionality suggested in this study imply an obligation to re-visit the ways in which power operates within the social organization of intergroup relations, and a need to understand identity and subjectivity as layered, shifting, and multiple. Although I entered this study with what I thought was openness to what intergroup relations might look like, the fluidity and multidirectionality of these relationships surprised me. While there were identifiable patterns regarding the relationships between people from certain groups in this study, few *carte blanche* assumptions could be made about how these relationships might unfold and where the nexus of power might be located in any exchange because of the intersecting nature of socially organizing relations involved. The shifting nature of intergroup relations are better understood when power is conceptualized as operating in "down up" ways rather than in exclusively "top down" directions. Within a conceptualization of power as operating in the micro practices of all social relations (Foucault, 1980; Ong, 1995), there is room for resistances such as those seen in this study as many nurses and patients resisted subordination. As Sawicki (1991) observes, "In his theory of resistant subjectivity Foucault opens up the possibility of something more than a history of constructions or of victimization" (p. 26). It seems, then, that the multidirectionality and intersectionality represented by intergroup relations in health care provision can be more easily accounted for when we understand how these relationships are negotiated in the different "fields of power" (Ong, p. 353) that are constructed by the intersecting forces of *race*, gender, class, nation, religion, and professional constructions. In summary, this investigation into intergroup relations in health care provision challenges traditional views regarding intercultural nurse-patient encounters by uncovering the range of complexities that operate within such relations.

Interpretive Lenses: Social Identity(ies) and Making Sense of "Difference"

Nurses engaged in internal dialogues, story telling, reductionism, and classifications in order to understand, or "make sense" of the intergroup encounters they faced in their day-to-day practice, and did so from a personal standpoint or perspective influenced by previous experiences, education, identity(ies), and values and beliefs. Further, the influence of social values and ideologies were central to identity formation. I came to understand this sense-making process as integral to how intergroup relations played out, influencing participants in their interpretations of and approaches to intergroup encounters. These interpretive frames allowed participants to bridge "difference" and accounted for the discrepancies between individual's interpretation of the same event or set of circumstances. Hence, what one person, drawing on previous experiences of discrimination, interpreted as racism might be understood as something entirely different by another who had not had the personal experience of racism. The conception of interpretive lenses takes us a considerable distance in accounting for variations in intercultural care provision and the dynamics at play in intergroup relations.

Although interpretive lenses are unique to each individual, I would argue they are not constructed in a vacuum or without social influence; rather, it seems more accurate to understand interpretive lenses themselves as socially organized by the structures and forces that mediate everyday life. Central to the idea of interpretive lenses as socially organized is a corresponding interest in how social identities, as constituents of interpretive lenses, are constructed, particularly in relation to "difference" and "Other".

One of the clearest illustrations in this study of the socially situated nature of identity(ies) can be seen in the lack of apparent awareness conveyed by several of the White participants regarding their own cultural identities. Their responses spoke to constructions of Whiteness as

natural or without "culture". Whiteness in these cases was contrasted to individuals and groups of Colour who carried "culture", suggesting that culture has to do predominantly with "difference" from dominant White culture. We see in this case the relational nature of identity, in which self is defined in relation to Other (Bannerji, 1995; Hall, 1986/1997; Woodward, 1997). Frankenberg (1993), drawing on her research with White women, concludes that within this framework of thinking about self in relation to Other, the White western self as a racial being has for the most part remained unexamined and unnamed. In her book <u>White Women, Race Matters:</u> <u>The Social Construction of Whiteness</u>, Frankenberg presents a set of linked dimensions that reflect the privileged and social construction of Whiteness.

> First, whiteness is a location of structural advantage, of *race* privilege. Second, it is a "standpoint", a place from which white people look at ourselves, at others, and at society. Third, whiteness refers to *a set of cultural practices that are usually unmarked and unnamed* (italics mine). (1993, p. 1)

The apparent obliviousness to White identity, when situated in the larger context, related to constructions of Canada as a White nation and were grounded in discourses of "difference" and Other. A critical reading of the data revealed that Other was constructed as inferior <u>or</u> exotic, interesting, and complementary. In both cases, the construction of Other relied on representing "difference" as Other and essentializing "differences" (often through stereotypes). Hall (1986/1997) suggests that to Other is not a singularly negative activity, but is rather the strange mix of envy and resentment.

> The play of identity and difference which constructs racism is powered not only by the positioning of blacks as the inferior species but also, at the same time, by an inexpressible

envy and desire; and this is something the recognition of which fundamentally displaces many of our hitherto stable political categories, since it implies a process of identification and otherness which is more complex than we had hitherto imagined. (p. 444).

In constructing Other as exotic, a certain fascination with the practices, beliefs, or appearances of people of Colour was expressed. "Difference" was emphasized, not in a negative way, but as "interesting". The comments of one nurse exemplified this perspective,

> When I worked on the Prairies, it was the native Indian population and the Inuit population. It was fascinating to work with that and see the kind of solutions they were coming up with and to see the differences in their whole cultural belief systems.

In this excerpt, "difference" is emphasized and constructed as "fascinating". The identified groups were also essentialized as cohesive and distinct. More disturbing were the constructions of Other as inferior. Once again, "differences" were noted, emphasized, and then represented as strange or inferior. A nurse explained how this might be expressed in practice,

> Sometimes as nurses I think we are not aware of the cultural values of our patients. Sometimes, unfortunately you notice something that might be funny to you. You might find it humorous or you might not be sensitive to it. You know, you might get "oh well, what the heck if he can't eat pork" (changed tone of voice) but that's not the way we should look at those things. Like if they don't eat pork, that is their religion. You just don't make fun of them.

The cases where White patients refused the care of nurses of Colour stand as particularly blatant examples of rejecting Other as incapable and inferior. These examples demonstrate the

relational aspects of social identity, and also give witness to the infiltrating influences of dominant societal ideologies that portray Whiteness as a location of unspoken superiority and privilege, while constructing Other as inferior and decentered.

Further reading of the data builds on these two notions of the relational aspects and the socially situatedness of identity(ies) by highlighting the shifting and multi-faceted nature of identity(ies). As with other group identities, Whiteness does not exist as a static or monolithic category. The fluidity of cultural identity in Canada is exemplified in the shift cited by one participant who noted the discrimination faced by her Eastern European grandparents upon their arrival to Canada. Now, two generations later, this woman, on account of her appearance, is easily included in the White dominant majority. Another participant described the variation within White Canadian culture with her observation that one of her patients, a Swiss woman, "had her little ways" that were quite distinct from her own even through this patient had been in Canada for over thirty years. Participants with "mixed backgrounds" or who had immigrated to Canada in particular spoke about carrying multiple identities that shifted over time and place. Participants shifted between identities, depending on context, as they "foregrounded" or "backgrounded" particular identities in order to make connections with patients and colleagues. In other situations, this iteration between identities was enacted in order to downplay intragroup connections (e.g., as in the case of the nurse who chose not to reveal her ability to speak Punjabi to South Asian patients in order to avoid extra demands on her time). I was initially puzzled by the contradictions presented by some participants. One participant, for example, seemed to understand racism with its deleterious effects at an intellectual level, and could articulate what "ought" to be; yet, she did not consistently translate these understandings into practice. During several episodes of participant observation, I had assessed her as rather intolerant and rude to

several nurses and patients of Colour. However, when I interviewed her, she expressed empathy for these same people and spoke articulately about the challenges inherent in intercultural health care provision. She spoke so freely that I doubted that she was "editing" her comments for the sake of the interview, although I did wonder about her insight into her own behaviours and communication style. Thus, it appears that interpretive lenses and identities can be negotiated in contradictory fashions, where certain people may hold both tolerant and intolerant views at the same time. Donna Haraway's (1991) ideas of "situated knowledges" and "partial perspectives" are helpful in explicating the positions and identities from which one engages in social relationships. She notes

> The split and contradictory self is the one who can interrogate positionings and be accountable, the one who can construct and join rational conversations and fantastic imaginings that change history. The knowing self is partial in all its guises, never finished, whole, simply there and original; it is always constructed and stitched together imperfectly, and *therefore* able to join with another, to see together without claiming to be another. (p. 193)

Conceptions such as Haraway's, communicating a sense of partiality, creativity, ambivalence, and fluidity as individuals negotiate between identities, contribute to an understanding of the narratives in this study.

Another nurse spoke at some length about how she was "in-between" when at work, "not like other Chinese nurses", but also distinct from Caucasian nurses. She explained that "I believe in using the best of each culture [Eastern and Western], and I put them together and use it to the best for the situation". She positions herself "in-between" and creates something new in the process. Her description conveys something alike to Bhabha's (1990) "third space", a place

of open negotiation and accommodation. He describes the third space as a hybrid place between two forms of culture that enables other positions to emerge.

> This third space displaces the histories that constitute it, and sets up new structures of authority, new political initiatives....the importance of hybridity is that it bears the traces of those feelings and practices which inform it, just like a translation, so that hybridity puts together the traces of certain other meanings or discourses....the process of cultural hybridity gives rise to something different, something new and unrecognisable, a new area of negotiation of meaning and representation. (1990, p. 211)

Identity, then, in the case of this nurse, is not only shifting and multiple, but also a positioning from which she brings about something "new" that fits each situation.

Both Haraway's (1991) and Bhabha's (1990, 1994) conceptualizations challenge the more traditional essentialist perspectives on identity that portray it as relatively stable, and even intrinsic with one clear, authentic set of characteristics shared by all members of a particular group that do not change over time (Woodward, 1997). Woodward points out that essentialist claims about identity may be based on nature (i.e., implying that "differences" based on *race* or ethnicity are innate) or on essentialist versions of history, "where history is constructed or represented as an unchanging truth" (p. 12). Undoubtedly, the non-essentialist conceptions offered by Haraway and Bhabha point us in an important direction. However, the limitations of these post-colonial, post-modern conceptions have been noted by scholars such as Stasiulis (1999) who remarks that non-essentialist portrayals of identity are "less helpful, however, in suggesting political, legal, and other strategies" (p. 376) for marginalized and oppressed groups. There appears to be, therefore, a basic tension between non-essentialist and essentialist positions;

between views that present identities as multiple, partial, and shifting and those that hold on to a more concretized version. This tension holds relevance for this study, for a close reading of the data suggests that while participants negotiated between various identities, they still held to some aspect of themselves as foundational or truly characteristic, and this was often linked to their ethnicity. That is, aspects of their sense of self were rooted in both personal and group histories (e.g., the participant who spoke of her work ethic as "bred" into her and part of her "nationality"). Stuart Hall's writing on "Cultural Identity and Diaspora" (1990/1997) brings some clarity to this matter. First, he acknowledges the shortcomings and contributions of an essentialist position that defines

> 'cultural identity' in terms of one, shared culture, a sort of collective 'one true self', hiding inside the many other, more superficial or artificially imposed 'selves', which people with a shared history and ancestry hold in common. Within the terms of this definition, our cultural identities reflect the common historical experiences and shared cultural codes which provide us, as 'one people', with stable, unchanging and continuous frames of reference and meaning, beneath the shifting divisions and vicissitudes of our actual history. (1990/1997, p. 51)

In citing the contributions of this position, he points to the productive force that group histories hold and concludes that such histories have "played a critical role in the emergence of many of the most important social movements of our time – feminist, anti-colonial, and anti-racist" (p. 52). However, he also lauds the second, non-essentialist approach to identity and posits that these two positions need to be brought together, as it were, to account for individual experiences and multiple positionings while remembering intervening histories.

Cultural identities are the points of identification, the unstable points of identification or suture, which are made, within the discourses of history and culture. Not an essence but a *positioning*. Hence, there is always a politics of identity, a politics of position, which has no absolute guarantee in an unproblematic, transcendental 'law of origin'. (Hall, 1990/1997, p. 53)

Hall's conceptualization of cultural identity, therefore, is useful in bringing together the individual with historical, social contexts and in this way is certainly congruent with the aims of this study. I suggest, then, that identity(ies) play an important, but not necessarily predictable or consistent role in constituting interpretive lenses. Moreover, when identity(ies) are understood as shifting depending on context and continually being renewed and rewritten "within the discourse of history and culture" (Hall, p. 53), few assumptions can be made about the identity(ies) of another.

The Contexts of Intergroup Relations and the Influences of Health Care Reform

The profound influence of health care reform and restructuring was a theme that undergirded many of the points that came to light in the investigation of the contexts of intergroup relations, that is, the contexts of nurses' work, and organizational structures, practices, philosophies, policies and resources. The remarkable demands of nurses' work today are such that there is much that mitigates connected care, especially in intergroup encounters. More recent trends (e.g., casualization, deskilling, and downsizing) along with longstanding issues (e.g., functional approaches to care provision, biomedical dominance) come together in particular ways to shape nurses' work as disjunctured and "heavy". Influenced by administrative discourses of fiscal restraint and limited resources, along with the practicalities of surviving increased workloads and staffing shortages, nurses' practice is, by and large, driven by an

"efficiency model". Moreover, the priorities of the organization which include the need to be constantly "creating beds" mean that nurses are caught up in what was referred to as the "turnover mentality". All of these conditions left nurses exhausted and dissatisfied and resulted in a lesser quality of care for all patients. Patients of Colour, especially those who did not speak English, were affected disproportionately as the particular challenges of intergroup care (e.g., understanding meanings of illness, seeking interpretation) were more likely to be overlooked in times of busyness.

Intergroup care provision and relations were also mediated by the changing and bureaucratic administrative structures associated with health care reform and regionalization as policies and programs were perceived to be in a state of flux. Many of the institutional practices implemented over the past few years speak to an awareness of the need to provide culturally appropriate services to all patients. Yet, values such as efficiency, self-care, and biomedical and allopathic dominance that drive health care are reflective of a system that is still monocultural at its core. Both agencies had clear organizational policies affirming multiculturalism and diversity but, at the same time, there were significant gaps between the ideals represented by these policies and their actual implementation. These gaps existed as the result of a complex interplay between factors such as time, energy, coordination, education, agency commitment evidenced through resource allocation, and the balancing of priorities. Further, resistances from staff, administration, patients, and community members interrupted the enactment of philosophies that affirmed diversity. Clearly, these gaps between the ideal and the real, between policy and practice, were influenced by restructuring within the health care system and shifting priorities, as well as by larger societal values and ideologies that maintain the health care system as predominantly monocultural.

