

**THE SOCIAL ORGANIZATION OF HEALTH CARE EXPERIENCES OF  
NON-ENGLISH SPEAKING CHINESE IMMIGRANTS:  
NEGOTIATING CULTURAL AND LANGUAGE DIFFERENCES IN A  
CHANGING HEALTH CARE CONTEXT**

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## ABSTRACT

This study investigated the ways by which the health care experiences of non-English speaking (NES) Chinese immigrants are socially organized. Using discursive ethnography as a method of inquiry, interviews were conducted with 14 nurses and 10 patients of Chinese descent; participant observations were carried out to understand nurses' daily work; selected hospital policies were also reviewed.

The findings indicate that nurses were aware of and respectful of the differences in care needs among an increasingly diverse population. However, notions of culture, ethnicity, "race" and language were found to operate in hidden ways to shape nurse-patient interaction. Yet, the experiences of some NES immigrant patients in receiving "lesser care" could not be reduced to personal prejudice or the lack of sensitivity on the part of the nurse. Rather, there is an important *material context* that organizes how nurses might read and respond to "differences" in care needs among their patients.

The material context of health care speaks to the changing relations of resource allocation under restructuring. In the current health care context where there is a prime concern with budget containment, patient discharge has become an important administrative means for maximizing productivity and efficiency of the system. On the one hand, the biomedical and legalistic discourses work in tandem to facilitate patient discharge by prioritizing accomplishment of clinical tasks, such that the cultural and language needs of patients tend to be rendered as low priority. On the other hand, clinical protocols and pathways hasten patient turnover and shorten hospital stay by standardizing patient care; standardization could in turn bring about an increase in workload among nurses. Expecting nurses to respond to differences in care needs without adequate

resources could result in feelings of frustration among nurses, and compromise their ability to provide adequate care across cultural or language barriers.

Although financial prudence is a legitimate goal of health care restructuring, findings of this study alert us to the potential conflict between achieving the economic interest of budget containment and providing equitable care to those patients who do not “fit into” the system because of their cultural and/or language background.

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## **CHAPTER ONE: INTRODUCTION**

### **Background to the Study**

Canada is recognized as a pluralist country. In addition to the Aboriginal peoples who are the original people in Canada, the Canadian mosaic is made up of immigrants coming from different ethnic and language backgrounds. As Canada has a low birth rate and an aging population, immigrants continue to make up an increasingly significant proportion of the Canadian population. As in other immigrant receiving countries in the Western world such as Australia, Britain and the United States, immigration has brought about significant demographic changes to Canada.<sup>1</sup>

Immigration patterns to Canada have changed drastically in the past few decades. In contrast to earlier immigrants who were predominantly from a European background, recent immigrants to Canada are mostly coming from outside of Europe. In 2002, for instance, the top five source countries of immigrants to Canada were China, India, Pakistan, the Philippines, and Iran. Immigrants from these countries made up about 40% of the total number of immigrants to Canada in that year (Canada, 2002a). In conjunction with ethno-cultural diversity, we also need to consider the different language backgrounds of newcomers to Canada. Almost half of the people who immigrated to Canada in 2002 were neither English- nor French-speaking (Canada, 2002a).

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<sup>1</sup> In the 1996 census, it was found that 11.2% of Canadians were neither white nor Aboriginals, a figure that has doubled in just 10 years (Mitchell, 1998). Among the visible minorities in Canada, the Chinese make up the single largest group. In Vancouver, for instance, about 15% of the population in 1996 was Chinese in origin. These trends in the 1990's continue into the 2000's. Among the 164,200 immigrants aged 15 years and older who arrived in Canada between 2000 and 2001, 68% were born in Asia, with China as the largest source country of immigrants to Canada. Toronto, Vancouver, and Montreal continue to be the preferred cities for immigrants, absorbing three-quarters of the immigrants arrived in Canada between 2000 and 2001. According to the 2001 census, the top five mother tongue languages spoken by people in Vancouver were English, Chinese, Punjabi, Tagalog, and Vietnamese.

In a multi-cultural society such as Canada, changes in the ethno-cultural and linguistic makeup of the population have important implications for the organization and delivery of public services such as health care. Specifically, cultural and language differences play an important role in shaping the health care experiences of immigrants in accessing and utilizing health care. In an earlier report, *Mental Health Issues Affecting Immigrants and Refugees* (Canada, 1988), it was noted that many migrants were reluctant to use formal mental health services because they perceived that “mental health therapists do not provide culturally and linguistically appropriate treatment” (p.36). In the province of British Columbia, the *Closer to Home Report* (British Columbia, 1991) has found that “many people of minority ethnic background are not using existing [health] services because those services are not culturally responsive or *accessible* to them” (p.C-36). This problem persists at the same time that immigrants continue to arrive and the population in Canada continues to increase in its ethno-cultural and linguistic diversity. According to the *Second Report on the Health of Canadians* (Canada, 1999), “there appears to be persistent language and cultural barriers to the provision and/or the utilization of health services in certain circumstances” (p.145). In other words, although health care is universally available to all Canadians through a publicly funded health system, some groups such as immigrants experience barriers to accessing and utilizing health care.

In light of these issues, health professionals and policy makers have been called upon to respond to the diverse cultural and linguistic needs among health service users. For instance, policy recommendations have been made urging health care institutions to adopt an inclusive and culturally sensitive approach to planning and delivering health services (see, for example, British Columbia, 1995). Initiatives have also been

implemented to enhance organizational change and to create partnerships among agencies in developing and implementing programs such as interpreter services (see, for example, *Health Care Interpreter Partnership Project, 1996; Multicultural Change in Health Services Delivery Project, 1997*). The federal government has also commissioned a report to review existing literature on the problem of language barriers in Canada (Canada, 2001).

At the same time that demographic changes in the population are taking place, the Canadian health care system is also being restructured. Health care reform has been an ongoing movement in different provinces in Canada for over a decade, and must be understood as an economic necessity as much as a desire to improve the existing system. In British Columbia, for instance, the Commission on Health Care and Costs has framed the necessity to reform health care by restraining health care expenditure within a stagnating provincial economy in the 1980s and 1990s (British Columbia, 1991). Efforts by the provincial government to contain health care costs continue into the 2000s, as health care expenditures continue to rise against economic downfall (British Columbia, 2001). At the national level, the final report of the *National Forum on Health* (Canada, 1997) stressed not only the desirability but also the economic necessity of improving the Canadian health care system by utilizing existing levels of spending more effectively and efficiently. Proposed actions for reform include shifting the emphasis from institutional to non-institutional care.

Even though the drive behind health care reform is to improve the existing health care system without compromising the basic principle of equitable access to quality care by all Canadians, health care providers and consumers report predominantly negative

experiences and perceptions of the process of restructuring. Specifically, health care restructuring has been translated into experiences of more stringent resources in terms of staff shortage, longer waiting lists, and increased workload in the immediate context of the health care encounter (Laschinger, Sabiston, Finegan, & Shamian, 2001).

### **Central Problem**

Changing economic relations or, more specifically, the problem of resource allocation in the Canadian health care system, have important implications for understanding the health care experiences of immigrants in at least three ways. First, as the health care budget gets tighter, priorities for services inevitably shift and competition for resources becomes more fierce. This affects diversity policies such as provision of interpreter services for non-English speaking patients, particularly when there is “deep-seated” resistance to changing the cultural and linguistic domination of hospitals as Eurocentric, middle class, and English-speaking institutions (Reimer Kirkham, 2003). It is important to note that in Canada, neither uniform policy nor legal liability are attached to the provision of interpreter services for patients not conversant in the official language(s) (Canada, 2001). In other words, implementation of policy for interpreter services is subject to the discretion and allocation priorities of individual institutions. Under the pressure of budget constraints, provision of interpreter services for NES patients could be compromised in an institution (Lynam et al., 2003).

Second, although the rhetoric of restructuring claims to be streamlining the system and moving towards efficiency, and thus making the system better, experiences of increased workload among health care providers could have specific negative implications for the quality of care that immigrants receive. Providing care for and

communicating with the patient across cultural and language differences can be time consuming. Even when interpreter services are available, finding and using interpreters adds to the time pressures of nursing staff already facing an increased workload (Lynam et al., 2003). According to the *Closer to Home Report*, “[t]his creates a reluctance among health care providers to deal with immigrant people” (British Columbia, 1991, p.C-37). Moreover, tension in the health care encounter with immigrants can be compounded by issues such as racism, “as the workforce and society become increasingly racially mixed” (British Columbia, 1991, p.C-37).

Third, the trends of health care restructuring, such as increased privatization and shifting of care from formal to informal care-givers, can influence some immigrant populations unfavorably, such as those who are non-English speaking. As newcomers to Canada come from various backgrounds, some may be unfamiliar with the health care system and the different services it provides, and therefore could be at a disadvantage negotiating with health care providers and getting the help they need once discharged from the hospital (Lynam et al., 2003). Expectations that non-English speaking (NES) patients will provide their own interpreters by using family members or friends means that the interpreter has to bear the economic cost of providing interpreter services to the patient on their own time, time that a wage-earner often cannot afford. Such an economic burden on the family or friend acting as an interpreter could mean that the NES patient either misses medical appointments, or seeks and utilizes health services without an interpreter and the benefits of adequate communication. Thus, although health care restructuring affects all Canadians, it is likely to affect immigrant families of lower socio-economic status more unfavorably. This is an important point to consider, as it has been



found that immigrants, especially recent immigrants, tend to concentrate at the lower strata of the labor force despite their occupational experience and educational background in their home countries (see, for example, Chui, 2003; Frenette & Morissette, 2003; Picot & Hou, 2003).

Thus, while changes in the health care system such as increased workload and longer waiting lists are immediately noticeable, the implications of restructuring on the health care experiences of immigrants are less visible, and tend to be glossed over by concerns such as economic effectiveness and system sustainability. In fact, health care restructuring affects all Canadians. However, we must pay attention to the differential impacts of restructuring on different populations, particularly those who have been marginalized and have experienced inequitable access to health services. This is important for ensuring that restructuring actually brings about positive changes for all, improving existing health services and preserving the core values of the Canadian Medicare system. Among these values are equity and universal accessibility based on need, rather than income, skin color, gender, sexual orientation, or other factors (Canada, 1997).

In light of the complex issues that health care restructuring brings to the clinical context, we need to examine the impact of restructuring on immigrants who have been found to experience inequitable access to health care due to factors such as language and cultural barriers. Specifically, we need to ask if health care restructuring and the changes it brings might further disadvantage immigrants in accessing and utilizing health care. This study is therefore designed to address this central problematic by asking the

question: *How are the experiences of NES Chinese immigrants socially organized under health care restructuring?*

### **Research Objectives**

In order to answer the research question as stated above, this study aims to meet three objectives:

1. Understand the experiences of NES Chinese-Canadians in seeking and utilizing health care;
2. Understand the experiences of nurses in providing health care to patients coming from a NES and/or non-dominant ethno-cultural background; and
3. Explicate those institutional processes that socially organize health care delivery to NES immigrant patients in the context of health care restructuring.

### **Locating “Experience” and the Lens to Reading this Study**

Before going on to further explicate the theoretical and methodological background to this study, I would like to clarify the lens that I am using in entering this research so that the reader understands the implications of my point of location.

Although this study focuses upon understanding the health care experiences of NES Chinese immigrant patients, its purpose is not to describe experience per se. Rather, experience, as conceptualized in this study, is the methodological point of entry for investigating the ways that everyday life is socially organized. Thus, analysis does not stop at describing what people tell us, and readers of this study should not consider *description of experiences* as the “end point” of analysis. Rather, analysis in this study aims towards explication of those larger relations that socially organize actions, experience, and access to resources in the everyday.

As members of the same society and in fact of the same world, none of us is immune from global economic forces and their relations of policy and allocation decisions. Because experience cannot be reduced to individual choice or intentions alone but is invariably organized by those larger relations at the extra-local or local level, each of our experiences no matter how diverse they might appear, provides an equally “valid point of entry” into the process of social organization that is immanent in our everyday world but may be invisible to us in the mundane ways by which we do our business.

Thus, the inclusion of only patients of Chinese descent into this study is not about privileging their experiences as “representative” of the experience of all Chinese patients; nor are their experiences used to “generalize” to the experience of immigrants from other ethno-cultural backgrounds. Rather, the experience of NES Chinese patients provides, at the theoretical level, *one point of entry* into understanding something of the ways by which health care is socially organized for immigrants.

In fact, in-depth exploration of the health care experiences of patients coming from a NES background requires sufficient language proficiency on the part of the researcher to communicate effectively in the language of the participants. My fluency in both Chinese and English allows me entrance into the experience of patients who are Chinese speaking, and indeed represents one of the strengths of this study and an opportunity for this study to make an important contribution to existing knowledge. It is by engaging in analysis of the experience of those patients who are NES that we can provide one critical point of entry for understanding the ways that our world is socially organized for different populations within a society such as Canada. The experiences of those who speak the dominant language have arguable been privileged in mainstream

academic construction of our social world because fluency within that language has been a “hidden criterion” for inclusion in so much of what we have studied. Thus, in its small way, this study represents one unique entry point from which we can begin to reflect upon and interpret potentially hidden elements of the social world as experienced by a particular social group, and thereby to deepen our knowledge about the implications of the process of social organization.

### **Organization of the Dissertation**

This dissertation is organized as follows. To begin, selected literature is reviewed to examine some major changes in Canadian immigration policy, Multiculturalism in Canada, the discourse of culture in nursing, and the experiences of immigrants in the Canadian health care system. In Chapter Three, a thorough discussion of “discursive ethnography,” the methodology used in this study, will be provided. Chapter Four presents the methods used in this study, including negotiating access and recruitment, sampling, rigor, ethical considerations, data collection, and data analysis. The findings of this study are presented in three major sections in Chapter Five. These include a critical examination of the discourse of culture, explication of the changing relations of resource allocation in health care, and discussion of the implications of those changing relations on the health care experience of non-English speaking patients. After a critical interpretation of the findings in Chapter Six, Chapter Seven concludes this dissertation with a discussion of the implications of this study for nursing practice, education, research, and health care policy.

## CHAPTER TWO: REVIEW OF SELECTED LITERATURE

In the following, I review selected literature pertinent to the health care experiences of immigrants in Canada. First, I provide a historical context to the changes in immigration policy in Canada. This changing context is important for understanding immigration as a strategy for nation building through *selective* recruitment of immigrants according to the changing needs of Canada for labor and population growth. As changes in immigration patterns inevitably bring about demographic changes in the country, the Canadian government has seen the need to respond to a population no longer homogenous in its ethno-cultural and linguistic makeup. This has resulted in the introduction of the policy of Multiculturalism and later the Multiculturalism Act in Canada. As described in my review of the Multiculturalism policy (Canada, 1987), this policy is an important step towards acknowledging the diverse nature of Canadian society.

At the same time that governments in many immigrant-receiving countries began to make efforts to address and acknowledge differences in culture and heritage among its population, leaders in health care also began to pay attention to the notion of culture and its relevance for health care delivery. I have chosen to review the theory of transcultural nursing, developed by the nursing scholar, Madeleine Leininger, as an example of a culturalist approach to addressing the health care needs of an increasingly diverse population. I also examine some counter discourses in nursing and health care that demonstrate the limitations of culturalist approaches to health care. What these critiques seem to suggest is that culture, alone, cannot explain immigrants' experiences of health and health care. I substantiate this insight further by examining how immigrants' health

care experiences intersect with a complex of race, class, and gender relations that determine immigrants' access to life chances and resources in their host country, including health care. Focusing on the Canadian context, I review some research studies on immigrant health based around three themes: language barriers to accessing health care, immigrants' experiences of help-seeking and illness management, and quality of health care encounters in the changing institutional context of health care. As the changing context of health care has direct implications for the health care experiences of immigrants, I follow up on this important issue by examining health care restructuring in Canada, and its impact on nursing. This provides an important political and economic background for understanding how health care might be differentially organized for immigrants in a society that has been described as "raced, classed, and gendered."

### **Immigration Policy in Canada**

#### *Immigration Policy before 1967*

1967 was an important turning point in the history of immigration policy in Canada. It was in that year that Canada replaced its overtly racist immigration policy with a "points system" that eradicated "race," ethnicity, nationality, and other factors such as religion as the bases for selecting immigrants. Before 1967, immigration policy was largely driven by the goal to build and maintain Canada as a "white nation" (Canada, 2000). This was largely achieved, on the one hand, by favoring immigration of people from Europe and the United States, and on the other hand, by excluding people from non-White backgrounds from coming to Canada.

One example that illustrates the explicit racist nature of earlier immigration policy in Canada was its practice of open discrimination against the Chinese. The presence of

the Chinese dates back to the 1850s, when some Chinese traveled across the Pacific Ocean to search for gold, and many more were later recruited to work as laborers on projects such as the construction of the Canadian Pacific Railway (Henry, Tator, Mattis, & Rees, 1995). Although Chinese laborers received lower wages and often took up the most dangerous and arduous jobs, jobs not wanted by White workers, the White population saw the Chinese as threatening their social stability and economic interests. As public antagonism against the Chinese intensified, the Canadian government responded by passing legislation that openly entrenched racism and discrimination against Chinese immigrants. In addition to the 1885 Chinese Immigration Act, a "head tax" was also imposed on all Chinese immigrants as an attempt to deter them from coming to Canada. In fact, Chinese immigration was almost totally banned in 1923 by the Chinese Exclusion Act, which remained in effect until its repeal in 1947 (Li, 1998).

While the Chinese have probably suffered some of the harshest treatment in the Canadian history of immigration policy, people from other non-White backgrounds have also been subject to unfair treatment in their process of seeking entry into Canada. For instance, the Continuous Passage Act in 1908, which required all potential immigrants to arrive by an uninterrupted journey from their country of origin, rendered immigration by East Indians almost impossible as there was no direct shipping service between India and Canada at that time (Canada, 2000). The 1952 Immigration Act further excluded immigration by people from non-European backgrounds by granting the government the power to determine a person's eligibility for immigration based on factors such as nationality, ethnicity, and perceived ability to adapt to Canada's lifestyle (Canada, 2000).

Racist policy on immigration in Canada had to end in the face of a changing global economy and the need for population growth in Canada. As the number of immigrants coming from European backgrounds dwindled, and as the need for skilled labor rose, the Canadian government perceived an urgent need to attract immigrants from the otherwise “non-traditional” source countries, in Asia, Africa, and Latin America. It is to this end that Canada began radically reforming its immigration policy by introducing a non-discriminatory points system in 1967.

#### *The Points System in 1967*

The points system, instituted in 1967 and incorporated into the 1976 Immigration Act, was designed as a non-discriminatory system for the selection of independent immigrants based on their “human capital value” to Canada. In the points system, potential immigrants are evaluated and selected based on the total number of points that each earns in the designated categories, such as education, age, working experience, personal suitability, and degree of fluency in English and/or French. While the points system as a whole continues to constitute the backbone of subsequent immigration acts and regulations, the categories for assessment and their relative weight or importance are subject to re-definition according to the changing needs of Canada for skilled labor and human resources. In this sense, immigration policy continues to be an important strategy for organizing nation building by regulating who can come and live in Canada.

#### *Immigration and Refugee Protection Act 2002*

Since passing the 1976 Immigration Act, immigration policy in Canada has undergone two major rewrites and more than 30 amendments (Canada, 2002b). The latest change to Canada’s immigration policy was the Immigration and Refugee



Protection Act, which became law on June 28, 2002. This Act, which replaces the Immigration Act of 1976, set out to achieve at least two important objectives. First, it was a response to Canada's continuous need for population growth and skilled labor. In the context of a globalizing economy, the Canadian government recognizes that Canada is in fierce competition with other immigrant receiving countries such as Australia and the United States for the global pool of skilled workers. In order to enhance Canada's advantages in attracting immigrants with the skills that Canada needs, the new Act opens up the category of "skilled workers" to a broader range of potential immigrants. At the same time, the new legislation continues to target an annual immigration level of 1% of the Canadian population, a move essential for sustaining population growth in the country.

Second, the new immigration act was written and implemented against the political backdrop of a perceived need to secure the borders and public safety of Canadians. In public consultation about immigration, Canadians have expressed the concern that Canada's "open and generous" immigration system is subject to abuse by criminals and other people who might pose a threat to Canadian society. Thus, the new Act includes measures to deal with the growing phenomenon of human trafficking, by introducing severe penalties for smugglers and traffickers. While this new Act is part of the continuous effort to reform Canada's immigration policy since the 1990s, its passing in June 2002 was also a timely response to the rising threat of global insecurity after the terrorist attack in New York on September 11, 2001.

### **The Policy of Multiculturalism**

Multiculturalism, a term coined in Canada, has been official policy since 1971. Following its enshrinement in the 1982 Constitution Act as part of the Canadian Charter of Rights and Freedom, the ideal and value of multiculturalism was proclaimed law in the 1988 Canadian Multiculturalism Act.

Multiculturalism has been described as a “Canadian way of nation building” (Canada, 1987), in the sense that it has served as a model for building a harmonious society among people from diverse backgrounds. Built on the principles of “equality, diversity, and community” (Canada, 1987), the Multiculturalism Act aims to preserve and enhance Canada’s multicultural heritage. This is to be achieved on at least three fronts. First, the Act protects the right of all Canadians to equal treatment and equal protection before the law, irrespective of their racial, ethnic, religious and language backgrounds. Second, the Act stipulates the responsibility of government agencies, voluntary organizations, and so on, to implement the multiculturalism policy, by devising practices, policies, and programs that are sensitive and responsive to the multicultural reality of Canadian society. Third, the Multiculturalism Act sets out the goal of combating discrimination, so that all individuals can fully and equally participate in the economic, social, cultural, and political life of Canada.

Since its introduction in Canada in the 1960s, the concept of multiculturalism has gained currency on the international political stage, as most Western countries seek ways to manage what Hall (2000) has described as “problems of diversity and multiplicity which multi-cultural societies throw up” (p.209). As we continue to see in the following, the concept of culture has also become more salient in the health care discourse, as health

care providers try to respond to the different health care needs of people from diverse backgrounds.

### **Responding to Difference: The Discourse of Culture in Nursing**

As immigration patterns began to change in countries such as Canada, the United States, Australia, and the United Kingdom, health care disciplines have made efforts to respond to the changing health care needs of their increasingly diverse populations. One of the areas that have drawn the attention of health care providers is cultural difference between immigrants and their native born counterparts in the “host country.” Differences in culture are important to address because, as Kleinman and his colleagues (1978) remind us, there are different “explanatory models” of health and illness, with Western biomedicine as only one of the possible models. These explanatory models, which are themselves socio-cultural constructions, shape the ways we interpret disease and symptoms, as well as how we evaluate treatment and what we expect from care (Kleinman, Eisenberg, & Good, 1978). Each of us can draw on more than one explanatory model (professional or non-professional) in our daily living and health care encounters, but the ways that patients and health care providers perceive health and illness are likely to differ if they come from different ethno-cultural backgrounds (Anderson, 1987). Immigrants who are unfamiliar with the health services in their new country experience even greater discrepancies in perception and expectation of health care between themselves and health professionals (Waxler-Morrison, 1990). Thus, as Anderson (1990) argues, it is important for health care providers to recognize differences in perspectives of health and illness between themselves and the patient, and to bridge

that gap by trying to understand the patient's health care needs from his/her cultural perspectives and social backgrounds.

In the 1970s, the nurse scholar Madeleine Leininger introduced to nursing the importance of understanding and learning about the cultural background of patients, as she began to develop knowledge which she later called "transcultural nursing," in an attempt to address the important issue of cultural differences in the ways that people respond to health and illness. A transcultural approach highlights the importance of understanding the patient's perspectives in terms of the specific values, beliefs, and behaviors characteristic of the patient's culture. The premise of the transcultural theory is that "[a]ll human cultures had some forms, patterns, expressions, and structures of care to know, explain, and predict well being, health, or illness status" (Leininger, 1991, pp.23-24), whereby culture is defined as "the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways" (Leininger, 1991, p.47). Thus, research directed by the theory of transcultural nursing examines the cultural values and life patterns of specific cultural or ethnic groups. Examples include studies examining "the beliefs and perceptions of African American women towards hysterectomy" (Augustus, 2002), or exploring "the meaning of hope and the generic caring practices that nurture hope among villagers in a Spanish speaking culture" (Holt & Reeves, 2001). A transcultural approach to nursing practice focuses on the provision of "culturally congruent care," with activities focused on the patient's "emic perspective," through the acquisition of cultural knowledge about the patient.

Approaches such as transcultural nursing have opened up an important discursive space to include other ways of seeing health and illness, and it may be an important first step towards challenging the hegemonic culture of Western biomedicine as the only way to practice health care. But as we continue to grapple with issues of how to deliver equitable health care to the increasingly diverse populations in many immigrant receiving countries, we also need to question whether culturalist approaches, which focus upon culture as the core determinant to experiences of health and illness, are adequate for addressing the complex issues that immigrants (and ethnic minorities) face in accessing health and health care in their "host country."

At least two major issues have been identified in the health care literature about the limitations of culturalist approaches to health care. First, there are concerns about using culture as a crude and over-simplifying explanation to inequalities in health status and health care experiences. As some scholars point out (see, for example, Ahmad, 1996; Culley, 1996), the ideology of culturalism tends to assume that people can be distinguished by their cultural differences, and that there are some "deterministic links" between culture and morbidity, mortality, and health behaviors. As culture is reified as the "root cause" of differences in health and illness experience, it follows that the solution to health and health care inequities depends on modifying the culture of a patient, such as changing "problematic" cultural behaviors through health education, or improving communication and getting across to the cultural needs of a patient through learning about his/her culture. In the first instance, as Ahmad tells us, the tendency is to "pathologize" culture and "blame the victim" for his/her own woes, without considering the ways that structural inequalities and racism organize differential access to health and

life chances by ethnic minorities. In the second instance, approaches such as ethnic and cultural sensitivity call upon the personal skills of the health care provider to tolerate, accommodate, and acquire knowledge about the *Other culture* (see Culley, 1997; Stubbs, 1993). When translated into practice guidelines or education materials, ethnically sensitive health programs often take the form of a “catalogue of checklists of cultural stereotypes” (Ahmad, 1996), or a “cookbook approach” (Duffy, 2001) that highlights the characteristics of a culture by focusing on its “exotic and unusual” elements, thus reinforcing its difference from the “norm.”

Second, a culturalist approach to health care runs the risk of ethnic essentialism when culture is conflated with ethnicity (Anderson, 1998), as if one could tell or map out the cultural identification of a person by his/her ethnic origin (Culley, 1997; Hillier & Kelleher, 1996). Specifically, the ideology of culturalism tends to conceive culture as enduring, something that immigrants and ethnic minorities transplant from the “Old World” to their new country (Li, 1999). This view reduces people coming from the same ethnic background to a “culturally homogenous” mass, irrespective of differences in class, gender, sexual orientation, and other social categories. At best, “cultural reductionism” (Ahmad, 1993) mis-recognizes the individual needs of patients when assumptions of health care needs are made based on the ethnic affiliation of the patient. At worst, stereotypes about people based on their ethnicity reproduces racialization of the patient when cultural or somatic attributes are used to construct rigid boundaries that differentiate between “us” and “them.” Hall (2000) reminds us of the complex interplay between culture, race, and ethnicity in racism. As he argues, “those who are stigmatized on ethnic grounds, because they are “culturally different” and therefore inferior, are often

also characterized as physically different in significant ways..." (p.223). This kind of racializing discourse around ethnicity is predicated on a kind of "sameness" (Hall, 1996), which is at the heart of culturalism and reifies people belonging to the same ethnic background as culturally homogenous and thus forever different from "us." But as Anderson (1998) argues, "[e]ach person is 'raced,' 'cultured' and 'ethnic'" (p.201). A patient from an ethnic minority background only becomes "different" or appears as more "ethnic" when his/her cultural background is juxtaposed against the "dominant culture"<sup>2</sup> that, however, "remains transparent and unspoken for the most part, positioned as 'normal'" (Reimer Kirkham & Anderson, 2002, p.6). Thus, culture is not a neutral concept; rather, it is subject to ideological manipulation and discursive construction. As Reimer Kirkham and Anderson argue, "[c]ulture has become a widely used metonym for 'difference' within nursing scholarship, without an appreciation of the ways in which the concepts of culture and race operate in tandem, most often with race as silent subtext to discourses of culture" (p.5).

Critiques of culturalism do not minimize the importance of culture in health care (e.g. Ahmad, 1996). Rather, they emphasize that it is the way in which culture is discussed and appropriated in discourses such as that of ethnic sensitivity, that might reproduce racialization, and gloss over structural inequalities and other barriers to accessing health and health care. This points to two important issues. First, we must not take the meaning of culture for granted; rather, as Lock (1993) urges us to do, we must

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<sup>2</sup> The notion of dominant culture is used here as a crude term to refer to the dominating centre of power that controls the production and reproduction of social meanings. Although my discussion focuses on ethnicity and skin color as the category that determines the divide between dominant/non-dominant, it is important to note that other categories such as religion, sexual orientation, class, and gender are also being used in many Western countries to construct certain groups as non-dominant and thus different.

ask the question “what do we mean by culture?” in health care. Second, we cannot simply explain experiences of immigrants to accessing health and health care by their culture. As I continue to discuss in the following selected literature, the experiences of immigrants in health and health care are not separable from a complex of race, class, and gender relations that determine their socio-economic locations in the “host country” as well as their access to health and health care.

### **Health Care Experiences of Immigrants: Intersection of Race, Class, and Gender**

Some existing research on the experiences of immigrants in health and health care suggests that these experiences cannot be explained by the culture or cultural differences of the immigrants. Rather, there is an intersecting complex of “race, class, and gender relations”<sup>3</sup> that seems to organize immigrants’ access to health and health care in their “host country.” In the following, I review selected literature on the experiences of immigrants in accessing health and health care in Canada. In this discussion, literature pertaining to the health care experiences of immigrants in other immigrant receiving countries such as the United States, Australia, and the United Kingdom are excluded because this study is not designed to *compare* health care experiences across national boundaries. Rather, the focus of this study is to unfold the complex process of social organization of health care, by explicating how some of the larger economic and political forces organize health care experiences of NES Chinese immigrants in Canada. In fact, the experiences of these immigrants are likely to crosscut experiences of their counterparts in other immigrant-receiving countries, as those global and transnational

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<sup>3</sup> Roxanna Ng (1993) argues that “race,” class, and gender are not separate analytic categories but are “interlocking relations” (p.225) which mediate nation formation by organizing our economic and social lives.



forces that organize health care in Canada are likely to be many of the same forces that organize policy and allocation decisions in these countries. Thus, although this study focuses upon health care in Canada, its analysis will also have some relevance to understanding the social organization of health care for immigrants in other multi-cultural societies such as Australia.

The following discussion of immigrants' experiences in health care is organized by three main themes. First, as language barriers have been identified as the most common barrier experienced by immigrants in accessing health care in Canada, I examine immigrants' experiences of language barriers and some of the complex issues around the use of interpreter services in health care. Second, I explore the experience of help-seeking and illness management of immigrants in light of their social and economic positions in Canada. Third, I look at the quality of health care encounters between immigrants and nurses, and begin to discuss the impacts of a changing health care context on the care that immigrants receive.

#### *Language Barriers to Accessing Health Care by Immigrants*

In Canada, where health care is publicly funded and accessible to all irrespective of the ability to pay, access issues faced by immigrants, especially those coming from non-English/non-French speaking backgrounds, are mostly related to language differences. Stephenson (1995), for instance, found in his study with Vietnamese patients that language barriers and inadequate translation services were the most commonly identified problems faced by those patients in the hospital setting. Elmi (1999) found that many members of the Somali community felt uneasy or unwilling to seek mental health services because few mental health workers could speak their language. Arab

immigrants in another study have also identified the lack of Arabic speaking health care providers and lack of interpreter services as a major barrier to accessing health care in Canada (Yuan, Rootman, & Tayeh, 1999). Anderson, in her various studies with Chinese immigrant women, found language as one of the most significant factors that deter non-English speaking immigrants from seeking and utilizing health services (see, for example, Anderson, 1996, 1998; Anderson, Blue, & Lau, 1991; Anderson et al., 2003).

