CULTURAL SENSITIVITY IN NURSING

CULTURAL SENSITIVITY IN NURSING:

MAKING A WORLD OUT OF DIFFERENCE

By

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ABSTRACT

This thesis examines the meanings that nurses attach to the concept of "cultural sensitivity". The findings are drawn from an extensive review of nursing's formal discourse (the nursing literature) and nurses' informal discourse (indepth interviews with 31 nurses practising in Southern Ontario). An analysis of this discourse shows that there are different emphases in the formal and informal discourse, and considerable variability between nurses in how cultural sensitivity is understood. The two general orientations identified are control and humanism. A control orientation regards cultural sensitivity as a tool for increasing the efficiency of nursing care. A humanist orientation involves viewing cultural sensitivity as a process of personal growth that occurs between the nurse and client. The formal discourse in nursing tends to emphasize the control orientation while the informal discourse tends to give the humanist perspective more prominence. The thesis concludes by suggesting that efforts to promote cultural sensitivity will continue to be problematic so long as these differences in how the concept is understood are overlooked.

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CHAPTER 1: Introduction

The increasing heterogeneity of populations has heightened awareness of biomedicine's limitations in providing care to cultural strangers. A mechanism intended to redress these inadequacies is "cultural sensitivity". In the past 15 years, the construct has rapidly emerged from obscurity to prominence in the discourse of nursing as reflected in a document recently published by the Registered Nurses Association of Nova Scotia (RNANS) (1995):

> The Canada Health Act (1984), and the 1986 Epp Report 'Achieving Health for All: A framework for Health Promotion' (Epp, 1986) state clearly that all Canadians have the right to equitable, accessible, and culturally and racially sensitive and appropriate health care (p. 4).

While the need for cultural sensitivity has become axiomatic in health literature, the concept itself is seldom defined. The statement provided by the RNANS supports an association between cultural sensitivity and equitable care for people regardless of their ethno-cultural or social background. A closer examination of the term, however, exposes problematic assumptions concerning the symbolic and functional dimensions of this claim.

The term cultural sensitivity is inherently relational and presumes a provider and recipient of care. The standpoint of provision is always that of the health provider. This acknowledges that the burden for restoring historic inequities lies with those of the dominant culture. Situating the construct in the hegemonic discourse of biomedicine functions to perpetuate the status quo. This is reflected in how health discourse construes culture as a problem and subsequently poses cultural sensitivity as a solution. The problem:solution

opposition exposes a fundament of biomedicine - that complex phenomena are reducible to observable causal processes and that these processes are amenable to control (Freund & McGuire, 1995, p. 215).

The purpose of this thesis is to gain insight into the emergence and meanings embedded in this construct by looking at its development in nursing. I examine the meaning of the term both in the formal discourse of nursing literature, and the informal discourse of nursing practise. The research attempts to answer the following questions: what meanings does the term cultural sensitivity have in these discourses; what are the similarities and differences in constructions between these discourses; what factors may be suggested to account for similarities and differences; and how are these various constructions experienced by social actors?

Analysis of meanings in these discourses reveals two principal orientations - control and emancipation or humanism. The control orientation presents cultural sensitivity as a mechanism for increasing the efficiency and behavioural outcomes of care. This orientation non-critically accepts professional authority which perpetuates status differences in the nurse/patient relationship. In contrast, the humanist orientation presents cultural sensitivity as a hermeneutic device to enhance understanding and growth between nurses and cultural strangers. Relational, personal dimensions of intercultural communication are emphasized, downplaying differences in status.

There are two points that must be immediately noted. First, both tendencies toward control and humanism are evident in formal and informal discourse, and more specifically, within each interview. Although one tendency seems to predominate in each interview, vestiges of the other are also

invariably noted. Second, the relative emphasis on each tendency in informal and formal discourse is reversed. Control is emphasized in formal discourse with humanist-oriented meanings occupying a marginal presence. In contrast, humanism is stressed in informal discourse with control limited to presumptive references reflecting the truth value of medicine and notions of 'harm'.

METHODOLOGY

This study's purpose is to identify and compare meanings of cultural sensitivity embedded in nursing discourse. I analyze the formal discourse as follows. I have reviewed the Cumulative Index of Nursing and Allied Health Literature (CINAHL) from Volume one (1956-1960), to Volume 31 in 1995. This review provides a proxy indicator for the emergence of cultural sensitivity in formal discourse. Each volume was evaluated for:

1) specific headings related to culture as a way of discovering patterns in the importance of culture in nursing and conceptual refinements in thinking.
2) numbers of articles under each heading to capture professional interest in culture and refinements in interest over time.
3) initial references to cultural sensitivity in category headings and article titles: this provides a way to situate the construct of cultural sensitivity more generally in formal discourse pertaining to culture.

In addition to this, I analyse nursing literature from the early 1970's to the present. The early work of Madeleine Leininger, who is widely credited with advancing interest in cultural care, receives particular attention. A contemporary context is provided by an extensive review of work published in the past 10 years.

The main focus of the study is to elicit the meanings of cultural sensitivity in informal discourse. I analyze the data inductively using Glaser and Strauss's (1967) method of constant comparison. I note thematic categories as I collect data and refine them as additional data are gathered. This ensures that conceptual categories emerge in ways which fit the data. I make minor adaptations in approach according to variations in the type of data used.

Recruiting Respondents

A total of 31 Registered Nurses in Southern Ontario participated in indepth, semi-structured interviews conducted between May and October, 1996. I used two nonprobability techniques to recruit respondents. The first, and most successful, was a snowball approach. I asked health care workers I knew in Southern Ontario to identify nursing colleagues and friends who might be willing to be interviewed. The individuals approached to participate in the study, were also asked to provide names of other potential respondents.

I also used convenience sampling, but with somewhat inconsistent results. With this, I contacted nursing administrators in various organizations and requested permission to approach their staff. When permission was granted, I asked them to provide nurses recognized for their interest or involvement in cultural sensitivity. I then contacted these individuals directly.

In each case, I briefly introduced myself and the study. Each nurse was then given an introductory letter explaining the study (Appendix A), and an optional "sample interview guide" (Appendix B[1]). This was intended to provide

[1] The sample interview guide shared with respondent does not include probes. This was done to avoid overwhelming respondents with the full range of questions that could potentially be asked during the interview. Changes made to the working copy of the guide were not recorded on the sample guide, since the latter was only intended to provide a general idea of the types of questions that could be asked.

nurses the time to decide whether or not to participate, and indirectly to promote trust.

Each respondent was reassured that their participation was voluntary and that all information would be kept confidential; each was asked to sign a form confirming their consent (Appendix C); and each was told they would receive an Executive Summary (Appendix D) of findings on completion of the study. Copies of transcripts were shared with respondents upon request.

Interviews

Interviews ranged in length from 45 minutes to slightly more than 2 hours. Most interviews were between 1 and 1.5 hours in length. A semi-structured interview guide (Appendix E) provided a general framework for the order and focus of key questions. However, changes were often made to more closely align with the particular interests and experiences of respondents. Numerous open-ended questions enabled respondents to identify aspects of their experience viewed as most relevant to the study. This promoted spontaneity and enabled new areas of inquiry to be pursued during discussions.

A variety of settings was used. Most often these included professional offices, the respondent's or researcher's home, or coffee shops. A letter of thanks was sent to all respondents following the interview. All interviews were tape recorded and subsequently transcribed for analyses.

Questionnaire

A short questionnaire was completed with each interview (Appendix F). It provided general information regarding respondent's professional education and intercultural experience.

Characteristics of Respondents

Of 31 Registered Nurses who participated in this study, 28 were female, and 3 were male. On the basis of self-identified ethnicity, nurses traced their ancestry to European, Asian, African, Hispanic, and Aboriginal descent. Six nurses had immigrated to Canada: 2 from the USA and each of the others from different continental regions. Three respondents voluntarily identified themselves as being members of visible minorities. Twenty one respondents were between 30 and 49 years of age. Three were 29 years of age or younger, and the remaining 7 were 50 years or older. Seventeen respondents spoke only English, 9 spoke two languages, and the remaining 5 spoke three languages or more.

Employment

Most respondents were employed in either community (12) or hospital settings (8). Several respondents were involved in teaching (4), or family practise settings (4), with the remaining nurses involved in a variety of less-traditional settings, such as being self-employed or working with a non-governmental organization. The majority were employed full-time (22), with another 8 working casual or part time. One respondent was unemployed when interviewed. Most identified working with a multi-ethnic clientele in their current position. Professional experience ranged from 1 to 42 years, with an average of 18.6 years.