Further explication of the nature of health care reform is helpful in understanding its far-reaching effects. The notion of health care in "crisis" that has driven health care reform is a global experience, scholars tell us (Angus, 1998; Evans & Stoddart, 1998). Even more remarkable than the fact that this trend is worldwide, is the observation that the "countries that perceive such a crisis actually spend widely differing amounts on health care, either absolutely or as a proportion of their national incomes" (Evans & Stoddart, p. 556). Common to the reasons cited for the need for health care reform are the need for fiscal restraint in an era of spiraling costs, the necessity for more efficient and accessible services, and the lack of equitable services. Although widely accepted as the key reason for reform, there are differing opinions among health care economists and analysts regarding the extent to which the system is actually in a state of financial crisis. Northcott (1994), for instance, points to the massive debt loads at federal and provincial levels and concludes "the provincial and local governments combined are spending almost as much on debt-servicing as they are on health care. In other words, if it weren't for accumulated governmental debt, Canada could afford its present health care system and more" (p. 15). However, he also goes on to acknowledge that health care costs measured as a proportion of the Gross Domestic Product (GDP) have been trending upward. Citing Organization for Economic Cooperation and Development (OECD) data, Angus (1998) informs us that Canada spends approximately 10% of its GDP on health care services (a relatively stable figure through the 90s), which is more than many other industrialized nations (e.g., in Europe and Scandinavia health expenditures as percent of GDP range from 6.6% in Britain to 8.8% in Sweden), but considerably less than the United States[95] (13.3% of GDP). Angus, in his fiscal assessment, posits that the health care situation in Canada has been exacerbated by two recent

[95] Health care analysts use such data to question why Canada continues to look to the United States' model for solutions to health care. Angus asks, "How much can be learned from a country that is the worst performer both in

recessions and by the federal governments downloading the federal deficit problems to the provincial governments.

However valid the claim of economic crisis as reason for health care reform, the reality is that reform has swept the country and is having a major impact on health care provision (Anderson, 1996; Anderson, Tang, & Blue, 1999; Armstrong & Armstrong, 1996; Beardwood et. al., 1999; Keddy et. al., 1999). Keddy et. al. in their analysis of the effects of health care reform on the professional and personal lives of Maritime nurses conclude "Whilst the concept [of reform] carries positive connotations, the results have been devastating to both consumers and health care professionals" (p. 58). Along a similar vein, Burke and Stevenson (1998) explain that while the proposals associated with health care reform represent real attempts to improve the quality, equality, and efficiency of health care, the limitations inherent in the various strategies employed to restructure Canadian health care can produce contradictory and unintended political consequences. Hence, inherent tensions are played out between values of efficiency and equality, or economics and ethics, as health reform is undertaken (Stingl, 1996; Storch, 1996).

There are several common elements of health care reform: an emphasis on health promotion; a concern for equity; the adoption of a market or business model; attention to matters of efficiency and cost containment; and a move toward decentralization and regionalization. Each of these characteristics carried ramifications for the participants in this study, some more obviously than others. The emphasis on health promotion, for example, does not appear immediately relevant to hospitalized care. However, several corollaries of the health promotion philosophy worked together to influence health care provision in hospital settings. First, as Burgess (1996) spells out, a link has developed between health promotion and a value placed on decreased health care service utilization. As a result, "community health services will be valued

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terms of cost control and of health status success?" (1998, p. 39)

for their cost-effective delivery of health care services and for programs that reduce health care utilization and costs" (p. 159). This emphasis on reduced utilization, along with the empowerment and self-care messages embedded in health promotion discourses (Anderson, 1996), have led to earlier hospital discharges and shorter stays. The nurses in this study, for example, were well attuned to the "turnover mentality" as they spent significant energy and time on planning discharges. They were also experiencing on a daily basis the increased workload that resulted from rising acuity in hospitals (as the least sick patients were sent home quickly) and were placed in situations of making difficult judgments regarding the readiness of patients for discharge. The discourses of early discharge, along with constant organizational pleas for "more beds", had filtered into nurses' ways of thinking to the extent that they too bought into the need for turnover and discharge, even when patients and families were not ready for discharge. This study speaks to the extra demands placed on nurses by the early discharge model. Others have written about the burden placed on families members as health care is dehospitalized without adequate resources (Anderson, Tang & Blue, 1999; Armstrong & Armstrong, 1996).

Another component of health care reform, the concern for equality, also came up as a point of concern in this study. Policy documents contain clear statements regarding the need to revamp the health care system to ensure more equitable access and health outcomes. The federal document *Achieving Health for All: A Framework for Health Promotion* (Canada, 1986) re-affirms the basic principle of all Canadians having a right to health care that is equitable, accessible, comprehensive, culturally sensitive, and appropriate. The British Columbian Royal Commission on Health Care and Costs (British Columbia, 1991) acknowledged that certain groups were not equally served because existing services were not "culturally responsive or accessible" (p. C-36). Equity and improved access were subsequently integrated into health care

reform discourses and became foundational starting points for subsequent policy development (e.g., *New Directions for a Healthy British Columbia,* British Columbia,1993; *Policy Frameworks on Designated Populations*, British Columbia,1995b). Yet, as health care reform and restructuring has progressed, there is growing skepticism about any actual improvements in equity or access. As one participant commented,

> P: Reform is supposed to make things better for people who are not, uh, you know, getting service or who are disadvantaged but what it seems to be happening is it's getting worse for them. There are many more homeless, many more food banks, many more this and that. I discuss with my colleagues across the country, that it's not just here it's really across the country and so that's why we're having this National Symposium at that level to really bring to the fore what reform is supposed to do is really not happening. I don't know, some may argue that it has to get worse before it gets better but, you know, the mental health changes with people on the street and so on so somehow we don't put the systems in place and even with the elderly, you know, we are shipping people out of the hospital and they keep coming back more and more and I think as a nation we're struggling with issues.

> R: Right, asking what is happening to our social net, to our social services overall?

> P: Yah, yah. So, uhm, yes, maybe on a micro level we've made some impact within our own organizations but on a global level...

Thus, even when inequities and unequal access have been acknowledged, current changes seem to be disadvantaging some more than others. As observed in a recent national symposium called to address ongoing barriers to health, some of the changes within health care reform may not represent an improvement as principles of inclusion and justice are overlooked (Masi, 1998).

The interpretations of this study add to the growing voice of those who question whether current health care reform initiatives are inadvertently worsening health care for vulnerable populations.

Most striking in this study were the ways in which health care restructuring, driven by discourses of cost containment, shaped the everyday lives of nurses, their ability to provide intergroup care, and intergroup relations at a more general level. The introduction of a corporate model of health care into both research settings was marked by changing administrative structures, objectives, and language, all of which are grounded in discourses of efficiency and cost-cutting. As Beardwood et. al. (1999) explain, "the smaller [downsized] health care sector is required to be more 'efficient', which has encouraged the application of private sector management styles including flexible performance and cost effectiveness, and the dissemination of a business culture to the health care sector" (p. 365). Corporate discourses were woven into the day-to-day functioning of the research sites. Terminology (e.g., referring to senior administrators as Chief Executive Officers, and clinical administrators as managers) reflecting this corporate commitment were readily integrated into everyday speech. Storch (1996), in noting the current pressure to promote the business nature of health care enterprises, states, "the influence of language in shaping thinking and instilling a gradual acceptance of ideas and approaches formerly not viewed as applicable to health care should never be underestimated" (p. 24). The adoption of corporate management strategies and structures (e.g., total quality management [TQM], continuous quality improvement [CQI]) were not as visible to staff nurses in this study, yet these strategies were requiring considerable management time and attention. Armstrong & Armstrong (1996) explain that techniques such as CQI have increased managerial control and therefore it is not that surprising that staff nurses were less aware and less involved in these initiatives.

However, the business sector management strategies that had most profound and obvious affect on nurses' work related to staffing changes, outcomes-efficiency emphases, and consumerism. Schemes to reduce personnel costs had been implemented in both agencies and typically involved reducing full time positions (FTEs) and staffing units with part-time and casual nurses. This change inevitably produced dissatisfaction among nurses as those without full-time positions were left with fewer benefits and little security, and all faced work contexts in which disjunctured care became commonplace. The trend toward deskilling (replacing RN positions with LPNs) added to the disjunctured nature of care. Keddy et. al. (1999) observed similar results in their study and reach the conclusion that

> Gross staff shortages, unit being served by casual nurses who may or may not be familiar with the units, or nursing jobs that have been taken over by the 'multiskilled', workers have become the most crucial issues facing the health care system. (p. 62).

They go on to ask, "Why have governments been so quick to eliminate nursing jobs?" and cite gender and class oppression, along with the nature of nursing work, as key contributing explanations.

As explicated in Chapter Six, when reduced staffing patterns are paired with the dehospitalization trend, care becomes increasingly fragmented, despite the accompanied discourses of efficiency. Armstrong and Armstrong (1996) expand on the ideology of efficiency that marks health care reform today:

> Efficiency is defined in terms of access to services and this in turn is defined in terms of the numbers of people who are processed by the institution, not in terms of whether the procedures were successful at improving people's health or reducing long-term government expenditures. Efficiency is equated with the number of procedures done and

parts fixed or at least treated. Outcomes are recorded by length of stay, not state of health when the patient leaves. Success is to a large extent reported in terms of doing more operations and other procedures, rather than in terms of reducing the need for such services or in terms of making people well. (p. 66)

My observations and nurses' descriptions told of how patients were efficiently processed, remaining in the hospital for only the most critical stage of their illness and/or recuperation from surgery. Thus, each patient required more care, yet there were no more nurses to care for this increased workload. At the same time, this rapid turnover meant nurses had less time to consider the unique needs of each patient as they "just did the basics". Routinization of care was reinforced by standardized care maps and clinical pathways. Beardwood et. al. (1999) and Campbell (1994) trace how nurses' work is further managed by patient classification systems that focus on the measurement and allocation of time for some tasks while ignoring those tasks that cannot be measured, or that are not valued. On two units in this study, informal workload measurement tools were used to justify the need to call in extra staff, however, as presented in Chapter Six, these tools did not account for the extra nursing time required to ensure communication with non-English speaking patients. Yet, nurses routinely talked about the extra time it took to care for these patients. This discrepancy suggested to me a disvaluing of providing for complete communication in a patient's preferred language that was influenced by the strong emphasis on efficiency and routine care. The core issue in this study is that intercultural care, by its very nature, requires more time and individualized care in order to understand meanings of illness, cultural preferences, and provide for interpretation, but current strategies of health care management, under the general rubric of "reform", make connected intercultural care difficult.

A final indicator of the corporate model of health care evident in this study was a consumer orientation. Beardwood et. al. (1999) also identify consumerism as an element of corporatization of the hospital, noting a shift from viewing health care as a social right to health care as a consumer right. The most obvious effect of consumerism on intergroup relations was portrayed in the experiences of nurses of Colour who felt they could not go to their managers when they were racially harassed. Their concern was that they would not be supported because "it's patient care, patient rights first". While no one would deny the importance of patient rights, it seems that some limit to consumerism needs to be sought, where the rights of employees to safe workplaces are ensured.

The last elements of health care reform, decentralization and regionalization, were discussed in some detail in Chapter Seven. Regionalization had a direct effect on how intergroup relations were managed, with a reshuffling of administrative lines of authority that resulted in a loss in momentum for a number of diversity initiatives. With what was perceived as an added layer of bureaucracy, decision-making was now deemed to be less autonomous and therefore less flexible and responsive in each facility. In the long run, regionalization might well enhance services as institutions will be in alliances that facilitate the sharing of resources (e.g., such as interpretive services).

In summary, health care reform played a major role in shaping the context of intergroup relations. Widespread restructuring, including the introduction of the corporate model and schemes to reduce personnel costs, has occurred despite "overwhelming scholarly evidence that change in this direction is not the solution to the crisis in health care" (Burke & Stevenson, 1998). This study, along with a handful of other Canadian studies (e.g., Anderson, Tang, & Blue, 1999; Armstrong & Armstrong, 1996; Beardwood et. al., 1999; Keddy et. al., 1999;

Sochalski, 1999; Wells, 1995), begins the task of critically analyzing the day-to-day effects of health care reform on the nature of nurses' work and the quality of patient care. I concur with Armstrong and Armstrong who decry the lack of evaluation of reform strategies for either human or financial costs over the long term. Extensive evaluation research, looking beyond the vogue measurements of shorter stays, increased turnover, greater use of out-patient services, and reduced expenditures, is certainly needed.

The Shaping of Intergroup Relations by Discourses and Ideologies

Demographic changes and societal ideologies and constructions within the community contexts influenced how care was provided on a day-to-day basis in the hospital. The influx of immigrants into one community challenged the hospital there to extend from serving a predominantly White population to provide culturally relevant care to these new residents. Common-sense constructions of minority groups as "them" in contrast to "us" involved certain expectations and stereotypes. In more blatant exchanges, the Us:Them dichotomy was used to suggest insurmountable incompatibilities between groups, with a clear message of the necessity of assimilation into mainstream Canadian ways. Yet, there was a decontextualization of hospitals from the community as evidenced in certain resistances to acknowledging that racialized community dynamics, supported by dominant ideologies, "entered" into the hospital. Closer examination of the discourses and ideologies mediating intergroup relations is central to the understanding of "how it works" for, as Dorothy Smith (1987) asserts, the analysis of ideological procedures is central to the task of institutional ethnography. Here I make explicit the ideologies that have been referred to throughout the previous chapters, uncover how they

constitute seldom questioned public and professional discourses[96], and, in so doing, demonstrate their influence on day-to-day intergroup relations.