The implications of language barriers on the quality of health care are multi-fold. First, it could compromise communication between the patient and health care provider; delayed diagnosis and treatment as a result of inaccurate communication could result in further complications and readmission (Saldov, 1991; Stephenson, 1995). Second, language barriers compromise negotiation of meanings about illness and treatment, thus affecting the ability of the patient to understand the meanings of treatment and to follow the necessary procedures. As Anderson (1990) argues, negotiation of mutually satisfactory care is essential to quality and cost effective health care. In the absence of a common language, it is difficult for the patient to obtain basic accurate information, let alone participate in the negotiation of treatment decisions (Anderson, 1996).

The problem of language barriers in health care has to be understood in relation to the policy of interpreter services in hospitals. In some studies, it was found that interpreter services were not always available, and that nurses might have to make do without the help of an interpreter (Anderson & Reimer Kirkham, 1998). In general, there is an expectation for NES patients to provide their own interpreting by bringing family members or friends (Anderson, 1996, 1998; Anderson, Blue, Holbrook, & Ng, 1993; Anderson et al., 2003). There are some major issues associated with the use of non-

professional interpreters in health care encounters. Specifically, underlying the use of family and friend interpreters is the assumption that they are familiar with biomedical terminologies and can thus translate word for word accurately. But as Anderson, Blue, and Lau (1991) argue, immigrants, especially those working in the lower echelons of the labor force, do not have the same access to the ongoing discourse about health and illness in society as their middle class counterparts do. The problem of accuracy is compounded when the family interpreter is a child, whose involvement in interpreting private information to the adult family members could infringe on the privacy and confidentiality of the patient (Anderson, 1998; Tang, 1999).

Despite its associated problems, using family and friends to help with interpreting is common practice among nurses either with or without institutional policy for interpreter services. Reimer Kirkham (1998) found that nurses used family interpreters for convenience and accessibility. Anderson and her colleagues (2003) found in their study that even when interpreter services are available in the hospital, nurses did not use those services because they were “too busy” to find an interpreter, or the nurse did not see the situation as warranting interpreter services.

These studies suggest that immigrants face a persistent problem of language barriers in accessing health care. The ways that health care agencies and health professionals respond to this problem, such as making do without interpreters, or relying on family and friends to mediate the often complex communication involving technical and biomedical language, tend to compromise the quality and safety of care that NES immigrants receive. Moreover, taking time off to act as interpreters could mean loss of wages for the family member or friend, money that those in the working class can ill

afford (Anderson, Blue, & Lau, 1991). This can mean that the patient has to skip a medical appointment, especially for those older, NES immigrants who rely on family not only for interpreting but for transportation (Dyck, 1992).

*Immigrants' Experiences of Help-seeking and Illness Management*

Although health care is available to all Canadians irrespective of income, experiences of help-seeking and illness management are inextricably tied to class or the economic position of an individual in the Canadian labor force.

Anderson, Blue, and Lau (1991), for instance, found in their study that management of a chronic illness is different for a working class immigrant woman and a middle class "White" woman because of their differential access to resources. The need to "restructure their life," for instance, is often not realistic for many working class immigrant women who, unlike middle class women, have little chance for job change or the economic freedom to quit their job. In fact, even when the job itself is contributing to poor health (Anderson, Dyck, & Lynam, 1997), quitting the job is often not an option for the working class poor (Anderson, Blue, & Lau, 1991). In a gendered and racialized labor market such as the Canadian one, immigrants in general and immigrant women in particular tend to concentrate in service and manufacturing jobs such as factory workers, cleaners, and restaurant workers. These jobs are often non-unionized, meaning that the workers are unprotected by labor legislation, and lack sick benefits and provision for retirement income (Dyck, 1992). Taking time off to attend medical appointments can be particularly hard for immigrant workers as it means loss of wages. The expectation of patients to "self-care" can be particularly challenging for working class immigrants. On the one hand, immigrants might face restricted access to resources in their community

due to lack of social support, language barriers, and lack of familiarity with social programs in their new country. Thus, even when immigrant women want to take responsibility for their care, their life circumstances might impede them from doing so (Anderson, Blue, & Lau, 1991). Further, to access available resources might not be an option when existing policies restrict access to certain community services by sponsored immigrants (Neufeld, Harrison, Stewart, Hughes, & Spitzer, 2002). At the same time, social and economic mobility for immigrant women is often not an option when opportunities for job training and learning English are impeded by time, dual responsibilities at home and at work, and immigration related policies that restrict sponsored women's access to resources such as language and job training<sup>4</sup> (Dyck, 1992; Lock, 1990).

In other words, experiences of immigrants in help-seeking and illness management cannot be explained by their culture or ethnicity alone; nor are these experiences the result of individual choices (only). These experiences are complex, mediated by state policy and economic positions of immigrants in their host country.

#### *Quality of Health Care Encounter and Changing Institutional Context*

Immigrants report both positive and negative experiences in the Canadian health care system. As some studies have found, in general immigrants are grateful for the care they receive (Stephenson, 1995; Anderson et al., 2003; Lynam et al., 2003). Nurses have shown awareness of the complex issues around culture; for instance, some nurses in

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<sup>4</sup> In Canada, the Immigration Act 1976 recognizes three categories of immigrants: family class, independent, and refugees. The Act allows Canadian citizens and permanent residents who are eighteen years or older, and who meet certain financial criteria, to sponsor certain relatives to immigrate to Canada under the family class category.

Reimer Kirkham (1998)'s study appreciated inter- and intra-cultural differences and avoided sweeping generalizations based on the patient's ethnicity.

However, there are also experiences of discrimination and racialization. In their study with South Asian women, Browne and her colleagues (2002) found that some women they interviewed were conscious of being treated as "different" when compared to their counterparts from "White" backgrounds. This could take the form of nurses refusing a minority women's request for basic courtesies in the context of the health care encounter, or the women's perception of receiving lesser care from nurses because of their racial background. Racialized inequalities in allocating resources could also mean giving less time or doing less for the patient. As Reimer Kirkham (1998) found in her study, some nurses saw the different cultural background of the patient as "an inconvenience or a problem," and tended to focus on providing only routine and task-oriented care, or even ignored the patient's needs. Moreover, culture and cultural differences might be used to justify patients' experiences of inequities and barriers to accessing health care, as culture is used to essentialize patients as "objectified others" (Anderson & Reimer Kirkham, 1998). In addition to culture, language can be a basis for racialization. For instance, Guruge and Donner (1996) found that nurses tended to ignore the needs of NES patients and spend less time with them.

An understanding of the health care experiences of immigrants cannot be separated from the material context of health care in which nurses work. As Reimer Kirkham (1998) has found, time constraints prevent nurses from communicating effectively by arranging for interpreters, from connecting with patients, and from understanding and negotiating cultural differences and meanings. Lynam and her

colleagues (2003) examined the challenges confronting nurses in the face of health care restructuring, and found that there was little organizational support to facilitate nurses in mobilizing resources such as interpreter services. The impacts of restructuring on nurses' workload and time could affect immigrant patients unfavorably (Guruge & Donner, 1996), as using an interpreter or communicating across language and cultural barriers require more time from the nurse, time that nurses don't believe they can afford.

Patients' reported experiences of health care suggest that we cannot explain differences in health care experiences by culture alone. In fact, the experiences of immigrants in health care, such as the lack of interpreter services and the experience of racism, as well as nurses' reported tendency to make do without adequate interpreter support, urge us to question how the Canadian society at large, and the health care system as one of its major institutions, are organized. As Anderson and Reimer Kirkham (1998) argue, the Canadian health care system is not separate from larger political and socio-economic contexts, rather, "it is enmeshed in a racialized and gendered construction of nation and the capitalist worldview..." (p.243), whereby "... the priorities that drive the larger economic system filter down into institutional practices... and, in turn, determine what each health professional is able to do" (p.254). In other words, *the ways that the health care system responds to cultural and language differences are themselves manifestation of the ways that the system is organized in a society described as "raced, classed, and gendered."* According to Anderson (1998), "[t]he allocation of resources remains highly contested, and the predominant mode of health care delivery still privileges some groups above others" (p.206). This is particularly salient when health care understood as resource allocation is getting increasingly more competitive in the

current era of health care restructuring. This urges us to examine health care experiences of immigrants not only in terms of inter-personal relationships, but also against the material context in which health care is organized and delivered. I turn now to an overview of health care restructuring in Canada, and its impacts on nursing.

### **Health Care Restructuring**

#### *Health Care Reform in Canada*

Canada's publicly funded Medicare system, which makes health care equally accessible to all irrespective of the ability to pay, is considered one of the best in the world (Mhatre & Deber, 1998). In fact, Canadians have regarded their health care system as an important symbol of their national identity, reflecting key public values such as equality, compassion, and dignity (Canada, 1997). Despite its world-renowned success and public support among Canadians, there is a question as to whether Medicare is sustainable in its present arrangement. Specifically, every province in Canada has been under pressure to reform its health system through cost containment and streamlining services.

In Canada, health care reform has to be understood against the backdrop of changing fiscal realities in the country. In the face of an enormous debt and budget deficits, the federal government has gradually "off-loaded" (Mhatre & Deber, 1998) its responsibilities for health care expenditures onto the provinces since the 1970s. In 1977, for instance, the provinces began to bear a bigger share in health care expenditures as the federal government changed its funding arrangement from shared cost to block funding (Burke & Stevenson, 1998). Following significant cuts to its funding transfer to provinces for health care and post-secondary education in 1985, 1990, and 1991 (Manga,



1998), the federal government further reduced its share in health care expenditures by instituting the 1996 Canada Health and Social Transfer (CHST), which consolidated health transfers with other social programs including welfare (Tuohy, 2002). In addition to the problem of “off loading” by the federal government, provinces are also facing their own deficit problems, rapidly rising health care costs, as well as an aging population that is likely to impose more demands on the health care system (Manga, 1998). In light of these fiscal challenges and changing population needs for health care, the provincial governments are under pressure to contain health care costs by increasing efficiency of service provision. In fact, Burke and Stevenson (1998) have observed that “[t]he political and economic necessity of controlling costs attends all discussions of health-care policy in Canada” (p.599). In the National Forum on Health (Canada, 1997), for instance, it was concluded that there was a need to control overall spending on health and improve the efficiency and effectiveness of the system. The provincial report *Patients first: Renewal and reform of British Columbia’s health care system* (British Columbia, 2001) emphasized that if health care spending continued to increase at the current exponential rate of growth, the existing health care system would no longer be sustainable.

The imperative to control costs has important implications for the directions that health care reform has taken in Canada. For instance, the merging of hospitals and regionalization of services and supplies are common measures for reducing administrative costs and improving operational efficiency (Manga, 1998). In order to deal with a reduced budget, some hospitals have had to go through downsizing and even closure, together with service cutbacks, staff layoffs, and substitution of in-patient care

by day surgery or out-patient services (Manga, 1998; Naylor, 1999). In British Columbia, the health care priority of cost-saving has affected different areas of service delivery. Among the measures taken are home care cuts for seniors, layoffs of unionized employees working in programs such as school immunization and vision screening, closure of community hospitals, and de-insuring of medical procedures such as eye examination.

In addition to its priority of improving system efficiency and effectiveness by cost containment, health care reform in Canada also has a focus on reforming primary health care, by introducing alternative payment arrangements for physicians and using non-physician professionals such as nurse practitioners for care provision, to name two examples (Tuohy, 2002). Despite efforts to improve primary health care, the public has experienced the effects of reform largely in terms of longer waiting lists, less bed space, and reduced coverage for drugs, medical procedures and/or support services such as home care. Health care providers such as nurses are also experiencing the effects of cost cutting measures on their work and their ability to provide quality patient care. It is to nurses' experiences of health care reform in Canada that I now turn.

### *Impacts of Health Care Reform on Nursing*

Cost cutting, a measure taken by provincial governments in Canada to contain health care expenditures, has been particularly hard on nurses who comprise the largest occupational group in the health care system. Nurses in different provinces in Canada share many common concerns and grievances about the impact of health care restructuring on their work. In particular, nurses are experiencing an increased workload both in nursing as well as non-nursing duties, including paperwork and other care

responsibilities (British Columbia Nurses' Union, 1998; Laschinger, Sabiston, Finegan, & Shamian, 2001; Dunleavy, Shamian, & Thomson, 2003). Institutional policies such as early discharge (Anderson, Tang, & Blue, in press), substitution of in-patient care with outpatient care and day surgery (Manga, 1998), and the practice of keeping patients in the community for as long as possible (British Columbia Nurses' Union, 1998), mean that those patients who are admitted into hospital tend to be sicker. Increased complexity in patient care responsibilities is likely to require more attention and time from nurses, thus adding to the workload of nurses who are already facing a shrinking workforce as a result of job losses and staff shortages. In some parts of Canada, nurses have also noticed an increase in casualization of nurses and employment of unskilled workers under health care reform (Fletcher, 2000; Keddy, Gregor, Foster, & Denney, 1999). The need to supervise or provide guidance to casual and unskilled colleagues could further deprive nurses of spending time with their patients at the bedside.

In direct and indirect ways, health care restructuring in the form of cost cutting impacts nurses both professionally and personally. The quality of nursing care can be compromised as a result of staffing cuts, decreased time, and increased workload (Laschinger, Sabiston, Finegan, & Shamian, 2001). This could ultimately hurt patient care and increase the risks to patients, as restructuring and its cost-cutting measures cause instability in the clinical context, bringing with them fewer resources to support quality nursing care, cancelled surgery and delayed admission, frequent transfers of patients, and bed closure (Nicklin & McVeety, 2002; Lynam et al., 2003). In addition to its effects on the quality of nursing care, restructuring also has human costs (Blythe, Baumann, & Giovannetti, 2001). This includes experiences of decreased morale and satisfaction, as

well as burnout and increase in illness contributing in high absenteeism (Advisory Committee on Health Human Resources, 2002). Nurses experience job dissatisfaction when the time they would like spending at the bedside to provide high quality, holistic care is eaten away by their increased responsibilities and heavier patient load (Laschinger, Sabiston, Finegan, & Shamian, 2001). Moreover, structural changes such as the merging of hospitals and closure of units, entailing relocation, job redistribution, or even layoffs for nurses, take an emotional toll on nurses, and break down relationships in the work place when nurses feel alienated from management by the business model (Blythe, Baumann, & Giovannetti, 2001). Deteriorating relationships and decreased communication between managers and nurses mean that nurses have less access to support and resources, thus affecting the quality of patient care. Potential conflicts in values and interests between maintaining good quality patient care and the corporation's concern with budget constraints could compromise professional standards of care (Wagner, 1998).

In fact, nurses in Canada have voiced their concern with "maxed out" tolerance for the changes in health care system (Nicklin & McVeety, 2002). As Fletcher (2000) found, there is a perception among nurses that the health care system is disintegrating after a decade of hospital closures, downsizing, job displacements, and staffing cuts. In the province of British Columbia, some nurses have described the situation of the health care system as "[t]urmoil, chaos, uncertainty" (Brunke, 2001, p.38), and many not only expressed a desire to leave the profession, but also would not recommend nursing as a career choice to other people (British Columbia Nurses' Union, 1998). In fact, as Shamian (2000) argues, the issues around working conditions and recruitment and

retention of nurses have become a “national agenda” across Canada. These issues are related to, rather than separate from the ways that health care restructuring is unfolding in Canada. More specifically, the changing institutional context in which nurses do their job and provide patient care is the same context in which immigrants negotiate access and utilize health care in their “host country.” In other words, the experiences of nurses and patients in negotiating health care across cultural and/or language differences have to be understood against the background of health care restructuring and its impact on the immediate health care encounter between nurses and patients.

### **Conclusion**

My review of selected literature suggests that although culture is an important concept to consider in health care, experiences of immigrants in seeking health care cannot be explained by cultural differences alone. Specifically, there seems to be a complex of race, class, and gender relations that organize immigrants’ life chances and access to resources in their “host country.” In direct and indirect ways, socio-economic positions have important implications for immigrants’ access to health and health care. For working class immigrant men and women, for instance, their jobs could be a direct hazard to their health. When those immigrants try to seek the care they need, their lack of dominant language skills and class position puts them at a disadvantage in a system that privileges middle class, English speaking persons from Anglo-European backgrounds. As some studies have shown, structural inequalities and discrimination in the health care system tend to be glossed over when cultural differences are used to justify the lesser or inadequate care given to patients from ethnic minority backgrounds. In the current context of health care restructuring, immigrants could face even more

difficulty in accessing health care as nurses face an increased workload, and are left with less time to negotiate care with non-English speaking patients across language differences.

Thus, although health care reform has direct implications for every Canadian, some are more likely to be adversely affected than others. These include the poor, who are economically disadvantaged to buy time and better services for treating their illness, as well as women who are relied upon as the taken for granted care-givers for the sick at home (Anderson, 2000). These also include people of immigrant backgrounds who, as we have seen, are in a structurally disadvantaged position to achieve economic mobility and to equitably access resources in their host country. Although there is an increasing volume of literature that critically debates the direction of health care restructuring and its impact on health services, relatively few discussions of health care reform in Canada have focused on the experiences of immigrants in a changing health care system. In the few studies that do include patients from minority ethno-cultural backgrounds as a focus of investigation (see, for example, Anderson, Tang, & Blue, in press; Lynam et al., 2003), discussion tends to center around the impact or consequences of health care reform on the work of nurses and the experiences of patients, with relatively little attention paid to the actual processes by which those experiences are organized. In this study, I address this knowledge gap by asking the question, *how are the experiences of non-English speaking Chinese immigrants **socially organized** under health care restructuring?* An examination of the process of organization or, more specifically, “social organization” (Smith, 1987), is important because this analytic approach will help us to understand health care restructuring beyond what is often seen as a top-down process whereby patients and

nurses are assumed to be “passive victims” of the effects of restructuring. Rather, the notion of social organization, as Smith conceptualizes it, re-locates people such as nurses as active participants, whose coordination of activities actually accomplishes the work of organizing the social, including organization of the clinical context in which health care is delivered to immigrants under restructuring.

In order to answer the research question of this study, “*how are the experiences of NES Chinese immigrants socially organized under health care restructuring?*” I focus on four sub-questions:

- 1) What are the experiences of NES immigrant patients in seeking and utilizing health care?
- 2) What are the experiences of nurses in providing health care to patients coming from a NES and/or non-dominant ethno-cultural background?
- 3) How do nurses make sense of the concept of “culture?” And,
- 4) What are the factors and institutional processes that facilitate or impede negotiation of cultural and/or language differences between nurses and patients of NES and/or non-dominant ethno-cultural backgrounds?

In order to address these questions that take into account the complex contexts of health care restructuring, I have chosen to use a methodology that allows me to understand not only the changing institutional context but also the hidden process by which health care experiences are socially organized. In other words, the methodology for addressing the problematic of this study must go beyond description of experiences to a level of analysis that explicates *what actually happens*, or how the experiences of immigrants and nurses are actually organized in the current context of health care. In the

following, I elaborate on the methodology for this study, which I call “discursive ethnography.”



## CHAPTER THREE: METHODOLOGY

### Discursive Ethnography<sup>5</sup>

In this study, the methodology used to investigate the research question is “discursive ethnography.” Discursive ethnography (DE), drawing upon the philosophical and theoretical underpinnings of Dorothy Smith’s institutional ethnography (IE),<sup>6</sup> is *one way* of practicing institutional ethnography. Specifically, discursive ethnography is concerned with investigating what Smith has called the “discursive problematic of the everyday/everynight world” (Smith, 1999, p.7).

The notion of “discursive,” as in DE, addresses a complex process of social organization understood as textually mediated and discursively organized. This phenomenon is a “problematic” because, on the one hand, the process of social organization is often not immediately knowable to us, though each of us is an active participant in accomplishing that process through concerting and coordinating our everyday activities, while on the other hand, our everyday experiences are not reducible to individual choices and intentions alone. Rather, what we do and experience in the

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<sup>5</sup> The term “discursive ethnography” is not my original invention; rather, I first encountered this term in Clifford (1986)’s writing on *Partial Truths* of ethnographic work. While I have used the same term to denote my methodology in this study, it is important to emphasize that what I mean by DE is different from what Clifford means. In speaking of “discursive ethnography” (Clifford, 1986, p.12), Clifford points to the changing nature of doing ethnography within the discipline of anthropology, whereby it is no longer tenable to assume the “transparency” of cultural representation without addressing the ways that power and history mediate ethnographic writing and thus the “knowledge” it purports to produce. Specifically, Clifford urges us to attend to the “discursive aspects” of ethnography and its textual production, by asking whose voices are represented in the text, as well as by questioning the discourses and historical or institutional constraints against which the ethnographic texts are produced. This is different from the ways DE is used here. Rather than being concerned with the poetics and politics of ethnography, DE focuses upon an investigation into the social, and how what happens to us in our everyday life is discursively organized and mediated by the text.

<sup>6</sup> In calling my methodology “discursive ethnography,” I am not seeking to offer a replacement of or competitive alternative to Smith’s institutional ethnography. Rather, DE is *one way* to practice IE as a method of inquiry. In fact, Smith (1992) emphasizes that there is “no orthodoxy” (p.92) to doing IE, and she approves of researchers taking IE in their own directions.

everyday is invariably organized by and hooked to some extended and generalizing relations in the “extra-local.”<sup>7</sup> In other words, our everyday experience in the “local” has to be understood as a manifestation of the ruling relations characteristic of contemporary capitalist societies.

Because discursive ethnography is a way to conduct institutional ethnography, the philosophical and theoretical underpinning of DE draws upon that of IE. In the following, I elaborate on DE by discussing the main theoretical insights of Smith (1987; 1990; 1999). In order to elaborate further on the organizing power of discourse and the text, I have integrated some ideas put forward by the literary theorist Mikhail Bakhtin into my methodology.<sup>8</sup> I conclude this section by briefly discussing the implications of these methodological directions for an inquiry to discursive ethnography.

### *A Social Ontology of the Everyday*

In doing institutional ethnography, Smith emphasizes the social nature of our reality, and she proposes a *social ontology* for inquiring into our everyday world. This social ontology has important implications for where to begin an inquiry and how to analyze beyond what we know and do in the mundane. An ontological grounding in the

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<sup>7</sup> The notions of the “extra-local” and “local” are central to Smith’s theorizing of the process of social organization. However, Smith does not seem to have provided an overt definition for each of these concepts in her writing. From my own interpretation of Smith’s work, I understand the “local” as referring to that immediate context or environment in which we live and work. This includes the school, home, work office, and other places that we do our daily business such as the grocery stores, banks, physician offices, and so on. Conversely, the “extra-local” speaks to a more abstract level of activities that are beyond the reach and even knowledge of ordinary people in the local. The “extra-local” can be understood as that level in which “ruling” takes place through the work of the complex of “ruling apparatus,” including the government, business organizations, as well as academia through which discourses are produced and circulated. Under the new world order of advanced capitalism, the work of ruling at the “extra-local” is no longer restricted at the national level; rather, it is constitutive of a complex network of trans-national and global forces connected by the prevailing ideologies and interests of neo-liberalism and “market fundamentalism” (Stiglitz, 2003).

<sup>8</sup> I am indebted to Smith for introducing me to Bakhtin and his work through her writing (see chapters 6 & 7 in Smith (1999)’s *Writing the Social*).

social also has implications for where to locate people or the “knower” in the process of knowledge construction in research.

A social ontology, as Smith has conceptualized it, is different from sociological traditions such as symbolic interactionism, where people are recognized as purposive agents who, together in their interaction and communication, make meaning about the world (Schwandt, 1994). For Smith, “the social” neither denotes “people’s goals, objectives, or intentions” (1987, p.167), nor does it align with its common usage “as order or as rules or as meaning” (1992, p.92). Rather, Smith’s social ontology points to a complex process of social organization whereby our everyday life is invariably organized by and hooked to some extended relations of means of production, resource allocation, and institutional processes. While Smith insists on preserving people as subjects rather than objects of study, she emphasizes the importance of exploring the everyday world not in itself, but in how “[it] is determined by the social relations of an immensely complex division of labor knitting local lives and local settings to national and international social, economic, and political processes” (Smith, 1986, p.7). Despite our diverging experiences, Smith argues that there exists a common social ground or “objective correlates” to our seemingly private experiences. In fact, the ways by which our local and particular experiences are articulated to some generalized and generalizing social relations is a property of social organization. This is what Smith (1987) calls the “problematic of the everyday world,” that is, how our everyday experiences are articulated to larger processes that organize the everyday world beyond the intentions of any individuals.

*Locating People in this Social Ontology*

One of the important ways in which Smith differs from other theoretical approaches to *the person*, such as the post-structuralist locating of people as “effects of discourse” (Smith, 1999), is her positing of people as “subjects” who participate actively in the “constitutive work” of social organization.<sup>9</sup> More specifically, the social comes into being through “people’s ongoing concerting and coordinating of activities...” (Smith, 1992, p.92). In other words, people are subjects who have agency; they are active participants in coordinating the social, or accomplishing the work of social organization in the local.

Inquiry, therefore, must start from people’s actual activities, or from the “standpoint” of their experience as it actually happens in the local, in actual material times and existence. Smith (1990) emphasizes that “[t]his insider’s standpoint is not subjective, nor is it phenomenological in the sense of an exploration from within of the constitutive moves of consciousness. [Instead], [i]t addresses from within the actual work of coordination, the ongoing co-ordering that brings into being, that *is*, the social” (p.9). By locating inquiry where people are actually active, we can try to unfold how people actually participate in the social courses of action, and how their local

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<sup>9</sup> Here, it is important to clarify how Smith has positioned herself in relation to poststructuralism and postmodernism. Although Smith has taken issue with the ways that poststructuralism tends to reduce subjects and their consciousness about the social world as secondary to language and its discursive structures, Smith is not refuting altogether the philosophical importance of poststructuralism/postmodernism. For Smith, the issue is how to “take up poststructuralism’s discovery of how discourse speaks through us and beyond our intended meaning, while at the same time avoiding its solipsistic confinement to discourse” (Smith, 1999, p.76). The possibility to act and to know beyond what discourse posits for us is, for Smith, the critical philosophical point of entry for producing an “alternative organization of knowledge” (1999, p.74) that challenges the existing relations of ruling and the ways our world and experiences are socially organized by those relations.

organization of the social reproduces and refracts the social relations of larger economic and political processes.

### *Social Relations*

The concept of “social relations” is essential to understanding the complex processes of social organization of our reality. In the social ontology, Smith emphasizes the social nature of reality, and points out that the purpose of inquiry is not to understand the everyday experience “in itself.” Instead, the “social” nature of reality points to the intricate connectedness of people, whose work has implications for everyone in a closely-knit division of labor organized and reproduced socially.

To understand reality as “social,” as an ongoing concerting of activities among people in real time and real place, highlights the complexity of the ways in which contemporary society is organized, where organization of the social “goes beyond the intention, even the control of any individuals or groups” (Frank, 2001, p.357). Specifically, the work or activity of an individual does not have meaning for him/her alone. Our action is socially implicated in the sense that what one does is always implied by and has implication for “more than one individual whose participants are not necessarily present or known to one another” (Smith, 1987, p.155). Smith has elaborated on the concept of “social relations” to highlight that complex but often invisible process linking individuals to each other, and more importantly, hooking activities at the local to the extralocal, or those larger social, economic, and political processes at the national as well as inter-national levels.

By “social relations” Smith means those socially organized processes that direct attention to, and take up analytically, “*how what people are doing and experiencing in a*

*given local site is hooked into sequences of action implicating and coordinating multiple local sites where others are active*" (1999, p.7, original italics). While Smith argues against reifying social relations as an abstracted process, she insists on the local situatedness of social relations as "concerted sequences or courses of social action" (1987, p.155), where individuals are active in doing the concerting and coordinating of activities. As these activities are understood to be taking place in real time and real place, coordinated by embodied, "active experiencers" (Campbell, 1998, p.58) where they live and work, there is an important "materialist" dimension to how Smith understands social relations. As Smith explains,

When we talk of social relations in the context of Marx's thinking, we are not talking of social relations as sociologists are accustomed to do. Social relations for the sociologist refer to the abstracted forms of normative structures held to link positions or roles, the relation between husband and wife, between positions in an authority structure, the interpersonal relations of group members, and the like. For Marx, by contrast, social relations are the actual coordinated activities of actual people in which the phenomena of political economy arise.... They are coordinated or articulated processes of action among persons taking place in time and having determinate form. Social relations are thus sequences which no one individual completes.... The basis of analysis is not the act, the action, or the actor. It is the social relation coordinating individual activity and giving people's activities form and determination. (1990, p.94)

Thus, Smith thinks of social relations "not as fixed relations between statuses but as an organization of actual sequences of action *in time*" (1990, p.160). While individuals are active participants in these sequences of social action, coordination of activities among people does not simply happen naturally; neither are they imposed upon people from above. Instead, social relations have to be understood as *active* manifestation of discourse, that which organizes people's activities by shaping their "social forms of consciousness," and aligning their activities with extralocal interests.

This process of social organization, as Smith argues, is largely mediated by the text. I will try to explain this complex process further by discussing how Smith locates discourse and the text in her theorizing.

*The Relations of Ruling, Discourse, and the Text*

Discourse, for Smith, plays an integral part in the social organization of our world. To understand our everyday reality as “social” or socially organized means that our everyday experience of working and living cannot be reduced to the merely idiosyncratic and personal, or attributed to individual efforts and choices alone. An understanding of our reality as social points to a complex of organizing processes outside of our immediate local context of living, whereby our lives are organized by forces or relations not immediately knowable to us. These relations are what Smith calls “relations of ruling.”

*Ruling Relations*

Ruling, in capitalist societies under “democratic” regimes, does not work by coercion or force. Rather, as Smith tells us, ruling is accomplished by a complex process of social organization, administered and organized by a governing apparatus made up of “institutions of administration, management, and professional authority, and of intellectual and cultural discourses which organize, regulate, lead and direct, contemporary capitalist societies” (1990, p.2). We can see that it is within and through this ruling apparatus that policies of different orders and decisions about resource allocation are made. In Canada, we can understand the government and its many ministries, including education, as making up the ruling apparatus, which is responsible for the organization of “ruling or institutional functions” such as health care, social

services, law and order, and so on. Each of these functions is organized by “ruling relations,” the network of administration and bureaucracy, including government policies. The ruling apparatus of the state does not “rule” by coercion or force. Rather, ruling takes place through what Smith calls “social organization,” a complex process that coordinates the activities of individuals such that what people do in their local context invariably articulates to the ruling relations and thus accomplishes the interests of the ruling class and the state.

Not everyone is included within the ruling apparatus, and thus not everyone has access to decision making and to the production of discourses, or those ideas, concepts, vocabularies and knowledge with which we give social forms to our experiences and understanding of our world. Rather, those people making up the ruling class are those who dominate and have control over the means of production in a society (Smith, 1987). In a capitalist country like Canada, members of the ruling class are often white males of middle or upper-middle class backgrounds, who are (over-represented) in positions of decision making and administration both in the public and private sectors (Henry, Tator, Mattis, & Rees, 1995). Smith tells us that, in order to maintain its power, it is in the interest of the ruling class to maintain control and domination over the means of production, by organizing the social relations such that they accomplish the complex division of labor for production. An important means for the ruling class to organize and coordinate the complex of “social relations,” or the work and lives of people in multiple local settings, is by controlling forms of social consciousness, through appropriating what Smith calls “the means of mental production” (1987, p.55), including the production of public and professional discourses. Access to the means of mental production and the



forms of social consciousness are central to the power of the ruling class to maintain its control over society. So how are the local actualities of people's lives organized such that they articulate to those decisions and policies made "extra-locally," or beyond the immediate local context where we live and work? Discourse and, more specifically, textually mediated discourse, provides the "bridge" through which what happens in the local actualities of people's lives is hooked to the extra-local relations of production, resource allocation, and policy decisions.