Educational background

Educational preparation in nursing included a diploma for 8, and a university education for 23. Of these, 13 had completed baccalaureate degrees, 8 had completed Masters degrees, and 1 respondent had completed

her doctorate. Most (17) nurses claimed they had received no formal education in cultural sensitivity. Those who had received formal preparation had done so principally through employer sponsored workshops, or seminars and workshops undertaken as part of their personal professional development. Four respondents had also contributed to formal discourse on cultural sensitivity through articles published in professional journals.

Self and Research

A significant aspect of this research was my own background as a nurse. My interest in cultural sensitivity derived from a variety of nursing experiences. As a new graduate, I worked in an isolated aboriginal community. I found standards of care inculcated in my nursing education often came into conflict with the behaviours of cultural strangers. The inability to resolve ideals of 'good' care with client's social cultural realities created significant tension. The concept of cultural sensitivity presented as a mechanism to resolve these difficulties was therefore appealing.

My interest in cultural sensitivity deepened with successive nursing experiences and I began to question what it meant in practise. For example, what did culturally sensitive care look like, and what differentiated it from more universalistic approaches to care? Also, several experiences demonstrated that often what was assumed to be culturally sensitive was experienced as culturally *in*sensitive by cultural strangers. This, in concert with other observations, led me to question the authority vested in "professionalism" generally, and in professionalized constructions of cultural sensitivity specifically.

Growing disenchantment with professionalism accompanied an increasing conviction that health knowledge played a secondary role in care. Most individuals, it seemed, wanted someone to listen and validate their concerns. I viewed this thesis as way to clarify what cultural sensitivity means to nurses, and as vehicle to ground my own understanding of it within a broader social science framework. I approached the thesis with several assumptions:

I believed that promoting intercultural communication was necessarily a 'good thing'. I vaguely defined cultural sensitivity as something which could redress the inequities between health workers and clients; a way of communicating belief in people's resources and their own solutions to health care problems. I expected that nurses would support a more professionalized view of cultural sensitivity which de-emphasized relational dimensions of care. I also expected them to talk about intercultural interaction in ways that entrenched the authority of the dominant paradigm for health. I also viewed cultural sensitivity as a skill-set; something the nurse did , and something that could be identified in interactions with cultural strangers. And, finally I assumed these skills would be 'generic' and relevant across cultural contexts. Thesis data dispelled many of these assumptions.

The commonality of experience I had with respondents was both an asset and a liability. I believe it promotes access to some individuals and groups. My insight into contemporary problems in nursing practise also enabled me to probe less obvious dimensions. However, among the limitations was my particular motivation for the study. Because of the anticipated differences between my views and nursing generally, I initially approached respondents with some ambivalence. This was resolved when I realized that

respondents struggled with many similar issues that had constrained my own experience, practise, and efforts to understand cultural sensitivity as a nurse. While I do not believe it is possible to remain detached from research there is a very real danger of over-identifying with respondents, specifically by over representing the prominence of themes which align with our unconscious concerns. I tried to counter this tendency in several ways; by openly acknowledging my biases and opinions in fieldnotes kept throughout the research process, and by avoiding leading questions. But some "slips" occurred as the following example demonstrates:

> **Researcher**: Did you have to unlearn things [from your training] as you acquired nursing experience? Cause I always think of it like a paramilitary training - at least it was for me.
>
> (Interview 21)

Fortunately in this case, the respondent did not share my view. Another strategy was to write a "dummy" chapter that presented "my story". This provided the most concrete basis for assessing where my experience threatened to intrude on the data. In spite of these limitations, the process, while imperfect, did create a climate where respondents could speak honestly and openly. For example, several respondents pointed out assumptions in the interview guide, or conveyed their dissatisfaction with formal discourse of cultural sensitivity.

THESIS OUTLINE

The overall purpose of this research is to identify and contrast the meanings of cultural sensitivity in nursing discourse. This thesis is organized as follows: Chapter 2 outlines the theoretical basis for this study. I use a social

constructionist approach as an orienting theoretical framework for the thesis. Briefly, social constructionism is an approach that emphasizes the processes through which social actors construct the meanings that contribute to their social realities. It is an approach that lends itself well to the purposes of my research. At the same time, it is an approach fraught with contradictions and conceptual problems. In Chapter 2 I reflect both on the possibilities and the limitations of the social constructionist approach. With it I discuss the contributions and difficulties associated with applying constructionism to this study.

The remaining chapters are substantive. Chapter 3 provides an analysis of cultural sensitivity in formal discourse. It also discusses the two predominant themes in this discourse; control and humanism. Control is reflected in approaches where the nurse understands cultural sensitivity as a means to promote conformity among cultural strangers. From this view, cultural sensitivity becomes a mechanism for increasing the efficiency and outcomes of nursing care. Humanism is reflected in approaches to cultural sensitivity that stress mutuality in interaction. The primary object becomes to develop an understanding between nurse and client. Chapters 4 and 5 discuss how these dual tendencies are expressed in informal discourse. Finally, in Chapter 6, I summarize the thesis' main findings and contributions.

CHAPTER 2:

A Social Constructionist Approach: Possibilities and Limitations

Constructionism provides the theoretical basis of this thesis. In this chapter I both describe and critique constructionism. I begin by discussing the basic tenets of the approach. Next I address areas where the adequacy of constructionism as an explanatory framework for this study appear problematic. More specifically, I argue that just as cultural sensitivity is a socially constructed symbolic resource, so too is the constructionist approach. Each represents a way of making sense and both derive from culture. I conclude by addressing how findings from this study support a limited idea of "truth". Throughout the paper, I suggest and explain ideas outside of constructionism that may more fully account for the parallels in cultural sensitivity and constructionist theory as social constructions. In addressing notions of truth, these complementary ideas are drawn together and used to clarify the role of social research.

CONSTRUCTIONISM

Over the past 20 years constructionism has emerged as the dominant framework in studying social problems. Specifically, constructionism analyses the processes by which phenomena become defined as social problems (Best, 1995; Pawluch, 1995; Spector & Kitsuse, 1987). Toward this end, constructionists focus on definitional processes, more commonly referred to as "claimsmaking activities" (Spector & Kitsuse, 1987). There are three facets of claimsmaking which receive consideration. The first concerns claims themselves - their contents and their rhetorical form. The second focus is on

claimsmakers. Those individuals or groups that purport to understand and define phenomena for various audiences. Some constructionists go further and try to explain how the interests and ideologies of claimsmakers shape the contents of their claims. The third focus is on the claimsmaking process - the strategies employed in pressing claims. One of the central aspects here, is in ascertaining how one claim ultimately gains acceptance over others.

The emphasis on definitional *processes* rather than the object of the claims being made reflects constructionism's rejection of objectivist approaches to social problems. Objectivists base analyses upon common sense assumptions of social problems. By so doing, objectivists uncritically accept the moral judgments embedded in any particular understanding of social problems, and they ignore the fact that definitions of these problems are contextual and change over time. This distorts analyses by disguising judgments of value as judgments of fact (Spector & Kitsuse, 1987, p.31). For constructionists, the objective world is always filtered through experience, all descriptions of social life must be understood as social constructions.

Why constructionism?

Constructionism lends itself well to an analysis of cultural sensitivity for two reasons. First, it provides a framework from which the questions of the thesis flow naturally. Second, it is unique in recognizing the dynamic nature of meaning creation and striving to authentically present it.

Constructionists commonly ask three questions (Spector & Kitsuse, 1987, p. 83): What is the content of claims?, How are claims organized and presented?, and Who benefits from the claim? The object of this thesis is to understand the meaning of cultural sensitivity in nursing discourse. As an

emergent construct, this thesis is directed toward answering the following questions: First, what does cultural sensitivity mean in both formal and informal discourse? What meanings are imputed to the term in the nursing literature, and by nurses from various practise settings? Second, what are the similarities and differences in constructions between these discourses? Third, what factors explain the dominance of meanings promulgated in formal discourse. And finally, how are various constructions experienced by social actors? As part of my analysis, I consider how experiences associated with various constructions shape nurses' experience in practise. My assumption here is that as people create meanings, these meanings reflexively act back to inform their perception of the social world.

Constructionism is derived in part from, and aligns well with the symbolic interactionist tradition which focuses on the meaning creating capacities of individuals. That is, the emphasis is on the way that people develop or construct a set of meanings about themselves and the world around them. Constructionism reveals how such definitions of social problems change over time and how such changes are explained by social processes. It is thus well suited to explain the ambiguous meanings and emergence of cultural sensitivity in nursing.

Apart from the natural correspondence between constructionism and the questions for this study, there are two additional and important reasons for its selection. The first concerns constructionism's effort to avoid the value biases embedded within other theoretical approaches. All research and theorizing is itself a construction that is motivated by, and predicated upon assumptions of value. While it is not possible to be aware of all values which may inform

research, constructionism attempts to make these explicit. Related to this is the constructionist imperative to authentically report the meanings of social actors (and not those of the researcher). This imperative indicates a fundamental respect for the generative capacity of individuals and an interest, not in judging, but in understanding their ways of making sense of the social world.