Professional discourses in this study were reflective of several influences. As discussed in the previous section, health care reform, an overriding marker of health care in the 1990s, had profound influences on intercultural care provision and intergroup relations in this study. Professional discourses regarding efficiency, cost containment, corporate models of management infused everyday conversation and structured daily practice. Nurses, by and large, had bought into the efficiency mode[97] and evidenced an acceptance of cost containment as inevitable. By buying into these discourses and accepting inadequate resources as the norm, nurses unwittingly become complicit in reproducing institutionalized practices that disadvantage patients, especially those from vulnerable populations (Anderson, 1998).

Within the framework of health care reform, professional discourses in this study can be understood as informed by an individualistic ideology. The emphasis on personal responsibility through self-care (evidenced in discourses of early discharge) and the relentless move to downsizing, for example, are premised on values that do not typically take into account institutionalized practices and structural barriers to health. Likewise, free market principles and capitalist values assume that equal opportunity exists for the benefit of maximum public gain.

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[96] Dorothy Smith differs somewhat in her use of the concepts of discourse and ideology in that she brings together divergent theoretical traditions (i.e., drawing of Foucault in her conception of discourse, and on Marx and Engel in her definition of ideology) in her work. In application, her use of discourse suggests a predominant focus on language and text, although she affirms that discourses are maintained by practices. Ideology in her usage refers to those ideas and images through which the ruling class "orders, organizes, and sanctions the social relations that sustain its power" (1987, p. 54). Ideologies carry a taken-for-granted component in that they constitute the basis of common perspectives. I am taking direction from Smith here and use discourses to refer to the ways in which languaging and conversation reflect common thinking and also organize thinking. Ideology falls less in the domain of language, and connotes underlying, shared beliefs and assumptions that sustain dominant interests.

[97] Efficiency discourses are not new to nursing (Leininger, back in 1978, observed that nursing demonstrated a "cult of efficiency") and could be understood as stemming from the early militaristic and religious associations of nursing. Yet, health care reform has accentuated these discourses in a profound sense.

Individualism assumes, thus, that the current social system provides sufficient and equal opportunity for individuals to move within the social system according to their abilities (Travers, 1996). Professional discourses also purported the values of egalitarianism on the basis of shared professional standards of practice. References to "treating all individuals equally" again suggested that individuals were viewed apart from the social contexts that shaped their opportunities and constraints. Finally, professional discourses were intertwined with public discourses grounded in notions of merit, critiques of immigration, and constructions of Canada.

Public discourses filtered into the hospital to inform how intergroup relations were constructed and negotiated. Discourses regarding the joint ideas of merit and entitlement placed emphasis on contribution to society through taxes as a measure of one's entitlement to health care services. Administrators reported that some nurses resented caring for patients who "did not pay taxes" (e.g., those on some form of income assistance). Another participant raised the issue of rights in relation to one's contribution to Canadian society:

> I don't think anybody should be over anyone else, I don't really believe that but....what about rights? Whose rights, like, you know. Somebody who comes into a country and has only been here less than a year and you have a Canadian who has been, say this is an elderly person who has contributed to society, I mean I don't know. I'm just asking.

Such comments are embedded in public discourses regarding merit, deservedness, and entitlement and challenge the foundational principle of equal access to health care for all Canadians written into the *Canada Health Act* (1984).

Immigration discourses take on various forms in society. In this study, they included comments about how current immigrants received generous government resources and support compared to earlier generations of White immigrants. Also drawing on notions of merit and

entitlement, other comments suggested that immigrants were "taking up our services", which resulted in "us" having to do with less (e.g., having to face earlier discharge). These discourses, creating deep schisms between "us" and "them", are rooted in constructions of Canada as a homogeneous nation (i.e., White, English-speaking) in which "average Canadians" are disadvantaged by the arrival of non-English speaking immigrants.

The colonial dominance of English was captured in discourses that suggested all should learn English. Furthermore, fluency in English was used as a marker of assimilation and thus allegiance to the Canadian project. While the more extreme comments regarding entitlement and immigration were not characteristic of most participants, the widespread acceptance of the lack of available interpretation services, for instance, seems to indicate a preference for English, an expectation of assimilation, and perhaps a lack of concern for those who cannot communicate in English. Similarly, discourses of Canada as a "Christian nation" establish dichotomous Us:Them relationships between immigrants of Colour who are assumed to be other than "Christian", and White Canadians who are lumped together into a category of "Christian".

Each of these discourses regarding entitlement, language, and religion derive from colonialist images and ideologies built on longstanding notions of nationhood and the superiority of European culture. The history of Canada includes many examples in which the dominance of White, English-speaking Canada, based on a presumption of the superiority of White northern Europeans, was asserted at the expense of other groups who carry similarly long histories here. Today, while official multicultural policies give an impression of diverse groups living in harmony, in reality this is more of an 'imagined community' (Anderson, 1983). Critics of multiculturalism observe that within this concept of community the dominant culture becomes the norm in which other groups are "multicultural" in relation to (Bhabha, 1990). Thus, public

and political discourse affirms pluralistic society, but, at the same time, resists the demands that the articulation of cultural and ethnic differences makes upon the dominant society. For example, some participants (including some who were immigrants) constructed Canada as a tolerant nation "sensitive to others' needs" and committed to "treating all as equal". Do these sentiments suggest a conflicting ideology at play – one that values equity, tolerance, and social justice? It seems then that colonialist ideologies co-exist with ideologies that espouse democratic values. Henry et. al. (1995) argue that these conflicting ideologies come together in what they term "democratic racism" in Canada, and form the prevalent ideology that sustains racism in Canadian society. Thus, while Canada is constructed as a tolerant "multicultural" nation, conflicting ideologies of the superiority of Whiteness justify practices and policies that advantage the majority (Whites) while disadvantaging the minority. Moreover, this construction of Canada as tolerant may become a censoring device (expressed through discourses of political correctness) that prevents open challenge of incidents that disadvantage and/or draw on racialized notions.

In this section, I have attempted to show how professional and public discourses and societal ideologies come together to shape intergroup relations in health care. The ideologies underlying these discourses typically go unnoted, but wield significant influence in how intergroup relations are played out in day-to-day encounters.

The Macrosocial Context: Capitalist Agendas, Eurocentric Assumptions

Considerable ground has been covered in this chapter in an effort to uncover the complexities involved in the social organization of intergroup relations or "show how it works". Now, as I seek to conclude this analysis and pull the themes together a little tighter, I continue

with the macrosocial level of analysis begun in previous sections to consider more closely how

Eurocentric assumptions and capitalist agendas are reflected within and perpetuated by our

health care system. In so doing, relations of power and ruling that organize everyday intergroup

relations in health care are uncovered to a greater extent. I am informed by Dorothy Smith's

conception of "relations of ruling" in this analysis and understand such ruling relations not as

individuals holding and exercising power per se, but rather as a complex nexus of social forces.

As Smith (1999) explains,

> While the ruling relations are an organization of power, it is misleading to reduce them to
>
> relations of domination or hegemony, or to view them as monolithic or manipulated. I
>
> emphasize again: the ruling relations form a complex field of coordinated activities,
>
> based in technologies of print, and increasingly in computer technologies. (p. 79)
>
> It is important…to keep in mind that the ruling relations are a more general dimension of
>
> the organization of society, extending into its systems of discourse, science, mass media,
>
> large-scale organization of all kinds, professional organization, and so on. (p. 91)

Such a broad-based network of organizing relations suggests the need for a rather far-reaching

examination. Moreover, Smith encourages us to "focus on the ways in which we are active in

producing and reproducing the social relations of discourses or large-scale organization, and,

inversely, the ways in which those social relations overpower our lives" (p. 226). Importantly,

this observation that social relations operate in dialectic fashion adds further intricacy to the

macrosocial analysis of intergroup relations within health care settings. The links between the

capitalist world system, Eurocentric worldviews, the health care system, and individual practices

and experiences are obviously complex. Yet, because the themes of health care reform and the

discourses and ideologies of dominant society were central in this study, it seems highly relevant

to pursue questions such as "What is driving health care reform?" "How does biomedicine mirror and reproduce dominant interests? "What interests are represented by discourses and ideologies of the day?" "How are health care providers complicit in reproducing social relations that structure everyday life?"

Baer, Singer, and Susser (1997) observe that "the development and expansion of a global economic system represents the most significant, transcending social process in the contemporary historic epoch. Capitalism has progressively shaped and reshaped social life" (p. 27). Health care systems have not been immune from the influences of capitalism. Navarro (1976) made this connection some time ago when he commented that contrary to widely held belief, the main centers of power in the health care system have not been the medical professions but rather sectors of the capitalist class, with an "active invasion of corporate America into the institutions of medicine" (p. 68). Although the American system with its for-profit, market competition health care delivery represents a clearer picture of the integration of capitalist interests, the Canadian system has not escaped the sway of capitalist values. As demonstrated in this study, the adoption of a corporate model of administration has been an integral aspect of health care reform, under the auspices of increased efficiency and effectiveness. Armstrong and Armstrong (1996) link this model with its specific management strategies (e.g., TQM, CQI) directly to American for-profit, capitalist-based practices. The consumer orientation of the corporate model was evident in this study, disadvantaging health care providers, especially nurses of Colour, and ultimately reflects market influences in a shift in the values shaping health care from seeing health care as a social right to seeing health care as a consumer right. Canadians are indeed in a paradoxical situation. Although we live in a capitalist society, we have long embraced principles of a socialist system (Keddy et. al, 1999). However, with a larger

populist shift occurring from the "collectivist ideals of the post-war consensus to a free-market, individualized ideal in which self-care, individual responsibility and the decline of the state are key" (Beardwood et. al., 1999), the security of our socialized health care system is at risk as never before.

Privatization of health care services is a key arena in which to understand the shift away from socialized health care. Privatization has increased steadily in the context of Canadian health care, with per capita private expenditures increasing annually while public expenditures have declined in recent years (Armstrong & Armstrong, 1996). The move to privatization is occurring in subtle ways, allowing us to hold on to the vision of publicly funded health care enshrined in the *Canada Health Act* (1984). For example, off-loading of public spending has resulted from de-listing of certain services and shorter hospital stays that often necessitate that families provide previously funded care. The subtle shift to privatization was also observed in this study when private duty nurses were hired by families to provide the one-to-one care required by their hospitalized sick loved ones but not provided by current levels of staffing. Participants typically encouraged this practice, understandably so in light of their workloads. However, this trend should be seen in the context of the larger influences of capitalism and the move to privatization with its accompanying dangers. Armstrong and Armstrong explicate the nature of these dangers:

> Canadian governments and institutions...are shifting more and more of the responsibility for provision and payment to for-profit companies and to individuals. This is a more dangerous experiment than it many appear because, according to the free trade agreement (NAFTA), once services have been privatized it would be extremely difficult and expensive to return them to the public sector. A giant American public relations firm has

described our public health care system as 'one of the largest unopened oysters in the Canadian economy', an opportunity to turn public services into private profits. (p. 187)

While restructuring and privatization may save government costs in the short-run, the long-term results will likely not be positive. For-profit motives typically drive up health care costs (as evidenced by higher American health care spending overall) and shift the focus or motive of health care from what is good for health to what is good for business and profit. Armstrong and Armstrong warn that for-profit organizations increase the return on their investment by reducing reliance on labour and by cutting wages. In health care, this translates into an emphasis on treatment based on technology and drug-therapy (two avenues that are tremendous revenue-producers for the large corporations that control them) with increased use of the least skilled worker and fragmentation of tasks, and a declining importance placed on care of the whole person (Armstrong & Armstrong). Accordingly, privatization presents a real threat to the ideal of connected care held up in this study and especially disadvantages those in marginalized positions in society. This point is picked up by Waitzkin (1983) who states that

> In a climate of fiscal crisis, an ideology of austerity is justifying cutbacks in health and welfare programs. Services whose effectiveness is difficult to demonstrate by the new methodologies are prime candidates for cutbacks and therefore face a bleak future. Poor people and minority groups, historically victimized by the free-enterprise system, will be the first to suffer. (p.677)

Health care reform, then, is certainly not a neutral process, and is profoundly shaped by capitalist interests. Although many of the values embedded in the discourses of health care reform are laudable (e.g., values of equity, community participation, services "closer to home") these values

are not necessarily reflected in the processes or outcomes of health care reform. It seems that health care reform has been unable to hold to its lofty intentions due, in part, to the influence of capitalist agendas.

The capitalist world system carries further influence within the health care domain. Li (1999), reflecting on the contributions of postmodern scholarship as a framework that counteracts scientific positivism, notes that the homogenization of capitalist culture worldwide represents a "hegemonic attempt to suppress cultural diversity and identity differences" (p. 9). Thus, the neocolonialism represented by the expansive influence of the capitalist world system carries at its core this dominating tendency. Drawing on this insight, it seems that any strides toward increased diversity throughout all levels of health care institutions are less likely as institutions move to greater levels of corporatization, with more centralized forms of management. Baer, Singer, and Susser (1997) speak to the predominance of representatives of the financial and corporate capital, upper-middle class professionals, and business class in control of hospitals. They go on to observe that while these players, many of whom are White males, may give full public support (e.g., in written policies and public statements) to programs aimed at increasing gender, race, and class diversity throughout the agencies, these "hospital elites" may privately sabotage such programs by withholding or discouraging funding. Although the make-up of hospital boards, for example, in Canada has changed with regionalization and emphasis on multisectorial representation, this study still revealed predominantly White administrative teams and also carried evidence of resistances toward diversity policies at all levels of these agencies.

Another illustration rising from this study of a health care system mirroring and perpetuating Eurocentric dominance was the noticeable absence of the integration of other

systems of healing into the biomedical settings of health care. When I asked participants how they accommodated alternate therapies, the unanimous response was that this was not a situation that presented itself frequently. Baer, Singer, and Susser (1997) see such biomedical dominance as a form of colonizing practices but also note resistance to them.