### Discourse

By discourse, Smith is referring to the complex of "ideological currency" (1990, p.214) made available to us through the mass media, the education process, the legal system, and other ideological institutions in the ruling apparatus. Rather than being some value-neutral or free-floating systems of thought, discourse and its ideological complex are produced, extra-locally, "by specialists and by people who are part of the apparatus by which the ruling class maintains its control over the society" (Smith, 1987, p.54). As a constituent of the relations of ruling, discourse "rules" by organizing and co-ordering the everyday, and hooking what we do in spatially and temporally dispersed local contexts to the interests and aims of those in the position to rule and in control of capital organization. At the ideological level, we can understand discourse as production of the social forms of consciousness, or those concepts, ideas, images, vocabularies and so on that dominate how we make sense of our world and do our practical reasoning in the everyday (Smith, 1987). However, this ideological function must not be reduced merely to a false consciousness in the sense of "fooling" us about what is "really" going on in our surroundings. Rather, there is an important aspect of "material organization of social

relations” to discourse. As Smith (1987) argues, discourse and the ideological complex produced by it provide the means by which the ruling class “orders, organizes, and sanctions the social relations that sustain its domination” (p.54). Examples of social relations integral to the organization of contemporary society are the gendered, classed, and racialized division of labor in the capitalist market as well as in the private space of the home. Li (1988), for instance, examines the ethnically structured inequalities sustaining the class structure in Canada; and Henry and her colleagues (1995) highlight the ideology of racism that sustains unequal access to economic mobility and employment opportunities by some Canadians, such as immigrants and Aboriginal peoples. There are also the sexist ideologies around mothering and femininity that naturalize the un-paid work of women in the home as care-providers and homemakers. Class, gender, and “race” relations are not merely “thoughts” or false consciousness; rather, they are actual work done by people in real material time and place. In other words, practices of “othering” ethnic and racial minorities, and other forms of discrimination, including sexism and classism, do not only shape inter-personal interactions. These practices actually have material implications for people’s lives, and for the ways in which resource allocation in a society is organized along intersecting axes such as ethnicity, class, and gender. In fact, the ability of discourse to organize and coordinate the work of people across temporal and spatial distance, and to articulate what they do to the extended relations of capital accumulation and production is integral to the relations of ruling. This process of “transposing” everyday local experiences into the extra-local relations is, in turn, “mediated by the materiality of printed and electronic texts” (Smith, 1999, p.73). More specifically, discourse “rules” by coordinating and

concerting the actions and relations among individuals at multiple sites and at different times. The ability of discourse to “intersect, interpenetrate, and coordinate the multiple sites of ruling” (Smith, 1990, p.6) is mediated and enabled by the text.

### Text

Smith wants to draw our attention to the emergence of the text and, more specifically, textually mediated discourse, as a new and powerful form of social organization in contemporary society. Texts in the form of material texts such as books, newspapers, magazines and reports, or in other forms such as visual images on television, radio broadcasts, and commentaries, carry in them particular characteristics that enable discursive organization of the social, transcending local particularities and the constraints of time and space.

The property of the text to coordinate people’s activities at a multiplicity of sites lies in its “indefinite replicability” (Smith, 1999, p.79), as well as in its materiality and objectifying properties. In contemporary society, where printing and electronic technologies are advanced, texts in different formats pervade our everyday lives, and organize our social consciousness in what we see and hear, and get to know about the world. Specifically, the text plays an essential role in organizing social relations because its material forms and replicability means that “the ‘same’ meaning... can occur simultaneously in a multiplicity of socially and temporally disjointed settings” (Smith, 1990, p.211). We can imagine how the same text, such as a nursing textbook produced in a specific geographic and cultural-ideological site (e.g. the United States), describing what it means to be a “good” nurse, can be used to organize the work and experiences of nursing students in different countries even if the text contradicts the local meanings of

health and health care. We can also imagine how a women's magazine depicting what a "responsible" housewife looks like could organize how women in different countries do their house-work and relate to their husbands and children. Thus, the text can enter people into social relations as ordered and organized by the discourse mediated in the text. Specifically, we can understand text as providing what Smith calls the "ideological coordination" between what people do in their local contexts and the abstracted discourses in the ruling apparatus. Mediated in replicable and material texts, discourse can intersect and interpenetrate multiple institutional sites, thus "reproducing the same order in an indefinite variety of actual local contexts" (Smith, 1990, p.2).

The production of texts, like discourse, is a political and social process. Although not everyone has access to the production of texts, each of us is an expert practitioner in "doing reading" or lifting the discourse out from the text. This is not some kind of mysterious process of ideological coercion. Rather, it speaks to the "coordinative schemata built into language" (Smith, 1990, p.3). After all, as the literary theorist Mikhail Bakhtin would remind us, language is not just a phenomenon of "grammatical or semiotic concerns" (1986, p.72), nor is it a "neutral medium" of communication (1981, p.294); rather, language is "social." It is the social nature of language that helps us to understand the organizing functions and power of discourse and the text.

To argue that language is social is to understand that there is no un-mediated relationship between the word and the object, or between the speaker and language. Bakhtin (1981) maintains that language is not given but posited; it is discursively "conditioned" and "ideologically saturated" (p.271), serving particular socio-political purposes and "historical tasks" (p.270) in the particular epoch in which it is used. One

way that language intersects with the socio-political interests and ideological development of a nation is in its power to unify or centralize thoughts and consciousness by suppressing those voices and worldviews that clash or compete with the dominant ideological system and culture. In this sense, what we might see as “consensus” or “unity” in expression of views or opinions has to be polemicized as effects of what Bakhtin calls “centripetal forces”<sup>10</sup> of the dominating language. As an ongoing political and historical production, or as what Bakhtin describes as “a living, socio-ideological concrete thing” (1981, p.293), language is not reducible to subjective consciousness or as belonging to any one person. Rather, Bakhtin emphasizes that the nature of words in language is “inter-individual” (1986, p.121), whereby a word’s meanings are never separate from the historical development from which it emerges; nor can the word ever be independent of the contexts in which it has been used. This notion of language as inevitably linked to and shaped by the intentions and accents of other people, and the historical and socio-ideological forces outside the immediate context in which we speak and act, is what Bakhtin refers to as “dialogism” or “dialogic relations.” On the one hand, we can understand the dialogic relations in human communication as a function of some *stable* spheres of meanings and utterances<sup>11</sup> that Bakhtin (1986) calls “speech genres.”<sup>12</sup> These speech genres play an important role in organizing our social reality by defining the semantic boundary within which utterances and understanding take place.

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<sup>10</sup> According to Bakhtin, centripetal forces are those forces in language “*that serve to unify and centralize the verbal-ideological world*” (1981, p.270, original italics).

<sup>11</sup> Utterance, according to Bakhtin, is “the *real unit* of speech communication” (1986, p.71); he uses it to emphasize the nature of language as social and contextual, involving actual speaking subjects in anticipation of a response from another (actual or potential) speaker.

<sup>12</sup> Bakhtin (1986) has made a distinction between primary and secondary speech genres. Smith (1999) has interpreted secondary speech genres as resembling what Foucault has called discourse.

Bakhtin (1986) emphasizes that even without our awareness, we acquire skillful mastery of a rich repertoire of speech genres, which enter our consciousness through public discourse, educational influences and so on, and organize our speech and activities in our everyday living and human interactions.

On the other hand, the relative stability<sup>13</sup> of speech genres helps to create and maintain “semantic ties” between utterances. After all, Bakhtin reminds us that we are not free to create our own words or to introduce totally new meanings into the existing language. Rather, the words available to us for expressing ourselves and for making sense of our experiences are inevitably shot through with other voices, and taste of the verbal-ideological contexts in which the words have been used. As Bakhtin (1981) argues, “[t]he word in language is half someone else’s” (p.293). This dialogic nature or “otherness” (Bakhtin, 1986) in language is important not only because it provides a common basis for communication in its literary sense; more importantly, it serves an important ideological function of “maximizing mutual understanding” of those meanings as posited by/through socio-political discourse (Bakhtin, 1981). The unifying power of language and its dialogism to crystallize and unify thoughts and consciousness is not confined by space and time. As Bakhtin (1986) states,

Two utterances, separated from one another both in time and in space, knowing nothing of one another, when they are compared semantically, reveal dialogic relations if there is any kind of semantic convergence between them... (p.124).

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<sup>13</sup> The notion of “stability” should not be mistaken as implying some innate or “natural” contents making up each sphere of human communication or activities. Rather, stability in speech genres has to be understood as an effect of power and hegemony which determine, under specific historical and socio-political conditions, the range of “discursive possibilities” (Bakhtin, 1984, p.202) for speaking and understanding.

It is important to understand the concept of “dialogic relations” as it points to the hidden but powerful organizing function of language and discourse that *transcends space and time*.<sup>14</sup> Not only does the dialogic nature of language organize communication between people, but language can also co-order activities in multiple local settings when people, even if separated by spatial distance, can distinguish and activate the discursively organized meanings carried forward in the same words. Thus, in his interpretation of Bakhtin, Allen (2000) argues that although Bakhtin reorganized the place of “agency” in language, there is “no individual psychology in [his] work” (p.28). This dialogic nature of language speaks to Smith’s argument of how forms of social consciousness are aligned by dominating discourses and their ideological currency, as discussed earlier. According to Smith (1999), Bakhtin provides “an account of language as meaning given determination prior to any particular local interaction and hence as playing a powerful role in the local organization of the social” (p.98). In other words, language in general, and discourse and the text in particular, are the “discursive mediation” between the trans-local and the local. We can also begin to see how the (material) text can organize and

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<sup>14</sup> What I have included in my discussion of dialogism is brief and in no way exhausts its theoretical depth. For the sake of articulating a clear argument here, I have focused on only some aspects of the notion of “dialogism,” which is far more complicated in its literary meaning and complexity as elaborated by Bakhtin. While Bakhtin emphasizes how words are always already inhabited by the meanings used by others, he also draws our attention to the possibility of creating new meanings every time that a word is uttered. For instance, he discusses the possibility of challenging hegemonic discourse by “double-voiced discourse” and heteroglossia. Yet, despite the possibility for creating new meanings, I would also caution against the “power” of the discourse of political correctness to organize and confine the extent to which individuals in the contemporary world can enact their agency of saying what they want to say against the hegemony of dominant meanings. Bakhtin argues against the assumed “monologic unity” of language; he reminds us of the “internal stratification of language,” with its social heteroglossia and polyphony, characterized by clashes of ideologies in the multiple voices spoken at any particular historical times (1981, p.264, p.272). We could understand “political correctness” through Bakhtin’s notion of addressivity and responsive understanding. As he states, “every word is directed toward an *answer* and cannot escape the profound influence of the answering word that it anticipates” (1981, p.280). The anticipated answer is, in turn, determined by the prevailing socio-ideological consciousness, as well as classes and other social categories.

reproduce social relations as we, as expert practitioners of language and dominating speech genres or discourses, learn to activate the meanings of the text and accomplish its relations through our actions. The organizing power of speech genres, discourse, and the text continues to increase as a result of technological advancement, such as the internet system, which breaks down the barriers of space and time in its transmission of meanings and messages. This is one of Dorothy Smith's concerns (Smith, 1999) in her theorizing of the text as playing a powerful role in social organization not only locally or nationally, but trans-nationally at the global level.

### **To Begin Inquiry in Discursive Ethnography**

As I mentioned earlier, discursive ethnography is not proposed as an alternative to institutional ethnography; rather, it is one of the many ways to practice IE as a method of inquiry. The notion of "discursive" is used here to highlight the important role of discourse and the text in the process of social organization. "Discursive" does not suggest an emphasis on the linguistic, as in literary criticism or theoretical analysis. Rather, Smith (1999) urges us to understand "discourse as social relations," whereby the social forms of consciousness, as carried forward and reproduced in discourse and the text, shape the ways we conduct our everyday business such that what we do is hooked back to larger relations, those same relations that control not only the relations of production, but also the relations of mental production.

Thus, discursive ethnography, as conceptualized here, is not about studying language or communication in the sense of literary study. Rather, DE is one point of methodological entry to explore and analyze the "institutional processes" organized around distinctive functions, such as health care. Here, it is important to emphasize that



by “institutions” or “institutional,” Smith is not referring to some kind of social institution such as a hospital or a bureaucratic system. By institutions, Smith (1986) means a complex of intersecting relations organized around a ruling function. For instance, the function of health care is organized by different parts of the ruling apparatus, including state agencies such as the Ministry of Health, the provincial and federal governments, professional organizations, and discourses of various orders including that of biomedicine and law. Discourse and its ideological complex play an important role in coordinating social relations or how people accomplish the institutional function (e.g. health care), by providing concepts and the social forms of consciousness with which people do their practical reasoning and carry out their actions. This is where I see DE as adding to IE, by exploring the ways in which discourse and the ideological complex organize our everyday. In the current era where technological advancement has an increasingly powerful impact on our lives, we need to understand the ways the text organizes what we do in the everyday. This is not to start from some abstract ideological place. Rather, inquiry starts from the everyday, and takes the everyday experiences of people as an entry point for explicating the ways in which the everyday is organized, whereby discourse and the text are a constitutive part of that process of social organization.

Thus, drawing upon the philosophical underpinning of institutional ethnography, discursive ethnography is also grounded in a social ontology that conceives reality as socially organized. Specifically, DE will begin inquiry from the “standpoint” of people’s everyday experiences, taking place in actual material time and place. To solve the puzzle of how the everyday world is discursively organized and mediated by the text, my

analysis will aim at working back to those ruling relations (discourse and ideology) that organize what people do in the everyday. However, my inquiry is not directed at “looking for” a discourse or delineating its structure. Rather, as Smith (1990) argues, “[d]iscourse and ideology can be investigated as actual social relations ongoingly organized in and by the activities of actual people” (p.160). This is what Smith means by starting inquiry in experience, not in the sense of subjective feelings or idiosyncratic experience, but as social relations where people are active participants in coordinating the everyday world in real material time and place.

To inquire into people’s everyday experiences and the material context in which these experiences take place, an ethnographic approach entailing techniques such as interviewing and participant observation is useful. In discursive ethnography, where an understanding of the ways that social organization is discursively and textually mediated is central, inquiry might also take the form of explicating the trail along which the text does its work of social organization; in some cases, analysis of specific texts and their hidden ideological frames might be appropriate methods in DE. Whatever methods are chosen, the aim of investigation in DE is to explicate the complex process of social organization by which our everyday lives are coordinated and how what we do and experience articulate to the ruling relations of larger social, economic and political processes.

## CHAPTER FOUR: METHODS

The following is a description and discussion of the methods used for data collection in this study, which took place between November 2000 and November 2001. In this study, fieldwork entailed time spent in negotiating access to and recruitment of participants, as well as actual data collection. In addition to intense periods of participant observation, other activities of data collection included interviewing and review of documents and policies. There were altogether 14 nurses and 10 patients recruited into the study, and a total of 27 interviews and nine episodes of participant observation.

### Context to the Study and Data Collection

The time period in which this study took place was marked by a few major events. First, there was the September 11, 2001 terrorist attack in the U.S. Although it is beyond the scope of this study to speculate on the impact of this event on the experiences of immigrants in Canada, it is worth noting that in June 2002, Canada passed the *Immigration and Refugee Protection Act* in an attempt to secure the border and improve public security of Canadians. With increased antagonism and inter-ethnic tension at the international level, we need to be particularly vigilant about patients coming from diverse ethnic and/or religious backgrounds being subject to increased racialization and discrimination in the Canadian health care system.

Second, the Liberal government was sworn into office in the province of British Columbia on June 5, 2001. Changes in the ruling government from a leftist New Democratic Party to a rightist Liberal Party did not halt the movement of health care restructuring in the province. Rather, health care restructuring continues in the direction of fiscal constraint, service cutbacks, closure of hospitals, and so on.

A changing health care context as a result of restructuring has implications for the experiences of patients and health care providers. In direct and indirect ways, health care restructuring can also play a powerful role in “organizing” the process and progress of research. In this study, the issue of “time” was salient in shaping the process of data collection. The salience of “time” is closely tied to a changing institutional context as a result of restructuring, whereby health care providers have to deal with a heavier workload and a more severely ill patient population that requires more time and attention from health care providers. Because of the time pressure that nurses are generally under, research might be seen as “extra work” that adds to their burden. When negotiating my access to hospitals, a few administrators raised questions about the impact of the proposed research activities on nurses’ time. Although I emphasized using a “non-intrusive” approach such as following a nurse around without disrupting her work, a few managers maintained that the nurse would still have to spend time orienting me to the ward and answering any questions that I might have about her work. One manager actually refused me access to her clinical areas because she did not feel that nurses could spare time for research, even if it was only a 15-minute interview.

The issue of “time pressure” also had implications for the length of interviews. While all nurse participants in this study were outspoken and willing to share their experiences with me, interviews with most front line nurses only lasted for an average of 30 minutes because of their workload. On a few occasions, the nurse participant had to sacrifice his/her coffee or lunch break to attend the interview. Because of the time implications of interviewing for nurses’ work, I had to exercise discretion in asking for a second interview with the nurse participants.

Adding to the complexity of data collection around the scarcity of time was increased tension between hospital management and nurses as a result of the nursing dispute, which took place in British Columbia between May and July 2001. The labor dispute between nurses and the government had a direct impact on the progress of this research. Specifically, nurses' job action resulted in the closure of some patient care units, and the re-shuffling of regular nursing staff to different clinical units in the hospital to which I was negotiating access at the time. In order not to impose further strains on nurses who, as one contact person told me, "were already over-worked," I had to stop fieldwork until regular hospital and nursing services resumed in July 2001. The climate in the hospital continued to be tense even after the job action was over. As one educator described to me, nurses were really "angry," wanting only to get their work done and provide care to their patients. It may be no coincidence that I was unable to recruit any front line nurses into the study from that particular hospital site. Amidst the tense nurse-administration relationship was an institutional climate of continuous fiscal constraints and uncertainty. For this study, then, the changing health care context has inevitably made access and recruitment more difficult, requiring more time for completion of data collection.

Although there is a two and a half year gap between data collection and completion of this dissertation, and it could be questioned whether the findings of this study would still apply now, I argue that the analysis and discussion of the findings remain relevant for understanding the overall context of health care in the present day. In fact, those relations that organized health care restructuring during the conduct of this research, such as the move towards a shrinking welfare state, seem still to be playing a

powerful role in organizing health care. For instance, we have witnessed in different provinces a progressive and continuous move towards restructuring the health care system by measures such as privatization, public-private partnership, closing down of hospitals, staff cuts etc. Thus, the interpretation that I provide in the following chapters is not restricted to the period in which data were collected; rather, it provides a basis for furthering our analysis and understanding of the complex ways by which health care is organized.

In the following, I discuss the methods used in this study by first describing the settings of the study. After laying out the criteria for selection of participants and the process of recruitment, I discuss how the important issues of sampling, ethical considerations, and rigor were dealt with in this study. Following a discussion of the methods of data collection is a critical discussion of the process of analysis and its philosophical underpinnings.

### **Setting and Negotiating Access**

In this study, data were collected from three hospital settings located in two cities of the lower mainland of British Columbia, Canada. The hospitals used in this study were of various sizes, and the services that each provides range from general to specialized in-patient care. Inclusion of three hospitals in this study was mainly a strategic move to facilitate more timely recruitment of participants. As my past experience in other research projects would suggest, not all clinical areas are equally receptive to nursing research, and the process of recruitment is often subject to institutional constraints such as workload and institutional climate. In order to enhance

the chances of getting access into the clinical areas and recruiting participants for data collection, it is therefore often necessary to include more than one hospital in a study.

The process of negotiating access into the hospitals was non-linear and time-consuming. In this study, the time taken to receive ethics approval from the hospital varied from two months to seven months. The process of negotiating access into each setting was also different, from the more indirect approach of submitting, in writing, an application for ethics review in one hospital, to attending multiple committee meetings in another hospital for presenting the study and answering questions from hospital personnel. Because of different institutional climates and acceptance of research, the rate of recruitment was also different in each setting. In one hospital, seven patients and seven nurses were recruited into the study, whereas three patients and four nurses were recruited from another site. As compared to these two settings, the recruitment rate for the third hospital was comparatively lower, with three nurses but no patients recruited.

Negotiating access into the clinical areas began immediately after receiving ethics approval from individual hospitals. This process involved meeting with specific ward managers to discuss the feasibility of using their patient care units for data collection. In this study, the clinical areas used for data collection were those whose medical and/or surgical adult wards would accommodate me and allow me access for data collection. Recruitment of nurse- and patient-participants began upon receiving approval from the manager for access. In order to establish rapport and to be able to more fully immerse myself into the field, I conducted fieldwork in one setting at a time. In other words, at any one time, recruitment of participants and conduct of fieldwork only took place in one setting before moving on to another one.

## **Recruitment of Participants**

In order to investigate the ways that health care is socially organized, I talked to nurses as well as patients about some of their experiences in the current health care system. A total of 14 nurses and 10 patients were recruited from the three hospitals. Two family members present during my interviews with the patient were also invited to participate in the study. In the following, I describe the criteria and process of recruitment.

### *Criteria for Recruitment*

The patient-participants targeted for recruitment were Chinese speaking (Cantonese dialect), or Chinese and English speaking, first generation Chinese-Canadians. There are two reasons why recruitment of patient participants was limited to first generation Chinese-Canadians. First, one of the foci of this study was to explicate the health care experiences of immigrants in Canada. In the last ten years, Hong Kong and China have been among the top ten source countries of immigrants to Canada. As people of Chinese descent make up a large proportion of immigrants to Canada, their health care experiences could tell us something about the ways that health care is organized for immigrant populations. Second, because I am fluent in both English and Cantonese, I was able to communicate and conduct interviews with those non-English speaking patients proficient in Cantonese only.

Other criteria for recruitment of patient-participants included that they were adult male or female, and were fully conscious and competent to give informed consent. As this study focused upon exploring the experiences of non-English speaking (NES) patients in the hospital settings, recruitment required that the patient-participant had



stayed at least over-night in a medical or surgical patient care unit. If a family member was present during an interview, that family member was also invited to participate in the study and share some of their experiences in providing care and/or interpreting for the patient-participant.

The criteria for recruiting the nurse-participants included being a registered nurse working as a bed-side nurse, a nurse clinician, or a manager or administrator in the hospital. The nurse participant could be of any ethnic background, and could speak languages other than English.

#### *Strategies and Process of Recruitment*

In this study, patient participants were recruited through a designated contact person in each hospital. In this research design, it was assumed that those patients identified by hospital personnel as Chinese speaking (as noted in the nursing Kardex) were likely to be immigrants born outside of English-speaking Canada. This criterion seemed to be an accurate guide for recruitment of first generation Chinese-Canadians, as all patient participants recruited into this study identified themselves as born either in Hong Kong, Taiwan, or mainland China, and all spoke Chinese as first language (see Table 1). The contact person was usually a clinician or the nurse in-charge, as they had first hand information about patients on the ward and therefore would be able to facilitate selection of appropriate patients into the study. Recruiting patients through a contact person was also a deliberate measure for protecting the patient from being coerced by the researcher into participation.

Table 1

*Demographic Information of Patient Participants (N =10)*

<u>Background</u>	<u>Number</u>
Gender	
Male	7
Female	3
Age	
40-49	2
50-59	2
60-69	3
>69	2
Unknown	1
Language spoken (First/second language)	
Chinese/English (a little)	8
Chinese only	2
Place of birth	
China	6
Hong Kong	2
Taiwan	1
Unknown	1
Years of residence in Canada	
1-10 years	4
> 10 years	5
Unknown	1

Table 2

*Employment History of Patient Participants (N=10)*

<u>Participant (Gender)</u>	<u>Before immigration</u>	<u>After immigration</u>
#1 (male)	--*	No employment
#2 (male)	Wholesale/retail	Operations
#3 (male)	Medical professional	Janitor, home-maker, care aid, Chinese herbalist
#4 (male)	Building contractor	Building construction
#5 (male)	Mechanics	Flight attendant
#6 (male)	Civil servant	No employment
#7 (male)	--*	No employment
#8 (female)	Product planner	--*
#9 (female)	Housewife	Garment factory worker
#10 (female)	--*	--*

\* Unknown

The specific steps taken to recruit patient-participants were as follows. First, on behalf of the researcher, the contact person went through the patients' list to identify those patients who met the criteria of inclusion. Second, the contact person took a pamphlet about the study (prepared in both English and Chinese; see Appendix A & Appendix B) to each potential patient participant, and explained to the patient that a researcher would like to talk to him/her about a research study. With the patient's permission, the researcher went in and explained the study further. In those cases where the patient was Chinese speaking only, a pamphlet written in Chinese was left for the patient to read. The researcher would follow up with those patients to clarify any questions that they had about the study. Those patients who agreed to participate were asked to sign a written consent form, acknowledging their understanding of their involvement in the study and their right to withdraw from the study at any time (see Appendixes C & D).

As compared to the recruitment of patients, the process of recruiting nurses was less straight-forward. Rather than adhering to a pre-set plan of recruitment, multiple strategies were adopted to facilitate recruitment of nurse participants during the course of this study. This was necessary because the institutional climate in some clinical sites was such that negotiating access to nurses became difficult due to factors such as workload, low morale, or lack of enthusiasm for research. Thus, the researcher used a flexible and strategic approach in order to maximize the success of recruiting nurses into the study.

A few strategies were adapted during the process of recruiting nurse participants. First, with the help of the contact person(s) in each hospital, introductory sessions about the study were organized and carried out in the participating patient care units at a time

that was likely to be convenient for most nurses. The purpose of these sessions was to introduce the researcher and the study to nurses and to recruit them into the study. Attendance at these sessions was voluntary. Each session entailed a five to ten minute oral presentation of the study by the researcher, followed by informal conversation to clarify issues and to answer questions about the study. Pamphlets about the study were given out to each attending nurse (see Appendix E). Those nurses interested in participating were asked to write their name and contact phone number on the back of the pamphlet and return it to the researcher. In this study, a total of six introductory sessions were held across the three hospital sites. The participation rate varied from one to six nurses.

Similar to other studies that tried to gain access to nurses in a busy hospital setting (see, for example, Blythe, Baumann, & Giovannetti, 2001), recruitment of nurses in this study was also challenging and time-consuming. Because of their shift schedules, not all nurses in the participating patient care units had a chance to attend an introductory session to hear about this research. Thus, I took the initiative to approach some nurses directly, such as those who were assigned to look after the patient participants. As I moved into the third hospital site, I tried to enhance recruitment of nurses by asking the contact person to recommend to me the names of a few nurses whom she felt might have an interest in this study. In using these two approaches, I ensured that the nurse understood their right to refuse participation.

In addition, pamphlets about the study were posted on the bulletin boards of most participating patient care units. However, no nurses approached the researcher through this means. In order to increase exposure of the research to potential nurse participants, I

asked for permission to sit in on an administrative meeting to explain my study to nurse managers as well as to recruit them as participants. Two nurse managers were recruited through this approach.

### **Sampling**

The sample entails some of the most important methodological decisions of a study. Because the sample has direct implications for the quality of data and thus the credibility of findings, a researcher has to carefully consider questions regarding the method of sampling, who or what constitutes the sample, and the sample size for a study.

In this study, the sample is a purposive sample made up of two groups of participants: first generation Chinese-Canadians who were hospital in-patients at the time of interview, and hospital nurses responsible for direct patient care and/or administrative roles. This sample was purposively selected for its relevance to addressing the research questions in this study; or more specifically, the sample was “appropriate” (Morse & Field, 1995) because the experiences of participants could meet the informational needs of the study.

Theoretically, the purpose of discursive ethnography (DE) is not to produce generalizations or abstraction of the phenomena created by the production of a theory. Rather, DE, like institutional ethnography (IE), aims to explicate the process of social organization that, as Campbell (1998) argues, is immanent in, but invisible to our everyday life. One of the major underlying assumptions in this study is that each of us is expert knower and practitioner of our everyday world, and that we are able to tell our experience from the “standpoint” of our everyday reality. Smith (1987) maintains that no matter where we stand, and no matter how diverse our experience might be, each of our

experiences is a valid point of entry for investigating into the social relations that organize the everyday. In other words, anyone can be a valid sample unit; whether the experiences among the participants are diverse or similar, they provide the basis for explicating what Smith calls the "objective correlates" to what might seemingly be the private experience of individual participants.

Because no one experience is privileged over another, it follows that the sample of patients in this study could be made up of anyone who is an immigrant in Canada and has had experiences in accessing and utilizing the mainstream health care system. However, I chose to limit the patient sample to people of Chinese descent. This is largely because of the practical consideration that being an immigrant from Hong Kong myself, my fluency in both English and Cantonese would allow me to interview those patients who are Cantonese speaking only. In other words, my own language background served as a benefit in allowing me access to those experiences that might otherwise be inaccessible due to language differences between the researcher and the participant. Moreover, like other ethnic groups such as Canadians of Japanese and East Indian descent, Chinese people have historically been subject to racialization in Canada (Henry, Tator, Mattis, & Rees, 1995). Although the sample of Chinese patients in this study is not meant to represent all other immigrants, it is my hope that their experiences will provide a useful point of entry for unfolding some of the complex ways by which health care is organized for immigrants in a health care system that has been described as "raced, classed, and gendered" (Anderson & Reimer Kirkham, 1998). A total of 10 Chinese patients made up the patient sample in this study (see Tables 1 & 2).

Like the rationale for the selection of the patient sample, the experience of any nurse is seen as providing a valid point of entry to investigate how health care is organized. Thus, nurses of any ethnic or language background were welcome to participate in this study. In addition to recruiting front line nurses with experience in providing direct patient care, the sample of nurses also included nurse administrators who had day-to-day experiences in making allocation decisions. I understood that it was important to include both front line nurses and administrators in the sample because their different experiences would provide different points of entry for explicating the complex process through which care provision and resource allocation are organized. A total of 14 nurses were recruited into the study (see Table 3). Among the 14 nurses, four were doing administrative work, two provided clinical support to nurses, and eight were front line nurses. The majority of these nurses spoke English as their first language.

Like other qualitative studies, the sample size for this study could not be predetermined. The decision to stop sampling was both theoretical as well as practical. As Smith (1987) maintains, the purpose of institutional ethnography is not to produce generalizations but to explicate the complex process of social organization, by beginning inquiry from experience in the everyday. In other words, adequacy of sampling for a study like this one does not depend so much on the actual size of the sample, but on the quality of the data and their ability to speak to those larger relations that organize our everyday, mundane experiences. From the dialectic process of data collection and data analysis, I was confident that the amount of data collected provided an adequate amount of information to begin shedding light on the complex process through which health care is organized. Given that 12 months had already been spent for data collection, and in

consideration of other constraints such as resources, I made the decision to stop sampling and withdraw from the field in order to move on to focus on analysis and the writing up of this research.

Table 3

*Demographic Information of Nurse Participants (N =14)*

<u>Background</u>	<u>Number</u>
Educational qualification	
Nursing diploma	8
Nursing degree	6
Clinical roles	
Staff nurse	8
Clinical resource person	2
Educator	0
Manager or team leader	4
Language spoken(First/second language)	
English only	8
English/Spanish	2
English/Punjabi	1
English/Spanish and French	1
Spanish/English	1
Filipino/English	1
Country of birth	
Canada	11
Nicaragua	1
Philippines	1
England	1



## **Ethical Considerations: Informed Consent and Confidentiality**

### *Informed Consent*

In all kinds of research studies, informed consent is an important safeguard against manipulation or deception of participants by the researcher. Three ethical elements are fundamental to obtaining informed consent. First, every participant “must agree voluntarily to participate – that is, without physical or psychological coercion” (Christians, 2000, p.138). In this study, it was emphasized to all participants that their decision to participate or not participate in the study was totally voluntary, and it would in no way jeopardize their employment or medical/nursing care. Second, each participant “should be informed about the research in a comprehensive and accurate way” (Hammersley & Atkinson, 1995, p.264). In this study, each participant was given information about the purpose of the study, the research activities involved such as interviewing and participant observation, and how data would be used. Participants were also encouraged to ask questions to clarify any misunderstandings or lack of clarity about the study. Third, as Morse and Field (1995) remind us, negotiating informed consent is a continuous process where the participant has the right to revoke consent at any time. In this study, it was stipulated in the consent form that the participant had the right to withdraw from the study at any time without consequence (see Appendixes C, D, & F).