I believe that theoretical frameworks are dynamic systems of meaning which function to guide research according to a constellation of ideals and principles. Reasons outlined above suggest constructionism is uniquely suited to the foci of this study. Application necessarily challenges the explanatory power of theory and raises areas for critical reflection and clarification. In the next section I will discuss how criticisms of constructionism presented in the literature relate to this study. Following this examination, I discuss several areas where the adequacy of constructionism in explaining cultural sensitivity appears problematic. I introduce ideas from the humanist tradition in social sciences to suggest alternate ways of conceptualizing these areas. As theoretical frameworks contribute coherence, these ideas are intended to complement, rather than supplant the constructionist premises which inform this study.

Critiques of constructionism

There have been several critiques of constructionism, some levelled by objectivists or non-constructionists, and others by those generally sympathetic to what constructionists try to do. Best (1995) describes the former as external critiques and the latter as in-house critiques. The external critiques centre on the existence of objective social conditions apart from the claims made about them and the need to study these objective conditions. The objectivist critique

underlines the fundamental and irreconcilable differences in the ontological assumptions made by constructionists and non-constructionists. The issues and assumptions that divide them will not be discussed here.

The more interesting critiques, from the point of view of this thesis, are the in-house critiques. Two criticisms are of particular relevance. First, is the charge that constructionism has too limited a view of what constitutes claimsmaking and ignores claimsmaking styles of marginalized groups who have limited access to resources utilized by dominant groups (Best, 1995, p. 339). Nurses are frequently identified as an "oppressed" group. Historically subservient to medicine, they have often been denied the means for expressing a distinctive "occupational voice". The professionalization of nurses has given many nurses increased autonomy and ability to present claims. However, the accepted forums for pressing claims, such as conferences and journals, are not accessible to all nurses. The profession is highly stratified according to educational background and practise setting. Diploma trained nurses most often work in clinical settings providing direct patient care. These nurses, who are accountable to a management hierarchy, often have little control over how work is structured. Their education background leaves them poorly equipped to enter the claimsmaking arena. Consequently, most are relegated to the margins of formal nursing discourse. At the centre of the claimsmaking arena are nurses with baccalaureate or advanced degrees. These nurses often work in research, administration, education or community settings, where autonomy and decision making are significantly enhanced. Discussion of specific claims within nursing, needs to acknowledge both groups as participants.

The second important critique concerns the influential paper presented by Woolgar and Pawluch (1985). I will briefly summarize their argument and address its relevance to understanding cultural sensitivity. Woolgar and Pawluch (1985) argue that constructionists are not consistent in their relativism. Certain claims, namely those generated by the claimsmakers under study are held up as ontologically suspect while the claims upon which the analysis may rest are treated as "facts". For example, the changing definitions of homosexuality (from sin to crime to disease to lifestyle) are pointed to as evidence of the socially constructed nature of our understandings of homosexuality without recognizing the subjectivity involved in the identification of homosexuality itself. "Sin", "crime", or "disease" may be labels, but so too, is "homosexuality". Woolgar and Pawluch demonstrate their point by looking at an analysis of the label "child abuse". Stephen Pfohl, a constructionist, documents how the definitions of child abuse emerged as a result of concurrent social forces, such as professionalization, and technical developments, such as the availability of x-ray machines. But throughout the analysis Pfohl never questions the ontological status of the phenomena, child beating. Woolgar and Pawluch term this selective relativism, "ontological gerrymandering". It creates and sustains the differential susceptibility of phenomena to ontological uncertainty; "Some areas are portrayed as ripe for ontological doubt and others portrayed as (at least temporarily) immune to doubt" (Woolgar & Pawluch, 1985, p. 216). They question whether it is possible to conduct sociological analyses without engaging in ontological gerrymandering (p. 223).

Unsuccessful attempts to resolve this inconsistency have since led constructionists to conclude that assumption free research is an unattainable

ideal (Best, 1995). This affirms Woolgar and Pawluch's (1985) suggestion that ontological gerrymandering may indicate "not mere technical difficulties in social problems arguments, but pervasive features of all attempts to explain social phenomena" (p. 224). The language upon which the researchers must rely for communication has cultural assumptions built into it (Best, 1995, p. 344). Some constructionists respond that the significance of ontological gerrymandering lies not in achieving assumption free research, but in making assumptions explicit (Best, 1995). This problematically implies that assumptions are identifiable if given adequate attention.

The issues raised by Woolgar and Pawluch's article are relevant to the thesis for several reasons. First, the critique points to the problem of assumptions which are integral to all efforts at making sense of the world. A constructionist analysis of cultural sensitivity exposes some assumptions commonly used in providing care across cultural divides. In this thesis, I discuss some of the prevalent patterns in formal and informal discourse. However, as assumptions are also embedded into the language and theory of constructionism, this analysis will necessarily be partial and incomplete. One's ability to detach from the social and constructed reality of participants is necessarily limited by assumptions inherent with communication. If we did not share assumptions, communication would not be possible. Second, these assumptions are deeply held and influence thought at an unconscious level. There is a limited extent to which they can be explicitly acknowledged. Unconscious assumptions guided the formulation of this research process and undoubtedly influenced process and results. While I may have recognized some of the assumptions that I, as an analyst, have introduced into the analysis,

there are other assumptions - those that may be unconscious - that I have not, and cannot recognize.

Limitations of Constructionism: Parallels in theory and application

Beyond the issues raised in the literature, there are several other limitations to the constructionist approach that I discovered in my efforts to apply it. I discuss those here. I frame my discussion in terms of the parallels between what constructionists do when they try to understand and explain some claimsmaking efforts, and what nurses do as they try to understand and explain cultural sensitivity.

Parallel 1: 'CLAIMS' AND THE SEMIOTICS OF CONTROL

Claims about claims

The first parallel concerns how the process of theorizing is itself a process of claimsmaking. Like the formal discourse on cultural sensitivity, it reflects dominant cultural values of control. This becomes problematic when examining informal discourse on cultural sensitivity where definitional boundaries are characteristically unclear, and where proponents of "claims" frequently avoid competition in the formal claimsmaking arena.

Language as a symbolic meaning system has values embedded it. Constructionists recognize that claims reflect moral universes. Embedded in claims are certain assumptions, norms, and values about how the world "ought" to be. Recognition of a social problem is therefore inseparable from a set of norms (Spector & Kitsuse, 1987). Values of control embedded in cultural sensitivity, parallel values implicit in a theory developed to understand claims. According to the Random House (1988) dictionary, the word claim is defined as:

> 1. To demand by or as by virtue of a right ...2. to assert and demand recognition of a (right, title, possession, etc.); assert ones' right to...3. to assert or maintain as fact... 4. to require as due or fitting: To claim respect ...6. An assertion of something as fact, 7. a right to claim or demand; a just title to something (p. 247).

As the dictionary explains, claims are foremost about possessing something as a right or due. One *has* claims. They are a form of property; a reflection of ownership and control. With cultural sensitivity, claims reflect nurses' attempts to impose definitional boundaries around interaction with cultural strangers. Embedded within them is a predominant value orientation toward control. They legitimise efforts to promote conformity among cultural strangers on the basis that it increases the efficacy and efficiency of nursing care. In constructionism, claims are reflected in assertions about the proper methods and objects of analysis. The view of claims as "objects in the world", limits the meaning of claims and discussion on claimsmaking in ways that reinforce an orientation of possession and control. This appears at odds with the broader intent of constructionism (to allow stories of social life to gain expression with minimal interference from the researcher). I believe this apparent tension demonstrates the need to critically appraise the relevance of constructionist claims to understanding the construct of cultural sensitivity.

The ambiguous reference to claims in constructionism, demands a critical understanding of how it both contributes and restricts analyses. Claims as expressions of control are not necessarily bad. Making sense of the world demands that some objects be considered worthy of attention and others not. The fact that researchers develop analyses along some paths and not others is a form of control. Yet it is justified, since the alternative to 'sense' is nonsense. While there are positive aspects to this, some analytical boundaries suggested

by constructionism present difficulty with the study of cultural sensitivity. When claimsmakers are unclear about definitional boundaries, such as what activities and interests fall within the arena of claimsmaking, resolution of ambiguity is left to the social researcher.