> Lower social classes, racial and ethnic minorities, and women have often utilized alternative medicine as a forum for challenging not only biomedical dominance but also, to a degree, the hegemony of the corporate class in the United States as well as other advanced capitalist societies. (p. 215)

With the financial backing from private and government sources for research and educational activities during an era of empiricism, and through key legislative passages (e.g., that centered health care services in hospital settings), biomedicine has asserted its scientific superiority and has established hegemony over alternative medical systems (Anderson & Reimer Kirkham, 1998; Baer, Singer, & Susser). The strong presence of biomedicine, with the associated professional organization of physicians, evident in this study can be understood in this larger sense of being tied to Eurocentric dominance.

A final indicator of Eurocentric dominance has to do with the preeminence of the English language and the apparent resistance to the provision of health care services in alternate languages. While there is acknowledgement of the need for diversity of approaches and broader representation, health care institutions (along with other fundamental structures of society) have not been transformed to reflect the different groups that make up Canada and "remain Eurocentric and classist....These institutions are, in fact, designed for middle-class Canadians who are fluent in English and who have Euro-Canadian backgrounds" (Anderson & Reimer

Kirkham, 1998, p. 251). When viewed in the contexts of a national history sustained by discourses of Us:Them that create 'Other', of health care discourses of fiscal austerity and 'crisis', and of the hegemonic influences of biomedicine, the slow introduction of language services becomes a reflection of the larger linguistic domination of the English language and imperialist Western culture both in Canada and increasingly around the globe. Cashmore, referring to this phenomenon as "linguistic imperialism" (1996, p. 199), reminds us of the ties between colonialist expansion and language, and also highlights the socially constructed links between language and nation. Although nations such as Canada are, and have historically been, multilingual, they are constructed as monolingual, or bilingual in the case of Canada, and in so doing, those speaking English as a first language are endorsed as "true" Canadians and accorded a range of privileges associated with this status. As observed by Ashcroft, Griffiths, and Tiffin (1995), language remains a powerful instrument of cultural control whereby the "imperial center" installs English as a "standard" against other variants which are constituted as "impurities" or at least second class. The power of language, therefore, must not be underestimated as a colonizing force that prescribes modes of communication and meaning, and inscribes social identity and belonging. Within health care settings, the dominance of the English language and the corresponding slowness in integrating interpretive services into day-to-day health care provision become symbols for the colonizing practices of the larger Eurocentric project that continues to construct Canada as essentially White and English speaking. Moreover, health care providers who accept the lack of interpretive services and implement alternative, albeit creative, strategies are unwittingly reproducing these colonizing practices.

Sherwin asserts that hierarchical structuring within health care that supports Eurocentric dominance is of concern not just because of its obvious injustice, but because "it provides an

ideological foundation for maintaining a hierarchically structured, stratified society....The role

patterns of the health care system rationalize society's sex and race [*and we might add class*]

inequalities and confirm the existing stereotypes that maintain these inequalities" (1992, p. 234-

235). Therefore, at a very fundamental level, the intergroup relations in the context of health

care described in this study are reflective and supportive of a broader realm of social relations.

Remembering Dorothy Smith's (1999) injunction to consider one's own complicity in such

social relations, the actions and attitudes of each health care provider can be framed as

supporting and/or resisting deeply engrained patterns of social relations in Canada. This

participation in the reproduction of social relations may be conscious in some situations and

unconscious in others. In this study, for example, some participants were highly aware of their

participation in racialized exchanges and resisted these exchanges to varying degrees. Other

participants were apparently oblivious to racialized dynamics, yet participated in them by their

implicit assumption of the centrality of "Canadian ways" or by their reticence to admit that

racially motivated behaviour might be occurring (e.g., between White patients and nurses of

Colour). Additionally, the multiplicity of social identity(ies) as oppressor and oppressed roles

that were held concurrently by participants in the study demonstrate that there may be

considerable variance in the ways in which any one individual participates in and reproduces

these larger social relations. A White nurse may, for example, reproduce stereotypical

assumptions regarding members of a particular group but may at the same time also resist gender

subordination. My discussion of research findings in this report began from the standpoints of

nurses and patients (Chapter Five) and proceeded to demonstrate how various contextual

influences interpolate day-to-day encounters (Chapters Six to Eight). Clearly, these meso and

macro influences operate within domains of human agency in which they are resisted or reproduced on a day-to-day basis in each individual intergroup encounter.

In order to create a health care system that does not marginalize those individuals and groups who are not constructed as part of dominant society, we will need to continue in the project of uncovering and challenging the effects of capitalist agendas and Eurocentric assumptions on day-to-day health care provision and will need to consider how each of us as health care providers is complicit in the maintenance of social relations that advantage some and disadvantage others. A way forward is needed in the domain of intergroup relations in health care that captures the interrelationships between individuals and their social contexts, acknowledges the racialized settings of health care, and offers direction for transformative knowledge and practice. In the next and final chapter, I offer some recommendations regarding such a way forward.

CHAPTER NINE:

A WAY FORWARD: CONCLUSIONS AND RECOMMENDATIONS

The objective of this study was to contribute to an understanding of the social organization of intergroup relations in health care provision. My thesis entering the study was that the health outcomes and health care experiences of people of Colour are different from those of the dominant majority population, and my aim was to uncover what factors contribute to these differences. I was also concerned that predominant theoretical and methodological approaches were unlikely to uncover the complex factors influencing intergroup relations in health care provision because of their tendency to focus on culture and diversity, apart from a critical evaluation of the contexts of intergroup relations. This study, employing the method of institutional ethnography informed by feminist, postcolonial, intergroup relations, and standpoint theories, has extended existing knowledge regarding the nature of intergroup relations, particularly in the provision of health care to patients of Colour, and the contexts in which this occurs. By drawing on analyses of study data, re-conceptualized theoretical approaches are also recommended that may contribute to more realistic and nuanced understandings of intergroup relations and bring about transformative health care practices.

Through this process of research, I have come to understand intergroup relations in the context of health care provision as much more complicated than typically represented. Under ideal conditions, intergroup provider-recipient encounters demonstrate "connected care", marked by meaningful and respectful interpersonal connections, an understanding of the illness experience from the patient's perspective, and a holistic grasp of the patient's health care needs. Interpretive lenses were employed by nurses to make sense of "difference" and influenced how they provided intergroup care.

However, various factors, stemming from both the provider and the contexts of care, prohibited such connected care in many cases. Depending on their interpretive lenses, individual nurses might participate in racialized discourses and practices. The organizational context of nurses' work was equally influential. Recent trends brought about by health care reform, along with longstanding issues such as functional approaches, the immediate nature of nurses' work, and biomedical dominance, came together in particular ways to constitute nurses' work as disjunctured and "heavy". These realities made it difficult for nurses to provide connected care, especially to patients who did not speak English. I also came to see that the organizational and community contexts, shaped by professional and public discourses, mediated intergroup relations in significant ways, and could be linked to larger capitalist and Eurocentric agendas.

Conclusions

Based on interpretations of the data, I put forward the following conclusions:

1. "Connected care" in intergroup nurse-patient encounters is characterized by a) meaningful and respectful interpersonal connections, b) an understanding of the illness experience from the patient's perspective, and c) a holistic picture of the patient's health care needs. "Connected care" is facilitated by deliberate efforts to connect at the level of shared, common humanity. A nurse's interpretive lens affects this ability to connect, as does the context in which care is provided.

2. Nurses make sense of intergroup relations through their personal interpretive frameworks that are derived from previous experiences, education, identity(ies), and values and beliefs. Specific strategies of "sense-making" include internal dialogues, story telling, reductionism, and classifications. Interpretive lenses influence how nurses bridge differences and therefore

account for discrepancies between individuals' interpretations of the same event or set of circumstances.

3. The context of nurses' work, characterized by disjunctured care and "heavy" workloads, results in decreased quality of care for all patients and leaves nurses exhausted and dissatisfied. Patients of Colour, especially those who do not speak English, are affected disproportionately because the particular challenges of intergroup care are more likely to be overlooked during times of busyness.

4. Intergroup relations are also mediated by organizational contexts. Even with affirmation of multiculturalism and diversity at the level of formal organizational policy, significant gaps exist between the ideals represented by these policies and their actual implementation. These gaps exist as the result of complex interplays between factors such as time, energy, coordination, staff awareness and education, resource allocation, competing priorities, and overt and covert resistances.

5. Health care restructuring, characterized by the implementation of corporate models of health care and grounded in discourses of efficiency, cost containment, equality, and consumerism, shapes the contexts of intergroup relations directly, often preventing the attainment of connected care.

6. Demographic changes and societal ideologies and constructions within the community contexts influence how care is provided on a day-to-day basis in the hospital. Yet, there is a tendency to decontextualize hospitals from the community settings, leaving the influence of racialized community dynamics and dominant discourses unexamined.

7. Liberal ideologies of individualism and egalitarianism underlie professional discourses that promote health care reform. Public discourses of entitlement and immigration are rooted in

constructions of Canada as a homogeneous, White, English-speaking, Christian nation that derive from colonialist images and ideologies that hold to the superiority of Whiteness. These Eurocentric assumptions, along with capitalist agendas influencing health care reform, keep health care institutions from truly reflecting and serving the diverse population of Canada.

8. Nursing and health care theories have, for the most part, fallen short of capturing the complexities inherent in intergroup relations in health care provision. Intergroup relations in health care provision are significantly more complex than typically represented, due to the multidirectionality of ascribing "difference" and the intersectionality of the structuring social forces of class, gender, age, nation, and religion. Intergroup relations are inherently dynamic, as individuals shift in group identification depending on context, and as the nature of groups themselves evolve over time and setting. This complex, dynamic nature may result in intergroup relations that present as contradictory, inconsistent, and ambivalent.

9. The social construct of *race* is mobilized in health care settings in subtle but damaging ways. Common applications of the construct of culture often draw on historical and colonial notions of *race* and thereby reinforce longstanding patterns of domination and inequities.

Implications

The recommendations that follow are grounded in a commitment that holds as its goals a high standard of equitable health care provision for all patients, and respectful work environments for all health care workers. This commitment is foundational to my praxis orientation that aims for significant social change in and as a result of research. Situating myself and this research in the realm of critical inquiry means that my "critique is never theory divorced from practice. It is practice; practical intervention in the social world" (Allen, 1991, p. *xiii*).

Therefore, the recommendations presented here reflect engagement with the project of transforming nursing practice and the contexts of nurses' practice.

The interpretations of this study carry implications for nursing theory, practice, education, administration, research, and public policy. I begin this section by discussing the implications of this study for theorizing and researching in the area of culture, *race*, and intergroup relations and follow with the argument that critical consciousness is required in order to comprehend and challenge the factors impeding connected intergroup care. These first recommendations regarding directions for theory development, research, and fostering critical consciousness provide the foundation for the remaining recommendations.

Theorizing Culture, *Race*, and Intergroup Relations in Health Care Provision

A main concern carried into this study was the nature of conceptual frames used in this substantive area and it is here that I begin my discussion. How we theorize culture, *race*, and intergroup relations in health care provision has profound effects on all aspects of nursing and health care delivery. I believe this study brings some clarity to what direction we might push our theorizing in order to bring about transformative knowledge and practice. In order to achieve such clarity, I pursue two questions here, both of which have been the source of some perplexity for me throughout this project:

1) How might we understand the relationship between individual and group? How useful is the concept of intergroup relations?

2) How are culture and *race* best understood so as not to concretize culture (and "cultural groups") or reinforce colonialist images?

Re-thinking Intergroup Relations

My dilemmas in theorizing intergroup relations escalated as I analyzed how participants constructed "difference", especially the occurrence of what was read by participants as conflict between members of different ethnocultural communities. The predicament of theorizing intergroup relations alerted me to the two potential dangers of a) constructing "difference" at the individual level without accounting for group identity, and, b) alternatively, of representing "difference" as occurring between clearly differentiated groups, and thereby leaving little room for agency or the multiple positionings that were evident in the study. The narratives presented in Chapter Five demonstrated the importance of individual nurses seeking points of connection, as one human to another, leaving me to question, should our theorizing hold as ultimate this person-to-person connection? It seems that a singular focus on the individual to the exclusion of group identification overlooks study findings that speak to how individuals derive their identity from group association (albeit several groups), and carries the real risk of slipping back into the type of acontextual theorizing critiqued in this study. If we relate simply on an individual basis, then the influence of social identities in shaping interpretive lenses, for example, can be put aside (e.g., thus leaving Whiteness unexamined). Further, the institutional features that advantage some and disadvantage others also avoid scrutiny if "difference" is understood as simply (acontextually) occurring between two individuals. On the other hand, evidence in this study suggested that an over-emphasis on group membership led to stereotypical judgments (most often inaccurate) and tendencies to homogenize groups. Images and constructions of groups then organize how individuals within groups are treated. Study findings also indicate that when preferences and behaviours are constructed as group matters, there is a sway toward accommodation of all requests (regardless of their reasonableness) as some providers are unduly

concerned with political correctness and the possibility of being labeled as discriminatory. Moreover, the observation that participants tended to present themselves as belonging to several groups, as well as situated "in-between" groups, raises the issue of which group identification might hold most salience at any point.

Thus, the analytic processes of this study alerted me to the complexities and potential limitations of drawing on "intergroup relations" as a theoretical lens. What I am recommending is not necessarily a departure from the theory of "intergroup relations", but is rather an attempt to create an openness in theorizing that allows for shifting identification with a group, the changing nature of groups over time and place, and the myriad of other influences that mediate relationships between individuals. Importantly, then, I argue that intergroup relations are best understood as occurring between individuals who are inscribed by group histories and social, economic, and political conditions. When beginning from the experiences of individuals, the strategy of seeking points of connection at a human-to-human level remains critical as a safeguard against stereotypical assumptions. At the same time, these individual encounters should be marked by a critical consciousness that considers and challenges those influences that prevent connected care, whether they be organizational features or societal discourses, leading to a multi-layered approach to the analysis of intergroup relations. Such an answer to the question "How might we understand the relationship between individual and group?" begins to sort out some of the dilemmas in theorizing intergroup relations. However, several other assumptions underlying this question require further exploration, especially the matter of how culture itself is constructed.