### *Confidentiality*

Confidentiality can be understood as an ethical requirement to protect the safety and privacy of research participants, by concealing from the data and publications any information that could expose the identity of the participants and the settings in which a study has taken place (Punch, 1994; Christians, 2000). In this study, a few measures

were taken to safeguard confidentiality of patients, nurses, and the hospitals. First, all consent forms signed by participants were stored separately from interview transcripts. Second, each participating hospital and participant was named by a code. Transcripts pertaining to a particular hospital or participant were identified by the corresponding code. Third, any materials that might identify the setting or participant were removed from the transcripts. Last but not least, all transcripts and research materials, with no identifiable materials on them, were securely locked in a filing cabinet. Only the researcher has access to the filing cabinet.

### **Rigor**

Whether the research is qualitative or quantitative in nature, there is generally a concern with the quality of the study in terms of its “methodological rigor.” More specifically, a study is usually evaluated by the extent to which the process and the product of research are valid and trustworthy, such that we can act on its implications safely (Lincoln & Guba, 2000). But unlike quantitative research, where there is general consensus on using reliability and validity as the criteria for judging the value and quality of a study, the question of rigor tends to be more ambiguous for qualitative research. The qualitative paradigm includes a widely divergent group of inquiries that often differ in their philosophical underpinnings and assumptions about reality (Sandelowski, 1986). The quality criteria used for evaluating one type of qualitative study may not be applicable or appropriate for other studies. In addition, as Sandelowski and Barroso (2002) argue, even when the same criteria are used, the process of evaluating a qualitative study is highly personal, in that the ways in which a reader views and judges a study are invariably shaped by factors such as past experiences, knowledge, and personal interests.

Specifically, Sandelowski and Barroso see the evaluation of research studies as entailing an important “aesthetic and rhetorical” element of reading and re-reading the research report that, in itself, is a product put together by the researcher to persuade the readers of its validity by using different “literary technologies” such as verbatim quotation and representing the findings in particular forms.

If we understand the process of evaluating research as being not so much objective and linear but rather an effect of reading and writing, it is important for qualitative researchers and readers to recognize the potential pitfalls of forcing “rigor” into the written research product, even though what is written did not actually take place in a study (Sandelowski & Barroso, 2002). In order to ensure that the findings of a study are actually credible and “morally defensible” (Thorne, 1997), we need evaluation criteria which reflect responsiveness to the nature of knowledge production in qualitative research as largely an interpretive and analytic process, while at the same time providing the needed “clues” for readers to judge the value and credibility of a study. Examples of such criteria, and principles I have used for ensuring rigor of this study, are epistemological integrity, analytic logic, interpretive authority, and representative credibility (Thorne, 1997).

Evaluation of epistemological integrity and analytic logic presupposes the criteria of “information adequacy” (Sandelowski & Barroso, 2002). Here, the researcher is required to provide sufficient information and to make accessible to the reader the line of reasoning behind the research, from coming up with the research problematic to making the various design and analytic decisions in addressing that problematic (Thorne, 1997). We can claim that a study is “epistemologically intact” if the research question asked is

congruent with its philosophical assumptions about the nature of reality and the nature of knowledge production (Thorne, 1997). In this study, the research question “how are the experiences of immigrants organized under health care restructuring?” is consistent with the ontological assumption that reality is “social” (Smith, 1987), whereby knowledge about our reality and the social relations that organize that reality are “immanent in” (Campbell, 1998) the everyday experiences of people. Thus, in order to explicate those relations that organize the health care experiences of immigrants, inquiry had to begin from the everyday experiences of patients and nurses in the current context of health system restructuring.

For this study to have interpretive authority, the researcher neither privileges nor rejects a priori theory in her analysis, but bases interpretation on what Lather (1991) might call “context-embedded data.” Specifically, interpretation took the form of a “dialectical or reciprocal relationship” (Lather, 1991) between theory and data, whereby a back and forth process of doing fieldwork, analyzing, reading, and writing allows theory and data to speak against each other, thus minimizing the effects of theoretical imposition or “researcher overenthusiasm” (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). Although member validation is a common strategy to check researcher bias in interpretation, this strategy is not unproblematic. Indeed, even though research participants have first hand information of their experience and thus are in a position to validate the researcher’s interpretation of those experiences, implied in such a practice is the assumption that there is a constancy or repeatability of meanings that participants ascribe to their experiences. But as Sandelowski (1993) reminds us, the telling of stories is an interpretive act whereby the content of a story can change with time, context, and

memory. Moreover, researchers and participants, coming from different “interpretive communities” (Sandelowski & Barroso, 2002), are likely to bring to the research and evaluation of its findings different expectations and interests (see, for example, Campbell, Copeland, & Tate, 1998). Thus, rather than using member checking, the researcher in this study made reflexive notes after each episode of data gathering in order to account for the personal and contextual factors that might have shaped her “seeing” and “analyzing” both in and beyond the field. Integration of reflexive notes in the writing helps to bring into the open those aspects of research that are “messy” but nonetheless influential in shaping the process of knowledge construction (see my critical discussion of the politics of negotiating access in the Discussion chapter).

Although the aim of this study is not to provide generalizations, efforts were made to enhance its representative credibility beyond the particular experiences of participants in this study. These included the strategy of using a “triangulation of data sources” (Thorne, 1997). To gather data by more than one method is particularly important for this study because prolonged engagement with nurse participants in interviewing was not possible due to their heavy workload. Thus, participant observation was an important strategy for further exploring issues emerging from the interview data, as well as for seeing any discrepancies between what was told in the interviews and what was actually observed in the everyday lives of nurses and/or patients.

### **Methods of Data Collection**

#### *Ethnographic Interviewing*

Ethnographic interviewing was used as one of the methods for data collection in this study. Here, ethnographic interviewing carries a particular epistemological meaning

different from the one used in traditional ethnography. Rather than using it as a way to get at some “emic” points of view of a culture or its way of life (see, for example, Spradley, 1980), the notion of “ethnographic,” as used in this study, speaks to a methodological response to locating “experience” as a starting point of inquiry, where investigation into our reality begins *from where people stand* in terms of their actual experience as nurse, patient, family member and so on.

There are at least two assumptions that underlie the use of interviewing as a method for investigation in institutional ethnography and in the way I conceptualize discursive ethnography. First, it is assumed that people are able to tell, at least concretely, about the “routine daily accomplishments” (Smith, 1987, p.154) of their everyday world. Second, it is assumed that social relations are embedded in the ways people talk. This is because the social relations and discursive/ideological complex that organize our everyday lives also govern our practical reasoning and understanding of our world. In other words, the only way we know how to talk about our everyday world is by drawing upon our “tacit knowledge” about that world and how we co-order our activities within it. As Smith argues, “[i]t would be hard for someone to speak unmethodically in referencing social organization of which she is a competent practitioner” (1987, p.188). For instance, in talking about how she coordinates her time in a shift, the nurse is also referencing the social organization that co-orders the clinical reality and the conditions under which she has to get her work done within the shift. Here, the nurse might not be fully aware of how her actions are hooked to social relations and decisions beyond her immediate clinical context; however, she is a competent practitioner in prioritizing her work, and she knows how to talk about it. Thus, even though people cannot tell us about

the complex process of social organization, the telling of their experiences are nonetheless “*expression*” of the social relations of their everyday world and its discursive organization (Smith, 1987). One way to access those experiences and its embedded social relations is by interviewing.

In this study, each patient- and nurse-participant was interviewed at least once to talk about their experiences as care receiver or care provider.<sup>15</sup> There were altogether 27 interviews, 14 with nurses, and 10 with patients (including two family members). The focus of interviewing was guided by, first, the conception of health care as “work organization” in which nurses, patients and their families are a constitutive part of its accomplishment, and second, by the purpose of explicating the discursive or ideological currency that organizes that work organization. In order to probe into these areas, trigger questions in the form of “descriptive questions” (Spradley, 1979) were prepared to facilitate conversation with participants. For instance, I asked nurses to talk concretely about their everyday duties, as well as inviting NES patients to describe their experiences in the hospital. As this study is specifically concerned with the organization of health care for immigrants in Canada, I also asked nurses to talk about what culture meant to them, and their experiences in providing care to a diverse population. (For a sample of trigger questions, see Appendix G).

In order to allow participants to talk freely about their experiences, each interview in this study was kept as open-ended as possible, with the flow of the interview guided

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<sup>15</sup> All interviews took place in the hospital. The majority of the interviews lasted for an average of 30 minutes, with the exception of two that lasted for an hour each.

equally by what the participant said and by the agenda of the researcher.<sup>16</sup> Moreover, this study took an evolving approach to the development of interview guides. Specifically, I tried to do what Smith has described as *following the threads along the way of investigation* (quoted in DeVault & McCoy, 2002, p.758), by continuously developing new trigger questions to explore emerging issues that are of concern to this study. For instance, after having noticed the omnipresence of the “text” during an observation, I followed up on it in subsequent interviews with nurse-participants in order to understand its meaning for their work. This would not have been possible had I adhered to a pre-determined interview schedule, without “following the threads” that a previous interview and/or observation had provided me. Here, we can begin to see the ways in which interviewing and participant observation have an important dialectic relationship, with the one informing the other in the evolving process of investigation. I turn now to the method of participant observation, and describe how it was used in this study to explicate the social relations of health care.

### *Participant Observation*

In addition to ethnographic interviewing, participant observation (PO) was another method used in this study for data collection. Briefly, participant observation can be understood as a research activity where the researcher goes to a setting to observe and describe the activities, people, and physical aspects of a social situation (Spradley, 1980). For research using an institutional or discursive ethnographic approach, PO can add to the

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<sup>16</sup> Regarding the art and skills of doing interviews, I take the position that there is always some specific purpose to conducting an interview, and thus the flow of an interview cannot be dictated solely by the participant’s concern or self interests. As DeVault and McCoy (2002) argue, “[a]s in any qualitative interviewing, there is a balance to be achieved between directing the interview toward the researcher’s goals and encouraging informants to talk in ways that reflect the contours of their activity...” (p.757).



richness of data by allowing the researcher to see, *through her “embodied participation”*<sup>17</sup> in actual material contexts of space and time, the ways by which participants live their experience and coordinate their everyday lives in particular settings.

For a participant observer who has membership in the research setting, one of the challenges is to “suspend her preconceptions” (Hammersley & Atkinson, 1995) about the setting so that she can remain critically aware of the happenings around her during participant observation. In this study, I have used two strategies to counteract the “mundane effects” of my familiarity with hospital wards in which I have worked as a nurse. First, I used theory to provide me with specific directions for what Spradley (1980) might describe as “tuning to things that, because of its mundane nature, usually get tuned out” (p.56). Here, I am aware of the potential criticism of introducing “bias” into the study by using theory to guide PO. However, I argue that making observations in research is never value-neutral because after all, PO is not about immersing oneself blindly into a setting; rather, *PO is always a situated act* as the researcher brings with her particular interpretive lenses to (selectively) see and hear. In other words, what the researcher chooses to observe is invariably a decision of theoretical concern. In this study, Smith’s theoretical focus on social relations has prompted me to pay attention to

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<sup>17</sup> Depending on the underlying philosophical orientation of research, the boundary and nature of participant observation could be defined differently. In this study, however, I take the position that whether or not the researcher actually takes part in the activities as a member of the setting being studied, she is invariably a “participant” in the social setting by virtue of her physical presence as an observer. As Emerson and his colleagues (1995) argue, in being a participant observer, a researcher should not attempt “to be a fly on the wall” (p.3); since she cannot avoid interaction with people in the setting, her presence is always “consequential” for what is taking place in the field. Thus, some of the boundaries drawn between different modes of participant observation are at best artificial, and at worst naturalizing the positivist myth of objectivity and control. An example is Gold’s classic typology (quoted in Adler & Adler, 1994) that

how the work that nurses do has implications for the work of others and is hooked to interests outside of the immediate clinical context. This dimension of nurses' work could have been missed if I were not directed by the theory to observe and look for the complex of relations that accomplish the everyday work organization of health care.

Second, I tried to un-do my tacit knowledge (as a nurse) about how clinical reality is put together by constantly re-negotiating my identity between novice and member while doing PO in the field. In fact, the way that a researcher positions herself would likely have an impact on how participants interact with her. At times, I deliberately took up the role as a novice or "acceptable incompetent" (Hammersley & Atkinson, 1995, p.103) in order to get "permission" for asking questions about issues that, to the participant, might be taken-for-granted rules and knowledge. One example was asking a nurse participant to go over with me how the clinical protocol as "text" works. My lack of knowledge about the "text" seemed acceptable to the nurse because it was a relatively new procedure in the setting. Conversely, when participants perceived me as a nursing colleague, I was expected to know "how things work" in the health care setting. Thus, it became awkward when I asked questions or made observations of events that seemed so mundane to the nurse-participant that s/he might have questioned my motive and "membership." It was therefore a constant challenge to balance the need to maintain rapport and acceptance (as member) without trading away the need to tap into the "mundane-ness" of nurses' everyday world by asking questions (as novice).

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distinguishes between the complete participant, participant-as-observer, observer-as-participant, and the complete observer.

Because the purpose of participant observation, as conceptualized in this study, is to explicate the social relations that organize everyday health care experience, the focus of observation is not so much on observing people's behaviors or their facial expressions during interactions, but rather upon understanding how nurses coordinate their work and the practical reasoning behind their activities. In this study, there were altogether nine episodes of PO, and all observation was carried out in the hospital. The process of PO included:

1. Buddying with a nurse participant for part of his/her regular shift: this entailed starting observation at 07:00, and spending a range of 2 to 8 hours with the nurse in each PO session. Here, spending a considerable amount of time with the nurse was necessary for observing a variety of nursing activities, as well as getting a fuller picture of how nurses coordinate and prioritize their work during the span of a shift.
2. Observing selective activities, such as discharge planning meetings, and a resource allocation meeting. It was usually not feasible to pre-plan participation in activities like these. In this study, I only learned about those meetings after I was in the field, and later negotiated permission from the person in charge to attend them as a participant observer. What this speaks to is the evolving nature of the research design in a study such as this.
3. Writing fieldnotes of observations made: in this study, fieldnotes<sup>18</sup> were usually written on the same day or on the day after an episode of PO. The purposes of writing fieldnotes were, first, to re-capture what was observed as fully as possible

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<sup>18</sup> In this study, fieldnotes are not taken as representation of truth, but as the researcher's "re-construction" of reality through her situated writing and interpretive knowing. For a more detailed discussion of writing fieldnotes in ethnographic studies, see, for example, Emerson, Fretz, and Shaw (1995).

and, second, to reflect on my experience in doing a particular episode of observation and being in the field as a researcher. Such reflection is important because it provided a context to the research process and to the data gathered through the researcher as instrument.

4. Data from participant observations were analyzed and synthesized along with transcript materials from interviewing and review of documents.

#### *Review of Documents and Texts*

In discursive ethnography, the texts are an important source of data for understanding the process of social organization because they are seen as serving a potentially important role in reproducing social relations by organizing what people do in their everyday lives. However, the types of texts to be reviewed in a study are often not amenable to being predetermined. Rather, the researcher has to follow the “threads” along the process of data collection and analysis in order to determine the types of texts to be explored.

In this study, for instance, the original intention of reviewing the text was to get an understanding of some institutional policies and practice guidelines regarding the provision of care to immigrant populations. Thus, I asked for permission from the contact persons to review the policies on their ward, such as those around interpreter services and diversity issues. As I progressed in my fieldwork with participant observation, I began to notice the “omnipresence” of the text, including the patient chart, in organizing what nurses do. Thus, I shifted my attention from reviewing hospital policies to exploring some clinical texts, such as clinical protocols and procedures. Here, my exploration of the texts was aimed at gaining an understanding of some of the

processes through which the work of nurses was organized by the text, rather than scrutinizing the wording and linguistic structure of a piece of text through textual analysis. One of the ways to examine the functions of the text in social organization is by asking people to tell us how they use a specific text. As Campbell and Gregor (2002) argue, “[t]exts appear in people’s talk because they are an integral part of what people do and know” (p.79). Some nurse participants in this study were asked to describe how a clinical protocol worked, and what their own experiences were with using the protocol.

### **Management of Data: Transcription and Translation**

In this study, all interviews were transcribed verbatim into interview texts. All interviews with nurse-participants were conducted in English and were transcribed verbatim into English. All interviews with patient-participants were conducted in Chinese. The researcher, who is fluent in both Chinese and English, translated these interviews from Chinese into English during the process of transcription.

It is recognized that there are complex issues involved in transcription. Mishler (1986), for instance, alerts us to the inevitable effect of transformation when speech is transcribed into written texts, whereby the texture and flow of speech can only be partially re-presented in written form. Added to the complexity of transcription are some issues related to translation of interview texts from one language into another, such as differences in interpretation of the same text by different translators, and the lack of equivalent words between two languages (Twinn, 1997). In this study, I take the position that there can never be “absolute accuracy” in translating a research text such as an interview. For, as Bakhtin (1986) reminds us, the text “can never be completely translated” (p.106), for every re-reading of a text is a new reading in a different dialogic

context. Moreover, there is no “truth” for the translator to re-capture, since the meanings that the participant might have ascribed to his/her story, as told in his/her own language, could change with time, context, and memory. Perhaps all that the researcher/translator can do is to re-tell the story in another language, and try to re-live its meanings as fully as possible.

### **Data Analysis**

In qualitative research, analysis is a highly abstract process that relies on the researcher as an “instrument” (Morse and Field, 1995) to do the mental work of conceptualization and interpretation of data. But as Denzin (1994) reminds us, “[n]othing speaks for itself” (p.500). Data can only mean something when they are filtered through the particular interpretive lenses, or the theoretical and philosophical frameworks that the researcher brings to understanding the world. The way that data are read would in turn affect what “knowledge” will be constructed through analysis. Thus, in order to make the “product” of research accountable, it is important to explicate the interpretive lenses and assumptions that undergird the work of thinking, analyzing, and writing of the researcher. In the methodology section, I have elaborated on the directions that Smith’s institutional ethnography provides for analysis and interpretation in this study, which I call discursive ethnography. In the following, I summarize the philosophical assumptions of this study, and discuss in more detail the nature of analysis and the strategies used for interpretation of the data.

#### *Theoretical and Philosophical Assumptions of this Study*

- a) Reality is “social” (Smith, 1987, p.125). In other words, actions and experiences of individuals cannot be explained by or reduced to personal intentions or choices

(alone). Rather, the everyday experience of individuals is organized by “social relations” which co-ordinate what s/he does with the actions of others.

- b) Because the social is constituted by the actual activities of people in real material time and space, *the social actually happens*, and thus can be investigated.
- c) People are expert knowers of how their everyday life is put together, and they are able to articulate it verbally. As Smith (1987) argues, “[t]he methodological assumptions of the approach we are using are that the social organization and relations of the ongoing concerting of our daily activities are continually expressed in the ordinary ways in which we speak of them, at least as we speak of them concretely” (p.188).

### *Purpose and Nature of Analysis*<sup>19</sup>

#### Purpose of Analysis

Given the theoretical directions of Smith’s institutional ethnography, analysis in my notion of DE is guided by several purposes. First, analysis attempts to explicate some possible connections between the local and extra-local. These connections are not only theoretical linkages or hypotheses, causal relationships or pathways; instead, the nature of analysis is “materialist and empirical” (Campbell & Gregor, 2002, p.89), with the explicated connections grounded in empirical data about people’s everyday experiences. We can conceptualize the connections between the local and extra-local as taking the

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<sup>19</sup> It is important to point out that although there are some clear purposes and theoretical directions to analysis in IE and DE, i.e. explication of social relations and the connection between the local and extra-local, this does not mean that we already know what we will find or that there is only one way to do analysis. In fact, the process of social organization at different institutional sites such as health care is complex, and it is often outside the scope of any one single study to fulfill all the goals of analysis as stated above. Thus, rather than trying to follow any methodological orthodoxy, the analytical approach to IE and DE should be directed by the specific purposes and problematic of a study. For instance, the analytic strategies for a study focusing on textual analysis would be different from the one looking at the institutional processes involved in the delivery of human services. Whatever analytic strategies are used, they should be appropriate for the purposes of a specific study and are defensible methodologically.

form of social relations. More specifically, these connections or social relations are *expressions of social organization by the ruling apparatus*. Second, in DE, analysis also focuses upon exploration of the organizing function of discourse and the text. On the one hand, analysis is concerned with investigating *how the discursive intersects with the material*, or how discourse organizes social relations or people's everyday activities in actual contexts of material time and place. On the other hand, analysis aims to map out some of the ways by which the text and textually mediated discourse mediate social organization and articulate what happens in the local to the political and economic interests of the rulers at the extra-local level.

#### Nature of Analysis

In discursive ethnography, as in other institutional ethnographic approaches, although the specific analytical focus for each study might differ, in one way or another analysis is guided by the ultimate goal of investigating the objectifying relations that organize the everyday/everynight world of people in multiple local settings. While these relations are assumed to permeate people's everyday experience and the ways that people understand and talk about their lives, it is recognized that people are often unaware of how what they experience is intertwined with and organized by those social relations. An understanding of social organization as "immanent yet invisible" (Campbell, 1998) calls upon the researcher to approach analysis and to locate the "knower" in particular ways. On the one hand, in order to "get close" to the social relations that are embedded in people's everyday reality, the researcher needs to have access to people's everyday experiences, by making observations and/or asking people to talk about what they do and



how their everyday lives come about. These everyday experiences of people, located in particular “standpoint” and material conditions, are what constitute data for analysis.

However, analysis must also go beyond a description of what people tell us about their everyday world, as they understand it. This is because even though people are recognized as expert knowers who have practical knowledge about how their everyday lives are put together, they cannot necessarily tell of those social relations that organize their experiences in the everyday. Thus, analysis must go into “explication” (Campbell, 1998) of those ruling relations that are hidden underneath what might appear as the mundane, everyday experiences of people.

For these types of methodological approaches, analysis is not aimed at looking for commonality or frequency in occurrence of events or experiences among people. No matter how diverse the experiences are among participants in the study, each of these experiences is considered as an equally valid “point of entry” for investigating the complex process of social organization, or what Smith (1986) calls the “objective correlates” to diverse subjective experiences. Because a rich and successful analysis would depend on the extent to which an analysis allows “differences in possibility of knowing” (Campbell & Gregor, 2002, p.59) from people’s varied standpoints, analysis in IE/DE does not privilege the common strategy of “theming” or grouping similar or dissimilar experiences into categories. In fact, Smith (1987, 1999) alerts us against abstracting the meanings of people’s experiences by forcing those experiences into the concepts (in the form of themes and categories) of the dominating discourses, among which academic discourse is no exception. In DE/IE, a successful analysis is one that “supercedes any one account and even supercedes the totality of what informants know

and can tell” (Campbell & Gregor, 2002, p.85). In other words, it is the ability to explain to people how what might seem mundane to them is implied by and has implications for social organization that makes an analysis valid and adequate.

The following procedures, or what I call interpretive practice, are the results of my own process of trial and error in reading and analyzing the research texts. They can be understood as methodic processes to organize the data for reading and for reaching analytic insights. After all, there is no formula to the analytic work of explication; the process of analysis is abstract rather than methodic. Thus, the following strategies should only be seen as one way to organize a large amount of data in the preliminary stage of analysis. Analysis, as Anderson, Dyck, and Lynam (1997) argue, is concurrent with data collection, entailing a non-linear, back and forth process of reading, interpreting, writing, thinking, and more data collecting. Because there is no one clear path to analysis, it is the responsibility of the researcher to write up the analysis in a way that is convincing to the readers, and to demonstrate how her analysis is reached with the support of data.

#### *Analytic Strategies and Interpretive Practices*

- a) reading of each transcript to get a sense of what was said and/or seen;
- b) organizing each transcript into segments by very broad “codes.” These codes pertain to the main area of investigation of this study. New codes were added along the process as necessary. Rather than being used for directing analysis, the codes were mainly used for organizing a long transcript by breaking it down into smaller areas. As such, effort was made to keep the number of codes to a minimum. Altogether 26 codes were used, examples of the codes are *health care*

*interpretation, resource allocation, discourse, language, culture, everyday  
mundane work of nursing, methodology, policy making/policy implementation;*

- c) reading those segments of texts that come under the same code in each transcript, and arriving at “analytic insights” from the reading and preliminary analysis of those texts. In order to elaborate on each analytic insight, interpretation and analysis of the texts were substantiated by quotes from the particular transcript. These analytic insights and interpretations form the basis for asking further questions. Preliminary analysis of data was shared with and reviewed by some members of the Dissertation Committee;
- d) reading the analytic insights of all completed transcripts (this took place at different points before as well as after completion of data collection), in order to get a sense of “what was going on?” in the field as a whole. The purpose here was not so much to identify similarities or differences among those analytic insights, but rather aimed at going beyond what was seen and heard, by treating the analytic insights (and the transcripts from which these insights were derived) as providing different pieces of puzzles for solving the “problematic,” i.e. those complex processes that organize the experiences of participants. Nonetheless, the researcher cannot rely on the data to tell her what was lying and hiding beneath its orderly and “mundane” appearance. Rather, I had to read “into” the preliminary analysis, by constantly (re)reading the data, asking questions, and interacting back and forth with the theoretical perspectives which I bring to this study;

e) analysis continues into writing, i.e. analysis does not stop when writing begins.

Rather, one informs the other, with writing, reading, and analysis constituting a continuous and dialectic process of inquiry.

### **Conclusion**

The complex and multi-layered nature of fieldwork, as I have experienced it in this study, should not be seen as merely a series of constraints, but instead acknowledged as a source of valuable information about the institutional context in which health care delivery takes place. After all, the reality of research is the same reality that the researcher purports to study. Or as Smith might argue, the relations that organize health care are the same relations that organize research. In this sense, what we get to see and hear in research is already “*disciplined*” (Campbell, 1998) by the relations that organize the world we plan to research. This speaks to the nature of research not as some apolitical or value-neutral activity, but as itself an organization of knowledge construction and what we can know about our reality. Thus, what I got to see and hear in the field should not be taken as some “representation” of reality in its pure form. Rather, it provides *one* starting point to examine our reality and how that reality is socially organized. The following is a presentation of what I have “read” from the data, from a methodological approach that aims to understand everyday experience as socially organized; and, through a theoretical lens that is concerned with how discourse and the text organize the experiences of non-English speaking immigrant patients, and nurses in the current context of health care restructuring.

## CHAPTER FIVE: FINDINGS

In this chapter, I present the findings from what I have seen and heard in the “field,” by organizing my analysis and interpretation of the data into three major sections. In the first section, I locate an understanding of the health care experiences of NES immigrant patients within the discursive context in which nurses made sense of the meanings of cultural differences in their practice. The discourse of culture, as unfolded in this study, tells us something important about the complexity and tension hidden in the health care encounter between nurses and patients coming from diverse ethno-cultural and linguistic backgrounds. While data in the study indicate that patients perceived as “culturally and/or linguistically Other” can be subject to receiving “lesser care” from the mainstream health care system, experiences of nurses in the study also remind us that this is not only an ideological issue of attitudinal prejudice or the lack of “sensitivity” on the part of the nurse alone. Rather, there is a very important *material context* that organizes how nurses are able to read and respond to “differences” in care needs among their patients.

I further explore this material context of health care in the second section of the findings, by explicating the changing relations of resource allocation under the current context of restructuring. Analysis of this section mainly draws on the experiences of nurses because, as providers of health care, nurses can provide us with some important information about the changing priorities of health care, and how those changes affect their practice and decision-making. In other words, to focus on the experience of nurses does not mean that their experiences are privileged over those of patients. Rather, the experience of health care providers provides an entry point into the process of social

organization, by illuminating their perceptions of the changing context in which health care is organized for NES immigrant patients.

As we begin to understand more about the changing priorities of health care and the particular material context in which nurses provide care to an increasingly diverse population, I pull together the linkage between the local experiences of health care and the larger relations and institutional processes that organize those experiences by examining the “problem” of language barriers in the final section of these findings. Specifically, by drawing upon the experiences of NES patients and nurses in trying to negotiate health care across language differences, I demonstrate how the economic priorities for efficiency and productivity organize access to (in)adequate interpreting support by NES patients, and how the ways that nurses are able to respond to language barriers articulate to the material organization of clinical reality. First, I look at the ways that nurses make sense of and talk about culture in their clinical practice.

### **The Discourse of Culture**

Despite the highly problematic and complex nature of our various conceptualizations of it, “culture” represents the context within which we normally associate human variations in traditions, behaviors and beliefs. How culture is negotiated and how cultural differences actually play out in the current context of clinical reality involve considerable ambivalence, tension, and contradiction. In order to understand these processes beyond their ideological meanings and significance, we need to understand how responses to cultural differences articulate with the material organization of health care in the current context of health care.

*Awareness of and Respect for Ethno-cultural Differences within the Patient Population*

When asked to talk about their understanding of culture, nurses in the study showed an awareness of the different ethno-cultural backgrounds within their patient population. These differences in backgrounds are related to changes in the population in Canada in the past few decades as a result of immigration. Specifically, nurses did not see their patients as constituting a homogenous group but as having different care needs. Nurses saw that respecting cultural differences is an integral part of respecting the patient as an individual,

N: With culture, I find that it's very important to respect the other person's beliefs, values, attitudes. The reason being is, each person has different ways of doing things. For instance, say a patient believes in something, or they felt strongly about a certain situation, I may have a different opinion, and that's fine, everybody is entitled to their own opinion. We need to understand that this other person is coming from a different world, or from a different background, and from different experiences of life.

Because cultural background and practices define an individual, some nurses recognized that it is particularly important to incorporate the patient's cultural needs into their care so that the patient can regain some control over his/her identity in the hospital.

One of the specific elements of culture to which nurses often made reference is food. This is perhaps due to the importance of food for health and healing. One nurse also understood the action of bringing food as showing care to the patient in the hospital. The hospitals have also taken steps to "accommodate" cultural differences in dietary needs by providing options other than what some nurses have described as "traditional North American food" such as carrots and mashed potatoes. Here, we can see some of the efforts made to negotiate between different cultural spaces,

N: So, culture, on (name of this ward), we take it very highly, and regard it with our life type of thing. So we try to incorporate anything, for instance, with our Oriental population, we know that they don't like tap cold water, so we try to make sure we have a lot of warm water by their bed side. With East Indian people, we find that they like to have some of their home-made food by the bed side, so we'll encourage the family, not only with East Indian family, we encourage family to bring in their own food. So we try to get as much of their culture involved in the hospital as possible and not isolating their culture while they are in the hospital.

Other elements of culture that nurses saw as important include religion and practices of other rituals such as those surrounding death and dying. One described working around a patient's need for religious practices. Another nurse talked about how she would negotiate care with patients in terms of using herbal medicine.

Clearly, we can see the efforts made both by individual nurses as well as by hospitals to respond to the different care needs of patients coming from a cultural background different from the mainstream. But negotiation across cultural differences seems a lot more complex than addressing "concrete" needs such as what food to provide, and what religious practices to respect and allow time for. As we continue to see, the ways that culture and cultural differences are played out in the clinical context crosscut the tension and contradiction that are frequently associated with the more political and ideological domains of ethnicity and "race."