Practical Implications

a) Boundaries

Spector and Kitsuse (1987) write that a "definition of social problems cannot be applied by the sociologist without regard to the perspective of the participants who make and respond to claims" (p. 79). They write that "the sociologist [must] ascertain how participants in an activity define that activity" (p. 79). In informal discourse on cultural sensitivity definitional boundaries are not clear. Although respondents were recruited on the basis of a self-identified interest in cultural sensitivity, it is obvious in several interviews that respondents have little previous exposure or particular interest in the term:

> Culture and cultural sensitivity? I never really amalgamated the two, I just always you know kind of had a heart for people that didn't speak the language.
>
> (Interview 5)

> I can't say I have a burning desire to find out about alot of cultures.
>
> (Interview 6)

There is danger in naming something as a claim which, as far as actors go, may have no particular meaning attached. Constructionism provides scant guidance for managing uncertainty in cases where a respondent's decision to participate may be less due to specific interest in the construct, than to other factors, such as curiosity about the interview process. It is possible that respondents who report no particular professional or personal interest in

cultural sensitivity agree to be interviewed for reasons extraneous to the research.

When boundaries around claims are not well established, the researcher is forced to make decisions about constituents of claimsmaking. Given the basis on which participation is sought, all respondents are considered claimsmakers, whether they reveal previous exposure to the term or not.

b) Competition

A second difficulty, is the assumption that claimsmaking behaviours are innately competitive. "The question", Spector and Kitsuse (1987) argue, "is not which explanation is more accurate, true, or even elegant, but rather how it is decided which will be accepted in a competition or conflict" among contesting claims (p. 64). The similarity in values between constructionism and formal discourse of cultural sensitivity delimit the focus to competitive styles of claimsmaking. Problems arise when trying to apply this logic to informal nursing discourse. Most respondents have never openly contested claims of cultural sensitivity. Their disavowals are characteristically non-competitive, reflecting a "live and let live attitude". This may reflect a legacy in styles of claimsmaking among groups historically denied access to forums for expressing themselves or instigating change. However, to suggest that disavowals lie outside the claimsmaking arena, and therefore are peripheral to analysis, would dismiss their potential impact on formal efforts to launch claims. An organization, for example, will have difficulty launching a cultural sensitivity campaign if there is not some level of acceptance among its employees.

Heuristic implications

The parallel values in formal discourse of cultural sensitivity and constructionism become problematic when trying to apply constructionism to informal discourse. The need to redress these difficulties leads attention to the deeper symbolic bases from which the resources for perception derive. Since values embedded in constructionism and formal discourse of cultural sensitivity reflect predominant values in western culture, it is reasonable to consider the parallel between them as a patterned expression of culture. Inability to discern the patterning of theory and analysis may lead to distorted analyses as anthropologist Edward Sapir (1949) explains:

> (It is) almost impossible for the normal individual to observe or conceive of functionally similar types of behaviour in other societies than his own, or in other cultural contexts than those he has experience, without projecting into them the forms that he is familiar with. (p. 659).

Sapir (1949) writes that to understand behaviour, one must perceive the unconscious cultural patterns which impute meaning to behaviour. Patterns arise from cultural form. Since the forms themselves cannot be observed, the source of cultural understanding lies in the patterned expression of form in individual behaviour (Sapir, [1994], p. 43). Observable behaviour then is like the tip of the iceberg, with the bulk of cultural form and patterns laying submerged beneath consciousness. Because their influence is unconscious, "the relations between the elements of experience which give them their form and significance are more powerfully 'felt' or 'intuited' than consciously perceived (Sapir,1949, p. 548). An understanding of social life, must therefore attempt to address and recognize the cultural assumptions that make something seem logical and natural. Consideration of Sapir's idea of unconscious

patterning not only provides one explanation of this parallel, but raises two additional areas for consideration in this thesis.

a) Logic

One cannot assume that theory is adequate to explain the behaviour of all society's members. While both sociologists and social actors may draw upon linguistic resources from the same cultural universe, the specific symbols and meaning systems they use may differ. Considering that formal claimsmakers often hold one or more university degrees, it is reasonable to assume that their symbolic resources differ from those who are socially marginalized by differences in education, class or race. This is demonstrated with the construction of the interview guide.

The nursing literature reveals several assumptions about cultural sensitivity that are subsequently incorporated into the interview guide - specifically, that the construct is accepted as a professional "good"; that it reflects deliberate nursing actions; and that it implies the standpoint of nurses. The following comment suggests that variation in how one associates the term, elicits meanings which significantly differ from formal constructions. One nurse who had not considered the term prior to the interview, uses a biophysical referent to inform meaning:

> ...sensitive meaning that you react to it, like a reaction to a strawberry...hopefully it will be a positive reaction...but I guess it could be a negative reaction too ... like if you encountered an Indian person that you could withdraw, or become cold or stoned, or just do your job and... get out of the room.
>
> (Interview 10)

Cultural sensitivity, in this example, is referred to as something potentially dangerous, over which the nurse has little control. For a Black nurse, the

meaning of cultural sensitivity is informed by experiences of patient abuse. The construct consequently implies a standpoint of mutual responsibility as indicated in the following comment:

> They need to understand my values are going to be different from them. ..they should expect that I will treat them as an individual as I expect them to treat me. Not well, 'the nurse before you didn't do it that way' -...I want to create an environment where they, as the patient, can feel open, willing and able to question me on anything that I do. But I also want them to value the answer that I give them, not just look at it like...'you're a black young female'... What's being done to help the care provider?.. what will the public at large be expected to understand and expected to do? I've advocated for the last 5 or 6 years...that we need to publicly... tell everybody, make billboards, make TV commercials... that when you come to the hospital [this is how you behave].
>
> (Interview 29)

The ability to make sense of claims assumes shared logic. The logic underlying formal discourse of cultural sensitivity, as these examples suggest, does not necessarily correspond to the logic underlying informal constructions. Those on the margins of formal discourse do not see the claimsmaking arena as the obvious place to express their ideas. I believe this reveals a limitation in the scope of behaviours most often delimited as claimsmaking. More fundamentally, it shows how a theoretical commitment in principal to reporting people's meanings, is in practise modified by culture in ways that make some behaviours appear logical and others not. Western societies emphasize competition and individual gain. It is, therefore, reasonable that theory would reflect this in behaviours deemed worthy of attention. I also believe it points to the need to expand constructionists' definitions of claims. For a theory committed to understanding the world through the eyes of claimsmakers to deliberately limit analysis to behaviours "out of sync" with how respondents naturally express themselves would be incongruous.

b) Shadow-claims

Culture selectively brings some elements into view while simultaneously hiding others. Constructionism asserts that claimsmaking can be adequately addressed by considering what people say. Focussing on visible claims alone, implies that all salient phenomena for analyses are observable and apprehendable. Aspects of social life not readily amenable to observation may be ignored. This fails to account for the symbolic meanings that fall outside the boundaries of formal definitional categories, and neglects to address that often what people say is not what they mean. The "shadows", if tapped, may reveal as much about how social actors understand the world as the formal processes of claimsmaking. It is only by probing the shadows that we can discern whether what people say is congruent with their behaviour. There are two areas where this relates to the thesis.

First, there is the question of the symbolic resources available to participants. Social actors may have limited symbolic resources for expressing themselves. In this study, nurses who have given cultural sensitivity extensive consideration, often have a vocabulary that enables them to convey highly nuanced thoughts. Nurses who have given the topic less focused consideration, often invoke a vocabulary that is codified, explicitly racialized or "incorrect". It would have been fairly easy to construct analyses on the words alone in ways which made an argument for the ethnocentric, discriminatory bias of nursing. I do not question that this exists; ethnocentrism exists everywhere else in society: there is no reason to suppose that nursing may be immune. The problem is that making evaluative statements on the words alone may miss what the words themselves are incapable of communicating. People may use

all the 'right' words and not be able to relate well to others. Conversely people may use simple and 'incorrect' words and yet be extremely proficient connecting with individuals across barriers of difference.

A parallel may be drawn to the use of the word 'claim' in constructionism. While some claims are used competitively (as with nurses who profess expertise on 'cultural sensitivity'), to extend this orientation to all nurses would impute meaning where it does not exist. Constructionism's commitment to revealing how people see their world implies flexibility in the interpretation of 'claim' that is concealed in standard definitions of 'claims' alone.

This suggests that to fully account for the moral universes embedded in claims one needs to address both textual and experiential dimensions of claims. The correspondence between these dimensions can often only be evaluated in the context of relationship. Since the term cultural sensitivity is inherently relational there is a danger of misrepresenting claims outside the context of relationship. Limiting this study to nurses also means that findings can only speculate how respective constructions of cultural sensitivity may be experienced by 'others'. What is reported however, is the way that such constructions are experienced by nurses themselves. Language patterns thought and action. So symbols used to define relationships with cultural strangers simultaneously shape the way nurses define their roles and experience their work.