Re-thinking Culture

At a fundamental level, any discourse of "difference" prompts a reconsideration of how the concepts of culture and *race* are constructed, negotiated, and conflated in the provision of health care. As illustrated throughout this study, the tendency to <u>essentialize culture</u> as a coherent set of values, beliefs, and practices is strong. Cultural groups were constructed as having discrete boundaries, as reflected in references to "the community", "us", and "them". The realities of such constructions in practice are mirrored in the culturalist perspectives of many nursing theories. As Culley (1996) observes,

> much of the call for multicultural or transcultural care relies on a reductionist discussion of stereotypes of the needs, behaviours and expectations of ethnic categories as homogeneous wholes and fails to address the continuing hierarchies of power and legitimacy between different centres of cultural authority. (p. 567)

Although cultural knowledge pertaining to particular ethnocultural communities was invaluable as background information for practitioners, an essentialized view of culture increased the risk of the application of stereotypical knowledge while overlooking intragroup variation on the one hand, and larger intersecting influences such as poverty, discrimination, and social inequalities on the other hand. Meleis (1996) speaks to this risk, noting that "...culturally defined groups tend to be stereotyped and homogenized, when in fact the variations within the culture may be greater than the variations from other cultural groups. Stereotyping is antithetical to individualized care" (p. 4).

Along with the tendency to essentialize culture, another theme evident in the study was the <u>abstraction of culture</u> away from the larger organizing social context. For example, with an

immediate attention to issues such as cultural and linguistic differences, and health practices, participants tended not to account for underlying factors and power differentials shaping health and illness. Once again, this inclination is not unique to nurses in practice, but is also reflected in much nursing and health care scholarship. As explained in Chapter Two, nursing has traditionally taken a micro focus, considering the health and illness of the individual apart from the larger environment in which they occur (Chopoorian, 1986; Starzomski & Rodney, 1997; Stevens, 1989; Thorne et. al., 1998). Within the realm of intercultural health care provision, this focus on the individual and his/her cultural beliefs and behaviours takes precedence over a consideration of structural barriers and inequities that shape the day-to-day experiences of individuals. Yet, as Meleis and Im (1999) point out, "It is not the culture that shapes the health care experiences of individuals. It is the extent to which they are stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized, and ordered around" (p. 96). Such a focus carries with it profound implications for education and policy initiatives. Stubbs (1993) notes that the basic assumptions of the multiculturalist perspective imply that what is required for improved health services in such situations is knowledge of different cultures, improved skills in cross-cultural communication, and the creation of particular ethnic programs, rather than a substantive analysis of the social structures and processes that block equitable health care and outcomes. Thus, the proclivity to abstract culture from its materialist base must be kept at the forefront of any recommendations made.

More insidious or difficult to identify than the tendencies to essentialize and abstract culture was the conflation of *race* with culture. These concepts operated in tandem, most often with *race* as silent subtext to discourses of culture. Solomos and Back (1996) have termed such forms of re-coding as "metonymic elaborations", explaining that "…racisms may be expressed

through a variety of coded signifiers" (p. 26), one of them being the coding of *race* as culture.

Solomos and Back (1996) capture this dynamic when they write,

> The semantics of race are produced by a complex set of interdiscursive processes where
> the language of culture and nation invokes a hidden racial narrative. The defining feature
> of this process is the way in which it naturalises social formations in terms of a racial-
> cultural logic of belonging. (p. 19)

Common applications of the construct of culture in this study often drew on historical and

colonial notions of *race* and in so doing reinforced longstanding patterns of domination and

inequities. These applications took on several forms. First, the easy classification of people into

cultural and ethnic groups itself was evidence of a racialized application of culture, based on the

assumption that discrete groups exist and can be used for explanatory purposes. Solomos and

Back (1996) claim that the central feature of such encoding is that social groups are fixed, made

natural, and confined within a pseudo-biologically defined culturalism. "The idea that races

existed involved the affirmation in popular, scientific, and political discourses that humanity

could be divided into distinct groupings whose members possessed common physical

characteristics" (Solomos & Back, p. 32). Often these groupings followed nationalistic

boundaries, such as "Chinese" or "Indian", which in themselves reflect and draw upon

colonialist images. David Allen explains that descriptions of groups within nursing literature

tend to be nationalistic.

> Ethnic/cultural locations very often 'happen' to be written within vocabularies of
> nationalist boundaries.....Almost all current 'nations' are, of course, colonialist creations.
> Even those that have had successful anticolonialist revolutions often stay mired in the

binaries of nationalistic identities that are the mirror image of the colonialist project they attempted to purge. (Allen, 1996a, p. 98)

Along with these racialized systems of classification, there was also evidence that certain ethnic groups were given increased attention. For example, in one setting cultural difference was ascribed to Chinese but not to Aboriginals and Iranians who could speak English. Moreover, more attention was directed toward those practices that were considered exotic, "interesting", or "different". Stubbs (1993) concludes that this selectivity "may relate to colonialist and racist constructions of the 'strangeness' of the cultural patterns of 'Asian' groups" (p. 39).

These patterns of classification relied on another manifestation of *race* within cultural discourses, namely the creation of Other. The illustrators of Othering provided earlier in this report must be understood as having their roots in imperial exploitation and the colonial project. During this era, identities such as "the West", "European", and "White", conflated with conceptions of rationality, civilization and Christianity, produced images of paganism and savagery through binaries such naked/clothed, oral/literate, and technologically backward/advanced (Rattansi, 1994). These images continue today with constructions of Other as childlike, passive, or exotic. We see, then, residuals of the evolutionary meanings of culture that re-articulate colonial images of Other, and reinforce existing relations of power. In addition, the Us:Them dichotomies described earlier (Chapter Seven and Eight) highlight the relational nature of *race,* in which the construction of Other (or Them) is in relation to an unspoken Us. Therefore, equally as important as these representations of Other were the representations of Us in this research. White dominant culture remained transparent and unspoken for the most part, positioned as "normal". Solomos and Back summarize this as follows, "In these representations, whiteness is equated with normality and as such it is not in need of definition. Thus 'being

normal' is colonised by the idea of 'being white'" (1996, p. 22). Jointly, these shortcomings of essentializing, abstracting, and conflating culture with *race* served to reproduce existing power differentials by reinforcing racialized notions of Other, leaving unexamined the dominance of White, capitalist society, and obscuring those structural factors that shape inequity in health and life chances.

The interpretations of this study have uncovered how culture discourses draw on the construct of *race* to re-inscribe longstanding patterns of domination and inequities, and how health care practices themselves draw on colonialist images (e.g., in the process of Othering). What direction might we take from this discussion? First, we are left with the task of evaluating the usefulness of the concept of culture for our theorizing and our practice. How might we draw on this concept without sliding into the tendencies of essentialism, abstraction, and conflation uncovered by this study? Here I take direction once again from postcolonial scholars who interrogate and politicize the concept, but do not toss it out. Culture becomes important as it speaks to "difference" in the interstitial spaces between cultures. As Bhabha explains, "It is the 'inter' – the cutting edge of translation and negotiation, the *in-between* space – that carries the burden of the meaning of culture" (1994, p. 38). Thus, what is identified as "culture" depends on its confrontation with that which is "different" from itself. To illustrate, my own familiar family practices of seeking simplicity and community, built on a group history of migration, suddenly become "culture" when they come up against other practices, and become something to be re-visited and possibly revised in a new context. Further, culture, as a container for "difference", may be mobilized in resistive, inclusionary, or exclusionary fashions. Along with this notion of "difference", I see culture as also carrying a sense of coherence and consistency in shared meanings, practices, and beliefs. Importantly, while these shared meanings are contested and

shift over time and place, there is the sense that "in spite of conflicts and resistances, these worlds of meaning somehow hang together" (Sewell, 1999, p. 58). In my understanding of culture, then, I am staying closer to Hall's description of culture as the "actual grounded terrain of practices, representations, languages and customs of any specific historical society" (1986/1997, p. 439). Such a description of culture accounts for shared group meanings, resists essentializing categorization, and considers the social histories (often migratory or postcolonial) of groups.

This conceptualization of culture carries some specific implications for nursing scholarship. While most nurse scholars acknowledge, for example, that "cultural groups" change over time and do not carry discrete boundaries, the study of specific health practices ascribed to entire groups belies continued essentialist tendencies. The real concern with these tendencies is a focus on "culture" at the expense of a concern with relations of power and other structuring forces that disadvantage those to whom the term "culture" is applied. A contextualized approach to theorizing is required that avoids the representation of culture as a prepackaged set of values, beliefs, and practices set apart from historical and present social positionings. Post-colonial frameworks, for example, enable us to address the ways in which state and professional ideologies and practices tend to reproduce racialized discourses, practices, and relations at various levels. In short, what is needed is a move away from reductionistic multiculturalist theories to an integration of *race* theory into our health care theorizing with clear explication of how *race* continues to operate today through processes of racialization and racism to provide a starting point that alerts us to the damaging effects of *race* in everyday life. Such a move away from culturalist perspectives will open up opportunities for research, education, policy, and practice initiatives that "describe and account for the operation of institutional racism within

health care, in terms of both service delivery and employment....and that question the dominance and relevance of Western models of health and illness" (Stubbs, 1993, p. 37). Importantly, some middle ground is needed in which we move away from the use of culture as a metonymic device for *race*, but also avoid the complete replacement of the concept of culture with *race*. Our theorizing, then, should be marked by a critical application of both concepts of culture and *race*.

The interpretations of this study also suggest the need to account for the complexities inherent in intergroup relations in our theorizing. Our theories must extend from the traditional White caregiver-recipient of Colour configuration to elucidate the range of inter and intragroup relationships and power dynamics that occur in our diverse health care settings. Intersectional theorizing is also needed to illuminate how the social categories of gender, class, age, nation, and religion operate in tandem with and in opposition to *race*, with subordinating and dominating relations being enacted through these social categories. And, remembering the dynamic nature of intergroup relations, an openness is required to allow for the shifts in group identification and the nature of groups over time and setting, and to uncover some of the "irrationality" (Rattansi, 1992) of racialization and constructions of "difference". In so doing, sweeping generalizations and stereotypes that may be taken up by those in practice settings are not as easily invoked. Further, as evidenced in this study, a range of extralocal forces enter into the health care domain to influence intergroup relations, and our theories must capture these influences. For example, the evidence of the social determinants of health points to deeply entrenched economic, social, and political patterns within our capitalist society that disadvantage some and privilege others. Here another caveat requires our attention: a contextualized approach does not equate with a reductionist approach in which all intergroup relations, especially in the realm of conflict, racialization, and exclusion, are attributed directly and solely to totalizing forces such as class

differences and capitalism, patriarchy, or White hegemony. Rather, our theories must leave room for the shifting, contradictory, and ambivalent nature of intergroup relations, as well as the agency of each individual. In essence, a multi-layered approach is required with linkages between analyses of the micropolitics of power and the macrodynamics of structural and historical nature (Torres, 1998).

Finally, I suggest that our theorizing be grounded in a commitment to transformative knowledge and practice. The preceding discussion begins to give substance to what transformative knowledge might look like – a broad-based knowledge that offers a contextualized view of culture, traces the effects of *race* in health care provision, accounts for the intersectional influences on intergroup relations, and analyzes the ways in which micro and macro relations of power structure health care experiences. Anderson (1998) describes transformative knowledge as

> Knowledge that is, first of all, undergirded by critical consciousness on the part of health care providers, and that unmasks unequal relations of power and issues of domination and subordination, based on assumptions about 'race', 'gender', and class relations. It is knowledge produced within the context of the encounter between health care provider and woman within a pedagogical relationships that acknowledges the wisdom of 'the people', and the mediating circumstances of people's everyday realities. (p. 205)

Such knowledge, I would argue, is essentially praxis-oriented by its nature (Thorne, 1997), leading to transformative practices that bring about necessary change within health care settings. Such change begins with individual practitioners as they examine the influence of their own positionalities on their encounters with patients who are likewise located in unique social configurations (Tang & Anderson, 1999). Such reflection may well bring about changes in the

ways in which they relate to patients, especially if providers recognize the power differentials that may be at play. Social change resulting from transformative knowledge also includes the restructuring of fundamental structures within health care that prohibit connected care, and result in racialized health care experiences and inequitable health outcomes. Our theorizing thus needs to make explicit links to practice and policy domains, the vehicles through which transformative change can be accomplished.

In sum, the complexities of health care, particularly in intergroup situations, call for the development of theories that incorporate critical perspectives regarding culture and *race*, uncover the shifting and inconsistent operations of intersecting oppressions, attend to dynamics of power, explicate the links between the historical positioning of some groups and their health outcomes and health care experiences, and pave the way for transformative health care practices. The inclusion of these themes into theorizing about culture, *race*, and intergroup relations serves as the foundation upon which the remaining recommendations in this study are constructed. Therefore, the following recommendations serve as illustrators of the links between theory, practice (including the practices of education and research), and policy that can be brought about by the application of transformative knowledge.