#### *Tension between Application of Cultural Knowledge and Stereotyping*

As nurses encounter patients coming from different cultural backgrounds, they also begin to accumulate knowledge about the different ways that patients might respond to health and illness. While nurses found such knowledge to be a useful resource for making connections with the patient and facilitating clinical assessment, they were also



aware of the potential pitfalls of over-generalizing and stereotyping a person's needs based on his/her ethnicity. As one nurse said,

N: I started nursing in the late 80's, and certainly there have been lots of Asian people within the community since the early 80's. The more you meet them the more you understand their traditions and, their language, I'm sorry, I don't understand any of the language! Wish I did. But it's become easier, for even though I don't know the language, I just feel that I'm more understanding of some of their traditions, and the ways, this is kind of stereotypes, I don't want to stereotype, but sometimes in the way they might react to certain situation. So you can sort of not predict, but read ahead and be a little bit more intuitive about what might offend someone, or what might make them more comfortable.

Although cultural knowledge cannot be substituted for clinical assessment of individual patients, knowledge about how people from different cultures might interpret and respond to illness symptoms such as pain could provide the nurse with some useful baseline information for initiating nursing intervention in a more timely and responsive manner. Two nurses have described the ways that they would draw upon cultural knowledge to facilitate assessment of their patients' care needs,

N (1): Like, for example, the Asian patient may not be as outgoing with saying that they are in pain, and they don't like to complain too much about pain. But East Indian culture will be very expressive about pain. By working with different cultures on the floor, they have made me be aware of that. So in my nursing practice, I'll be more attune to making sure that I ask frequently to an Asian patient, "are you in pain?" because I know that they would be more stoic.

N (2): You can get a lot in just even a 10-minute quick assessment. You can ask a patient and get an overview of how they are doing, and what their needs are. When we are talking about cultural things, going in if you know that you have Chinese, or an East Indian patient, or Italian, like I guess each of us get pre-conceived ideas of what to expect, which is not always best, but it's good to sort of know that this patient may react to pain a little bit differently. Certain cultures seem to have less of a threshold for pain tolerance. You sort of keep that in the back of your mind when you talk to them.

Thus, in interacting with patients from different ethno-cultural backgrounds, nurses have to keep a careful balance between using background knowledge about

different cultures to facilitate nursing care and avoid the pitfalls of stereotyping a patient based on broad ethnic categories such as Asians and East Indians. Such awareness seems particularly important for providing health care in a multicultural society such as Canada, where there is no direct relationship between ethnicity, nationality, language, and cultural identity. One nurse spoke about the dynamic and complex nature of identity, where it is untenable to make assumptions about a person based on appearance and language,

N: Although I think it would be nice to have a sheet or something that outline some practices or beliefs (about a culture), I think that would be generalizing a bit too much because, just because this person is of this culture, it doesn't necessarily mean that s/he follow all these things. I think it's just learning individually with patients... Because as we know, living in Canada, you can't tell by looking at somebody what culture they have... If somebody speaks a different language, I always assume there is some different culture that comes with that. But I am also aware that there are lots of people who speak English as their first language and still have a different culture.

The experiences of nurses above highlight their perception of the importance of treating each patient as an individual, without making over-generalizations about the patient's care needs based on his/her ethnic or cultural background. With increased complexity to the clinical reality brought about by a changing population, the making of any simple assumptions about a person based on attributes such as ethnicity, skin color, or language have become untenable. Some experiences of nurses in this study, however, seem to suggest that assumptions based on these factors do operate in the clinical reality. As we see in the following, notions about "who is one of us" or "who is the cultural Other" may have important implications for the quality of nurse-patient encounter.

#### *Hidden Assumptions Associated with "Who is One of Us"*

When asked to talk about what culture means to them, nurses in the study tend to associate culture with its anthropological significance as beliefs and behaviors, or as what

one nurse described as “their food, their language, their traditions.” But there are other ways that the discourse of culture could unfold in the clinical context beyond its meanings as preferences for food or practices of rituals. Specifically, the notion of culture can itself be an ideological terrain of contestation over identity and power, where culture intersects with other categories such as ethnicity, skin color and language to define the boundaries of who belongs and who doesn’t. In the following excerpt, a nurse reflected quite critically on her own prejudices in an experience she had with a patient who was racialized because of her cultural and language backgrounds,

N: I don't have any prejudice against East Indians but in this case it was a lady who was extremely, extremely loud. She didn't speak any English but it just felt like she was yelling at you every time she opened her mouth, especially in the middle of the night. She would call the call bell and you would come, first, you're not gonna understand what she's saying, so you're pointing, “Water? Bathroom? What do you want?” And then she's yelling at you like we would yell at someone who doesn't speak English; you figure if you speak louder, then they'll understand what we're saying in English. So she was the same way. She would get more agitated and yell at us louder because we didn't understand what she was saying. She had been in the country for quite awhile, like ten years and she didn't speak one word of English. And she had this extremely odd way of going to the bathroom, like she squatted on the toilet seat and I mean it was comical when you look at it, you couldn't help but laugh. But at the same time, you're laughing at something that's quite cultural and even though it made you uncomfortable, it was at the same time quite frustrating cause you just kind of stereotyped her as someone who was dumb, who was from the back quarter like doesn't know anything and uneducated or what not. And at the same time, “what is she doing here? We can't do anything for her because she doesn't follow any instructions, she doesn't do what we tell her to do. Just send her home!” And I think it made sense at the time when you look at it, it was something that we weren't comfortable with the way she was. Because it wasn't the way we were. She's not one of us so she's different, so we are not gonna spend any time trying to understand her. We're not going to spend any time trying to soothe her when she gets agitated because that's just her. I believe a lot of the people on the floor were quite prejudiced and just stereotyped her as something not quite pleasant.

In this example, the ways that the patient behaved were “culturalized” or interpreted as a manifestation of her culture, which was assumed to be inferior in

comparison to “ours.” Here, construction of the cultural Other intersects with other public discourses, including the common discourse of immigration, that which puts the onus on immigrants to assimilate into the host country by learning to speak the official language. Thus, not only was the patient seen as “not belonging” because of the perceived differences in her culture, her lack of English language skill also marginalized her as “not deserving” hospital care because of her inability to follow instructions and to fit into the role as a “good and compliant patient” within the mainstream health system.

Hidden assumptions about “who belongs” and “who doesn’t” affect the health care experiences not only of patients coming from ethnic minority backgrounds; instead, racialized assumptions could also apply to White patients. In one episode of fieldwork, I made an observation of how assumptions about a patient based on his skin color could provide the nurse with misleading cues about the patient. In this particular case, the White elderly male patient, who was having difficulty in comprehending the nurse’s verbal messages, was mistaken by the nurse as cognitively impaired. The common assumption that people of a European background come from “here,” and thus are members of the dominant cultural and language group, could have led to the nurse’s expectation that the patient was fluent in English. The following fieldnotes recall the process through which the nurse came to reflect upon the accuracy of her assessment of the White patient,

As a visitor came to see Mr. X in the first bed, Marg (pseudonym of the nurse) and I have noticed that they were talking in a language other than English. As we went to check Mr. X’s temperature, the visitor told us that they were speaking Yugoslavian. The visitor spoke with quite a heavy accent, and I couldn’t understand everything that he tried to tell us, but I heard him saying a couple of times that his English was not good.

As we were leaving the room, Marg said she began to wonder if Mr. X actually understood what she had told him earlier that morning. Marg said she thought that Mr. X was having some problems related to dementia and his old age. Now knowing that English is not Mr. X's first language, Marg began to reflect upon the assumptions that she has made about Mr. X: that Mr. X was unable to understand her not because of dementia, but because of language barriers!

The two examples above illustrate to us some of the hidden but powerful ways by which notions of culture, ethnicity, "race," and language operate to shape clinical encounters between the nurse and the patient. Albeit in different ways, assumptions of "who belongs and who doesn't" could equally put patients from different racialized groups (Whites and non-Whites) at risk for inadequate care. In the case of the East Indian female patient, perceived differences in her cultural and language backgrounds from the "norm" had subjected her to discrimination and neglect by her care providers. On the contrary, because the White male patient "looked" to the nurse as being "one of us" (that is, presumably "Canadian" and English speaking), his difficulty with communication due to language barriers was overlooked and mis-interpreted as a clinical problem of dementia associated with age. In both cases, the health care needs of the patient were prone to be compromised by ineffective interaction and communication with the nurse.

Just as hidden assumptions about "who is one of us" or "who is the cultural/linguistic Other" have important implications for the quality of care that patients might receive, these assumptions could equally affect the caring experience of those nurses coming from a minority ethno-cultural background. One nurse advocated for her colleagues by speaking against how some patients have demeaned non-White nurses as professionally incompetent by racializing them as culturally different and thus inferior,

N: We get a lot of elderly patients who make comments about our nursing staff, like "I don't want her looking after me," because they are from a different culture, they are not White. Those patients always refer to the nurses as "they," "they aren't good nurses." I do have several patients in my six years (of nursing) that would say, "well, I don't want 'them' looking after me, they shouldn't be nurses," or "they don't have the training" or whatever. That does get your back up. It is sort of a reverse thing, patients instead of nurses.

What this excerpt tells us is that, nurses from an ethnic minority background are subject to "reverse discrimination" by those patients who hold a racialized image of the "competent nurse" as White (and female). Another nurse had first hand experience facing the potential threat of racial discrimination by a patient. Not only does this experience alert us to the existence of racial tension in the clinical space, it also speaks to the additional emotional stress to which nurses of ethnic minority backgrounds are subject in their day-to-day work,

N: I remember one patient, I was covering for him while another nurse was on break. And seemingly he was prejudiced towards black people. I don't know whether he knew that I was half-black. But when I walked into his room, I felt nervous. I felt a little bit uncomfortable, and I thought "what's going to happen? Is he going to treat me differently? Or what's he going to say?" Nothing ever came of it, he never treated me any differently. But I know I was carrying that in my head, feeling a little apprehensive walking into his room.

These various experiences of nurses and patients seem to be telling us that the reading of "difference" in the clinical situation is not a neutral process but invariably intersects with some racializing assumptions that differentiate between "us" and "them." Specifically, there appears to be a dominant cultural center from which the Other is evaluated: who is the competent health care provider, and which patient is considered as belonging and therefore deserving of health care. This cultural center seems to play an important role in setting the norms for defining what are acceptable or otherwise unacceptable behaviors of the patient, and what are legitimate care needs that "deserve"

the stringent resources of the health system. One nurse talked about the perceived discrepancies of care expectations between patients coming from a non-Caucasian culture and those coming from “here,”

N: I find that the Caucasian culture, which is the larger percentage of patients that we seem to get, they don't expect you to do things for them that they are able to do for themselves. Whereas some other cultures, I don't know if it's around nurse-patient relationships or if it's when the nurse is a woman, if that makes a difference, maybe this is what women do for them at home, so they come in, the nurses are women, they expect to have things done for them that normally we wouldn't do. Like what the other nurse talked about this morning on coffee break, about that (East Indian) patient who wanted his legs washed, and you know it's something he is fully capable of doing himself. But I don't know if it's because she is a nurse or because she is a woman that he expected that she should do it for him.

R: Have you had personal experiences of that kind?

N: Oh yeah! I care for that same patient we were talking about this morning, and went into some of the same experiences, that he seemed to require a lot of my attention, more than what I thought he really needed. But I think it was a cultural thing, where he just wanted me to be there more for him, and do more for him, than what I felt I needed to do for him.

R: So how did you respond to his expectations?

N: I just tried to explain to him that, you know, I am busy, and I had five other patients and it's not something that's a priority for me right now, and if it was a priority for him, maybe he could do it himself or (to be done by) his family members. And I felt a little bit of guilt telling him that, because maybe this is what will happen in his country; if he was in a hospital in his country, maybe this would happen. *But here, it's just the way it's structured, we just don't have the time.*

This experience of the nurse alludes to a complex and hidden ideological process by which cultural difference in care needs are read and responded to in the clinical context. The ideology of self-care, that which is presumably a norm in the dominant culture, defines the parameters for what are legitimate care needs, and how much care the patient can expect to receive from the nurse. Even though a dependent sick role is

understood as possibly associated with the cultural meaning of good care, the patient's expectation for more care from the nurse is rendered illegitimate when that expectation is gendered, and interpreted in relation to unequal gender relations assumed to be characteristics of East Indian culture. One nurse further alluded to how cultural difference is subject to be gendered, as she talked about her perception of East Indian men wanting to be "served" by female nurses,

N: The East Indian male patients tend to think that everything should be done for them, everything should be brought to them, they shouldn't have to do anything, they should be what we'll call "waited on," and they probably tend not to like to be told everything they need to do by female nurses.

Along a similar vein, a different nurse made sense of the sick role behaviors among East Indian women in terms of their life circumstances and experiences of oppression at home,

N: A lot of East Indian cultures, we find that they need a lot more hands on nursing care post-surgery and I think because in their culture, the females are used to doing an awful lot at home, more so than maybe Canadian women, who are born and raised here, who have their husbands or boyfriends sharing more of the household duties. So when they come to the hospital, they tend to just want the nurse do everything with them, even if they are capable of getting up, getting themselves water, or going to the washroom. They go in more of the sick role than some of the other patients that are born in North America, maybe. And that, I think, in a way have a bit of a break from their home life because I know there is a lot more put on them in their home life.

Here, we need to be cautious of a hidden element of racialization that reifies the image of East Indian men as oppressors and East Indian women as the oppressed. But the above excerpts also points to a complex process whereby "difference" is subject to discursive re-organization, such that the ways that differences are responded to by nurses articulate with the material context of the clinical reality, or as "the way the system is structured."



Thus, negotiation of differences in care needs in the clinical context does not take place in a vacuum, and the manner in which culture and cultural differences play out in the clinical context cannot be reduced to merely ideological differences between cultural spaces. Rather, there is an important material context in which cultural and language differences are responded to in health care, as the ways that the system is structured organizes the options available to them and the time that nurses are allotted to respond to cultural and/or language differences. It is to this material context that I turn in the next section.

### **“How the System is Structured:”**

#### **Changing Relations of Resource Allocation in Health Care**

##### *Health Care Restructuring and its Implications for the Clinical Space*

During the period of data collection in this study, the environment in the hospital settings seemed to be pervaded by a feeling of uncertainty about the changes that the new government would bring to the health care system. There was the perception that changes would take the direction of budget cuts. In one administrative meeting that I attended, the themes of fiscal challenges, budgetary control, and inadequate resources came to the forefront in the discussion among nurse managers. Specifically, there seems to be a predominant concern with how to make do within what one manager has described as “a context of shrinking dollars.” When I asked her how health care was going to change within the province, one nurse administrator had this to say,

N: I think it will be business-driven. I think there is deep belief that there will be pain as we go through it. At the end there'll be money for re-investment in where it's appropriate. I think the restructuring will be painful. And my worst fear is that, given the age of many of the nurses, that nurses would choose retirement

over staying through chaos again, when hospitals are closed and things like that, which is the rumor now, I don't know how true any of it is.

There seem to be some important ways by which budget decisions made at the policy making level filter down and shape activities and decisions at the clinical level.

One nurse manager alluded to the implications of budget policy for the quality of patient care, as she talked about the challenge of balancing between the competing interests of controlling the budget and maintaining an appropriate level of staffing,

N: With the deficit, with the new government saying that there is only this much money and you have to stay on budget... The biggest challenge that faces you everyday is to get the right staff at the right place at the right time within the budgeted amount of money. That is the biggest trouble. At the back of your mind, you have the budget, you know you have to be on budget. So you constantly balance the needs of the patient and the needs of senior leadership who are saying you need to come in on budget.

One way to fulfill the economic interests of budget containment is by efficient utilization of hospital beds through patient discharge. In this study, there is an emerging discourse of "bed utilization" as an administrative strategy to deal with what one nurse has described as "an incredible access and exit problem" within the health care system. One nurse manager explained what bed utilization means to a surgical patient care unit,

N: Bed utilization is needed to make sure that the flow of patients requiring surgery, the needs of patients requiring surgeries are met by discharging the patients that are here that meet the requirement for discharge. Because the waitlist is so great, we only have "X" number of beds on each floor in order to accommodate the surgical patients. So therefore we can't have patients sitting in bed for longer periods than are needed to recover from the surgeries. And so once they have recovered, we set all the necessary functions in place for them such as home care, such as social work if necessary, so that we can utilize our beds for our surgical patients.

Thus, we can understand efficient bed utilization as a maximized use of available bed spaces in the hospital by "processing" patients through the system as fast as possible. In

order to avoid backlogs in the system, existing patients need to be discharged from the hospital so as to free up spaces for patients waiting to get in. One manager shared with us how she would deal with the problem of “access,”

R: Let’s take the situation today, that there are 33 patients waiting at Emergency to come up to the patient care units. What kind of things can be done to free up a space, or can spaces be freed up at all in these situations?

N: What we do when we have these situations is, we talk to the physicians, to explain the situation, and get them to go up to the units and look at their patients, to see if somebody can be discharged. Because we know we have some room in utilization, we know that there are times when a patient doesn’t need to be in this acute hospital. They could be at home on home care, or they could be in another type of facility that would provide for their needs. But if people aren’t working on that discharge, and putting a plan together and putting the supports in place, it can mean that a patient stays in hospital longer. That’s where the physicians have a responsibility and accountability. And so we can bring them into the loop, to say that Emergency is in a desperate situation, and get moving on your discharges. *That can produce beds.*

What this example seems to tell us is that the clinical decision for discharge might no longer serve a “pure” clinical function. Rather, patient discharge seems to be heavily driven by the economic interests of budget containment, whereby discharge decisions have become an integral aspect of accomplishing the management function of efficient utilization of hospital beds. The hidden economic dimension to patient discharge is further illustrated in the following example that sheds light on the potential tension between the interests of management for efficiency and productivity and the core values of health care to work in the best interests of the patient,

N: I have stood at the nursing station and said, “that patient can’t go home,” and that means that a surgery is being cancelled. And the manager will say, “but that patient has to go home,” and I will stand my ground and what it takes is sharing the patient’s story. When I tell the story or when the manager meets the patient, then she can deal with the pressure (of delaying the discharge). But what happens is, the people behind her don’t want the story, they just want the numbers. And

that's not what health care is about. Health care is about the stories and the people, you can't lose track of that.

What this excerpt seems to be highlighting is that, patient discharge serves an important function of keeping the "flow" of the system. As such, the "timeliness" of a discharge is central to maximizing access by efficient "exit" of patients. Data in this study suggests that there is a potential conflict between "timely" discharge and patient's actual readiness for discharge. Two nurses have alluded to the practice of "early discharge" in the hospital,

N (1): There are definitely instances where people don't want to get out of bed. Sometimes it gets to be a battle of wills which is really not appropriate in our profession, but we don't have the luxury of letting people hang around until they are ready to go home, but it's just that we have to utilize every bed right to the max.

N (2): We have a huge crunch on bed utilization so it's no longer okay for your patients to stay a day or two while they're waiting for their discharge from the doctor, and certainly more responsibility is put on our part to get them home as soon as they're able. We do have to use the multi-disciplinary team, the social worker and the home care resources and all those things to allow us to get them out sooner. So their stay is considerably shorter... People don't get the time to recover here like they did before.

One non-English speaking patient had a direct experience of being discharged from the hospital before he felt ready to go home. The lack of dominant language skills put the patient into a more difficult position to negotiate care outside the rules and regulations of hospital policy, when the care arrangement made was to his disadvantage.

P: Like the other day at (name of a hospital), the doctor gave the notification, that night, he was still saying "a few days," I could understand it, that means a few more days in the hospital. But as soon as I woke up the next morning, I was told to go home! The nurse came in and asked me to get ready and go into the waiting room, asked me if I had any clothing with me. At that time, I was feeling a bit unhappy about that. If you asked me to go, then I had to go right away? I didn't even have any clothes with me, and I had to call my family to come and take me home. I couldn't have taken a bus. They asked me to sit in the waiting room, I

was still feeling dizzy, haven't eaten anything, I was NPO (nil by mouth). Feeling dizzy, so how could I sit? I felt that it's too mechanical. I guess someone must be in need of the bed desperately. There must be an emergency case waiting for my bed. But asking me to sit in the waiting room right away? I didn't know when my family would come. Because when I called home, all the children were at work. They were going to come at about 12 o'clock. The nurse asked, "when are you going to go?" I said, "about 12 o'clock;" she said, "you can't do that, it is the hospital policy that you have to leave by 10 o'clock." That was about 9 o'clock when they notified me (about the discharge). I said an hour wasn't enough; I couldn't quite express myself in English, and she was English-speaking. I said it had to be about 12 o'clock.

In some cases, to discharge the patient home prematurely could result in medical complications that, in turn, could require re-admission, thus incurring extra costs to the system. One nurse brought this issue up but seemed reluctant to specify the details of her experience,

N: People often don't feel ready to go home, and I think it's very stressful for them and their families that they need to go home. Not everybody is like that. A lot of people are very happy. And they realize that there's a crunch in the hospital and the reason they got treated in a timely manner was because other people were going home sooner. But it does impact them because there's the odd time when someone will develop an infection and have to be re-admitted, which is always stressful on the family and the hospital.

R: Have you seen that happening?

N: Yeah, yeah, yeah. I can't be specific but, yeah.

What the excerpt suggests is that the current practice of discharging patient early before they are ready has potential implications for the health of the patient. However, this might be accepted as "patient buy-in" because, as the nurse above indicates, the only way that a patient gets to access the system is by another patient's discharge. Patient and family "compliance" to discharge can be reinforced by the public discourse and media coverage on the health care crisis. One nurse manager had this to say on this issue,

N: I think because it has been in the news so much in the last while, people know that waiting list for hospital beds are long, so they need to do their part (by accepting discharge).

Those expected to “do their part” include not only the patient but also the family. In fact, presupposed in patient discharge is the assumption or expectation of the family to take over the care-giving responsibilities in the community. Specifically, families are increasingly expected to play a central role in facilitating patient discharge by providing “continuity of care” in the community as care-givers at home. In asking a nurse administrator if there was a shift from institutional care to community care, this is what she had to say,

N: I think it has been shifted to the families, not to community care... I think our “dream” was that there’ll be more money in the community. I don’t know if there is more money in the community. I think that, the burden has shifted, but has shifted to the families.

Another nurse explained how the family is involved in patient care, and highlighted the role of the family in facilitating patient discharge from the hospital,

N: We involve the family as much as we can, and instructing them if necessary on appropriate transfers, and mobility, and we also communicate with the family what services are available for them so that they can feel comfortable knowing that family members are going to come home and this is going to be set up for them. Ah, that’s just communication with the family, and getting them involved but not overtly involved, but anything that they need to know, we make sure that they are, gets communicated to them what is needed of them, to make sure that the transition home for this patient is smooth and successful.

Although the system relies on the family to facilitate an efficient transition of patient from hospital to home, expectation of the family as caregivers in the community tends to be justified by a discourse of “supportive family.” The discursive construction of what constitutes a “supportive family” seems to provide a basis for nurses and other health care providers to make assessment of whether a family is doing what it is expected

to do. The discourse of “supportive family” can in turn be used to justify allocation decisions in the economic interests of an increasingly “stringent” system.

By sitting in a few discharge planning meetings, I have noticed that the staff made assessment of families on the basis of the extent to which those families are “supportive” to the patient. I asked a nurse participant to clarify for me what a “supportive family” would look like,

N: A supportive family is one that I would suggest is one that is willing to try to meet the needs of the patient, I mean every family member to whatever degree is a loving family member, but it's how willing they are to take what information we give them, and work with that, and encourage the patient themselves that the support will be there, and that this is going to be done at home, and that all the needs for the patient from a supportive measure is met, so that they can be safely and successfully transferred home, and feel good about, they take the initiative to ask questions and become involved in what is needed as far as physio and whatever is required to make that patient successful transition home.

Contrary to the descriptors of a supportive family are those unwilling to take on the care-giving role, thus creating problems in patient discharge by occupying a bed unnecessarily. In other words, family's involvement in care-giving has direct implications for the material organization of health care, such as its “bed utilization.” A nurse had this to say about what might cause a problematic patient discharge,

N: Usually it involves some social situations at home. Quite a lot of our population is aging, and the focus has been to have people stay in their homes for as long as they could. And where a problem usually comes in, is maybe we have a very frail 80 or 90 year old who falls and breaks a hip, who has been managing at home with extra help; but because they fall or they have some other situation that they need to be in the hospital. And then they just aren't able to go back and live on their own. That's where it slows down, where a lot of these people, either their family or themselves, they don't want to be waitlisted for a care home. And that's where it becomes a problem, because all of a sudden, we can't send these people home, they can't cope on their own, the family members are usually all working, they can't cope with them in any way, so that's where the backlog starts, especially if they're sitting in a surgical bed... I think with our aging population getting more and more, and families reluctant to, well, families that really can't,

because of economics, everybody works, you know, daughter, sons, daughter-in-laws, there isn't a lot of options for them to do, so, that can be a problem.

While this nurse seems to be sympathetic to the family circumstances of caregivers and the potential difficulties in providing care-giving at home, however, some families seem to have less choice than others in their care-giving roles. Thus, the notion of "supportive family" seems a highly evaluative term that has the power to control and organize resource allocation for the patient and the family, by defining what they deserve or don't deserve. This could be the case with sponsored immigrants who, according to Canada's immigration policy, are not eligible for certain social programs including long term care support at home for the first 10 years of residence. Those families evaluated as "non-supportive" of a sponsored immigrant are subject to being *disciplined* by a health care system that is purportedly accessible to all. The following nurse told us about how the system might respond to the dilemma that an un-supportive, immigrant family creates for patient discharge,

N: It becomes an extremely difficult situation in the fact that the sponsor is either not willing to, not able to, or not available to respond to the needs of these persons. And so, they become, ah, (silence), they become not a burden, but they become a challenge in the fact that they are no longer surgically requiring an active surgical bed, but we have no other place to put them. So therefore they tie up active surgical beds that have patients requiring surgeries is being denied because I don't have the access to that bed. And so it becomes a very big problem as to what we do with these persons, and if there's no sponsors around, they don't qualify for long term care, they don't qualify for many things, so our social worker has to work extremely hard to find out where best this person can be placed. We often get family members who just refuse to take them home. But I know that it becomes a real issue for us because of the fact that we are not going to deliberately send someone out of the hospital, but, when you have issues with family members have sponsored them and are not willing to take them home, we have often had to go to the extreme of charging them a thousand dollars a day, or eight hundred dollars a day for bed use, because of the fact that we cannot tie up active surgical beds. It seems very cruel, but when they have families, and they have huge, most of these people we have examined the areas and the avenues very



closely, and the family members are capable of taking the people home, just reluctant to take them home. And so we have many methods of doing it, the last resort is charging them... It's a ploy that we don't care to use. But occasionally it becomes necessary, and it's usually effective.

In fact, "sponsored immigrant" might have unwittingly become a label for gate-keeping certain populations from accessing the stringently protected resources in the community. In one discharge planning meeting, one health care provider in the meeting reviewed the case of a patient and said that, "we can't do anything for the family because the patient is a sponsored immigrant." So even though all families are expected to provide care-giving at home, some families, such as those of sponsored immigrants, are at a disadvantage to compete for resources to facilitate them with care-giving. Just as the hospital system is tightening its budget, community resources are also under constraint. As one nurse manager said,

N: Depending on how independent the patient was, there are only so many hours that s/he would qualify when going home. I mean there aren't unlimited resources... Because that's all there is out there to give, it's not an unending pool. There is a limit to the money, resources, manpower. Though the need might be more, there just isn't that to give.

If there aren't enough resources in the community to support the patient for recovery in the community, and if it depends on the patient's personal resources to cope with illness at home, some patients could "fall through the cracks" in the system. This could be the case for those NES immigrant patients whose social and family support systems have been disrupted due to migration. This could also be the case for those patients whose conditions aren't serious enough to warrant a longer stay in the hospital, and yet don't have the skills or knowledge to manage their illness adequately at home. One non-English speaking Chinese patient, who had a chronic illness with recurring

symptoms, felt “trapped” by a health care system that he perceives as providing inadequate support in the hospital as well as in the community,

P: Like my illness, no one would follow it up after discharge from the hospital. I don’t know who to turn to. I heard that there are community nurses. But how to apply for those services? I don’t know. My English is not good, and I don’t know where to go... I am really worried that once I am discharged from the hospital, the problem reoccurs.

The wife of this patient described the difficulty they faced about seeking care,

Wife: The worse is when he gets pain all the time, but it is not severe enough to consider it an emergency. The pain was here all the time, the eyes were turning a bit yellow, and the appetite was poor. After eating some food, it would get bloated, and he would feel uneasy for the whole day. But the pain wasn’t severe enough to warrant coming into the hospital. Under such circumstances, the family doctor would say “this is normal,” the most is giving him some anti-inflammatory medications. This is the most worrisome situation. You don’t know when an emergency might occur, and you don’t know if you could go to the Emergency department when it recurs. This is the problem.

So far, what we have seen is how primary concern with the budget and efficient utilization of resources filter down to the clinical level by shaping (organizing) decisions such as patient discharge. As we continue to see, efficient processing of patient discharge is mediated by the text and discourse; this, in turn, has implications for containing the material implications of difference and thus, maintaining the economic interests of the system for efficiency and productivity.

*Management of “Difference” as Textually Mediated and Discursively Organized*

Patient discharge as an administrative strategy to maximize efficient utilization of resources in the hospital is not imposed down from the policy makers to health care providers; rather, this process is complexly organized by discourses such as the legalistic and biomedical discourses, and is mediated by various clinical texts.

The pervasiveness of the legalistic and biomedical discourse is hard to miss in fieldwork. In fact, these two discourses seem to work in tandem and in such a way that intersects with the economic interests of budget containment by defining what are legitimate and priority clinical actions. One area where the legalistic discourse organizes the work of nurses is by holding them legally liable to provide evidence of their actions through clear documentation. One nurse sheds some light on the intricate ways by which the legal requirement to chart actually defines the boundary of her work,

N: There's so much charting to do, we're continually told to "cover ourselves" to show we've done what we needed to do. Say someone has an epidural catheter in, if you don't chart that day that he has color, warmth, movement, and sensitivity to his feet, and if there's a problem the next day, then it comes back to us and say, "why didn't you chart?" *If you didn't chart, that means you didn't check, right?* I think it's really hard because we do so much paperwork, it almost takes away from the patient care at times. But then you are at a crossroad: do you want to provide that personal care and be with the patient more? Or do you want to make sure that you have done the legal documentation?

Not only does extensive paperwork take time, and thus take away the time that nurses could otherwise spend with patients, the need to provide "textual trails" of their actions means that what clinical actions a nurse might take are invariably determined by what she needs to chart in order to "cover herself." During my fieldwork, I was quite overwhelmed by the large number of texts that nurses are responsible for recording. These texts are predominantly biomedical in nature, on which nurses record the clinical status of the patient in relation to areas such as intake and output, wound condition, readings on blood sugar and vital signs, neurological assessment, medication profile, and level of pain. In some clinical areas, nurses are also required to assess and update on the patient's level of independence for performing daily living activities such as bathing and feeding. While clinical data required on those texts are important for assessing and

ensuring physical and biomedical safety of the patient, the legal liability involved in documentation means that those texts also serve a hidden function of containing the boundary of nursing within the clinical parameters as defined by those texts. The ways that the clinical texts co-order what nurses would look for and do in caring for a patient, such as assessing and re-assessing a patient's physiological status as well as level of independence, in turn play an important role in facilitating the process of patient discharge. For instance, during a doctor's round, one doctor told a patient that their goal was for the patient to be able to dress himself, take a shower, and walk, then he could go home. Textual evidence for these goals would be made readily available through nurses' assessment of patient's ability to perform daily living activities. Although it is the physician who makes the final discharge decision, one nurse manager emphasized that "he relies very, very heavily on our observations," observations that are recorded and readily available for the doctor through the various clinical texts for which nurses are held accountable for charting.