Related to this, is the second implication of shadow-claims. There is a silent language that surrounds claims. One of the first cues to realizing divergences in meanings between respondents and the literature, is in observing the non-verbal behaviour accompanying their responses. In some

cases, as the interview proceeds respondents appear increasingly tense and uncomfortable providing responses. Occasionally definitions offered at the beginning of interviews are subsequently recanted, or the respondent will suddenly remark that she is having a hard time answering because "it" (the meanings) function at such a gut level. An invisible wall seems to exist between meanings presented at the beginning and end of several interviews. In several cases, the wall breaks when I draw attention to the uneasiness. The following example contrasts the definitions provided at the beginning and at the end of one interview:

EARLY (reflecting on experiences in an aboriginal community)

> **Respondent**:...when you look at the basics of what you had to so, as far as treatment and those don't change. But maybe the way you go about it changes a little bit...that's just sort of the concept I had in dealing with them and I never found it to be a problem. I guess because you're prepared to be a little more flexible and you're in their territory, so you do more adjusting.

LATER

> **Respondent**:...I know there's a difference within cultures, but I guess its something that I've always been sensitive to in dealing with people and I don't like putting people into categories. It really bothers me to do that...
> **Interviewer**: So by talking about it in this ways, it's almost like imposing categories on something, experience?
> **Respondent**: It does, and I just can't seem to categorize. I don't like to go through compartments like that.
>
> (Interview 15).

Retrospectively, it is evident that cultural sensitivity for this nurse means identifying problems with care. Questions on cultural sensitivity, are thus understood as asking the nurse to identify the inadequacy of her care. What is not reflected in the text, is that with the first few answers the respondent gives no indication of this concern. It is only as questioning proceeds that her unease

becomes obvious. The disjuncture in non-verbal behaviour from the beginning to the end of the interview, raises questions about the hidden, emotive dimensions of claims among nurses who occupy marginal positions in the claimsmaking arena. The interpretation of cultural sensitivity as a tool for identifying deficits in care, was crystallised the following exchange:

> **Respondent:**...Like you know people...have said to me, like the [nurses] that I work with, like they'll say that I'm not discriminatory. Like I've heard people say that I'm not discriminatory...
> **Interviewer**: You've just given me insight on something - because this idea of cultural sensitivity is so vague, that I think everybody has their own operational definition of it. And because I've structured all my questions about asking people all their experiences in thinking about cultural sensitivity...its almost like without any intention, but I think that sometimes it makes people feel that they're on the defensive to explain.
> **Respondent**: Well, I don't feel that I'm on the defensive, but I think gee, you know - maybe I should be doing more...like I should be reading more about some of these differences in these cultures.
>
> (Interview 22)

These examples highlight the importance of looking beyond the observable aspects of behaviour. Identifying potential gaps between what people say and what they do raises issues that can be further explored with respondents to ascertain congruency in meanings. This in no way diminishes the import of observable claims. But failure to attend to the dialectic between observed and unobserved dimensions of claims promotes distortion, either by missing the shadows, or by dwelling too much in the shadows which provides room for researcher's unconscious assumptions to interject themselves unchecked in the analysis.

Parallel 2: DETACHMENT

The second parallel between constructionism and formal discourse of cultural sensitivity as constructions concerns the question of standpoint. Cultural sensitivity is a way of objectifying nurses relationships to cultural others. Recipients of care have little or no control in preventing the construction of definitional categories. This reflects nurses detachment from cultural strangers. In a similar way, constructionism assumes a stance of detachment from participants in the claimsmaking process. Consequently, it objectifies the researcher's relationships with nurses, and negates the dynamic of communication between them. This raises several problematic considerations with respect to applying constructionism to the study.

Practical implications

a) Interactional meanings are not static

The stance of detachment assumes that meanings between the viewer and subject are separate. This is reflected in the fact that in formal discourse of cultural sensitivity, the nurse speaks for the experiences of cultural strangers. With constructionism, this is reflected in the notion that researchers can apprehend the meanings of claims, without influencing the content of claims themselves. All information is filtered through perception and senses. Understanding is derived through processes of engagement, which inevitably carry the potential for a confluence of meanings. The following example shows how interaction precipitates an ideational cascade between researcher and respondent which deepens understanding. The respondent is explaining how her view of cultural sensitivity has gradually transformed during the course of her career:

Respondent:...[it was a progressive] breaking free of the ties, or the lines, the net, the mesh we grow up in...
Interviewer: I've talked to people at different stages of their careers [who] have been interested in culture for different periods of time. ..now that I'm thinking of that ...it seems to me all like levels of effacement - or a willingness to let go of the ties
Respondent: I was thinking of effacement as removing your faces, your mask. Removing some of the things that constrict. You're also talking about it in terms of labour
Interviewer: An opening...Ah, because you're looking at it...[that] ...the taking off of face is actually the exposure of [one's true] self
Respondent: Yeah, and being open, vulnerable, and therefore truly connecting...and then I guess the opening of labour is truly vulnerable, and yet is creative. And that's giving birth to new life.

(Interview 2)

In another example, an effort to summarize and verify understanding inadvertently introduces a new way of thinking about cultural sensitivity to the respondent:

Respondent:...So what is culture? My definition is a design for being; what makes you do the things you do. That's broad and yet simple.
Interviewer: Like a social DNA?
Respondent: Yeah, I like that - a social DNA. I like that. I may use that...
(later) its the social DNA, its a design for living...
(and later again)..The second step is understanding your own culture; recognizing that you have some values and beliefs. Your own social DNA that impacts on you.."

(Interview 8)

It is also through dialogue that respondents introduce and expose problematic assumptions underlying the research. For example, when I ask one respondent to identify what she sees as characteristic of culturally sensitive people she comments that the question is biased: it implies a universal set of characteristics and will elicit the cultural biases of nurses when answered. She believes that the constellation of characteristics deemed

culturally sensitive will depend on which client population is being considered:

> **Respondent**:...I think...some cultures would identify different characteristics...For example, Polish students..would come to see me because they would need more homework, ...[students from] the African cultures...[who] had spent 5 or so years in a refugee camp where they didn't heave any formalized structure...found they loved [group work and] wanted to go slower...[and students from] Spanish cultures...were very non-time conscious...if you had a 2 o'clock appointment then maybe you'd come at 4:30.
>
> (Interview 14)

She raises questions about other biases embedded in the guide. Shared meanings, which occur naturally in communication, reflexively influence our perceptions. The stance of detachment suggests a separation between researchers and claimsmaker's meaning systems, which is contrary to how processes of communication occur.

b) Presumes that there is not shared life experience

The stance of detachment implicitly acknowledges that those things which separate people are more important than those shared in common. As the thesis will show, while difference is emphasized in the formal discourse of cultural sensitivity, the opposite is true in the interviews. Respondents frequently disavowed the applicability of cultural sensitivity to practise, embracing instead, a view that "people are people".

The most obvious problem with a stance of detachment, is that it dismisses as irrelevant or unimportant that which nurses and cultural-others, or researchers and claimsmaker-others share in common. Recognizing areas of shared life experience immediately establishes a basis for engagement. It means, that one recognizes something of themself in the other. In this study, many nurses have experienced prejudicial treatment as cultural-others. When

asked what cultural sensitivity means to them, they simultaneously answer from their experiences as nurses and as others. This is eloquently demonstrated in the following example:

> Because I was born black I will live and die black, and the people I encounter will remember me as the black girl who did X. Or, if they describe me, that is ...one of the tools they will use to say that Rose was a..They may forget that Rose had 3 degrees and owned her own home and drove a green car. But they will say that Rose was a black girl that worked in nursing... that's the first thing they're going to use to describe me; one of the most important things they will evaluate me by.
>
> (Interview 29)

As a former nurse and researcher, I encounter a similar tension in trying to remain detached from respondents. I share experiences that are frequently similar to those described by respondents. It creates a peculiar dynamic, of juxtaposing the role of researcher simultaneously with that which is both familiar and'other. The detached stance is artificial since people rarely compartmentalize their experiences in such rigid ways. Facets of one's 'self' are mutually reinforcing and are taken wherever we go.

The numerous problems with constructionism's stance of detachment do not detract from the importance of the underlying intent, which is to promote authenticity with research processes and results. Detachment provides an important, albeit unattainable, ideal for research. An understanding of authenticity, in relationships and research, reorients constructionism in ways that more closely approximate how communication and meaning generation naturally occur.

Heuristic implications

a) Authenticity in relationships

Authenticity refers to relationships where individual behaviour is

"harmonious with, or true to, their inherent...structure or historically emergent form" (Preston, 1996, Jan. 30). It involves situating oneself *in* the historically derived patterns of relationships, and not conceptualizing relational antecedents as something "out there". Knowledge derived from authentic interaction, is absorbed and merges with an individual's psychic processes. One gradually learns to see themselves more completely through the eyes of the other. This creates the conditions where a deeper understanding of selves can occur.