Considering Research

Closely related to the issue of theorizing culture and *race* is the question of how one applies these insights to one's research endeavors. This study has pointed to the complex and dynamic nature of intergroup relations, and has also revealed the many challenges inherent in theorizing culture and race. Considering the interconnectedness between theory and research, such theoretical challenges cannot be divorced from research. If the naming of "cultural groups" typically draws on deep-seated colonialist images, can research involve specified ethnocultural

groups without reinforcing colonial tendencies and histories? How does one pursue the nature and outcomes of intergroup relations, with clearly stated research questions, while allowing for the range of variations and configurations, all of which are shifting continuously, uncovered in this current project? Further, how might a program of research make visible and track the complex nexus of "ruling relations" at organizational and societal levels that shape intergroup relations and health care provision (e.g., the possibility of connected care) so profoundly? How does one speak with participants in ways that clearly communicate the intent of research (i.e., in "everyday language") while simultaneously avoiding obfuscating academic language and everyday discourses that reinscribe racialized and colonizing images of Other? These are the sorts of questions that will interrogate the program of research that lies ahead of me and, in a sense, serve as goalposts for me. Much of the richness and potential for transformative knowledge development represented by these questions lies in the bringing together of individual standpoints with group-based social histories and experiences within health care settings. The project of uncovering the nature of social relations in intergroup encounters in health care provision requires a commitment to continually bring together the local with the extralocal, the micro with the macro, in an effort to understand the ways in which individuals are active in producing and reproducing social relations and are, in turn, shaped by these same relations.

At a more concrete level, the findings of this study suggest the need for further research in several key areas. The intersectionality of constructions and negotiations of "difference" suggests the need for further investigation. This study did not include any male nurses but did elicit gender themes around how the profession of nursing was constructed. How do gender and *race* play out in intergroup relations with male nurses? As well, the evidence of religion as conflated with *race* and as a source of conflict points to a topic little is known about. Language

came up repeatedly in this study as a marker of "difference", and more theoretical and empirical work should be done that looks at the communicative, political, and ideological functions of language in health care, especially as health care agencies are beginning to allocate some monies toward the establishment of interpretive services. Another strong message was that intergroup relations are challenging, but perhaps not as "difficult" for nurses as caring for certain other patients, especially those with chemical dependencies in the lower echelons of society (e.g., homeless, IV drug users). Furthermore, classist assumptions and stereotypes were as prevalent as racist ones, suggesting that much work ought to be done in this area as well. Future research therefore is needed to understand the intersectional influences at work in intergroup health care provision.

Social identity was recognized in this study as an important constituent of one's interpretive lens and therefore is crucial to how one understands and approaches intergroup relations. Little work has been done in health care looking at the constructions and effects of social identity, although there is a growing body of theoretical work in the social sciences that could be profitably applied. The social positioning of nurses of Colour was particularly salient in this study. The racialized experiences of nurses of Colour that were spoken to in this research have also been identified by other researchers and require further focused study. In addition, the allusions made by participants in this study that nurses of Colour in extended care settings were especially vulnerable to racialized experiences call for careful research.

This study focused on health care encounters between nurses and patients and in the analysis of the context of care, identified the role played by physicians. This investigation could well be pushed further to include other members of multdisciplinary health care teams, as there was evidence that multidisciplinarity and increased specialization further fragmented care. A

further research question might examine the relationship between multidisciplinarity and intergroup relations. This study also begins to track the relationship between health care reform and quality of intergroup care. Further empirical evidence is needed in this regard. The ideological underpinnings and their effect on the delivery of equitable, just care must be uncovered.

Finally, the method of institutional inquiry, still relatively unknown within the domain of nursing research, was well suited to this investigation. The ethnographic methods employed extended beyond the typical self-report of qualitative research and were invaluable in explicating the negotiation of intergroup relations, the contexts of nursing practice, and the extralocal forces at play. Methodological issues were discussed in Chapter Three and Four and leave room for further consideration. For example, my experiences challenged some of the classic feminist assumptions regarding power in the research relationship, and also suggested that the positioning of the researcher by participants may be as important as how the researcher presents herself. I also struggled with the matter of intersubjective construction of knowledge in a praxis-oriented, critical inquiry. These are the sorts of methodological challenges that will demand our careful attention as we move forward with more research in this genre.

In considering implications for future research, my recommendations here provide both a general direction that tackles some of the difficult theoretical and methodological challenges inherent in research in the area of culture and health, and several more specific research questions that derive directly from this study. When taken together, these recommendations serve as an outline for my own proposed program of research, as well as investigative directions for other nurse and health care researchers.

<u>Fostering Critical Consciousness</u>

Because of the profound but often invisible (overlooked or taken-for-granted) influences

on intergroup relations uncovered in this study, I argue that special attention must be directed

toward fostering critical consciousness among nurses[98]. Critical consciousness, characterized by

self-awareness, insight into mainstream stereotypes and societal ideologies, and social agency, is

needed in order to understand the influence of one's own social identity and interpretive lens,

and to challenge predominating practices, discourses, and sustaining ideologies in racialized

work settings that mitigate connected care. Critical consciousness should be marked by insight

into one's own collusion in racializing practices and discourses and how one is caught up and

participates in power situations and consciously or unconsciously reproduces patterns of

dominant society (Lather, 1991). Moreover, considering the dynamic nature of intergroup

relations and the shifting patterns of power relations, any journey toward critical consciousness

must be typified not by formulaic explications of essentialized groups or interests that oppress

Others, but rather by thoughtful considerations of how power might operate in certain situations,

how various intersecting axes of influence might shift where and how power is expressed most

strongly, and how societal discourses and ideologies operate in these shifting contexts.

I suggest that the fostering of critical consciousness occurs primarily through an

educative process that applies equally to practicing nurses and students. The goals of

consciousness-raising lie in the domain of exposing taken-for-granted positions and offering

alternatives. Herein lies a risk: that pedagogical efforts toward consciousness-raising might in

and of themselves become authoritarian and reproductive rather than liberating and

transformative (Lather, 1991; Lupton, 1995). Lupton puts it this way:

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[98] Ideally, all nurses – front-line nurses, educators, administrators, academics, researchers, and policy analysts --
would evidence critical consciousness.

The point is not to seek a certain 'truth', but to uncover the varieties of truth that operate, to highlight the nature of truth as transitory and political and the position of subjects as inevitably fragmentary and contradictory. If it is acknowledged that discourse formations and subject positions are not bounded systems, but are open to dispersal, contradiction, contestation, and opposition, then the opportunity to construct alternative discourses and subject positions is facilitated. (1995, p. 160)

An overarching theme within the project of consciousness-raising, thus, is to foster critical analyses of and visions for transformative health care practices.

Undoubtedly, consciousness-raising is no straightforward educational goal with easy evaluation, for as Moodley (1992) observes, "ethnocentrism and racism reflect individual predispositions and social forces beyond the reach of conventional pedagogy" (p. 7). Moreover, as a pedagogical aim, it is relatively new to nursing, although educational and social theorists (especially feminist), often drawing on the work of Paulo Frieire, have purported it for some time (e.g., Lather, 1991; McCarthy & Crichlow, 1993; Roman, 1993a, 1993b; Tatum, 1992). Educational scholars such as Ali Rattansi (1992) and Philip Cohen (1992) provide us with some general insight into how educational models might contribute to or detract from critical consciousness. They point to the reductionist tendencies and inadequacies of both multicultural and anti-racist models. In the case of multicultural education, cultural groups are concretized, "difference" is accented without careful situating within a broader context, and discrimination is typically accounted to individual prejudices. Anti-racist education, on the other hand, is incomplete in that singular theories of racism are typically put forth that do not account for the variations and inconsistencies of racializing practices and discourses. An expanded anti-racist framework is required that is pluralistic in nature to account for the shifting, ambivalent nature of

intergroup relations in the context of culture and *race,* and that has multi-faceted approaches that attend to both macro (e.g., state policies that challenge capitalist and Eurocentric dominations) and micro (e.g., individual stances that resist racialization) matters. Furthermore, sole reliance on rationalist educative strategies will likely not be successful due to the irrationalisms embedded in intergroup relations (Cohen, 1992; Rattansi, 1992). Importantly, the complexities and dynamisms of intergroup relations should not necessarily be viewed as denying any hope for critical consciousness and coherent and effective responses to racializing practices and discourses. Instead, Cohen reminds us that these inconsistencies underscore the fact that "the popular culture of racism is neither so unified, nor the positions within it so fixed as is sometimes supposed", leaving "points of possible engagement for antiracist work" (p. 93). Thus, I am positioning the more concrete recommendations that follow in the realm of such a framework that brings together the extralocal with the local while carrying a pluralistic approach that varies in strategies and emphases in order to capture the dynamic and at times irrational nature of intergroup relations. Thus, the foci and strategies I propose are reflective of anti-racist models, with the addition of increased attention to the intersectional and ambivalent variations in the ways in which *race* and racisms operate.

Although the purpose of any pedagogical programs is the same for practicing nurses and students (i.e., to raise critical awareness), educational contexts require strategies unique to each setting. Therefore, I am organizing my recommendations here to first address nursing curricula, and then educational programming for practicing nurses. I propose that the accomplishment of critical consciousness through educative efforts is dependent on both content and process. First, content of an interdisciplinary nature in which students are exposed to various social explanations that account for the social positioning and experiences of certain groups, is

necessary in order to provide students with the theoretical grounding necessary for critical consciousness. Such a theoretical grounding implies education based on critical perspectives (e.g., those deriving from feminisms, post-colonialisms, and other critical social sciences) as well as the interdisciplinary preparation of nurse scholars, educators, and researchers. Second, although the main curricular foci extend beyond specific practices or beliefs of various cultural groups, attention to particular cultural concepts (e.g., notions of balance and imbalance, hot and cold, yin and yang) may well be included with care being taken not to present these as tied to entire groups of people in essentialized fashions. As Anderson notes, "Attentiveness to cultural nuances is not in opposition to an antiracist agenda; we all come to interactions with cultural and symbolic meanings that organize the ways we experience our worlds" (1998, p. 205).

The process component of fostering critical consciousness might feature learning activities that promote self-reflection, especially regarding one's own positionality and responses to "difference", and generate ideas for social change. As educators, we should strive to help learners (both nurses and students, Whites and people of Colour) see themselves and each other differently: not as individuals whose relations to racializing practices and discourses must be either "innocent" or guilty", but as participants in social and ideological networks. While these networks are not of their own making, learners, whether nurses or students, can come to understand and challenge them (Maher & Tetreault, 1997).

Purposeful self-reflection with resultant consciousness raising does not occur without careful planning and deliberate intervention. Indeed, Maxine Green (cited in Bloom, 1998) claims that much of public education is geared toward training students to "blandly accommodate" or meet the demands of our consumer society, rather than preparing students to recognize and challenge that which prohibits a truly democratic society. This observation could

certainly be applied to nursing education. Rather than challenging students with experiences and conversations that push one to examine one's social positioning and assumptions, nursing educators have often taken the route of avoiding placing students in discomforting patient care situations. Green notes that certain educational environments are more likely to awaken consciousness, particularly those in which communication and dialogue are central, for "consciousness seldom develops in isolation" (cited in Bloom, p. 44). Therefore, Bloom proposes that critical consciousness can be fostered through educational theories and practices that

> insist upon the importance of inclusive social dialogues in the classroom: dialogues that raise consciousness and challenge official knowledge; dialogues that reveal, rather than conceal conflicts; dialogues that take risks; and dialogues that foster both reflective solidarity and responsibility for the well-being of our society. (p. 43)

Grossberg (1994) refers to such educational strategies as a "pedagogy of articulation and risk", emphasizing the importance of guiding students to a deeper understanding of their own involvement in the world. These types of more confrontational learning experiences require that students have (or are taught) the art of listening to perspectives other than their own and those that have not traditionally been heard in nursing curricula or mainstream society. At a more concrete level, Tatum (1992) suggests four strategies for promoting student development and reducing student resistance:

> 1. The creation of a safe classroom atmosphere by establishing clear guidelines for discussion;

2. The creation of opportunities for self-generated knowledge (It may seem easy for some students to challenge the validity of what they read or what a professor says, but it is harder to deny what they have seen with their own eyes);

3. The provision of an appropriate developmental model that students can use as a framework for understanding their own process (The emotional responses that students have to talking and learning about racism are quite predictable and related to their own racial identity development. Informing students at the beginning of the semester that these feelings (e.g., guilt, shame, and anger) may be part of the learning process is ethically necessary and helps to normalize the students' experience).

4. The exploration of strategies to empower students as change agents. (Heightening students' awareness of racism without also developing an awareness of the possibility for change is a prescription for despair). (p. 18)

I would add to this list the possible contributions of role modeling critical consciousness. At a personal level, the evolution of my own critical consciousness has been influenced by role models who have challenged my assumptions, education that has exposed me to a range of critical theoretical perspectives, and personal experiences that have placed me in minority positions.

As I commented earlier, the central intent of the educational strategies recommended here (i.e., the fostering of critical consciousness) is the same for both students and nurses. As clearly illuminated in this study, current reductions in continuing staff education (part of the cost-containment strategies of health care reform) and increasing demands on bedside nurses make it difficult to implement any comprehensive programs in practice settings. Yet, pleas from participants for more educational opportunities and safe forums for discussions regarding issues

of culture, *race*, and difference, for example, point to the need for formal and informal education. This need, though, is qualified by previous experiences recounted by participants that suggest that nurses are typically suspicious of inservice education that promotes "culturally sensitive care" because of interpretations that these efforts are directed toward making them aware of their shortcomings and discriminatory attitudes, and thereby inducing guilt. In response to this type of milieu, certain recommendations are offered. First, educational sessions are needed to provide opportunity for open dialogue regarding the challenges of intergroup health care provision and to provide information regarding some of the complexities and contradictions inherent in intergroup relations. Skilled facilitators will be required who are able to create safe environments in which frank but respectful discussions can occur. These facilitators may be clinical educators if they are qualified to address the issues, or other guests (e.g., community representatives from agencies who offer workshops dealing with diversity, or guests from academic institutions). Second, this study suggested that the role played by "champions" who are passionately committed to matters of diversity and intergroup relations is critical to envisioning health care environments that provide respectful care to all, and the implementation of key policies and programs having to do with diversity. Hospital administrators should consider who these "champions" are (they may be in formal positions, or may be informal leaders with interest and commitment) and involve them more directly in the day-to-day provision of intergroup care. For example, if a nurse leader with such a commitment to these issues was given the portfolio of diversity (e.g., as diversity resource nurse or diversity clinical nurse specialist), he or she could provide invaluable guidance and leadership in offering educational sessions and providing informal consultations in difficult situations. In her/his interactions with health care providers, a nurse leader in this position (as well as those leaders in other management and education

positions) might well foster critical consciousness by taking a non-threatening, non-blaming

stance that nonetheless raises for examination common attitudes, practices, and discourses that

contribute to racializing or inequitable health care. In my own experience in this project, I found

that the careful posing of questions in certain situations guided nurses to a level of reflection that

allowed them to begin questioning some commonly-held assumptions and practices.