A predominant focus on biomedical tasks, and the legal obligation to focus on completing the tasks required for different charts, might partly explain why, as a few nurses in this study have noted, that nursing seems to be increasingly task-oriented. This could particularly be the case when patient care is increasingly standardized by different clinical texts such as clinical protocols and pathways, which further fragment and routinize the work of nurses. One nurse gave a description of how standardizing care through clinical texts such as pathways breaks down the work for different health care providers within the multidisciplinary team,

N: A pathway is like a patient care map, where you divide the picture up into systems, so you'll have the urinary system, the eliminatory system, mobilization, and so on.... For a hip replacement, on the day of surgery, they'll come back to the ward on bed rest; the first post operative day, they'll be up in a chair for 20 minutes with the physiotherapist and the occupational therapist. On the second day, they'll be up twice, they'll be taught their exercises in bed that they do on their own. On the text, there would be a comment on the IV, a comment on the dressing, a comment on the urinary output, a comment on the vital signs. So the nurse will be looking for fever, for pain control, and for urinary output.

Even if standardization of patient care ensures consistency and systematic care for each patient, it serves at least another important function: the administrative and economic interest of maximizing efficient organization of resources such as bed spaces. One nurse manager spoke highly of the ways that standardized care enhance efficiency by entering the patient, together with nurses and other health care providers, into the work of preparing for patient discharge,

N: The standard of care is all there, it makes it good for everyone. Everything is laid out and planned, and that the patient is aware of it, nothing is a surprise. Instead of walking in and say, "OK, you are going to get up and walk to there," and they are thinking, "Oh no, I just had a knee replacement, I can't possibly walk," they know how it's going to be before the surgery, they know what is expected of them. They know what the nurses and the OT and the Physio are going to do for them. They know how much they have to do, and that they are going to go home on Day 5 or Day 3 or whatever day it's planned for that. Things are already arranged and in place at home, like the bars on the bathroom, the raised toilet seat, the walker and so on. For the workload of nurses, it's much easier, they know what they are gonna do on each day; they don't have to chase a doctor for an order to remove the IV or to get the Foley out. It's good for the doctor, cause they know they don't have to come in everyday to write all those little orders, they know that their patients are going to get the same consistent care, and that everything is prepared for discharge, it's all done, it's all taken care of, everything has been set up.

It seems that standardization of patient care has taken over some of the power from the doctors, who are subject to be "disciplined" if they don't do their part in

efficient movement of their patients according to the plan of care as laid out in the protocol or pathway. One nurse manager had this experience,

N: Most of the doctors have become quite “compliant” knowing that they may not get a surgical patient in tomorrow if they don’t have a bed for him.

Equally, standardized care also has implications for the work of nurses.

Specifically, standardization, together with technological advancement in biomedical treatment, has increased the workload of nurses by hastening patient turnover and increasing the pace in the clinical space by shortening hospital stay. One nurse reflected changes in her nursing experience over the last 10 years and had this to say,

N: When I was trained, a patient who had a gall bladder operation would be in the hospital for two weeks. Now, they come in, they have it, and they go home. They won't even be in overnight to stay. Before we had hip pathways for a total replacement, the patient would be in for ten days. And now with the pathway charting and the objectives set out, we're discharging patients after a total hip replacement sometimes in four days. So you take into consideration that in a ten day period, you have two patients who have come acutely ill from the operating room to barely getting around on day four or five and going home and then you have another acute patient. Whereas in a ten day span, you would have a patient who is gradually getting better, mobilizing a little more. But today it's a question of utilization of hospital beds, and can they do that last little bit at home, is it safe for them to do it at home and if it is, then they go home, so that's the crunch that we're in, we're just treating more people in the same number of beds that we've always had. And the staff doesn't increase with that. The same number of staff, the same number of beds, but yet more patients getting in.

As a result of increased patient acuity, higher patient turnover, and thus increased workload for nurses, the quality of nurse-patient interaction could be compromised. As one nurse said,

N: You can barely get the patient looked after sometimes, all of that is very stressful for everyone, the pace, the amount of change, the number of patients coming and going home, who are getting sicker and way more acute than they used to be ten years ago.

This could have important implications for the ways that nurses interact with patients coming from non-dominant cultural and/or language backgrounds, especially when responding to “differences” could mean imposing extra burden on the already heavy workload of nurses. One nurse described the “extra work” involved in trying to be “sensitive to” differences in care needs among the patient,

N: On our evening rounds, we always take cold water and juices around; but I have learnt also just to take a few cups of hot water on my tray because there are always takers. You know, that’s good. We have to get over our thing too about, who wants to drink lukewarm water, right? It’s just so nauseating because that’s the way we see it. But if that’s what you’ve been brought up with for whatever reason. But then, you see, one of the things that it does for us is that we are always running for hot water, and we have to go and get it heated up and wait for it, so it’s an added burden. Whereas for a glass of water, you can get from the tap in the room.

What this excerpt seems to suggest is not so much that the nurse was complaining about the “difference” in itself, but the context in which this difference is responded to, and the implications of that response to her work in terms of “added burden.” One nurse tells us more about the material context in which cultural differences in care needs are responded to,

R: Let’s say in the last 10 years or so, do you feel that your experiences with people from different backgrounds might have an impact on how you interact with your patients?

N: Yeah, it does. Unfortunately, good and bad, and you’d like to think that they are all good experiences, but sometimes you have to realize that certain frustration levels that come with trying to accommodate all different cultures. And you hope to stay open-minded, but it gets frustrating in our busy days when you have to think, “Ok, I have to make sure that this happens, or this happens,” you know, for these people, and it can be frustrating. And it does affect the next time round. But even if the experience was negative, hopefully it sets you up to deal with it in a more positive way, cause sometimes you just learn through your bad experience as well.

The feeling of frustration associated with different expectations of care needs of patients coming from diverse backgrounds could intensify any existing resistance in the hospital to change the ways that “the system is structured.” One nurse commented on the reluctance among some of her colleagues towards responding to cultural differences, “I won’t do this because I don’t do this.” One nurse administrator had the following observation about the attitudes among some staff towards “differences,”

N: People come into hospitals, and they are expected to fit in, “this is the way we do things, and we have always done it this way.” So you really take what you get, rather than a customer service focus of how we can do or put in place to help you have the best stay here that you can. So again, it’s the mindset of what I am here to do; if you come in, I’m going to take your vital signs, I’m going to give you that injection, I’m gonna to do all these stuff to you; but I’m not quite to sit down and really trying to communicate with you and find out who you are, and how this is for you.

The predominant focus on the “tasks” rather than on the person could render the individual needs of a patient, including cultural differences in care needs, as low priority. One nurse manager elaborated on the intricate relationships between biomedical focus, legal liability, and task-oriented nature of nursing, and its implications on the ways that nurses respond to cultural and language differences,

N: We do have the translation service in place now for interpreting the different languages and making sure that the patient and the family understands what’s going on in the plan. But in reality, I don’t know how often the staff access that. I think that if they are having a difficulty, then they call for that interpreter. But then that would be a small proportion of their time, so I think that in everyday practice, I don’t think that is done well. If I look at it from a patient’s point of view, I think that we have a lot of opportunity to improve on that, and to take another person’s culture into consideration. But I think, again, if you put it in the context of demands on the system, and demands on the nurses’ time, that it probably is something that gets put much lower on that priority list.

R: So what would be top priorities for nurses working on a frontline?



N: Just from what I see, is very much to get meds given, to make sure that the dressings are done, and just trying to keep all of that in line, prioritizing that, and getting it done.

R: And you made an interesting comment when you were saying that things like how to address diversity issues may not be perceived as something that the staff are most interested in. What are some of the other things that staff may have more interest in as compared to diversity issues?

N: Again, I think that as nurses, we are still task oriented, and so there is an interest in making sure that you are doing something correctly, because of the liability issues; or learning more about physiology, and some of the different surgeries, some of the new procedures. So some of these could be viewed as really hands-on, and something you can use right away in a very tangible way. Whereas they think diversity might be viewed as more intangible and, nice to know, but not really crucial to know. So I think that the focus needs to shift away from what I do to you, to who you are as a person, and how can I help you during this hospital stay, and not just into your hospital stay, but is there anything that I can help you put in place while you are here, that will help you in your life at home. I don't think there is that focus.

Predominant focus on the clinical elements of care could have the effects of marginalizing what is considered "non-clinical" as un-justified. Here, the discourse of Western science and biomedicine could erase the voices of patients from other cultural spaces by rendering their needs as non-scientific. As one nurse said,

N: We get a very small portion of Italians as well. The Italians are very, they are a lot more emotional than Canadians or, as far as pain and everything, we find that the East Indians and the Italian population, they are a lot more vocal, a lot more emotional about their pain and situation that they can't ambulate because they are having too much pain or because they just had surgery. They don't seem to understand that it's a good idea now to get up, maybe post-op day 1 or day 2, start ambulating so there's less complications. They feel that they should be in bed about a week. And then we try to explain to them that it's actually more beneficial for them to get up and move around for different reasons.

In this example, I don't take issue with the scientific reasoning behind the importance for patients to get up and ambulate in order to prevent complications. Yet, there seems to be a hidden but important non-clinical function that biomedical science serves in resource

management, such as by managing the different expectations of care and containing the barriers to efficient running of the system (e.g. patients wanting to stay in bed) by means of suppressing the competing voices of patients from Other cultures as not clinically sound or beneficial. At closer scrutiny, what the nurse has reasoned as “a good idea now to get up,” despite the different responses towards pain and surgery, serves at least another purpose besides the clinical goal of preventing complications: that of discharge. Another nurse has given me another side of the reality of hospital care, that is, how nursing actions are invariably determined by the urgency to discharge patients by keeping them moving along the system, even if it’s against their choice.

N: And while the patients are in hospital, I guess they just sort of go through the hoops and they have to pretty much, I mean we're pretty strict at making them do what they have to do. They don't have an option of staying in bed if they don't feel like getting up. You know, they just have to keep moving and keep marching... No matter how bad they are, they know they have to get up, that's part of the deal and so there's a faster recovery.

Differences in care needs and their material implications are subject to be contained by standardization of patient care, that which writes differences in care needs out from the system by bringing about “sameness” in care. One nurse emphasized the benefits of standardization of clinical care,

N: The standards for caring for whatever surgery we have are the same no matter what color, black, white, brown, green, whatever.... You are planning for whatever surgery they've had, that's where your planning focus around.

Although standardization could seemingly bring about “equality” in patient care irrespective of the background of the patient, it also has an effect of erasing differences in care needs by giving every patient the same procedures. So long as differences have material implications for the clinical reality, “management” of differences by

standardization and increasingly task-focused nursing care serves an important, albeit hidden function of maintaining the economic interests of budget containment within the health care system.

In this section, I have looked at the prime concern with the budget, and how that has driven clinical decisions such as patient discharge as an administrative strategy for maximizing efficient utilization of resources, even if this is to the disadvantage of some patients (e.g. through premature discharge), or some families who are disciplined for being “un-supportive” in the care-giving roles expected of them. I have examined how the economic interests for budget containment are accomplished through a complex process that is textually mediated and discursively organized, and how, in the process of standardizing patient care and rendering nursing as increasingly task-oriented, the material implications of differences are being managed. In the following, I continue to examine the implications of health care changes for immigrant, non-English speaking populations, by focusing on the “problem” of language barriers. I examine how the ways that “the system is structured” organize the ways that nurses respond to language differences, and what they do in turn reproduce the existing relations of resources allocation in the economic interests of the system.

### **The “Problem” of Language Barriers: Implications of Changing Relations of Resource Allocation on Health Care Experiences of NES Patients**

#### *Language Differences Constituted as a “Problem” for the Nurse*

Data in this study seem to suggest that the ways that nurses might respond to language differences are shaped by the ways that the clinical reality is materially organized. The workload of nurses, which has increased as a result of faster patient turn

over, has important implications for how nurses might respond to language barriers. One nurse sheds some light on the intricate relationships between workload and her experience of providing care to NES patients,

N: I think it depends on what's going on on the floor, how busy you are, so many things. If you're having a good day like today, it's not slow, it's steady, but there's not a lot of rush, there's no emergencies. So you have time to sit down with somebody and find out what they need. But if you're having to rush and someone is calling you, and they can't tell you what they want, or you did something wrong or you didn't catch something simply because you couldn't ask that person a couple of questions. Like people who come in through the emergency and come right up to the floor and you didn't know they were diabetic, you don't find that out and you don't bother testing them for diabetes but later on, I mean a family member will pop by in two or three days time and say "why is my mum having so much sugar?" So depends on, I think it's more the workload and how much time you're given to interact since they don't make allowances for how much time you have to spend with somebody to communicate. You're just expected to be able to do it, within that amount of time, with that amount of patients.

What this nurse seems to be saying is that "they" or management isn't providing nurses with adequate support to deal with the implications of communicating with NES patients over language barriers. In fact, what this nurse seems to be implying is that, a language barrier is constituted as a "problem" for nurses, who are expected to contain the material implications of language barriers by responding to them with no extra resources.

The material implications of language barriers on the clinical reality and on nurses' work are at least two-fold. First, language barriers could be seen by nurses as getting in the way of doing their work and thus compromising their ability to deliver safe and effective care. One nurse talked about the challenges in doing pain assessment over language barriers and the potential risks of taking clinical actions without accurate communication with the patient,

R: I have heard nurses expressing a feeling of frustration of not being able to get across to patients because of language differences.

N: Oh, totally, because you can't do your work, you are guessing whether a person is in pain by a lot of signs and symptoms that are not necessarily (accurate). I think when you study pain, you find out that a patient in pain will go to sleep as an escape mechanism, and nurses will commonly assume that because the patient is asleep, he has no pain. So that's something you can't judge, you need to be talking to the person and finding out exactly what their level of pain is, because you are administering narcotics, they have an effect on the respiratory system, you just don't want to be giving people things assuming that they are having pain when they are not, or we are not giving them things when they need it.

Second, doing an accurate and thorough assessment will take time, and it is likely to take even more time to communicate with patients over language barriers. The need for extra time for accomplishing certain nursing duties adds to the already heavy workload among nurses. Nurses could therefore feel resentment about the time implications of interacting with and providing care to NES patients. I asked one nurse to talk about differences in patients' expression of pain, and she had this to say,

N: I think the signs are there, I think you get used to cultural differences, some people express more pain and some are more stoic. I think if you are paying attention, if you have time to pay attention, if you are not run off your feet, then you can identify it pretty much no matter what. It is sometimes having the time, or being willing to put in the time because if somebody doesn't speak the language, perhaps it would be easier to say, "Oh, I didn't know they have pain," instead of trying to investigate it. I'm sure that happens because it gets frustrating at times. But you can tell by how people look and if they move or if they refuse to get out of bed, those are big clues (for pain), right? And I think the workload makes a difference in that one.

What this excerpt seems to suggest is that the workload of nurses plays an important role in shaping how nurses might respond to language barriers in their clinical encounter with NES patients. Not only could a heavy workload deprive nurses the time to communicate with the patient, the "inconvenience" that language barriers bring to the

already heavy workload of nurses could create conditions under which discrimination and racial tensions are fuelled within the clinical space. One nurse talked about the implications of language barriers on her work, and reflected on how the extra burden that language barriers impose on the workload of nurses could compromise the ethical standards of equal respect for every patient irrespective of their ethnic or language backgrounds,

N: I think it makes you more socially conscious and I think you're more politically correct when you are nursing, you're dealing with people from so many different cultures, doing so many different things. And it's also quite challenging and sometimes frustrating because sometimes the ward is really busy and you have to deal with someone who doesn't know the language. I think you feel yourself to be more prejudiced or sometimes even racist than you actually thought. That you always seemed to think you were quite an impartial person and that you took everyone as they came and you had no preconceived notions or stereotypes and then, when you're put in a stress situation where you have to confront something, like say you have in the case of like an Asian who's been in Canada for twenty-seven years and doesn't know a word of English, you get there and for that moment in time you don't stop to think where they have lived for twenty-seven years, and if they've lived within their own culture. So when I come here, it's like "why can't you give me any information, you're sick, I need to know your background, what to look for, what diseases do you have, what surgery have you had in the past," and they can't speak to you, it's quite frustrating.

As a result of the "inconvenience" and "extra burden" that language barriers impose on nurses' work, nurses could feel frustrated about having to interact with NES patients. As a result, language barriers sometimes become the basis for lesser care. One nurse described what she saw as the implications of language barriers for the quality of care that NES patients receive,

N: The patient who has a language barrier doesn't get as much attention. That's sad, but I believe it's true, because not being able to communicate is frustrating for the nurse too. So you are thinking in the back of your mind, "Oh, I've got to go back to that bed, she doesn't speak any English, how am I going to do my assessment?" And it's natural that you are not going to spend as much time around that bed as the other beds.

In face of language barriers, the nurse above said she would have to confine her assessment of NES patients to a physical assessment, such as listening to the chest and the abdomen, without going into exploration of the patient's subjective feelings and care needs. From the perspective of NES patients, not being able to describe one's feelings or to understand information due to language barriers could affect their experiences of health care in various ways. One patient talked about how he would cope with language barriers by guessing and gesturing,

P: When I first came in, before the surgery, as I was waiting, it was surely a difficult time emotionally.... But the biggest problem is the problem of language and communication. Because I only know very little English, a few simple sentences I can understand, but if I can't understand, that's the biggest problem. For example, when they ask me something, ask me what happens and so forth, I can't describe it myself. When the doctor wants to tell me what he's going to do for me, can't communicate it to me. For instance, if I want to ask him about the progress of my illness, what I should do, there's no way that I could communicate it to him. I believe that this is the biggest problem.

R: How do you normally deal with this, say if you want to express something to the doctor?

P: The simplest thing is to use gestures. The next is to use some facial expression. If I can understand part of a sentence, maybe I can guess what it is about. But if the whole sentence is beyond my understanding, then I won't be able to guess.

Another patient also depended on guessing the message that the health care provider tried to impart to her. As she described it,

P: Sometimes, like going to have x-ray at the bowels, the family couldn't go into the room with you. After it was done, like last time, I was fine, the doctor put his thumb up, so I figured it was OK. Later on, he talked to the nurse, a Caucasian nurse, I could sort of guess that he said it was OK. Later, he was quite good, he asked someone, not a nurse, but some workers working here, who could speak Chinese, and told me that it's done and it was fine, asked me not to worry, like that.

She also said that if she couldn't understand what the doctor was saying to her in English, "I'd just smile to the doctor."

The lack of a common language between the patient and health care provider could have direct implications for the quality of care that the patient receives. This could mean signing consent for medical procedures without full understanding of the procedure. One patient had the following experience:

R: You told me earlier that you came here ten days ago for your operation. Can you remember the process of giving consent, and who explained to you about the operation?

P: As far as I could remember, there was no explanation. But even if he explained to me, I wouldn't be able to understand. I had the confidence that if he was going to operate on me, signing the consent is for what I should be having done. So I didn't have to think about it, and I didn't need explanation, I just signed on it.

R: So when you were signing, you understood that it was about the surgery?

P: That's right. I could understand the word "surgery."

Inability to communicate could be emotionally charged for the patient, as misunderstanding of health related issues or clinical instructions could result in wrong clinical actions and thus could incur negative consequences for the patient's body and health.

P: If the nurse knows a bit and could communicate (in Chinese), I feel less scary. Because if I don't understand what she is saying, and can't respond to her, sometimes worried that she might have misunderstood me, or I have misunderstood her.

As health care interactions could involve intimate contact between the patient and health care provider, such as in doing physical examination, not being able to understand instructions could be particularly frightening for the patient, especially if the patient is in



a less powerful position in relation to the health care provider due to gender, class, language ability, and/or other factors. A nurse described how she had to mediate a tense situation between a NES female patient and a male Caucasian doctor,

N: Usually if I know when the doctor's gonna to come in, I try to get a family member who can translate to come in. Otherwise, sometimes there is not very much communication between the doctor and the patient. The doctor will be examining them. And I don't think they really know what is going on. I think it must be very scary for [the patient]. I saw a situation once where a Caucasian doctor wanted to examine an Asian patient before he did the surgery on her. And I walked into the room, and they were both, she was very scared, and he was very frustrated because he couldn't get her to lie down. He wanted her to lie down to examine her, and she didn't know what he wanted. And I guess she was scared, he was frustrated. So I walked in, and I sort of just took the patient's shoulders in my hands, and just sort of guided her down on the bed. And then she understood and everybody relaxed. But the doctor didn't think to do that, and it was obviously a tense situation and I think very scary for the patient.

In the above situation, not only had the doctor-patient interaction been an unsatisfactory and frustrating experience for both, but also language barriers could have compromised the ability of the doctor to gather some needed information through accurate clinical assessment, and thus delay timely treatment for the patient.

Presumably, the smooth running of the system and the efficiency of clinical work depend, at least partly, on the expectation of the patient to be English speaking so as to be able to provide the needed information for efficient processing of clinical activities.

Efficient functioning of the system also seems to depend on nurses to "contain" the material implications of language barriers, by dealing with the implications of language barriers on their work. Expectation of nurses to deal with the material implications of language barriers on the clinical reality means that they have to use means that have the least implications for their work and for the smooth running and efficiency of the clinical reality. Without extra or adequate support from management, nurses might have to resort

to strategies that are time-saving. This might help us to understand more about why nurses would prefer certain options over others in dealing with language barriers in the clinical context. It is to this issue that I turn in the following.

### *Strategies Used for Dealing with Language Barriers*

In responding to language barriers, some of the most common strategies that nurses in this study have identified as using are different non-verbal means such as gestures, drawing, and ready-made translation sheets of single words. Family members of NES patients also provide nurses with the most common resource for interpreting. These strategies seem to share one common characteristic – time-saving. One nurse described her experience with using gestures to communicate with patients across language barriers,

N: We do a lot of sign language. Like if we are trying to find out if they are in pain or not, we'll hold let's say the abdomen if they had abdominal surgery and we'll do a grimace, or we'll ask by using certain words we can pick up, whether we pronounce them wrong or not. If we want to know other things, if we want to know whether they are passing gas, you just sort of point to your rear end that sort of things, and try to express yourself. And I find that a lot of times, it works really well. And we both end up laughing. If you want to find out if they are nauseous, you point to your abdomen, then your mouth, and sort of make, like you are throwing up and you are sick. So there are ways of expressing it, usually by sign language. We try to do what we can until their family members or interpreters come up.

R: Have you ever had experiences where all these strategies didn't work at all?

N: Yes, it does happen. And that way, you just rely on your instinct, you do what you think is the best for the patient at the time. And then hopefully the family members would come in, and then you can sort of talk back and forth with them.

Even though gestural language is perceived as a useful resource for mediating communication with NES patients, nurses are also acutely aware of the inadequacy of communicating in this manner. Drawing upon an actual example, one nurse elaborated

on the kinds of issues that arise when they rely upon gestures in lieu of verbal communication,

N: A patient was brought in with abdominal pain, and probably spent a long time in Emergency. By the time she finally got up to us, the family members that were with the patient saw that she was comfortable and sleeping, so they went home. Well, when the patient was in the ward, she woke and started having pain coming back, and she did not speak any English at all. It was very frustrating for her and for us because we didn't know what she was trying to tell us, and there wasn't anybody that spoke the language around, and so it was a lot of gesturing, trying to communicate that way with using gestures and facial expressions, we did finally figure out that it was abdominal pain, and we were able to address it that way. But you don't really know for sure, you're just hoping for the best in that kind of situation.... I remember there were things the patient was gesturing in a very vague manner, and the staff was getting very frustrated, "well, what does she want?" "I don't know," and what do you do? You just sort of try to get by, and I think a lot of the stuff that the patient was trying to communicate to us never did get to us. So she probably left here feeling pretty upset or frustrated.

Nurses described their experiences with communicating with NES patients using languages such as "muddling through." During fieldwork, I have made an observation of the limitation of using gestures for mediating communication across language barriers, particularly for assessment of more complex clinical symptoms such as pain. As I wrote in my fieldnotes,

Interaction between the nurse and patient was two-way. For instance, the nurse asked the patient if he had any children, and told patient about her marital status and number of children she had. The patient asked the nurse back if her children were from her first marriage. Thus, they were making connection with each other through exchanging information about their families.

While there didn't seem to be a language problem for chit-chatting between the patient and the nurse, who obviously could engage in a conversation with each other with questions and answers, it was somewhat a different situation when it came to communication regarding clinical issues. For instance, before the procedure for wound care started, the nurse asked the patient if he had pain, the patient said there was a little. When the nurse asked if he needed some medication for his pain, the patient moved his hands outward into the shape of a larger ball, and said something like "larger" or "bigger." The nurse finished the sentence for him, and understood him as saying that he didn't need any

medication until when there was more pain. The patient nodded and seemed to agree with what the nurse was trying to say for him.

In this example, because of language barriers, the nurse was unable to obtain subjective information from the patient about the quality and quantity of his pain. Even though the nurse seemed to have understood what the patient wanted to tell her through his gestures, there is no guarantee of accuracy when communication between the nurse and the patient depends on guessing each other's meanings.

Just as nurses tend to rely on non-verbal gestures to communicate with NES patients because those strategies are time-saving, they also see the family as providing a readily available option to assist with interpreting. As I asked one nurse-participant,

R: Are families usually involved in helping with interpretation if the patient can't speak English?

N: Definitely, definitely because if you don't have anyone who speaks that language on staff, then that's your next resource or that's your first resource because they're generally at the bedside all the time. So I mean certainly we use as many gestures as we can, body language even, you know, with their hands, but if we can't do that and the patient doesn't understand and the family is at the bedside, it's the quickest, easiest way to get a response from the patient.

Involvement by the family of NES patients in patient care is not only confined to the time when they are in the hospital. If the nurse is desperate enough, she might request a family member to go to the hospital to assist with interpreting,

N: Usually if they get to the point where I'm in urgent need of information, I'll call that number I have and I'll basically demand that a family member comes in because we need to ask this person questions, "so can we get someone to come to the hospital to visit, we need to communicate and I can't communicate with this person." And then if they come in, get them to write down a couple of phrases like bathroom, water, chest pain (chuckles), things like that that you can point to that person, or you do a little bit of acting and you tell them when I do this, it just means chest pain, chest pain and then get the family member to come in and help you out a little bit just for the communication part.

Even when the family member or patient is fluent in English, it does not guarantee that they are equally fluent in using the Western biomedical language to express symptoms and specific health care needs. One family member who provided interpreting for a NES patient talked about the difficulties he faced with medical terminology,

Family member: I think the biggest problem is not knowing some medical terminology, like the bile duct or gall bladder. Like if I arrive at Emergency and want to tell the doctor about my mother's problem, if I did not have much previous exposure to those terminology, I might not be able to tell him at all what the problem was.... To be honest, immigrants don't have too much chance to come across those terminology. This is the biggest problem. It's not that I can't express myself (in English), it is the lack of knowledge about those terminology.

One patient, who immigrated to Canada from Hong Kong, gave a more concrete example of the difficulty he faced in negotiating health care in the mainstream system. On reflecting upon his own experience of re-admission to the hospital for a medical complication to his previous surgery, this patient had this to say,

P: Let's say if you have pain, what kind of pain is it? For those who aren't grown up here, how to explain the pain? There are many different types of pain. Some symptoms of pain might be expected. But the pain could also be due to leakage or internal bleeding; these are more critical conditions. But if you aren't able to explain to the doctor about your feelings, he might think that it's normal to have the pain, and you might have to wait. During the waiting period, before they could find out about the seriousness of your condition, you could be in danger, and you might have missed the time for being saved .... Knowing English doesn't mean that the person has biomedical knowledge. The doctor might think that you understand well, he thinks you know how the pain is like and expects you to explain to him what the pain is like. In fact, you only know to say, "it's painful."

Thus, even though he had adequate English language skills to communicate with health care providers, his lack of familiarity with the common health care discourse could put him in a difficult position to express his care needs.

The assumption that those patients or family members who have immigrated to Canada, and acquired English language skills could express their health problems adequately may place an undue expectation upon them, and create a disjuncture between the responsibilities placed on the patient and/or family members and their actual ability to understand information expressed using biomedical language. I have made an observation of how this assumption could compromise the accuracy and effectiveness of a clinical action. The following is a reflection of what I have observed about an interaction between the nurse and the family of a Chinese-speaking patient,

One difficulty that the daughter has identified in being his father's interpreter was her lack of familiarity with biomedical terms, thus not being able to express feelings and symptoms like pain (such as the quality of pain). I actually observed an incidence when a student nurse came into the room to give the patient an injection in the presence of the family. The nurse was talking to the family in a tone and a speed as fast as she would normally speak. The nurse told the family the name of the medication, and explained that it was similar to Heparin. Although Heparin might be common-sense knowledge for most people brought up in this country, it wasn't familiar to this family. In fact, after the nurse has left, the family talked among themselves to try to figure out what the medication was for. I clarified for them that it was to thin the blood.

In this example, the nurse seemed to have assumed that the family was fluent both in English and in the biomedical language. Her failure to allow time for the family to ask questions and to clarify any misunderstandings about the clinical procedure could be a reflection of the time pressure with her work, as well as the un-reflexive use of biomedical jargons among health care providers.

In fact, nurses are aware of some of the complications in using family members as interpreters. For instance, one nurse brought up the issue of accuracy of interpretation and "who is the speaker," when she noticed that three family members of a patient provided three different interpretations of what the patient had said, filtering what the

patient/nurse has said into what they thought the patient should know or tell. Another nurse had a similar experience,

N: I asked the family member, "does your father have pain?" They'll look at me and say "no," and I think, well, why don't you ask the father he is having pain right now. So I'll have to ask them, "would you mind asking your father these questions and then relaying the message to me."

Another nurse sheds light on the ethical issues around using children as interpreters for NES parents,

N: A bad example is, when I've got a 10 year-old daughter of a fifty-five year old woman who speaks no English, has just been diagnosed with lymphoma and I want to find out something or explain something to the mother, that's an inappropriate place to put a child, and sometimes it's the only option. And what I will do is, I would rather wait and try and get a non-family member, medical interpreter in, in that situation. Even when you're asking about things like, "have you had a bowel movement?" and things like that, I notice some families are very close and some kids are very used to being put in that situation because they're dealing with their mum in the community all the time, so it's not as big a deal. But I like to try and be a little bit more sensitive to that, because it's not like we're at a grocery store or a bank, we're talking about the health of their mum which puts a whole different spin on things for the kid.

Although nurses are aware of the limitations and complex issues related to using non-verbal communication and family members as interpreters, they might have to continue drawing upon these means because other options such as using interpreter services might not always be available, accessible, or feasible for them. One nurse spoke of the "hidden conventions" in mobilizing help with interpretation:

N: We do have interpreter services, it's 24 hours. But they prefer to have 24 hours notice for an interview, so you have to plan ahead, like I was saying once a week we have the rounds, and then you might want to address certain issues, and we'll need an interpreter to communicate that to the patient, let's pick a time, and do it that way. But in an emergency situation like, if the patient looks in great distress, and it doesn't matter what time, you can phone interpreter service, and they'd have somebody that we can use. If they aren't able to come here to the hospital, we'll bring a phone to the bed, we'll do whatever we can.

R: Have you ever used the service yourself?

N: Oh yeah.

R: What was your experience in using the service?

N: It was excellent. The person couldn't come here because they were actually working on a unit where they were doing a one-to-one, they couldn't leave their situation. But, we were able to have the phone, and connect and talk to the patient of what was going on, resolved it successfully, so it worked. But that can't be just for everything, we need to have an unusual circumstance to use that because you are taking somebody away from their job, because it's not their job to be an interpreter, they are a nurse, or a tech, or a porter, but they have signed up as being available to do interpretation.

Even though interpreter services are available, and that the nurse has found them useful, she knew that those services are only to be activated for "unusual circumstances," circumstances that can either be planned ahead, or that which are desperate enough to justify "taking someone away from their job."

What this seems to suggest is that, the decision to use interpreter services is not purely a clinical decision but rather one that is guided by an awareness of the larger context of work relations. Given the workload and the limited amount of time to manage her work, to arrange for a staff or professional interpreter could be seen as time consuming to the nurse, time that the nurse might feel unable to afford on a busy day. One nurse pointed to the difficulties of mobilizing help with translation on top of an already hectic workload,

N: It takes a lot of your day when you're having patients coming back from the operation room and things are flying, and people are coming and going, and then you have to stop to find translation services.