The awareness of self implied in authentic behaviour also means knowing one's boundaries. Respect of another seems to be contingent on one's awareness and acceptance of their own limitations. One nurse who works in neonatal intensive care underlines the importance of self-awareness:

> ...sometimes I get more involved with the family and sometimes it hurts to be sensitive... I'm aware of that [and sometimes] dealing with a baby that I've looked after for 8 or 9 months, I've said OK, I don't want to look after a baby that's going to be here for a long term. I want to be with a baby that's going to come and go within a couple of weeks...you know, I want a break. Because I know for myself to dive right into a situation again where you're dealing with somebody that's going to be there for 6 months or whatever, I would probably [end up needing to] close myself off emotionally.
>
> (Interview 27)

The deeper dimensions of caring described by this nurse reflect moments of what can be considered a "relational convergence". These occasions consist of a temporary effacement of egos, which permits a merging or 'cross-fertilization' of personalities and cultural forms to occur. It is at these "rich points" of connection, that the creative transformative potential of authentic relationship lies (Agar, 1994). Buber (1958) eloquently characterizes it as an 'I-Thou' relationship; an all encompassing momentary "meeting", where the sum

of individual attributes is felt as greater than their parts. "Just as the melody is not made up of notes, nor the verse of words nor the statue of lines...so too with the man to whom I say *Thou*" (Buber,1958, p. 8). Intercultural convergence provides a glimpse of more fundamental connections between individuals. As such, it enables people to briefly transcend social, cultural and professional boundaries.

For some, cultural sensitivity is an ongoing process, a continual unfolding of oneself in an effort to penetrate the essence of the phenomenal and social world around them. Thus the idea of 'being culturally sensitive', like 'being authentic', constitutes an ideal; it is ever illusive but steadfastly guides behaviour. To assert one's 'authenticity', as in "I am authentic" or "I am culturally sensitive", would be a contradiction in terms. It reflects an assertion of ego and implies external standards against which one's behaviour can be measured. Indeed, as Selznick (1992, p. 72) points out, a claim to have realized the ideal is itself the hallmark of inauthentic behaviour.

b) Authenticity in research process and results

The inherent risk of relational engagement in the process of research is the problem of overidentifying with respondents. This can lead to confusing researchers' personal or professional claims with those of the respondents. The concept of authenticity is predicated on an understanding of boundaries. Relational engagement can enrich research by providing rich points of insight through connection and transformation of selves, but these moments are likely the exception rather than the rule. There is, throughout the research process, a constant need for discerning those elements of experience and meaning that are shared and distinct. While the constructionist stance of detachment does

not seem to accord with how communication unfolds, it is instructive as an ideal. Researchers must consciously move back and forth between the data, their experience with the data, and their experiences apart from the data. Authenticity as a process of "becoming", reflects proximity to respondents. Measurement is based on the extent to which respondents see their meanings and 'selves' accurately portrayed in results.

Parallel 3: DUAL TENDENCIES

The third parallel concerns two thematic orientations evident in constructionism and the discourse on cultural sensitivity. Specifically, each exhibits an orientation toward control and at the same time a counter orientation toward humanism[2]

As explained, constructionism is culturally patterned in ways that appear to accentuate control. Formal nursing discourse, as I will show, also emphasizes a control orientation as evidenced in its preoccupation with behavioural change. Interestingly, however, the informal discourse tends to move more toward humanism. While themes of control are still evident, most respondents stress concepts that characterize a humanist orientation.

The humanist orientation stresses equality, authenticity, and creativity in discourse between nurses and others. It is expressed in constructionism and formal discourse in varying ways. In constructionism, it is reflected in the premise that meaning creation is a dynamic process that unfolds through interaction among social actors. This supports the view that meaning generation is unpredictable and can potentially be used to create conditions

[2] For purposes here, humanism reflects values of relationship, mutuality, and self-enhancement.

which enhance human growth. As people bring their personalities to bear on cultural forms, old meanings may be renewed and transformed. It is also reflected in the constructionist presumption that the views of social actors are significant and worthy in their own right, without having to ascertain their "truth" value.

A humanist orientation is reflected in the formal discourse of cultural sensitivity at several levels, each of which will be discussed more fully in the substantive chapters of the thesis. First there is the ideology of 'care' that guides nursing theory and practise. Caring has both technical and moral dimensions (Chambliss, 1996). The moral dimensions of care stress the intangible relational aspects of nursing. Numerous factors are identified as mediating nurses' ability to 'really' care for cultural strangers. Second the literature claims to support self-determination among groups historically disadvantaged. (These appeals are frequently undermined by subsequent reticence to relinquish claims of professional expertise). Finally, humanist tendencies are also evident in some of the nursing literature which discusses cultural sensitivity as a vehicle for promoting growth and development among both patient and nurse. This literature critically reflects on the limitations of "professionalism", and urges nurses to recognize lay knowledge and experience, rather than "expertise", as the generative source of health.

The co-existence of these dual tendencies is unaccounted for by constructionism. Of particular concern to this thesis is the significance of these tendencies, and the inverse emphases expressed in formal and informal discourse. A possible explanation is found in the ideas of Erich Fromm.

Heuristic implications

According to Fromm (1976), individual behaviour (and by extrapolation, culture) is characterized by two fundamental "potentialities". The symbolic frameworks of culture, interacting with individual personalities, influence the characterologic orientation which will prevail in society. Fromm (1976) dichotomizes these potentialities as "having" or "being" modes of existence[3]. The having mode emphasizes control and compliance with authority. The being mode emphasizes dialogue, individual growth and development. These modes of existence appear to align well with the thematic orientations noted above.

a) Having mode: authoritarian (control and skill)

Western cultures, with their impulse to control phenomena, orient behaviour toward the having mode. The having mode represents an authoritarian discourse, which is hierarchical and emphasizes compliance with dominant values. This aligns with the focus on competing definitional categories in constructionism, and the difficulty of analytically managing claimsmakers who use noncompetitive strategies with claims. Fromm's having mode also aligns with the formal discourse of cultural sensitivity, such as the reduction of culture to a variable of behaviour, and efforts to promote compliance among nurses through promulgation of skills and assessment guides.

b) Being mode: humanist (authenticity and creativity)

The being mode emphasizes dialogue and mutuality in interaction. It

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3 To promote clarity, when concepts of 'having' and 'being' are discussed with respect to data, they will be referred to as 'control' and 'humanist' orientations. Having and being are used here to capture the links with Fromm.

also encompasses notions of being genuine, or "true" to one's self. In the following example, the respondent indicates how cultural assessment guides, discussed with formal approaches to cultural sensitivity, seem artificial and counter-intuitive. In this way, the respondent distinguishes her view that culturally sensitivity ought to be an extension, expression of 'self', rather than a need to conform oneself to externally imposed forms:

> I hope I don't wilfully make the decision to be culturally sensitive. I hope it's just something that comes across...I hope it's just something that's a natural thing. [To consciously consider] that just because someone walks in and they're Indian...and I'd have to work on this to understand this person...It would make me very uncomfortable, very strained. I'd have to put [cultural sensitivity] mode up in my brain, like I'm flipping pages looking for the Indian page. 'How do I behave with an Indian person?' - it wouldn't be comfortable at all. I wouldn't enjoy working with people...I think they'd feel I was a phony
>
> (Interview 10)

Building on Fromm's ideas, it is possible to conjecture that the formal discourse and claimsmaking styles that most often attract constructionism, reflect the having mode. The informal discourse, which is characteristically non-competitive, often falls outside the purview of constructionist analyses. Having and being modes are not purely descriptive. Central to Fromm's conceptualization, is the extent to which the characterologic orientation in society allows individual's generative potential to unfold. This leads us to the fourth and final parallel.

MEANINGS, MOTIVES, and the SEARCH FOR TRUTH

Constructionism helps understand the processes by which specific definitional categories become accepted over others. This is sometimes

explained on the basis of professionalization or claimsmaker's self interest. Formal discourse of cultural sensitivity would seem readily amenable to such explanations, for political interests are often thinly veiled (Leininger, 1970; 1991; 1993; 1996; Majumdar, et al 1995). However, applying this to informal discourse again presents difficulty. Few respondents express interest in formally sharing a 'stake' in cultural sensitivity. Most explain their motivations and interests in terms of self-enhancement:

> It's one of the highest moral principles and...it's how I would want to be treated, I- thou and the other..the development of self, the help giving. Becoming all you can be - yourself and the other...Growth in both of us...the spiritual dimension.
>
> (Interview 2)

> Acceptance is just self-love. So It's just learning about yourself and...to work out of a loving way - and I don't [mean] that in a charitable loving way; [rather] it's like out of a loving spirit. It doesn't mean that you have to like everything about somebody, but to me you can't do that [in a] really open way unless you [are] really in touch with all the kinks in yourself".
>
> (Interview 1)

Constructionists recognize the difficulty of trying to impute motivation to behaviour. However, the kinds of words used in these and other examples, suggest an orientation that is not well accounted for by the professionalization thesis. Though we cannot speak with certainty about individual motivations, these examples suggest a need to broaden constructionist analyses in ways that account for non-competitive styles of claimsmaking.