In conclusion, the fostering of critical consciousness can occur in a range of settings and

by a variety of strategies. However, it will not occur without careful attention and deliberate

action. Interestingly, the efforts to promote critical consciousness suggested here are not that

unlike those proposed within current discourses on reflection, reflective practice, and critical

thinking (Atkins & Murphy, 1993; Brookfield, 1991; Palmer, Burns, & Bulman, 1994;

Richardson, 1995). All incorporate notions such as identifying and challenging assumptions, and

imagining and exploring alternatives for changed practice, but place varying degrees of emphasis

on matters such as the contexts of nursing practice. What I am recommending here in the form

of critical consciousness is aimed specifically at uncovering the social structures and processes,

such as racialization, that marginalize certain groups of people. Moreover, critical consciousness

is praxis-oriented in the critical sense of being committed to bringing about social change toward

emancipatory ends. In today's nursing education marked by "curriculum revolutions" and

"caring curricula", the critical consciousness and praxis envisioned here may not necessarily be

easily incorporated, especially when conflict is introduced in a deliberate fashion. Although the

trend in nursing education is to purport praxis and transformative knowledge, several scholars

have concluded that the relativistic, humanistic underpinnings of these claims tend to depoliticize

the intent of the "revolution" and make critical challenge of discriminatory attitudes or

hegemonic structures more difficult (Mulholland, 1995; Varcoe, 1997b). Therefore, it seems

unlikely that the implementation of these recommendations will occur without astute political

insight, careful planning, and considerable effort.

Facilitating Connected Care

Several further recommendations can be made regarding the nature of the intergroup

nurse-patient encounters. Connected care, with human-to-human engagement, is held out to

nurses as an ideal to aspire toward. In making these connections, two extremes must be avoided:

the first being that of discounting or overlooking the material ramifications that result from being

disadvantaged and excluded due to one's historical positioning, in essence taking an

individualistic, acontextual approach. The second extreme results in an overemphasis on culture

and *race* that sees a patient's "difference" (e.g., the visibility of "difference" or the absence of

English) at the forefront, and decision-making on the basis of stereotypical knowledge and

assumptions. Instead, interpretations of the data suggest a call to each health care provider to

seek human connection with patients that is a) based on a respect for the inherent dignity and

uniqueness of each individual, b) involves the suspension of judgment or assumption, and

c) accounts for the ways in which each individual is inscribed by his/her social positionings. In

this way, a nurse approaching a patient who does not speak English acknowledges the patient,

connects with him/her through appropriate body language[99] (e.g., gestures, touch, eye contact,

kind and empathic facial expressions), and thus communicates that she/he is present for the

patient. Of course these non-verbal expressions do not preclude seeking interpretive services but

communicate the basic regard that is essential to connected care. Neither does the approach of

connected care deny the importance of culture and *race* in shaping health care experiences.

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[99] In suggesting non-verbal communication strategies, the emphasis needs to be placed on those strategies that are culturally appropriate. Thus, the nurse needs to remain alert to gestures or strategies that might be offensive to patients from diverse backgrounds.

Rather, the nurse understands individuals as inextricably shaped by their social histories and therefore draws on her/his knowledge regarding culture, *race*, and health. This knowledge is not a taxonomic listing of the preferences and practices of certain "cultural groups", but rather an understanding of how patients may be disadvantaged, stereotyped, and marginalized on account of their "culture". That is, the nurse actively reviews patient circumstances for indications of how hospital services might not be appropriate, and how their life situations (e.g., group history, poverty) may place them in disadvantaged positions. Moreover, through the enactment of critical consciousness as described in the foregoing section, the nurse analyzes his/her encounters with patients in order to understand how the contexts of connected care are imbued with power and how each interaction is therefore organized by relations of power. As Tang and Anderson explain, "Instead of assuming the clinical context as 'equal' or 'value free', the practitioner also needs to examine how power differentials and the dynamics of the healthcare encounter influence the process of healing that the patient experiences" (1999, p. 92).

It is this added dimension of critical consciousness and awareness of possible influencing factors that makes respectful connected care distinct from nursing's more general call to caring (e.g., Leininger, 1981; Watson, 1979, 1985) or presencing (Parse, 1992). Yet, some of the critiques regarding the implications and limitations of the caring literature may also apply here. Liaschenko (1997), for instance, has reservations about possible intrusiveness and even surveillance associated with a nurse's desire to "know the patient". She also observes that resulting knowledge may unnecessarily complicate nursing practice, but concludes that attentiveness and heartfelt listening are important in maintaining a patient's sense of integrity during the illness experience. Halldórsdóttir (1997), drawing on her research that elicits patient perspectives regarding care, tells us that along with competence and connection, patients value a

professional distance that keeps the nurse-patient connection within the professional domain. These cautions, then, are kept in mind in this recommendation for connected care.

I have also argued that connected care is dependent on much more than a nurse's good will, skill, or motivation. Connected intergroup care is equally influenced by contextual factors such as administrative support, clarity of policies, and availability of resources. This study clearly demonstrated the centrality of administrative support generally and in regard to intercultural care specifically, constantly "read" by participants, in facilitating connected care and ensuring safe work environments for nurses. As Bhimani and Acorn (1998) recommend, "managers must set the tone for the organization and hold a firm belief in diversity as an organizational strength. Commitment is needed that comes from the top of the organization" (p. 35). Support, therefore, must be evidenced by individual managers (e.g., in their attention to harassment issues), and by the agency's allocation of resources (e.g., interpretive services).

The matters of resources and services are particularly salient to the facilitation of connected care. As pointed out by one participant, there are certainly "low budget" changes such as signage and increased choices by nutrition services that communicate moves toward inclusivity rather than exclusivity. The case of interpretation services, a larger fiscal commitment, requires clarity regarding organizational commitment and policy intent, and then a coordinated implementation of services that includes staff education regarding the appropriate usage of these services. In particular, health care providers should to be made aware of the advantages of using trained interpreters, and the potential limitations of using family members as translators. Trained interpreters should be available to hospitals on a 24-hour basis. Practically, this might be facilitated by having main language groups represented by professional interpreters (on-site during peak hours and on-call during night hours), complemented by telephone

interpretive services (such as that offered by AT&T) employed for less common language groups. Collaboration and cost-sharing among health care agencies in the provision of these services is likely more easily accomplished now due to regionalization.

While both hospitals in this study had organizational policies (referred to as "noble statements") regarding diversity, implementation of the intent of these policies at the bedside (i.e., in connected care) was not consistent. Because of the many factors contributing to this policy-practice gap, no one simple solution is likely. Besides the obvious allocation of increased resources (e.g., for staff education, improved services, and so forth), it seems to me that the policy-practice gap might be narrowed by closer attention to where decisions are made and the processes of policy implementation. Several participants indicated that they felt removed from decision-making in the organization (with managers saying "well, I'd be the last to know"), suggesting fairly centralized decision-making. My recommendation would be, therefore, to include increased representation from front-line staff[100] on key decision-making bodies, especially those committees and/or task forces having to do with issues of diversity. Such representation would also assist in implementation of policy, especially if those assigned to committees are "informal leaders" on their respective units. There is a convincing body of literature in the research utilization domain that points to the effectiveness of informal leaders (also referred to as "opinion leaders") in implementing clinical policies (Lomas et. al., 1991; Lomas, 1993). I turn in the next section to the matter of challenging nurses' work environments.

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[100] By front-line staff, I mean nurses employed in staff nurse positions, not those in related clinical positions such as unit managers or clinicians, although their contribution is also important. The involvement of front-line staff on committees would require release time from their other duties, which would stand as another indicator of an organization's support and good intention.

Challenging Work Environments

The interpretations of this study uncovered the many impediments to connected care embedded in the nature of nurses' work. Functional orientations, the organization of nursing care delivery, and biomedical dominance work together to bring about disjunctured care. Nurses also described their work as "heavy" to the extent that they "just do the basics". The embodied nature of nurses' work, patient acuity and "off-service" patients, the nature of current health care priorities, and the availability of clinical resources contribute to nurses' increased workloads. Many of these factors are the direct result of health care restructuring; other factors pre-existed this recent trend, but have been exacerbated by it. Although not the focus of this study, gender subordination, the hegemony of biomedicine, and the struggle to professionalize also contribute to disjunctured care and increased workloads.

Having identified these structural factors, how might we increase the agency of nurses, as individual practitioners and as a profession? My sense was that the primary issue here is not one of commitment; nurses, by and large, desire to provide connected care, but feel they are prohibited from doing so by the nature of their work. I believe that nurses must claim (or reclaim) agency, claim voice in resisting these work environments. Working together with representatives from their professional associations and unions can facilitate this. Certainly, even "simple" strategies such as claiming overtime and completing unsafe work condition forms are ways of resisting. Having said this, it is understandable, in light of the downsizing and job insecurities of the past decade, that nurses have been hesitant to resist. Notably, the inculcation of critical consciousness among nurses discussed earlier is important in bringing about agency.

Administrators are now faced with the opportunity to improve work conditions for nurses, and in turn, quality of care for patients[101]. While vast infusions of monies are not likely (nor would it be responsible to call for an inordinate increase in resources), there are several recommendations to be made that require only modest resources. First, increased clinical support positions would help to reduce workloads and disjunctured care. The employment of more clinical educators and/or clinical resource nurses would provide front-line nurses with more immediate support and education. These clinical educators/clinical resource nurses are especially important in providing support to beginning practitioners and inexperienced nurses. Furthermore, the re-instatement of nurse leaders who directly supervise patient care is also recommended for the sake of decreasing fragmented care and offering clinical support to nurses, especially those with less experience. Second, current staffing patterns should be re-evaluated. Because of the negative effects of casualization, more full-time positions must be re-created. As well, although 12-hour shifts are popular with many nurses, I suggest that discussions be initiated on units regarding the possibility of implementing more 8-hour shift rotations for RNs for the sake of increased continuity of care. Third, while I believe that primary care is likely the best delivery system to ensure holistic care, it is not realistic to suggest the widespread implementation of this more expensive model. However, modified systems of primary care where a RN and LPN work together with clear communication may also reduce the effects of disjunctured care. With the delegation of nursing tasks that such arrangements entail, RNs and LPNs alike should be provided with clear guidelines as to safe delegation. Finally, the added workload implications associated with non-English speaking patients must be addressed in a more open and equitable manner. As explained earlier, while technology-based interventions

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[101] Ironically, the recent renewal in concern for work conditions is driven predominantly by the nursing shortage and the need to retain and recruit nurses, not by a realization that downsizing and restructuring has "gone too far".

(e.g., epidurals, central lines) are easily defended and incorporated into workload measurement indices, it seems there is a certain reticence to formally account for the workload inherent in providing care across language barriers. It may be that health care planners and providers see this as a particularly delicate issue, one in which stigma may be attached to non-English speaking patients, or one in which favoritism for these patients or even racism may be perceived by English speaking individuals. Regardless of the reasons underlying this hesitation, the reality of increased workload associated with language requires attention in order to achieve connected care for these patients.

Our professional associations and unions have been active in resisting the trends that have contributed to current conditions, and must continue their efforts. Because front-line nurses were generally not that familiar with professional standards of practice and the options available to them through which to voice concerns, it seems that the associations and unions should put further effort into educating nurses, especially through a network of active workplace representatives.

Finally, senior level administrators and policy makers (at hospital, regional, and provincial levels) should be kept informed of current conditions and their associated outcomes, and challenged to address the shortcomings of today's health care delivery. The trends toward increased bureaucracy and centralized decision-making make such communication more difficult, but more representation of nurses on boards, committees, and other bodies making policy and operational decisions affecting health care delivery is one way to bridge this gap. Moreover, the difficult challenge set out to these senior health officials is to develop policies based on evidence and research, rather than on trends and political agendas. This shift will require clarification of the objectives driving health care (i.e., is our priority to provide efficient

care at any cost or is it to provide equitable health care that attends to health outcomes) and a corresponding re-alignment of priorities, as reflected in policy statements and resource allocation.

In summary, when taken together, these recommendations remind us of the importance of creating work environments that foster safe patient care and nurse satisfaction. This study has clearly uncovered the interconnectedness between conditions of nurses' work and their ability to provide connected care. It is time for health care administrators to carefully consider their priorities, and bring forward the imperative of creating environments that promote connected care, and in turn, satisfied nurses. This shift in priorities is particularly apt in light of the nursing shortage now upon us. As indicated in Chapter Six, hospitals should strive toward the following characteristics common to "magnet hospitals": autonomous practice, recognition of clinical expertise, nursing leadership, support for continuing education, supporting beginning practice, use of a primary nursing care model, flexible scheduling, and nursing staff development (CNA, 1998). With improved work environments, nurses will be in a better position to provide the type of connected care they are committed to and that results in improved quality of care for all patients. Additionally, nurses at all levels must claim agency and attend to their professional obligations to serve public interests and promote the common good (Starzomski & Rodney, 1997). And, in light of the evidence that the marginalized members of society are those most disadvantaged by current health care changes, nurses must advocate actively on their behalf. As nurses committed to social justice become engaged with policy development, a more informed, just approach to policy development will ensue.

Confronting Racializing Practices and Discourses

This discussion remains incomplete without more specific recommendations regarding the racializing practices and discourses uncovered in this study. The efforts toward fostering critical consciousness described above are essential, especially because many of the racializing practices and discourses tended to go unnoticed, and were, for the most part, not intending racial discrimination in an overt or deliberate sense. Yet, the results remain damaging. Each nurse ought to examine his/her own tendencies to stereotype and operate on unfounded assumptions. The most critical form of self-awareness will be that which explores the ways in which one's social positioning influences one's participation in intergroup relationships.