Nurses also know very well what it means to the bilingual staff who have to deal with the double burden of doing interpreting on top of their regular assigned work. Thus,



to bring in a staff interpreter is a decision that hinges not only upon the work of the nurse who needs to communicate with a NES patient, but also on the work of other people such as the staff interpreter. That is why such a decision might not be seen as warranted except in "unusual circumstances." Moreover, even when interpreter services are theoretically available on a 24-hour basis, they are not always useful or accessible. As one nurse said,

N: I have found that interpreters aren't really around, and sometimes the language you need to be translated and there's no one here to do it. So interpreters are good but at the same time, if you call the telephone, the AT&T people, well the patient is deaf, so they are no good to me cause the patient can't hear and can't communicate through the phone.

The ways that nurses respond to language barriers tell us something important about the clinical reality and the manner in which it is structured, and that there is a very important material context in which health care delivery takes place. Specifically, there seem to be stringent criteria for using resources in the clinical reality, such that nurses don't easily access the resources to deal with language barriers. Even when interpreter services are available, there is the issue of appropriateness and feasibility because of workload issues that affect not only those nurses who need interpretation, but also the staff interpreters who volunteer their time to help with providing interpreting services. Moreover, there is an expectation for patients to "fit into the system" by being able to provide the needed information for efficient processing of assessment. The lack of appropriate and effective measures to facilitate accurate and safe communication between health care providers and NES patients means that those patients who don't "fit in" might have to endure with compromised quality of care, such as receiving lesser time and

interaction from the nurse, and being unable to understand instructions and participate in his/her care in a safe and meaningful way.

### **Conclusion**

In the current context of health care, there seems to be a primary concern with the budget. The economic interests of efficient utilization of resources, such as through shorter hospital stays and earlier patient discharge, in turn has important implications for the workload of nurses and thus how they are able to respond to language and cultural differences of patients coming from diverse ethno-cultural backgrounds.

Management of “differences” has become necessary and important as cultural and language differences have material implications for the clinical reality in the sense of imposing “extra burden” on the already stringent resources, including nursing human resources in the hospital. But management of “differences” is more hidden than direct. In fact, in multicultural societies such as Canada, it is common practice for hospital settings to have at least some kind of policy on diversity to reflect the multicultural and multi-lingual characteristics of the population. This is the case in all of the three hospitals in which fieldwork was done in this study. However, implementation of these policies seems to be vague and sporadic rather than systematic. Data in this study suggest that there is a hidden and complex process by which cultural and language differences are being managed such that their material implications for the clinical reality are contained. This process is, in turn, mediated by the dominant discourses, particularly the legalistic and biomedical discourse, and by clinical texts. The text and discourse organize the experiences of patients coming from a NES non-dominant ethno-cultural background, by rendering non-clinical needs, such as the need for interpreter services and

different cultural expectations of care, as “low priority.” Moreover, by prioritizing biomedical tasks as *the* legitimate clinical activities and streamlining hospital care through the text, the work of nurses are confined to the completion of those tasks that serve the economic interests of the system for efficiency and productivity.

Although the ways that the health care system is changing have implications for the health care experiences of everyone, there seems to be indication that the economic interests to contain the budget are in conflict with providing equitable care to those patients who don’t “fit into” the system. These include those patients who have come from a non-dominant cultural and/or non-English speaking background, and are seen as imposing extra burden on a system perceived as non-sustainable. In the following chapter, I will discuss in further detail how we can understand the findings of this study within a broader context of health care restructuring, and the directions we might take in addressing the health care needs of a diverse ethno-cultural population in a country like Canada.

## CHAPTER SIX: DISCUSSION OF THE FINDINGS

### Introduction

In this study, there is a common thread that runs through the findings – whether we are looking at the experiences of patients with culturally different expectations of care needs, the experiences of non-English speaking (NES) patients who had to access and utilize health care in the absence of adequate interpretation, or those experiences of nurses who were expected to deliver care across cultural and/or language differences without adequate institutional support – we cannot understand these experiences independent of the material context in which nurse-patient encounters take place. This material context is characterized by the primary concern for budget containment, accomplished by business-driven strategies such as efficient bed utilization through patient discharge. Efficient patient discharge is in turn enhanced by standardization of clinical care as mediated by clinical texts such as protocols and pathways. What these findings seem to suggest is that clinical decisions, including patient discharge and how nurses might respond to language and/or cultural differences, are no longer decisions based solely on the clinical needs of the patient; nor can we explain those experiences in terms of inter-personal relationships such as prejudices or lack of understanding or “sensitivity” on the part of the nurse (alone). Rather, there seems to be some larger relations and forces that organize the material conditions under which nurses provide care for and interact with patients coming from a non-dominant cultural and/or language background.

In order to critically understand that material context, I begin by examining health care restructuring as a backdrop to understanding the changing context in which health

care takes place in Canada. In this discussion, I focus on examining some of the economic and political interests at the international level that underlie policy and resource decisions at the national level. These interests are what Smith (1987) calls “extra-local relations” that are not always immediately knowable to us, but play a powerful role in organizing our everyday experiences in our local contexts of living and working, including seeking and providing health care. These include the neo-liberal ideologies and capitalist interests for capital accumulation and privatization. Although Canada still enjoys a publicly funded system, findings in this study seem to indicate that those interests are already in operation to shape policy decisions and the actual experiences of both receivers and providers of health care, e.g. priorities of productivity, efficiency, budget-driven care and discharge decisions. But nurses and patients are not coerced (by force) to abide by these policy decisions. Rather, the ways that economic interests of capitalism and neo-liberalism are sustained is through a complex process of social organization, which coordinates what nurses do and hooks what they do to the interests of those larger relations in the extra-local. This process, as I argue, is mediated by various forms of text<sup>20</sup> and is discursively organized. In addition to discussing the hidden, non-clinical functions that text plays in organizing health care, I also explore a theoretical insight related to how the discursive intersects with the material, by examining the intricate ways by which dominating discourses, such as those professional discourses (biomedical and legalistic discourse) and discourse on immigration could play a powerful role in reproducing the economic interests of the health care system and the state.

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<sup>20</sup> In the use of the term “text,” I here refer specifically to material text in the form of clinical protocols, procedure manuals and other documents organizing the everyday work of nurses.

Specifically, these discourses enter people into the social relations or work organization of health care such that what people do, including nurses and doctors, as well as patients and families, serves the interests of the system and, in doing so, reproduces its existing relations of resource allocation, such as by containing the material implications of “difference.”

Here, we begin to see how health care is not apolitical but, as I argue, is a constitutive part of the “ruling apparatus.” Health care “rules” through its hidden function in the social organization of class, partly by reproducing the racialized/gendered inequalities to resource allocation. I try to demonstrate this point by examining some of the web of implications of discharge decisions and the textual organization of patient care on immigrant families of working class background. This will bring us to the important but contested question of whether health care decisions made in the economic interests of the budget are in conflict with equity, particularly when “differences” in health care needs among our ethno-culturally and linguistically diverse population are seen as imposing extra burden on the health care system.

In fact, the prevailing forces of neo-liberalism and advanced capitalism could also play a powerful, albeit hidden role in organizing research and thus knowledge construction. I end this chapter with a discussion of this issue by focusing on the methodological issue of the politics of gaining access to hospitals in the current context of health care.

### **Extra-local Relations Underlying Health Care Restructuring: Ideologies of Neo-liberalism and Global Capitalism Driving National Health Care Policies**

Health care restructuring is not a new phenomenon, and it seems to be a worldwide phenomenon among many developed countries in the world. The discourse of health care restructuring has largely been associated with what are perceived as limited resources, such that it becomes justifiable to cut existing health services, close down facilities, and so on. This dominant discourse has become so well accepted that people tend to explain their experiences in terms of it, that is, that “there are not enough resources” to sustain health care at its present level.

The reasons why resources become perceived as increasingly limited are multiply layered. Fierlbeck (1997), for instance, analyzed the situation in Canada and came to the conclusion that health care reform in the country was largely a response to the rising costs in health care expenditures, related to factors such as “a structural bias toward expensive acute care, the lack of coordination between relatively autonomous providers, the oversupply of physicians, and the development of sophisticated but costly drugs and medical equipment” (p.19). While these factors could all have contributed in significant ways to the need to reform the health system, less visible are the ways that larger political and economic interests at the inter-national level influence national policy and allocation decisions.

The increasingly loudly-voiced call to restructure health care by promoting privatization of health care speaks to the spread of the market model and the ideology of neo-liberalism in a changing world order towards global capitalism. In fact, the enthusiasm of some provinces (e.g. Alberta, British Columbia, Ontario) to introduce for-

profit care into their existing health system signals a weakening welfare state in Canada. At least two forces have contributed to changes in the direction of social policies and the role of the Canadian government in providing for social goods such as health care and education. First, the threat of "capital flight" (Coburn, 2001, p.52) in a globalized market has weakened the power of individual countries to define and defend the boundaries of their social and public policies. This is because increased global competition for capital and investments puts pressure on many states to make policy concessions to the business sector, lest the country be marginalized by the "world community" and lose its power to compete in the global economy (Navarro, 1998a). At the international level, we have seen how developing countries could be forced to cut their social programs, deregulate their industries, and open their market to private businesses in order to receive loans and assistance from international monetary agencies (see, for example, Isla, 1993; Peabody, 1996; Zaidi, 1994). In the name of the "logic of international competition," Canada has also been under pressure to make a "leaner and meaner state" (Coburn, 2001, p.56) by decreasing public deficits through reduced spending on social programs. According to Navarro (1998b), public deficits could be seen by some as counter-productive to economic growth (and thus the profit margins of private businesses) because "[t]hey absorb national savings, increase interests rates, and reduce investments" (p.608). In 1989, the International Monetary Fund has called upon Ottawa to slash \$9 billion from its budget by trimming transfer payments to the provinces and by raising more revenues through higher taxes (reported in the B.C. newspaper, the *Times-Colonist*; quoted by Terris, 1999, p.153). Ottawa, in turn, has responded to those policy recommendations by imposing a General Sales Tax of 7% on goods and services (Terris, 1999). Moreover, the



federal government has gradually pulled back from its responsibility and involvement in social programs by reducing cash transfers to the provinces (Naylor, 1999). With reduced revenues from the federal government, many provinces in Canada felt the need to “restructure” their existing social programs, such as by “rationalizing” health care and by other cost-containing measures such as hospital closures and staff cutbacks, resulting in increased workload among nurses and longer waiting lists. Thus, through a complex of processes, the forces of global capitalism find their way to influencing national policies and allocation decisions that which, in turn, have direct implications for the life of people in the immediate context of their everyday life.

Second, concurrent with the rising forces of economic globalization and a weakening welfare state in many countries is the spread of neo-liberalism. According to Coburn (2000), “the essence of neo-liberalism, its pure form, is a more or less thoroughgoing adherence ... to the virtues of a market economy, and, by extension, a market-oriented society” (p.138). In societies where markets are privileged as “the best and most efficient allocators of resources” (Coburn, 2000, p.138), including social resources such as health care, state intervention is seen as undesirable and inefficient for the operation of a free-enterprise economy. Thus, with the growth of the neo-liberal doctrine both nationally and internationally, we have witnessed reduced commitment of the Canadian government in the financing and provision of essential social programs. Moreover, there is a growing tendency to “recommodify” (Coburn, 2000) social resources, by allowing “merit goods” such as health care to be privatized and sold for profit.

Although, as I have tried to argue above, that what might appear as distant forces of globalization and advanced capitalism have direct implications for policy making at a national level, including allocation decisions to health care (as a result of a shrinking welfare state), the debate of health care restructuring tends to focus on the fiscal problem of containing a healthy budget by reducing deficits through trimming health programs. Such a focus on the national issue of fiscal health tends to obscure the powerful link between the global and the local, and the powerful organizing power of the global forces of capitalism and market ideology. If we look more carefully into the ways that health care is being restructured, we can begin to see that in one way or another, the global forces have already infiltrated into the “local” by organizing the ways that the provincial governments respond to the interests of the global market by changing the ways that health care is financed and delivered.

The political and ideological process of health care restructuring is characterized by the very complex and intricate relationships between the federal and provincial governments. In the popular debate on health care, it is commonly perceived that health care restructuring at the provincial level is a direct result of federal cutbacks on funding. Yet, there is another layer to this scenario. One important feature in funding arrangement between the federal and provincial government is that each province is allowed to make individual decisions on how to spend the global budget (now called the *Canada Health and Social Transfer*) on health care, post-secondary education, and welfare (Deber, 2000b). This latter point is an important fact to bear in mind because it suggests that the provincial governments should not be seen as only passive victims of federal budget cuts. Instead, as Deber (2000a) reminds us, each provincial government has total flexibility in

setting spending priorities for its social programs. In other words, the provincial government has a direct role to play in protecting or otherwise undermining the welfare state in Canada through its allocation decisions. Quite contrary to the rhetoric that “Canadian health care spending is ever rising and out of control,” there is evidence to suggest that provincial governments have actually constrained their investment in health care. Between 1992 and 1997, for instance, Canadian health spending per capita has actually decreased when adjusted for inflation and population growth (Deber, 2000a). What seems to have happened, therefore, is that some provincial governments have appropriated the rhetoric of “federal budget cutbacks” and strategically use the situation to reduce their intervention in public services by introducing market mechanisms and privatization. Specifically, health care reform at the provincial level is part and parcel of the globalizing force of neo-liberalism towards “restructuring” (*read shrinking*) the welfare state.

An understanding of provincial governments as having “agency” to make decisions for allocation decisions to social services including health care is an important point to bear in mind particularly within the Canadian context where the planning and delivery of health care falls under the jurisdiction of the provincial governments.

If the purpose behind reforming health care is not only about “good economics” in the sense of sensible cost control while preserving equitable access to health care, then perhaps it is no surprise that the market-driven ideologies and management strategies of efficiency have already infiltrated into the Canadian health care system *in the name of reform*, and that privatization or for-profit care has gradually happened in one form or another.

In the province of British Columbia, for instance, we are witnessing an increasingly powerful infiltration of the neo-liberal doctrines into the publicly funded health system. Even when the leftist NDP was in power, there were already emerging signs to indicate government withdrawal from the welfare state. In 1991, the B.C. government issued the *Closer to Home Report* (British Columbia, 1991) as a blueprint for restructuring the province's health care system. The notable focus "closer to home" was interpreted in the report in at least two different ways. One of the interpretations was geographical, that is, "[m]edically necessary services must be provided in, or as near to, the patient's place of residence as is consistent with quality and cost-effective health care" (p.A-6). Another interpretation, however, signifies much more clearly a shift of care from the public sector to the private sector of home and community. As stated in the report, "[t]here are many costs involved with keeping people in institutions, and from a quality of life as well as an economic perspective, we must encourage home and community care" (p.C-154). But as Livingstone (1998) reminds us, de-institutionalization has to be matched by increased financial support for community-based care, or else it is merely a strategy to trim government budget by shifting the burden onto family and community care-givers. Nonetheless, the provincial governments are not under any legal obligation to provide community care or home care (Deber, 2000a). This form of privatization, or shifting the burden of care from the publicly funded system to the private unpaid system of the home is accompanied by a process of "early discharge" in hospitals. As Anderson, Tang, and Blue (in press) have found in their study, done between 1997 to 2000, organization of hospital care was largely driven by the discourse of "efficiency," whereby there was pressure to discharge patients home

as soon as possible. In this study, we saw an emerging business-driven discourse of “efficient bed utilization” for justifying the hospital practice of moving patients through the system as fast as possible. Patient discharge, as findings in this study indicate, is no longer “pure” clinical decisions; rather, they are economic means for the hospital to offload some of their expenses because, as Deber argues, to send someone home means that “the hospital need no longer pay for their nursing, drugs, rehabilitation, etc.” (p.14). Restructuring could therefore mean cost shifting from the public sector to the private sector, including the un-paid sector of home and community.

With the Liberal government coming into office as of 2000, for-profit health services have increased in scope, and the government has employed different tactics to trim health care expenditures exploring various “innovative” cooperative strategies with the private sectors. Moreover, there are different policies for shrinking or “starving” existing services, such as by closure and/or merging of health care facilities, and staff layoffs.

Measures to “restructure” the welfare state, such as by trimming government expenditures incurred through involvement in social programs including health care, have direct implications for the experiences of people both as service providers and receivers. Cost cutting, a measure taken by provincial governments in Canada to contain health care expenditures, could hit particularly hard on nursing because nurses comprise the largest occupational group in the health care system.

However, an emphasis on over-expenditure and cost containment tends to skew the debate about health care reform in Canada towards the gloomy view that Medicare is no longer sustainable. There is continuous debate on both sides of the argument, and it is

not within the purpose of this study to partake in this debate. However, we need to pay attention to the ways that a prevailing perception that the system is no longer sustainable might help to legitimize and open the door for wider public acceptance for privatization of services and the resultant demolition of the publicly funded system of Canada. Moreover, as the findings of this study suggest, neo-liberal ideologies such as that of efficiency, productivity, and market fundamentalism are already filtering down from the extra-local level to the local clinical encounter. These ideologies organize experiences of health care providers and patients/families such that what people do reproduce the economic interests associated with neo-liberalism and advanced capitalism. This complex process by which extra-local forces organize local experiences, as I continue to argue, is mediated by the text and discourse.

### **Health Care Restructuring as Social Relations**

#### *The Process of Social Organization: Health Care Restructuring Brought into Being by the Work of Nurses and Families*

As I have discussed above, there are extra-local relations and interests that underlie health care policy and allocation decisions at the national level. In other words, what we might see as budget containment in the local in terms of service cutbacks, hospital closures and so on, has to be understood in light of the larger interests and ideologies that might not be immediately knowable to us. The public discourse on health care restructuring, however, tends to focus around the “local” national concerns of a non-sustainable system. Such a discourse renders the larger forces that drive national and provincial health care policy even more invisible. Moreover, a focus on a non-sustainable system and inadequate funding support from the federal government tends to

justify the “cuts” implemented by the government at the provincial level, such that health care providers are expected to make do with shrinking resources, and to keep the system going by “compensating” for the governmental policy decision of budget cuts.

In this study, we have seen how nurse managers would try to accomplish the budget targets on behalf of senior management by strategies such as careful calculation of staffing level and maximized utilization of bed spaces in the hospital. We have also seen how nurses would do their part in controlling the “access and exit problem” in the hospital by “keeping the patients marching through the system,” so that the patient can go home on time without delay and unnecessary blockage of an expensive hospital bed.

What these observations seem to be speaking to is an important dimension of “social organization” (Smith, 1987): that is, people play an active role in “bringing health care restructuring into being” by coordinating their activities in ways that accomplish for the state its economic interests of budget containment. I want to further examine this complex process of social organization by drawing upon the findings associated with how nurses manage the “problem” of language barriers in their clinical reality.

The ways that nurses in this study responded to language barriers in the hospital point to a complex network of “social relations” upon which smooth running of the health system depends. Social relations, as discussed here, are not reducible to “interpersonal relationships” between individuals from different social categories. Rather, integral to the notion of social relations is a closely-knit division of labor, whereby the work of one has implications for and is implied by the work of another, even though they might not know of each other’s existence (Smith, 1987). Manifestations of the complex of social relations in health care include the ways that nurses make allocation decisions regarding

the use of interpreter services. As indicated in the findings of this study, even though interpreter services were available in one form or another (staff interpreters or professional interpreters), nurses tend to refrain from mobilizing these services except in “unusual circumstances” because of the hidden implications of time for both the nurse who needs assistance with interpretation and the staff interpreter who volunteer his/her time to do interpreting.

Here, we can begin to see how the activities of one nurse in a specific clinical area could have implications for another nurse in another clinical area, as both of them are organized by the same material conditions that determine their workload and thus how well they are able to respond to the language need of NES patients. In making the decision to use gestures and other non-verbal strategies rather than asking for a staff interpreter who would have to stop his/her work and come to do interpreting, this decision minimizes the time implications of using interpreter services both for herself and for the staff interpreter. In making do or what some nurses in the study have described as “muddling through” with the less than adequate strategies of gesturing and guessing meanings, the nurse is inadvertently playing an active role in containing the “extra burden” that language barriers are perceived to be imposing on the system.

In fact, the complex network of social relations that constitute the work organization of health care extends beyond the professional domain to include other people such as the family. In the current context of health care where care-giving is offloaded from the institutional setting to the community (Neysmith & Aronson, 1997), the family is expected to participate in care-giving related activities in one form or another, such as to assist with interpreting at the bedside.



Reliance of nurses on the family to assist with interpreting, as found in this study, speaks to the “invisible work” upon which the work organization of health care depends. Although the work that family provides are a constitutive part of the social relations that constitute and sustain the political economy of health care, such work is often rendered as “non-work.” In the public or government discourse of health care restructuring, for instance, there is relatively little mention or calculation of the “monetary value” of the work that families and communities contribute to the economy of the health care system in terms of un-paid care-giving. Rather, the un-spoken or taken for granted expectation for the family to fill in for the system what it is not prepared to provide, or “in the way it is structured,” is justified by a hidden expectation of moral obligation upon the family to show caring toward their sick family member. But the work that family does in relation to care-giving is actual work that “takes place in real time, in real places, using definite material means and under definite material conditions” (Smith, 1990, p.163). This is the case when assisting with interpreting could mean loss of income for the family member who has to take time off work in order to come to the hospital to mediate communication between the nurse and his/her sick family member (Anderson, Blue, & Lau, 1991). This is also the case for nurses who are expected to “manage” the material implications of language barriers on their workload with no allowance of extra time or support from management. In both cases, the work that nurses and families do plays an active role in containing the “problem” of language difference and its material implications within the legitimate boundaries of allocated resources. In a sense, what are commonly understood as institutional constraints in the face of restructuring and budget cutbacks actually play an active role in “concerting” and organizing the activities of people in the economic

interests of the system. This is what it means when we understand health care restructuring not as a top-down process but as being “brought into being” by what people do and how they make allocation decisions in the local, such as in the case of the nurse who uses time-saving means to communicate across language barriers, thus minimizing the material implications of “differences” on her workload and that of other people (e.g. staff interpreters).

Thus, by drawing upon the example of language barriers, we begin to see how what happens in the local, including the experiences of nurses and patients in trying to communicate across language differences with gestures or guessing, cannot be reduced to individual intentions (alone). Rather, those experiences are invariably hooked to the extra-local relations of resource allocation that organize the clinical reality, and thus how nurses are able to respond to language barriers in the first place. This process of socially organizing what happens in the local in the interests of the extra-local is highly enhanced by the “text,” a phenomenon that, as we see in the findings, is emerging as a powerful force for organizing health care in the name of maximizing efficiency and consistency in patient care.

### *The Emerging Power of the Text as Social Organization of Health Care*

The ways that the text, in the sense of material text such as an actual clinical protocol or procedural manual that nurses can put their hands on and read from, exerts power in organizing health care are various and often hidden. In its various forms, the text plays a powerful role in organizing the activities of health care providers. On the surface, texts such as clinical protocols and pathways could appear as playing a clinically focused role in breaking care down into clearly delineated tasks, so that every patient

going through the same procedure or surgery is ensured of being given the same, standardized care. However, I argue that the text also serves a non-clinical function of organizing the work of health care providers, so that what happens in the local reproduces the extra-local interests of budget containment and reduced welfare state. There are at least a few ways by which the organizing function of the text intersects with the economic interests that underlie health care restructuring.

First, texts can be understood as a manifestation of “ruling strategy” which fixes people within the complex of social relations in ways that accomplish the interests of the state. We have seen how the text such as clinical protocols and pathways can enter different health care professionals into their specific roles and are organized to work up to the ultimate institutional goal of patient discharge. We have also examined how patient discharge is no longer “pure” clinical decisions but rather, have become part of the administrative strategy for maximizing efficiency in utilization of resources such as bed spaces. In other words, by entering people into the courses of action that aims towards timely patient discharge, the text articulates what people do to the larger economic interests of budget containment. In fact, the text is “powerful” in social organization because its function is not restricted by space and time. The property of the text to coordinate activities of people at a multiplicity of local sites lies in its “indefinite replicability” (Smith, 1999, p.79). Specifically, the objectifying property of material text renders the text transferable across sites, as the materiality of the text makes it possible “to crystallize and preserve a definite form of words detached from their local historicity” (Smith, 1990, p.210). This is what happens when a clinical procedure is used across different health regions, whereby the same procedure is carried out exactly the same way

in different hospital sites. No matter how diverse are the hospital sites, the text can organize the activities of people in the same way, and articulating what people do in multiple local sites to the same set of economic relations and policy decisions that organize the material context under which health care providers do their work.

Second, the text plays an important role in managing the material implications of “differences” on the system by standardizing patient care, thus writing out the space for negotiating care needs that fall outside of what is inscribed on the specific text. As noted in my findings, clinical texts such as protocols and pathways standardize patient care with clearly laid out procedures aiming towards expected day for patient discharge. While it can be argued that standardization has the potential to enhance the quality and consistency in patient care, we must also be cautious of a hidden function of standardization: maximizing efficiency at the expense of treating each patient as an individual. This process of rendering what are the “locally and inexhaustibly various character of the actual into standard forms of organizational action” (Smith, 1986, p.8) is, as Smith reminds us, a distinctive property of ruling in the interests of capitalism. Although it might appear as adhering to an ideal of equality, standardization of patient care through the text serves an economic interest of maximizing productivity by writing out any “interruptions” that differences in care needs might bring to the “smooth” and “efficient” running of the system.

Third, the organizing function of the text aligns with the capitalist interests for maximizing efficiency and productivity by rendering no health care provider as indispensable. As patient care becomes less and less individually based but standardized by the text and focused around specific tasks, it allows the health care workforce to be

transferable between sites, as any nurse or health care provider coming on duty can pick up the tasks at any time and at any site. Even the doctors, who used to have power in making discharge decisions are now subject to be organized by the priorities and care procedures as laid out in the clinical protocols and pathways. The text also plays a hidden role of surveillance of the work of health professionals, e.g. pathways exposing the work of health professionals under the gaze of others.

Thus, what might appear as a clinically based strategy for ensuring "equal" standards of patient care, such as by standardizing clinical procedures through protocols and pathways, also serve an important function of mediating the process of health care restructuring in the economic interests of budget containment. In fact, Smith (1990) alerts us to the changing nature of power as "textually mediated" (p.224). As indicated in the findings of this study, the text "rules" by engaging people within the generalized relations of health care processes, assigning individuals, receivers and providers of care alike, with less and less power to carry out actions according to individual intentions. This is what Bakhtin and Smith would both emphasize that, although people have agency to act, actions of individuals cannot be reduced to individual intentions (alone). This textually mediated nature of social relations, as Smith (1999) argues, is an increasingly powerful feature of social organization in the current society where advancement in technological information renders almost no one as immune to the organizing power of the text in one form or another.

### *The Discursive Intersects with the Material*

In fact, how the ways in which nurses do their work and coordinate activities in the clinical reality seem to serve the larger economic interests of the system is not due to

some mysterious process by which nurses are coerced to act in certain ways. Working hand in hand with the text in the process of social organization is discourse, such that the discursive intersects with the material in the interests of the ruling.

Discourse, including the textually mediated discourses and the ideological currency carried within them, plays a powerful role in social organization by giving forms to our local consciousness, by providing and privileging certain interpretive schemata for understanding our world and organizing our activities, binding what we do and how we think in multiple local settings to the extended relations of ruling and production. An example in the findings of this study that helps us to understand how the discursive intersects with the material is the way that the biomedical and legalistic discourses work in tandem with health care restructuring and its economic interests of efficiency and budget containment. Those dominating discourses, mediated in different texts including clinical protocols, nursing manuals and so on, define the boundary of nursing such that nurses focus on accomplishing the tasks for facilitating patient discharge, at the expense of addressing the individual needs of patients, including the need to respond to cultural and language differences. Although the text is subject to being interpreted differently, how nurses might read the text tends to be "disciplined" by the legal consequences of not reading it according to the discourse of biomedicine. As I have examined in the findings, nurses seemed to know what to look for in their clinical assessment of the patient so that they could enter into the chart what is expected of them from a legal point of view. In reading a clinical text, the nurse lifts the discourse of biomedicine out of the text and enters herself into the "courses of action" according to what is defined as "legitimate" work. How nurses do their work according to the

priorities as defined by the biomedical and legalistic discourse, including a focus on the task and thus putting cultural and language differences to low priority, in turn play an important role in accomplishing the economic interests of the system by enhancing efficiency and productivity in the clinical reality. In fact, Smith argues that we are all expert practitioners of how discourse works as a result of our education and our engagement in public discourses through reading and conversation.

In fact, we must not underestimate the power of public discourse in organizing health care. As the findings of this study indicate, health care is not immune to but actually reproduces what Bakhtin (1986) might call the “dialogic relations” of public discourses such as that on immigration. The public discourse of immigration in Canada, which is largely a racializing discourse (Henry, Tator, Mattis, & Rees, 1995), constructing immigrants as “imposing extra burden” on the social services in their host country, has silently found its way into health care by organizing the ways that nurses perceive their patients and interact with them. As some nurses in the study have described, there is a hidden expectation of immigrants to fit into the health system by learning English. The failure of the patient to communicate with health care providers tends to justify why some patients, such as those who are non-English speaking, tend to receive lesser care from nurses. In this way, discourses of immigration intersect with the material interests of containing the “extra burden” that immigrants are perceived to be imposing on their “host society,” by organizing the allocation decisions that the nurse makes (e.g. how much time to spend with patient, how to respond to language barriers and need for interpreter services). Discursive construction of immigrants as “outsider within” (Sharma, 2002), who are likely to “abuse” the generosity of their host country

and its resources (Thobani, 2000), articulates with existing immigration policy to legitimately restrict access to certain resources by those people coming to Canada as sponsored immigrants.

Thus, we begin to see the complex ways by which health care is a constitutive part of social organization. Moreover, not only is health care situated within the larger ideological and discursive context of the political economy of capitalism, including its neo-liberal and market driven restructuring movement in other public sectors beyond health care, but health care also plays an important part in reproducing racialized inequalities associated with resource allocation. This points to a hidden but powerful function of health care in the social organization of class, to which I now turn.

### **Health Care as a Ruling Apparatus: Capitalist Relations of Resource Allocation and Social Organization of Class**

In the previous sections, I have tried to illuminate how allocation decisions made in the economic interests for budget containment are translated into the local encounter of health care by organizing clinical activities such as patient discharge. What this tells us is that health care activities cannot be reduced to clinical decisions based on the needs of the patient alone; rather, they are subject to being organized by larger economic and political relations. In health care, the implications of social organization seem to extend beyond accomplishing the economic interests of budget containment within the health care system. Rather, as I argue in the following, health care plays an integral part in the social organization of class by reproducing the capitalist relations of resource allocation.

By "capitalist relations of resource allocation," I refer to the complex network of social relations that are implicated by and also reproduce the economic relations of policy



and allocation decisions in the interests of capitalism and the ruling class. One example of policy decisions in health care that sustain the capitalist relations of resource allocation is the shifting of care from the hospital to the community. Although justified by the assumption that home is the best place for the patient (Coyte & McKeever, 2001), shifting of care from the public sector to the private sector is a strategy of cost containment as the government offloads its care-giving responsibility onto community caregivers without matching resources being put into the community. This is what a few nurse managers in this study have observed. Coyte (2000) has also found that despite increased demand in home care services, expenditures on those services represent less than 5% of total health spending.

Specifically, a lack of matching resources to the community means that the community in general, and the family in particular, would have to pick up the material as well as financial implications of care-giving, which are consequences of the hospital practice of patient discharge, decisions that, as we have discussed in the findings, were largely made in the economic interests of budget containment. The government policy of shifting care from the public sector of the hospital to the private sector of the home could reproduce class inequalities, as this policy could have differential impacts for families of different economic means and material circumstances.