Emphasis on self-growth in informal discourse reveals a highly experiential approach to cultural sensitivity, however, constructions do not exist in isolation. Meanings of cultural sensitivity experientially intersect with other constructions, such as race, class and organizational structure. It is clear that the formal discourse of cultural sensitivity is felt to constrain the potential of

several nurses. The following comment reveals how the meaning of cultural sensitivity is linked to promulgation within an authoritarian organizational atmosphere:

> We got this sheet on 'you're treating these people wrong; they have sensitivities' And I thought, 'Oh great!' Right at the start it always comes across 'you've done something wrong'...and I hadn't really.
> (Interview 11)

When nurses respond negatively to the term, they are invariably reacting to its use as a construct for control. This suggests an experiential consistency with constructions of cultural sensitivity; patterns of control reflected in formal constructions dynamically interact with institutional structures in ways that intensify feelings of frustration for many nurses. The control orientation in formal discourse potentially comprises the humanity of nurses as well as cultural strangers.

Heuristic implications

These examples suggest a need to reformulate constructionism in ways that more fully account for non-competitive experiential dimensions. I believe the cues for this are to be found in considering the epistemology and objects of constructionism as products of culture. What is the function of meaning construction for human beings? If we can accept some premises regarding the significance of cultural productions, then we may be able to consider alternate explanations for apparent gaps in understanding.

Becker (1971) writes that cultures function to help people resolve the paradoxes of human existence. There are two central paradoxes. First is the awareness that our biological finitude coexists with an overwhelming need to answer "who am I and what is the meaning of my life" (Becker, 1971, p. 141).

We can only formulate answers about our existence through interactions with others. But in the process we learn that the interiority of our thoughts is utterly unrevealable. So the 'self' apparent to others, and subsequently reflected back to us, is always a partial rendering of the richness of our inner life. This leads to the second paradox; the 'mystery' of our being, our true self, is precisely that which cannot be fully shared or known (Becker, 1971, p. 28; Hall, 1981, p. 182). So while we are impelled to resolve the paradoxes of our existence through interaction, in the process we learn that knowledge is always partial and incomplete. Consequently, we can never speak with certainty about the meaning of our existence. We learn that we are ultimately and irrevocably alone. Becker claims that efforts to resolve the paradoxes of our existence do not occur in some abstract realm. Instead they arise from the material circumstances of everyday life.

a) Cultural sensitivity is part of quest for meaning

Constructionism and discourses of cultural sensitivity may be seen as examples of people trying to make sense of the social world which surrounds them. That is, they are concrete examples of humans trying to resolve the paradoxes of their existence. While different meanings are reflected in discourse, there is a shared basic assumption that there is value in people communicating across cultural divides. A valuation of human experience is also reflected in constructionism's efforts to accurately portray the life-world of social actors.

Variation in expression of this value is undoubtedly influenced by many factors. I have suggested that culture is one important factor by discussing the various parallels between constructionism and discourse on cultural sensitivity.

However, as Fromm (1976) and Sapir (1949; [1994]) point out, cultural patterns (or characterologic orientations) are not static. It is plausible that nurses intuitively recognize the need to redress the overwhelming emphasis on control in the health services. The emergence of humanism in informal discourse would provide support for this.

b) Truth and "truth"

The quest for meaning is fundamentally a search for the truths of human existence. Constructionism and discourses of cultural sensitivity, as products of culture, may be understood as efforts to perceive these truths. Ideas used to enhance the constructionist account of cultural sensitivity, share a rejection of objectivist claims to "know" the nature of reality. They acknowledge that "knowing begins with the awareness of the deception of our common sense perceptions that our picture of physical reality does not correspond with what is 'really real'"(Fromm, 1976, p. 40). We can only understand the world through interactions with others. As both Fromm and Becker point out, it is precisely the limits of our perception that keep us from apprehending that which is really real. Among theoretical perspectives, constructionism is unique in trying to work through, rather than deny this paradox. The insights of ontological gerrymandering reveal that communication cannot proceed independent of realist assumptions. This is evident in presumptions of detachment in constructionist research and in the tenacity of biomedical 'truths' in discourse of cultural sensitivity.

The dynamic flux of social constructions, constructionists argue, should prevent social scientists from making evaluative statements about the social world. Since we cannot ascertain the nature of reality, the role of social

scientists instead ought to be to try to understand how social actors ascribe meaning to their "realities", to report on how meanings are constructed and leave the ascription and judgments of truth value to claimsmakers. According to Ibarra and Kitsuse (1993, p. 23), there is no theoretical imperative for valuative appraisals; to judge the truth value of claims in any objective way is not possible and, therefore, beyond the purview of social scientists. Their point has merit as a reflection of constructionism's commitment to reporting people's meanings as authentically as possible, however it also presents two difficulties. To assert that social science ought not to tackle questions of the social "good" is itself a question of value. It dismisses the fact that theory is a dynamic meaning system which not only draws on the symbolic resources of culture, but simultaneously acts back to shape those resources. Since words reflect moral universes it is not possible for the practise of theorizing to be separated from questions of morality. While I agree there are enormous problems with researchers making normative assessments of claims, I can also imagine situations where claimsmakers may refrain from statements of value, either because of fear or their level of emotional development. In such cases, focussing only on what people say may paradoxically (and contrary to the intent of constructionism) invalidate their experience. The researcher cannot speak for respondents, but she is able to report observations and to suggest what these say about the unspoken depths of claims.

Constructionism's claim that there is no moral imperative to evaluate questions of the good, dismisses the reality of constructions as experienced in individual's lives, and as influence the form and content of research. Formally constructionists accept the premise that "a situation defined as real is real in its

consequences" (WI Thomas cited in Fleras & Elliot, 1996, p.49). Speaking of social constructions does not mean that they are false, yet the latent meaning of constructionist analyses often communicates otherwise. To return to the example of child abuse, limiting the analysis to the creation or construction of the label itself ignores the experience of those who have been subjected to such abuse. A child may have no vocabulary for incest. This does not mean the experience of it is any less damaging to their potential as human beings. Diagnostic criteria associated with definitional categories are contestable, but to focus on labels alone suggests that what is experienced as real, is also not really important. Doing so keeps the structural bases of constructions, and the intersections between constructions concealed. Limiting analyses to labels is analogous to limiting the definition of claims to matters of possession and control. The broader symbolic mesh of constructionism reflects a desire to counter authoritarian approaches to social research. Consequently, there ought to be a methodological imperative to consider the experiential dimensions of social problems with definitional processes.

Ignoring the real consequences of constructions also ignores that the impetus and focus for research frequently relate to how researcher's experience social constructions in their own lives. Using the experiential dimensions as a basis to begin challenging questions of 'the good', must allow the researcher to be real in interactions with respondents. Being real, refers to authenticity with research processes and results. A syncretistic relational convergence carries the potential for transformations in meanings among both participant and researcher. As the process of connection changes meanings, it also changes selves. A change in understanding suggests that something of the 'other's' life-

world, or self, has been absorbed. This communion of selves brings with it a moral obligation; a reciprocal connectedness which binds people in being accountable to each other. The moral obligation for researchers is to reflect the lives and experiences as truthfully as possible. I believe this overriding intent of constructionism is practically limited by difficulties discussed in this chapter. But what are these truths, and how do these clarify what the role of the social scientists ought to be?

Recognizing the inaccessibility of Truth, one can speak only of truths contingent on individual experience. That is, to conduct research that "grounds knowledge in something more than rhetorical argument and on the other hand recognizes that the truths so obtained are tentative and even transitory" (Wolfe, 1993, p.135). How are constructions experienced by social actors, and to what extent do they allow people to realize their innate creative potential? As Becker (1971) writes "we can't ask in any ultimate sense what is real, [but]...we can ask experientially, what is false" (p. 159). Acknowledging the experiential consequences of constructions, and consciously working with the realization that all research is value-laden, impels constructionism to incorporate the contingent truths of claims with description. It does not mean that researchers decide the moral import of claims for respondents, but rather forthrightly report their experiences, accepting that:

> Social science can play a role in strengthening capacities of social institutions to enrich what is human about human beings, without necessarily deciding what particular set of values any institution ought to maximize. Since human beings are meaning producing creatures, they can figure out for themselves what their most important values ought to be. *The social scientist's task is to help them by protecting and appreciating what makes it possible for them to be more fully human* ([italics added] Wolfe, 1993, p. 180).