As well, this study revealed a widespread hesitation to speak openly about matters such as "difference", racism and discrimination. This hesitation likely stems from the current milieu of "political correctness", as well the assumption that Canada is a tolerant, multicultural nation. More open dialogue is required to raise to the surface the experiences and underlying values related to intergroup interactions. This dialogue might be facilitated through small forums that allow for safe exploration of feelings and opinions (as discussed earlier in this chapter) but also confront racialized constructions, more open presentation of anti-racist materials in hospitals, and role modeling by nurse leaders.

In other situations, discriminatory and racialized discourses were obvious and without apparent reservation. Administrators at every level must evidence clear commitment to the establishment of respectful, harassment-free work environments. Further attention should be devoted to the implementation of anti-harassment policies. Clear standards regarding what constitutes harassment, with well-laid out responses, must be widely circulated in health care settings. Then, when racially-motivated harassment occurs (e.g., White patients harassing nurses

of Colour), front-line nurses and managers alike can confidently respond in a consistent fashion to confront such actions. Cohen recommends "a rule of proportional response" (1992, p. 97). If people use racist language to actively intimidate or disadvantage members of ethnic minorities, he suggests that it is appropriate to apply whatever sanctions are required to stop such behaviour. When racializing humor, stories, or images are invoked as a "device of social closure" to exclude minorities, he recommends that educational strategies be employed to counter such discourses.

The suggestions made thus far regarding the confrontation of racializing practices and discourses are fairly specific and could be understood as aimed at a micro level. However, remembering my earlier emphasis on the importance of multi-faceted approaches, I broaden the discussion here under the rubric of confronting racializing practices and discourses with some concluding comments regarding the general task of bringing about transformative change in health care settings. While colonizing tendencies may no longer be as blatant as previously, the continued dominance of English, the resistance to incorporation of diverse healing practices, and the general trend toward Othering those who are not constructed as belonging to mainstream Canadian population made visible in this study must be challenged in order for a health care system to emerge that is truly pluralistic at its core. The challenging of such colonizing practices requires insight at individual levels into one's own collusion in the reproduction of unequal social relations, as well as broad-based revamping of system structures that routinely perpetuate existing patterns of advantage and disadvantage.

In this study, I have made links between capitalist agendas, Eurocentric assumptions, health care reform, and connected care, and have presented in this last chapter both general directions for theorizing and research, as well as more specific policy and practice recommendations. I have drawn on critical social theories in order to illuminate the social

processes involved in intergroup relations in health care provision and see the frameworks provided by such theories as central to any project of challenging existing practices and structures that systematically disadvantage those in marginalized positions. Ultimately, the long-term project of bringing about change begins with the uncovering of that which ails the health care system and prohibits connected care. Careful theorizing, including global economic and political analyses thus becomes an important first step in bringing about transformative change (Anderson & Rodney, 1998), through its contributions of uncovering exclusionary practices, discourses, and structures, by opening up alternate visions for health care, and by its more concrete equipping of individuals to become advocates and change agents. Practice sites such as research, pedagogy, and policy formulation then become locations where change can be addressed at a more tangible level. Although individual change is important, collective energies must also be directed toward identifying, challenging and ultimately dismantling those aspects within the health care system (often fueled by capitalist agendas, Eurocentric assumptions, and constructions of a "White" Canada) that contribute to racialized health care practices and inequitable health outcomes.

In conclusion, this study has explored the social organization of intergroup relations in health care provision. The findings illuminate the complexities of intergroup relations and demonstrate how the construct of *race*, intersecting with gender, class, nation, age, and religion, operates in health care settings to shape day-to-day health care provision. The study has also brought to light how organizational and societal contexts of health care mediate intergroup relations. The study, thus, provides direction for promoting intergroup relations and health care provision that are marked by respect and connectedness, and offers a vision of transformed health care practices and structures.

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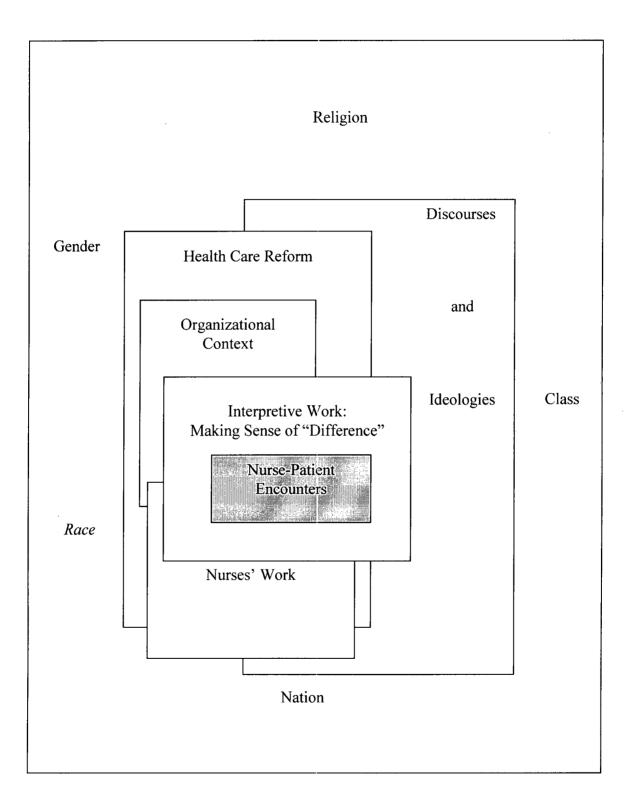**Appendix A**

Definitions of Key Terms

Definitions of Key Terms

Culture: The shifting, complex, and socially constructed system of ideas, values, beliefs, and way of life of a group of people who share a certain historical, religious, racial, linguistic, ethnic, or social background (Allen, 1996a; Fleras & Elliott, 1996; Henry et. al., 1995).

Discrimination: The denial of equal treatment and opportunities; the enactment of prejudice in the form of denying or excluding a person because of that person's inclusion in a socially devalued category (Fleras & Elliott, 1996; Henry et. al., 1995)

Ethnocultural Group: A community of individuals who hold an awareness of common identity on the basis of common ancestry, shared history, culture, or geographical origin. The salient feature of ethnocultural groups is the self-identification as a distinct people (Fleras & Elliott, 1996).

Hegemony: The situation in which certain social groups exert social authority over other subordinate groups by coercion and by winning and shaping consent in "common-sense" ways so that the power of the dominant groups seems natural (Hebdige, 1979).

Ideology: The system of ideas, often in the taken-for-granted realm, that attempt to explain, justify, legitimate, and perpetuate a specific set of circumstances; the ideologies of the groups in power are most likely to prevail (Fleras & Elliott, 1996; Hebdige, 1979).

Intergroup Relations: Those aspects of human interaction that involve individuals perceiving themselves as members of a social category, or being perceived by others as belonging to a social category (Taylor & Moghaddam, 1987).

Marginalization: The process through which persons are peripheralized on the basis of their identities, associations, experiences, and environments. Through differentiation, "mainstream" society is represented as at the center of a community, and those relatively excluded from power and resources are at the periphery (Hall, Stevens, & Meleis, 1994; Northway, 1997).

Oppression: The domination of certain individuals or groups by others through unjust use of power such as physical, psychological, social, cultural, economic force (Henry et. al., 1995).

People of Colour: A group of people who are non-Caucasian, non-White who generally lack access to power, wealth, or privilege compared with the dominant group (Fleras & Elliott, 1996).

Postcolonialism: The theoretical and empirical work that centralizes the issues stemming from colonial relations and their aftermath (Cashmore, 1996).

Prejudice: A mental state or attitude of prejudging, generally unfavorably, by attributing to every member of a group characteristics falsely attributed to the group as a whole (Henry et. al., 1995).

Privilege: The benefits and advantages enjoyed and often taken-for-granted by those belonging to dominant groups.

Race: The socially constructed category used to classify humankind according to common ancestry and shared phenotypical characteristics such as skin colour. As a social construction, it is employed to reinforce unequal relations between dominant and subordinate groups (Fleras & Elliott, 1996).

Racism: The ideology, structures, and practices by which exclusions inherent in wider social structure are related, in a deterministic way, to biological and/or cultural factors attributed to those who are seen as a different *race* or ethnic group. Involves the exercise of power to deny or exclude those who belong to a devalued group (Essed, 1991; Fleras & Elliott, 1996).

Racialization: The political and ideological processes whereby certain groups are identified by direct or indirect reference to their real or imagined phenotypical characteristics in such a way as to suggest that the group can only be understood as a supposedly biological entity (Cashmore, 1996).

Appendix B

Design: The Social Organization of Intergroup Relations in Health Care Provision

Design: The Social Organization of Intergroup Relations

Religion

Discourses

Gender

Health Care Reform

and

Organizational
Context

Ideologies

Class

Interpretive Work:
Making Sense of "Difference"

Nurse-Patient
Encounters

Race

Nurses' Work

Nation

Appendix C

Letter of Information to Agency

Appendix D

Letter of Information to Nurses

Appendix E

Demographic Profile of Participants

Demographic Profiles of Participants

	Nurses	Administration	Patients
White	9	9	3
Person of Colour	11	1	2
Canadian-born	11	9	2
Foreign-born	9	1	3
Age			
> 65	--	--	2
51 – 65	9	3	1
41 – 50	3	5	2
31 – 40	6	2	--
25 – 30	2	--	--
Highest Education			
Graduate Degree	--	3	1
Degree	4	5	1
Diploma	16	2	--
High School	--	--	2

Appendix F

Research Time Line

Research Timeline

PHASE	DATE	ACTIVITY
Preparatory Phase of Field Work	April 15, 1998	Successfully defended Dissertation Proposal to UBC Committee
	May 26, 1998	University Ethics Approval
	June 12, 1998	Site A Ethics Approval
	October 23, 1998	Site B Ethics Approval
First Phase of Field Work (Site A)	June 1998 – January 1999	Field Work Unit #1. - 16 interviews - 37 field visits
	October 1998	Initial Conceptual Structure
	October 1998 – February 1999	Field Work Unit #2 - 11 interviews - 18 field visits
	February – March 1999	Formal Analysis of Field Work Site A
Second Phase of Field Work (Site B)	March – May 1999	Field Work Unit #3 - 8 interviews - 10 field visits
Total Field Work Hours: 220		
Analysis	June – November 1999 December 1999 – January 2000	In-depth Analysis and Writing Final Revisions to Dissertation
Dispersal Phase of Field Work	June - ongoing	Conference Presentations (February 1999, June 1999, February 2000, April 2000)
	February 2000	Present study results to nurses in Site A (10 sessions)
	April 2000	Present study results to nurses in Site B (4 sessions)

Appendix G

Interview Guide

Interview Guide

Questions For Nurses:

Tell me about what a typical day is like for you.

How would you describe the patient population on this unit?

Tell me about what it is like for you to care for clients from a variety of ethnocultural communities.

What influences you in intercultural health care? What helps? What makes it more difficult?

How would you describe intercultural health care provision on your unit? In your hospital?

How do the qualities of this unit influence your provision of intercultural care?

How does the larger hospital environment influence your provision of intercultural care?

How does the community environment influence your provision of intercultural care?

What health care policies influence your provision of intercultural care?

What are some issues to be considered in delivering health care in an intercultural situation?

What do you think it is like for patients from ethnocultural communities to be hospitalized?

How do you think your ethnicity/culture shape the way you provide nursing care?

Questions For Patients/Families:

What has your time in the hospital been like?

What have been your feelings and ideas about your health care?

What happens in terms of health care and getting taken care of?

Do you always understand what is said to you and what is happening with your care?

Is there anything you are not getting that you think you should be getting?

Do you think there are people who have special difficulties in the hospital?

Prompts:

Can you tell me more...

In what way....

So what you're saying is....

What were you thinking when that happened....

What was that like for you....

Appendix H

Biographic Forms

Nurse Biographic Form (Confidential)

Name: _____   Code #: _____

Site: _____   Code #: _____

Unit: _____   Code #: _____

2. Education: _____ (Diploma or Degree)

   School(s) of Nursing: _____

3. Employment: Full-time _____
                  Part-time _____   Hours/Week _____
                  Casual _____   Hours/Week _____

   Title of Current Position _____

   How long have you been in this nursing position? _____

   Previous Experience in Nursing: _____

   _____   _____

   _____   _____

   _____   _____

   _____   Total Years: _____

4. Where were you born? How would you describe your heritage?

   _____

   _____

5. Age: 20 - 25 _____   26-30 _____   31-40 _____   41-50 _____   Over 50 _____

6. Mailing Address and Telephone: _____

   _____

Patient/Family Information Sheet

Name: _____   Code #: _____

Site: _____   Code #: _____

Unit: _____   Code #: _____

Sex: _____

1. What is the reason for your hospitalization? _____

2. Where were you born? _____
   How would you describe your heritage?

   _____

3. What language are you most comfortable speaking? _____

4. Age: 20-29 _____ 30-39 _____   40-49 _____   50-59 _____   60 - 69 _____
   Over 70 _____

5. What is your occupation? _____

6. What is your education? _____

7. In what range does your family income fall?
   < $19,999   _____
   $20,000 - $39,999   _____
   > $40,000   _____

8. Mailing Address and Telephone: _____

   _____

   _____

Appendix I

Consent Forms

I understand that if I have any concerns about my rights or treatment as a research participant, I may contact Dr. Richard Spratley (822-8598), Director of the University of British Columbia Office of Research Services and Administration.

My signature below shows that I have agreed to be in the study and that I have received a copy of this consent and an information letter about the study.

_____ Signature of Participant   _____ Date

_____ Please print your name

_____ Signature of Researcher
Sheryl Reimer Kirkham

Appendix J

Transcriptionist's Consent Form