Underlying the policy of shifting care from the hospital to the community is the assumption that all families are equally available and have equitable access to resources, including the financial means and time, to provide care-giving and support to patient upon their discharge from the hospital. However, not all families can equally absorb the economic burden associated with care-giving. In fact, informal care-giving by the family

is costly. According to the *National Profile of Family Caregivers in Canada* (Decima Research Inc., 2002), almost half of family caregivers pay out-of-pocket costs to provide for the needed transportation, medical supplies, prescription and non-prescription medications, costs that could be as high as \$300 dollars a month. Family care-giving could also mean loss of income, as caregiving responsibilities could require the caregiver to quit his/her job or retire early (Decima Research Inc., 2002). In other words, not every family can afford to put out extra costs incurred in care-giving at home. Given the economic implications of care-giving at home, differences in class and material circumstances could make the experiences different for the patient. Those patients with families who don't have the financial means to buy more equipment and services are likely to have "lesser quality of care" than their middle class counterparts who can better afford the costs of care-giving at home. Thus, depending on the class background or economic circumstances of the family, experiences of care-receiving at home could be very different for patients coming from middle class versus working class families. Here, we begin to see how the health care policy of shifting care from the hospital to the community could reproduce class inequalities by organizing differential consequences of patient discharge on patients and families of different class backgrounds.

If we understand the hospital practice of patient discharge and the offloading of caring responsibilities onto the family as a means to achieve the economic goal of cost-cutting in the system, parallel to this process is the shifting of care-giving costs from the expensive hospital sector onto the less expensive community sector. In Canada, it was found that 80% of paid and un-paid care-givers are women (Armstrong, 2002). Among those providing domestic and caring support in the community, immigrant women of

color constitute the major pool of cheap labor for providing the service of home-making and care-giving to higher income families (Neysmith & Aronson, 1997).

The position of immigrant women of color within the Canadian labor force might have little to do with their educational and professional background (Man, 2002). While women in general are found to be disadvantaged economically as compared to their male counterparts, women from visible minority backgrounds tend to experience higher unemployment and lower incomes as compared to other Canadian women (British Columbia, 1999; Saraswati, 2000). Different state policies seem to play a concerted role in keeping immigrant women of color at the lower strata of the labor market; these include the restricted access to English and job training by female, sponsored immigrants, as well as employment policy that lacks flexibility in recognizing educational and working experience from abroad, thus forcing many immigrants to accept under-employment.

Ironically, however, the health care system, and its shifting of care from the hospital to the community actually thrives on state policies and institutional practices that sustain and reproduce a racialized and gendered division of labor. In addition to the family, it is the cheap labor provided by immigrant women of color that “absorbs” the consequences of health care restructuring by providing the needed labor in the web of social relations that accomplish the shifting of care from the hospital to the community, in the (economic and political) interests of the capitalist state. What might be understood as “passive privatization” (Deber, 2000a) therefore could mean more than the shifting care from the hospital to the community; it could also mean an un-spoken legitimization from the government in allowing the private sector to have an increased share in

delivering health services to the community, services that are paid out of pocket by consumers who are able to afford it.

Thus, I argue that we have to conceptualize class not only in terms of the traditional Marxist sense of “relations of production,” but also in terms of the “relations of resource allocation,” including resources such as health care and other social services. Here, I am not privileging one category over another, such as privileging class over “race” or ethnicity, or gender. Rather, I want to show how racism, sexism, and classism in state policies articulate with the larger economic interests of the state, by reproducing the complex of social relations, such as a racialized/gendered division of labor, for sustaining its capitalist relations of resource allocation.

Although Canada has a publicly funded health care system, class and the capitalist relations of resource allocation are not only relevant but are implicitly at work in the many ways that health care policies have implications for people in different social classes. Class in the sense of relations of resource allocation is reproduced in health care by the roles that the health care system plays in organizing differential experiences of oppression. In other words, although health care restructuring has implications for *all* Canadians, health care experiences are not likely to be the same for different populations, as those experiences would depend, at least partly, on whether they have the means to mediate the impacts of allocation decisions (as driven by the economic interests of cost-saving and budget containment) on their lives and access to health care. This urges us to ask if, and in what ways, the priority for efficiency might be in conflict with the provision of equitable care to the ethno-culturally and linguistically diverse population in Canada.

### **The Contesting Questions of Equity, Efficiency, and “Difference”**

Health care reform has been an international phenomenon in the past few decades. Although the impetus behind reforming health care is usually staged as an economic necessity in face of “spiraling” health care costs, to focus around non-sustainability tends to justify the “cuts” implemented by the government (at both the federal and provincial levels). As we have seen in this study, the general public seems to “buy in” with the view that “efficiency” is necessary for the survival of the system, even if discharging patients to the community means going beyond what the family is able to do, or if it is achieved at the costs of potentially compromising patient safety and the quality of care.

Scholars such as Gilson (1998), however, alert us to the fact that health care reforms gearing towards maximizing efficiency “have considerable potential to harm equity” (p.1891). This is because a predominant concern with cost-saving tends to disadvantage those patient groups whose health care needs are likely to incur more costs on the system. Moreover, as Gilson argues, improving “technical efficiency” of the system does not mean that barriers to health care access and utilization, such as language and cultural barriers, are eradicated. In fact, we must not assume that everyone is located at a level playing field. As the findings of this study indicate, the implications of health care restructuring in terms of stringent hospital resources, shifting of care from the hospital to the community and so on, are not the same for different populations. For patients of a NES background, for instance, changes in the clinical reality such as a heavier workload for nurses could often mean that those patients would have to endure the lack of adequate communication with health care providers. For patients coming from a non-dominant ethno-cultural background, their health care needs might not be met

because meeting those needs could mean taking more time from nurses. In both cases, the system fails to provide “equitable” care to the patient based on his/her needs. This could result in the patient receiving lesser care in terms of inadequate understanding of treatment, lack of response to his/her cultural expectation of care by health care providers, or, in some other cases, being subject to discrimination.

In the current system where efficiency is privileged and accepted as the priority, it is easy for the value of equity to give way to efficiency, particularly if equity means incurring more economic burden on a system perceived as non-sustainable and at risk of breaking down. This is the case when differences in care needs have “material implications” for the system, such as requiring more time from the nurse in order to fulfill something extra from “how the system is structured.” Moreover, standardization of patient care, a strategy to maximize efficiency and productivity of clinical activities, promotes “sameness” of care, assuming that the provision of the same procedures ensures equal and quality care for all patients. Here, “differences” in care needs are contained within “sameness,” as every patient is given the same package of care, irrespective of their ethno-cultural and language background. In other words, efficiency in health care is partly achieved by containing the “material implications of difference,” or the extra economic costs that differences in expectation of care incur on the system.

Thus, in trying to understand the complex ways by which health care experiences of people coming from a minority language and/or ethno-cultural background are organized, it is important to conceptualize “difference” beyond its meanings as an object for ideological construction. Rather, there is an equally important economic or material dimension to “being different.”

The notion of “material implications of being different” draws our attention to the ideological terrain of differentiating between “us” and “them,” and the implications of that differentiation on resource allocation including health care and income. In this study, we have briefly examined the experiences of patients coming from a NES background being perceived as Other than Canadian, and being subject to discrimination and negation by the nurse. In other words, patients seen as “different from us” might be subject to bear the material implications by receiving lesser care. This is also the case when nurses of color are found to be located in low-paid jobs with little prospects, or are less likely to be promoted (Hagey, Choudhry, Guruge, Turriffin, Collins, & Lee, 2001). The economic implications of health care restructuring such as service cutbacks and staff layoffs could further subject health care workers from ethnic-minority backgrounds to racism and unjust treatment in the workplace (Das Gupta, 1996; Turriffin, Hagey, Guruge, Collins, & Mitchell, 2002). Outside of health care, people of color, such as immigrants coming from non-European backgrounds, are found to be at a disadvantage for economic achievement. This could have direct implications for health as low income has been found to be associated with poor health. Moreover, as discussed earlier, changes in health care policy such as shifting of care from the hospital to the community is likely to hit low income families harder in terms of the economic burden of care-giving, as the family is expected to fill in for the system what it is not prepared to provide through the ways in which it is structured by larger economic interests for efficiency and reduced intervention by the government in the welfare state.

If we understand the “material implications of being different” in relation to the process of social organization in the interests of capitalism, we can begin to see that the

ways that “the discursive intersects with the material,” whereby discourses such as that of immigration and immigrants as Other, as culturally inferior, actually help to legitimize the economic positions that immigrants tend to occupy in their host country. This also applies to health care when, as we have seen in the study, discourses of immigration filter down and shape how the nurse might interact with patients coming from a minority background.

In fact, Bhabha (in Olson & Worsham, 1999) argues that the problem is not that we are different, but that differences become the site for contestation in situations of competition over resources. One way to break up or “de-authorize” (Bhabha in Olson & Worsham, 1999) the organizing power of “ruling,” that which draws upon dominating discourses including the binary coding system of us versus them, is by intervening in the “relations of mental production” (Smith, 1987) dominated by the ruling class, such as by critical research. However, as I discuss in the following, those relations that organize health care are the same relations that discipline construction of critical knowledge by organizing access for research.

### **Social Organization of Knowledge Construction:**

#### **Politics of Negotiating Access in Health Care Research**

While discussion of negotiating access in the research literature tends to focus on the process of gaining entry into a field or agency through formal approval, I want to emphasize that the process of negotiating access does not stop at receiving ethical approval. Hammersley and Atkinson (1995) have rightly argued that “[access] is far more than the granting or withholding of permission for research to be conducted” (p.55). Specifically, obtaining ethical approval does not guarantee that the researcher would be



able to obtain access to the place and people from whom data are to be gathered. Rather, there can be a "gap" between formal entry and informal entry. As I argue in the following, this gap points to the complex and changing institutional context in which health care is delivered and knowledge is produced through research.

*Organization of Access to Clinical Settings by the Scarce Resource of "Time"*

The factor of time deserves particular attention as it plays an important role in organizing and mediating the process of negotiating access in complex ways. In the current context of health care restructuring in Canada, time has become an increasingly scarce commodity within the health care system, where factors such as downsizing, staff cutbacks, and increased acuity and complexity of patient conditions often translate into a heavier workload for nurses. In this changing health care context, where there is heightened emphasis on maximizing "efficiency" by early discharge and fast turn-over of patients, finding time to provide even the basic standard of care for patients is often a struggle for nurses (Anderson, Tang, & Blue, in press). In the context of this constraint of time, it could become even more challenging for nurses to spare time for participating in research.

The perception among people in the field that "time" is scarce, and that research activities compete with clinical imperatives for the scarce resource of time could set up a barrier for negotiating entry into the settings even when formal approval has been obtained. It might be argued that the gap between obtaining formal approval (ethical approval from an agency) and gaining informal entry (in terms of actual support and participation from people in the field) speaks to the hierarchical structure of health care organization, where decisions made at the level of top management are not necessarily

“supported” by staff at the front line. Support here does not mean verbal or attitudinal approval only; rather, support for research needs to take the form of giving “time,” as participation in research involves embodied involvement, with material implications as participation in research requires actual time and work of participants. The question is therefore more than the attitude of potential participants. It draws our attention to the institutional context in which health care is organized and delivered, in which “time” and workload are two of the most influential factors determining the process of negotiating entry.

Thus, the changing institutional context in which health care is delivered is the same context in which research is conducted. As such, the process of research is also subject to the same factors that organize nurses’ work and interaction with patients. In addition to the impact of “time” on the dynamics of negotiating access, as I have discussed above, other factors such as staff morale and the tense relationship between management and front line staff could all impact on the process of research. These factors are directly or indirectly related to health care restructuring. The process of negotiating access could become even more political and complex by a changing structure of nursing management, where there is a changing emphasis in health care on the “budget” or the logistics of financial effectiveness in service delivery and management of manpower. As I continue to argue, this shift in the priorities of clinical settings has implications for the process of negotiating access, where management could act as a gate-keeper to research by exercising power over resource allocation of staff time.

*The Political Process of Negotiating Access: Gatekeeping and Negotiating Power*

Changes in the management or leadership structure at the ward level might also have changed the dynamics of negotiating access into the field. Over the past decade or so, many hospitals have experienced changes in the leadership structure in nursing. Specifically, what used to be head nurses have been replaced by ward managers and clinicians. This is characterized by changes in the leadership role, where clinical support and managerial support seem more specialized and split. As one ward manager told me, her role as a manager is mainly responsible for the budget, hiring staff, and disciplinary issues, whereas the clinician provides clinical support to staff and deals with the day-to-day issues of the ward. In this sense, the managers are in a position to manage resource utilization, including staff time. They might see themselves as having the obligations to protect staff time so as to fulfill the immediate clinical duties, rather than facilitating the conduction of research (that which, after all, is going to directly benefit the researcher only). Taking a nurse away for research interview could be seen as competing with the ward interests to get things done with the available (and often limited) resources and manpower. Research activities could in fact be competing for available health care resources, and could be seen as in conflict with the more immediate clinical activities.

While I do not question the importance of putting clinical imperatives before research imperatives, I want to unfold the often hidden layering of power that could hinder or facilitate the process of negotiating access, particularly during the “sensitive period” of restructuring, where resources become highly competitive among clinical units. This could have important implications for a study such as this one, where it could be seen as a potential threat to the clinical areas concerned. No matter how carefully the

study is presented, it could arouse suspicion and fear of criticism which, even unwittingly, might put the participating clinical areas into a vulnerable position for further cutbacks or other disadvantages. Thus, negotiating access could be a lot more complex and politically charged than one might have imagined. Despite my emphasis that the study was not aimed to evaluate the hospital, as one manager said, "you are going to find something interesting anyway." In the current context of political correctness and ethnic/racial tension, a study on culture and immigrants could arouse feelings of discomfort among managers and nurses.

Thus, even though I had official approval to access the hospital wards from top management, it has not guaranteed my access to the clinical areas. In fact, middle management seemed to have the power to "gate-keep" the conduct of a particular study. In a sense, negotiating access is also a process of negotiation of power at different levels of an agency, from senior administration and professionals (mostly physicians) holding power to review a research proposal and grant entry, to middle management with control over access to the clinical areas, to front-line workers whose participation the researcher depends upon. Power here could be understood as the organization of resource allocation (staff time). In this sense, gate-keeping has to be understood beyond the exercise of power on a personal level, but as part and parcel of the complex work of maintaining the relations of resource allocation in health care. More importantly, power has a further and important meaning of the social organization of knowledge production through granting access or otherwise denying entry to the field for specific research.

In fact, one should worry about the implications of health care restructuring for research: if it's getting more and more difficult to conduct (certain kinds of) research in

health care settings, there is less chance for bringing about change by providing what Smith (1999) calls “an alternative organization of knowledge which does not reproduce the ruling relations” (p.74). In this sense, the underlying relations and factors (e.g. neo-liberal emphasis on profit) to restructuring health care are also playing an increasingly important role in organizing what we can know about our society. *More importantly, social organization of knowledge through research begins at the process of negotiating access.* Without access to the field, no critical research can be done to challenge existing hegemony in the way that society and our knowing are organized.

## CHAPTER SEVEN: CONCLUSION

In a multicultural society such as Canada, the health care system is often criticized as privileging the dominant cultural group, and being insensitive to differences in the care needs of its diverse population. Specifically, as existing immigration policy allows immigration of people coming from ethno-cultural and linguistic backgrounds different from the mainstream, recommendations for changes in the ways that health services are delivered tend to focus on meeting the cultural and language needs of the newcomers who might not be familiar with the dominant cultural systems that guide the delivery of health care in their host country.

The notion of culture deserves our serious attention when trying to understand the health care experiences of immigrants in their new country. The ways that cultural differences play out in the clinical context are complex. As some nurses in this study have rightly pointed out, there is no linear relationship between cultural identity, ethnicity, skin color and language. Thus, nurses may fall into the potential pitfall of stereotyping if cultural knowledge is applied uncritically and/or when assumptions about culture are based upon how a person looks or the language s/he speaks. What this suggests is that meaningful steps towards improving health care in a multicultural society are not only about imparting cultural knowledge to nurses but rather, assisting nurses with the reflexive application of knowledge based on assessment of individual patients (Anderson, 1990). Such an approach, as Anderson argues (1990), would include critical reflection on the part of the nurse on his/her own cultural background and socio-historical location, as well as the culture of health that s/he brings to her/his clinical encounter with the patient.

While the ways that cultural differences are read and responded to in the clinical reality involve tension and in some instances may even induce racial discrimination, the findings of this study would remind us that how health care is organized for immigrants in societies such as Canada cannot be reduced merely to an ideological issue of attitudinal prejudice or the lack of sensitivity on the part of the nurse. Instead, there is a very important economic dimension to the organization of those experiences, whereby the material context of health care plays a powerful role in organizing how nurses are able to read and respond to the care needs among NES immigrant patients.

In the current context of health care restructuring, where there is a predominant concern with the budget, the ways by which the clinical reality is materially organized speak to the prevailing neo-liberal ideology of market fundamentalism, that which privileges efficiency and productivity in the economic interests of the system. The power of the market-driven interests in organizing health care is evident in the ways that clinical activities such as patient discharge have become important administrative means for achieving the economic goal of budget containment. Here, we are not looking at a process that coerces people to act in certain ways. Rather, the power of the process of social organization seems to lie largely in its invisibility in co-ordering our activities in ways that fulfill the larger interests of ruling. This invisible power of social organization is enabled by discourse and the text.

The findings of this study show us how discourse and the text works in tandem in mediating the process of health care restructuring by facilitating efficient patient discharge in the economic interest of the system. At one level, the dominating biomedical and legalistic discourses play a powerful role in setting the boundary of

clinical care by defining what are priority and legitimate clinical actions. Nurses are confined to carrying out those biomedically-defined tasks as they are legally bound to provide “textual trails” for their actions. At another level, material texts such as clinical protocols and pathways provide a “linkage” for hooking local activities to the economic interests of the system, by confining each health care provider to performing and completing those tasks as standardized and inscribed on the text. Standardization of patient care has particular implications for patients coming from a minority ethno-cultural background, as it erases the space for negotiating differences in the perception of health and illness. In this way, standardization of patient care has meanings beyond an indication of advanced clinical practice; in a more hidden way, standardization also serves a non-clinical function of controlling the potential “disruptions” that immigrants and their differences in care needs might bring to the system.

Thus, we can begin to see how what happens in the immediate clinical encounter, such as the processes leading up to patient discharge, are not merely “local” activities; rather, these activities are invariably hooked to some larger economic and political relations that organize resource allocation and thus the material context in which nurses and patients experience health care. This is why analysis must go beyond describing experiences as people tell us. This is also why we have to locate inquiry in “experience,” because it is our everyday experience in real material time and place that provides an *actual anchoring point* for tracing back to the hidden process of social organization that co-orders our activities according to the interest of ruling.

The experience of nurses and NES immigrant patients in this study alerts us to how our “agency” to act could be complicit in reproducing inequity by sustaining the



existing relations of resource allocation in the economic and political interests of the system. We have seen how administrators and nurses may keep the system going by “compensating” for the governmental policy of budget cuts through their actions. This includes nurse managers trying to increase productivity and efficiency by maximizing utilization of hospital beds, even if “early discharge” might be to the disadvantage of some patients, such as those who are not physically ready to go home, or those who lack the dominant language skills and/or knowledge about different health services to negotiate alternative care arrangements. This also includes how nurses might play an active role in managing the “material implications” of language barriers by responding to the needs of NES patients with “time-saving measures.” While we can understand why, in some situations, nurses might need to respond to the clinical urgency of communicating with NES patients by using gestures or family members to assist with interpreting, we also need to pay attention to how these measures may at the same time serve an economic function of containing the material implications of language barriers on the workload of nurses. The material implications of “difference” such as language differences are subject to be managed not by some “rules;” rather, they are contained by the actions of nurses, whose ability to respond to those needs are organized by the same relations of resource allocation that determine their workload in the first place.

Here, we can begin to see how nurses can, unwittingly, become *active participants* in bringing health care restructuring into being when their actions and everyday allocation decisions accomplish for the system its economic interests of budget containment. As I have discussed in these findings, even when interpreter services are available, nurses tend to use those services only in “unusual circumstances” because of

their implications on the work of themselves and that of the staff interpreters. This is not to say that nurses intentionally put some patients at risk for inadequate care by depriving them of the extra support they need. Rather, how nurses might respond to the “extra demand” of NES immigrant patients within the confines of “how the system is structured” is a *manifestation of social organization*, or how our everyday, mundane experiences are organized by the ruling apparatus and its economic and political relations. If accomplishment of the interests of ruling relies on the work of people at local contexts, we can see a possibility for change through our critical understanding of the ways that our everyday experience, no matter how mundane they might seem, are organized by and reproduce the larger relations of decision making and allocation of resources at the extra-local level of power.

The experiences of NES immigrant patients in receiving lesser care or compromised communication point to more than places of inadequacy in health service delivery. Rather, those experiences tell us something important about some of the very complex and hidden ways by which differential access to resources is organized. Even in societies such as Canada where health care is publicly funded and purportedly equally accessible to all, *inequity* may be *passively accepted* as the “inevitable consequence” in a system perceived as “un-sustainable.” Although maintaining the financial health of the health care system is an important goal and a legitimate impetus behind restructuring, we also need to be critically aware of the hidden ways by which achievement of economic benefits might compromise quality and equity in health services. The experience of NES immigrant patients in this study, however, suggests that some patient populations could be at a more disadvantaged position to negotiate care than others in the current context of

restructuring. As the system is structured in ways that privilege the dominant cultural and language group, such as by expecting patients to be English speaking and thus being able to communicate with health care providers within a context of heavy workload and limited time for communication, the existing relations of resource allocation do not allow the time needed for adequate communication between nurses and NES patients.

The active role that members of the health care system play in accomplishing the economic interest of budget containment, such as by containing the material implications of difference, urges us to critically re-examine the location of health care as a constitutive part of the “ruling apparatus.” Health care “rules” in the sense that it articulates with other forms of the ruling apparatus, such as immigration policy, in organizing access to resources by immigrants in their “host country.” We have seen how sponsored immigrants are not allowed access to certain benefits for the first 10 years of their residence, as a condition of “sponsorship” under the current immigration policy in Canada.<sup>21</sup> In complex ways, these policies have far reaching consequences for certain groups. As eligibility criteria for immigration such as educational background and skills level are more readily met by men and women from the developed countries and men from the Third World, many women from the Third World can only enter Canada as “dependents” of their spouses. Unlike independent immigrants, sponsored immigrants are subject to restricted access to some state-sponsored programs. These include job training that is pivotal to assisting immigrants, especially those coming from non-English

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<sup>21</sup> To qualify for sponsoring a relative or family member to immigrate to Canada, the sponsor is required to sign an Undertaking with the Minister of Citizenship and Immigration. Specifically, the sponsor has to promise providing support and basic requirements for the sponsored family member for a period of three to 10 years. During this period, sponsored immigrants are expected to be self-supporting, and are not eligible for receiving social assistance from the government (see Canada, 2004).

speaking backgrounds, with integrating into the labor force of their new country (Abu-Laban, 1998; Neufeld, Harrison, Stewart, Hughes, & Spitzer, 2002). Consequently, many women immigrants end up in the lower echelon of the workforce, and are unable to improve their English language skills because of the difficulty to find time to attend English classes outside of their paid work and family obligations (Anderson, Blue, & Lau, 1991). These women immigrants, who are likely to experience difficulty in accessing health care because of their lack of English language skills, could be subject to further disadvantage in the current health care context where health care providers can ill-afford extra time to communicate with them across language barriers (Anderson et al., 2003; Lynam et al., 2003).

It could also be argued that health care plays an important “ruling” function of managing the “problem” that immigrants bring to their “host country,” by containing the “burden” that cultural and language differences impose on the health care system. Here, we are not looking at unique or isolated phenomena within the boundary of one country. What we are seeing, based on the experience of nurses and NES immigrant patients, are the ways that global and trans-national processes find their way into organizing what people do in diverse local contexts, and articulating what they do to the economic and political interests of those in ruling.

An understanding of the problem of inequity in health care, therefore, cannot be reduced to the inter-personal level or local level of policy making alone. We need to understand the complex process of social organization by explicating, as this study tries to do, the linkage between the local and extra-local. To locate the ruling power in the extra-local does not mean that we are powerless victims to the process of social

organization. Instead, we have agency to challenge the power of ruling by *acting otherwise*. This, as I argue, begins in our actions and decision-making in the everyday. This is the place where nurses and other health care providers can “interrupt” and challenge inequity, by being critically aware of the hidden process of social organization that co-orders our activities, and how our everyday experience, no matter how mundane they might appear, have implications for the experience of others.

### **Implications**

An understanding of how our everyday experiences are organized by, and articulate with some larger economic and political relations raises important implications for nursing practice, education, research, and health care policy making. Rather than considering themselves as passive victims of health policy and budget cuts, nurses can enact critical agency in their clinical *practice* by having critical consciousness about how their actions, such as in making allocation decisions on using interpreter services, have implications for either ensuring or compromising the quality of care that the patient receives. This is particularly important when some patient populations, such as those who are non-English speaking, are at a disadvantage to advocate for themselves and to negotiate health care within the current environment where resources are limited and access has become increasingly competitive.

In order to assist nurses with enacting critical agency in their practice, it is important to provide nurses with an *education* and a knowledge base that would assist them with making moral and ethical judgments about their everyday actions and allocation decisions. Although nursing is a practice discipline, the education of nurses needs to reflect a balance between providing nurses with practical training in the safe and

efficacious application of skills and preparing them to practice in an increasingly complex health care context that requires more than skillful performance of tasks. As the findings of this study alert us to an increasingly important function of text in socially organizing the clinical reality, we require educators capable of critically reflecting upon the discourses inherent in curriculum and learning experiences. Further, the nursing education community would be well served by serious examination of the ways in which the content and process of nursing education may constrain the potential of the discipline within the bounds of the dominating discourses and thereby serve the interests of those in power.

In order to develop a critical knowledge base that assists nurses to enact their moral agency within their everyday practice, *research* should be directed at developing an “alternative organization of knowledge” (Smith, 1999) that challenges the hegemony of existing relations of knowledge production. This includes the conduct of research that aims at explicating the hidden process of social organization, by beginning inquiry from the everyday experience of people. This also includes the conduct of both qualitative and quantitative studies inclusive of those populations that have traditionally been excluded from participating in mainstream research due to factors such as language difference. In order to better understand the complex relationships between access to health care and changes in health policies such as budget cutbacks, we require research that includes indicators such as language backgrounds and immigration status so that it might reveal the differential impacts of policy changes upon those marginalized populations whose health care experiences may be misrepresented or obscured by the general trends.

As the findings of this study suggest, minority populations such as non-English speaking patients may be significantly and disproportionately disadvantaged by policy changes such as staffing reductions. In order to make equitable *policy* in health care, policy makers need to be critically aware of and take into account the differential impacts of their budgetary decisions on different populations, particularly those who are at a disadvantage for participating in influencing policy because of such factors as language, age, or marginalized status. This calls for research that can provide policy makers with the “evidence” for equitable policy making.

As a step towards achieving some of these implications, I intend to take my research further by building upon the present study to create a comprehensive program of research. This includes further ethnographic exploration into, first, the organizing function of discourse and the text; and second, the ways in which health care articulates with policy and discourse of other ruling apparatus, such as immigration and employment, in organizing differential access to resources by different populations. Future studies will also include comparative studies of health care experiences of English-speaking and non-English speaking patients, as well as patients coming from European and non-European backgrounds, so as to explore how categories of ethnicity, “race,” class, gender, and language play their role in the complex process of social organization in a multicultural society such as Canada.

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## APPENDIX A

Pamphlet to the Patient/Family (English version)



School of Nursing  
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Vancouver, B.C. Canada V6T 2B5  
Tel: (604) 822-7417  
Fax: (604) 822-7466

Pamphlet to the Patient/Family (Revised 02 November 2000)

**"Culture and language: Experiences of immigrants in a  
Changing health care context"**

(Title of dissertation research: "The discursive context of health care: Social organization of health care experiences of immigrants in/through the discourse of culture")

Sannie Tang, Ph.D. (c), School of Nursing, U.B.C.  
(Pamphlet will be translated into Chinese)

**About this study**

As we know, the Canadian population is made up of people from different language and cultural backgrounds. While the Canadian health care system is one of the best in the world, some Canadians have difficulty seeking and utilizing health care. In order to improve health care access by all Canadians, this study aims to understand the complex issues that patients face in the health care system.

**How you would be involved**

I would like to invite you to consider participating in this study to talk about your health care experience, such as how you get health care providers to understand your health care needs. If you agree to participate:

- 1) I will have an in-depth interview with you and, upon your permission, follow-up interviews in the hospital, or at your home. I will ask for your permission to have our conversation tape-recorded, which will be transcribed verbatim by me or a transcriptionist. You have the right to refuse to have our conversation tape-recorded;
  - 2) I will observe an episode of your interaction with the nurse;
  - 3) I will review your current and possibly previous hospital records at this hospital.
- These activities might take a total of two or more hours of your time, and they will only take place with your consent and at a time convenient to you.

**Your right as a research participant**

Confidentiality of you and data will be protected by the following measures:

- 1) all gathered data will be numbered by a code;
- 2) there will be no information on any data to identify you or your family, the hospital or the nurse;
- 3) all data will be securely stored and kept in a locked filing cabinet;
- 4) only three persons will have access to the data: the researcher, her supervisor, and Dr. Sherill Grace who will assist with supervising the researcher with data analysis.

## **APPENDIX B**

**Pamphlet to the Patient/Family (Chinese version)**

## APPENDIX C

Consent Form for the Patient/Family (English version)

## APPENDIX D

Consent Form for the Patient/Family (Chinese version)

## APPENDIX E

### Pamphlet to the Nurse





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Pamphlet to the Nurse (revised 02 November, 2000)

**Culture and language: Experiences of immigrants in a  
changing health care context**

(Title of dissertation research: "The discursive context of health care: Social organization of health care experiences of immigrants in/through the discourse of culture")

Sannie Tang, Ph.D. (c), School of Nursing, U.B.C.

**About this study**

As we know, Canada is experiencing significant demographic changes. As health care providers, we are faced with the urgent need to respond to a population that is increasingly diverse in its ethnocultural and linguistic makeup. But how do we understand and attend to the needs of people who come from a background different from our own? How do we make sense of these differences? And, what are some of the factors that influence the ways we organize and deliver health care to a diverse population?

**How you would be involved**

I would like to invite you to consider participating in this study to talk about some of the complex issues that you face in providing nursing care to a diverse population. If you agree to participate:

- 1) I will observe your daily routines during a shift or part of a shift;
- 2) I will have a 15-30 minutes interview with you and, upon your agreement, we might also have a follow-up interview. I will ask for your permission to tape-record our conversation, which will be transcribed verbatim by me or a transcriptionist. You have the right to refuse to have our conversation tape-recorded;
- 3) I will observe an episode of your interaction with a patient.

These activities might take a total of two or more hours of your time, and they will only take place with your consent and at a time convenient to you.

**Your right as a research participant**

Confidentiality of you and data will be protected by the following measures:

- 1) all transcripts will be numbered by a code;
- 2) your name will not appear in any transcript or publication, and no information on the transcript will identify you, your institution or patients;
- 3) the floppy computer disks on which data are stored, and the hard copies of transcripts will be kept in a locked filing cabinet;

## APPENDIX F

### Consent Form for the Nurse

## APPENDIX G

### A Sample of Trigger Questions to Patient and Nurse

## A Sample of Trigger Questions

### Questions to the patient:

1. What are some of your experiences in the hospital?
2. How do you normally get the nurse to understand your needs?
3. Are there instances where your needs are not met or you felt you were being misunderstood? Could you elaborate on those experiences?
4. How would you describe your relationship with the nurse and doctor?
5. Is your family involved in your care? If so, in what ways are they being involved?

### Questions to the nurse:

1. Could you describe to me what is a typical shift for you, and how do you normally prioritize your day's work?
2. Is "culture" something useful for you to think about in planning care for your patients?
3. Could you tell me some of your experiences in providing care to patients of different ethno-cultural and language backgrounds?
4. Would it make any difference to your shift if one or more of your patients are non-English speaking? How would you organize your work if you have a NES patient under your care?
5. Are families involved in patient care? Under what circumstances would you involve the family in patient care?