Summary

Numerous problems arise when trying to apply neat theoretical sense to the inchoate rationality of social life. The principal focus of this thesis is to analyze the construction of cultural sensitivity in formal and informal nursing discourse. In this chapter I have discussed how the tenets of constructionism uniquely equip it to address the object of this study. However, my efforts to apply constructionism also raise for me certain problems inherent with the approach. First, the constructionist emphasis on claims and claimsmaking requires expansion to encompass unspoken aspects of claims and non-competitive approaches to social problems. Second, the stance of detachment, while necessary for heuristic purposes, is an unattainable ideal. I have argued that detachment needs to be reconceptualized according to the idea of authenticity. Third, dual tendencies in theory and discourse of cultural sensitivity are indicative of the more fundamental way that communication is patterned by culture. The inverse emphases on these tendencies, together with the preceding parallels support the need to recast constructionism (and cultural sensitivity) as a products of culture. I have argued finally for incorporating the experiential dimensions of claims into our social analyses. Specifically, we need to consider how constructions are experienced in allowing people to develop and express their generative potential.

CHAPTER 3:

Cultural Sensitivity in Formal Discourse

The purpose of this chapter is to examine how the term cultural sensitivity is constructed in nursing's formal discourse. The chapter is comprised of three main sections. First, I trace the socio-historic context within which the term cultural sensitivity emerged. I also briefly describe trends in nursing literature of cultural sensitivity and the meanings underlying formal use of the term. Second, I address how these meanings reflect a predominant orientation toward control. Particular attention is given to how control is bolstered by assumptions of objectivity and reductionism. Terms associated with this discourse, and ways that language is used in patterning thought and action are also discussed. Finally, I provide examples emerging from the margins of health discourse to illustrate how some nurses are attempting to move from a hegemonic toward an emancipatory construction of cultural sensitivity.

Background

Cultural sensitivity as a construct has emerged very recently in nursing. As a proxy gauge for its appearance, I review all volumes of the Cumulative Index of Nursing and Allied Health Literature (CINAHL) from its inception in 1956-1960, to 1995. The development of article headings relating to culture, and the numbers of articles listed under these are summarized in Figure 1. From 1960-1971, there is a single listing for culture. During the 1970's and 1980's a rapid increase in nurses' interest in cultural care, results in numerous refinements. This includes headings for 'cultural deprivation' (1972), 'transcultural care' (1981), 'cross cultural care' (1985), 'cultural values' (1988),

'transcultural care' (1993). Cultural sensitivity, which first appears in an article title in 1976, is not listed as a specific subheading until 1994. The largest number of articles listed for all headings between 1956 and 1994, is 62. In 1995, the second year cultural sensitivity is listed as a title heading, 86 articles are listed under it. This is the largest number of article entries for all culture-related headings from 1956 to 1995, which suggests the intensity of recent interest in the construct.

Table 1: Title headings and numbers of articles listed in CINAHL Vol. 1 (1956-1960) - Vol. 31 (1995)

year	# articles for 'culture' heading	new heading	# articles for new heading
1956/60	11	0	n/a
1972	23	Cultural deprivation	17
1981	40	Transcultural nursing	17
1985	19	Cross cultural care	9
1988	23	Cultural values	33
1993	62	Transcultural caring	19
1994	45	Cultural Sensitivity	50

The recent emergence of cultural sensitivity belies a long history of relationships between health care workers and cultural strangers. Support for this is most easily inferred from medicine's response to the massive influx of

immigrants at the turn of the century. Of particular interest is how social prejudices are expressed in medical responses to these groups (Kraut, 1990). In the late 19th Century, Jarvis conducts a psychological study on a "representative" population of immigrants which identifies up to 87% of ethnic groups as "feeble-minded" (Albee, 1981, p. 13).

Spurious medical rationales are incorporated into the immigrant section process and are frequently used to reject groups deemed undesirable (Kraut, 1990). Certain facial expressions, for example, detected during medical exams, are believed to be indicative of mental disorder (Kraut, 1990). Pseudoscientific medical rationale provides a veneer for racial prejudice as Naidoo and Edward (1991) explain:

> "Blacks escaping slavery in the United States were often denied admittance to Canada by such spurious legal means as 'medical determinations' that they were unable to adapt to the cold' (p.211)

While the scientific basis of medicine has undergone massive change, health workers approach to health of cultural strangers remains problematic. Satzewich (1989) explains that medical exams of immigrants reflects a racist bias well into the 1960's.

Sociopolitical Considerations

The emergence of cultural sensitivity in the early 1970's reflects the influence of several broad sociopolitical forces during the late 1960's and early 1970's:

Before the 1970's, there are several waves of immigration in Canada. Government policy prefers to recruit Euro-Caucasian immigrants on the assumption that they will more readily integrate and thus pose less threat to the integrity and unity of Canadian society. During the 1970's, changes in

immigration policy and international geopolitical considerations, leads to significantly larger numbers of immigrants from Asian countries (Fleras & Elliott, 1992, p. 39).

Before the 1960's there is a widespread belief that ethnocultural differences will disappear as a result of contact with industrialized societies (Fleras & Elliott, 1992). However ethno-racial unrest during the 1960's, fosters the gradual realization that diversity is here to stay. In the United States this is attributable to desegregation, race riots and the civil rights movement. In Canada, this is attributable to several factors, most notably, the rise of Quebec nationalism which culminates in the FLQ crisis in the late 1960's. The Canadian government seeks to quell the separatist movement in Quebec with the Official Languages Act of 1969. This subsequently ignites resentment and launches an effective political lobby among ethnic minorities who want affirmation of their place in Canadian society. The government's effort to extinguish special status of aboriginal peoples in the White Paper of 1969 galvanizes aboriginal people across Canada into unprecedented political activism. Fearing an expansion of the ethnic violence witnessed in Quebec, the government introduces a policy of multiculturalism in 1971.

Multicultural policy formally supports diversity in Canadian society. It exemplifies the ideal of Canadian society as a "mosaic" which, in principle at least, encourages minority groups to retain their ethnocultural uniqueness. This is a contrast to the "melting-pot" ideal in the United States which emphasizes integration and assimilation.

The formal policy of multiculturalism creates a climate where appearing responsive or 'culturally sensitive' to ethnocultural diversity becomes socially

desirable. It also provides a moral - ethical framework for legitimizing cultural sensitivity, on the basis that doing so promotes equity and access to health care for all citizens. A similar rationale can be found in national and international health promotion policy during the 1970's and 1980's. Examples include the influential Epp Report, "Achieving Health for All" (1986) and the World Health Organization's Alma Ata Declaration of "Health for All by the year 2000" (1978).

These policies, which recognize that health is associated with one's position in society, focuses attention on the disparate health status experienced by aboriginals, immigrants and refugees. Equity and accessibility to health care are consequently affirmed as rights for all citizens. Cultural sensitivity provides a euphemistic way to refer to these rights in nursing. Implying cultural sensitivity is a right (supported by appeals to policy) creates an obligation on health professionals to provide it.

Since previous waves of immigrants have not evoked interest in culture, it is possible that nursing's sudden interest in cultural strangers reflects societal concerns that these immigrants, who are often different in appearance and behaviour, are perceived as threats to social order. Ethno-racial foment of the 1960's may create a desire to manage diversity proactively within the profession through covert mechanisms of social control.

It should be noted that nursing does not begin to establish itself as a distinct profession until the early 1960's. Limited specialization of nursing practise throughout the 1960's, in the context of broader sociopolitical influences, may explain why the interest in culture does not gain momentum until the 1970's.

Descriptive overview of literature

The concept of culture is first addressed in the American nursing literature. My impression, following a review of the literature on cultural sensitivity, is that the American literature tends to endorse changing clients' behaviours more explicitly than the Canadian literature. The American nursing literature also seems to place less emphasis on recognizing how the nurses' cultural biases influence care. This could reflect differences in sociopolitical attitudes toward cultural strangers in either country; specifically in national ideals between the American melting-pot versus the Canadian mosaic. Canadian nursing relies heavily on literature from the United States. This is evidenced by the fact that all Canadian publications that address culture draw on American literature for support. Therefore I do not try to separate American and Canadian literature in the discussion of formal discourse in this study.

Overall, formal discourse of cultural sensitivity addresses cultural sensitivity in the context of three main substantive areas in nursing: theory, knowledge (research and education), and clinical practise. The importance of cultural sensitivity with each presumes an understanding of the "nursing process". It is this to which I now briefly turn.

The nursing process refers to the five-part conceptual framework that informs all aspects of nursing care. The five parts of this process are: assessment (collecting information on patient's condition), problem identification (identifying how data deviates from norms, and using this to identify particular goals of care), intervention (those things the nurse plans to do to ameliorate problems and achieve nursing goals), and evaluation

(determining how well interventions achieved the goals of care). The process is ongoing, with the final phase providing data for subsequent assessments.

Overarching this framework is a tacit understanding of biophysical processes, biomedical diagnoses and theories of patient care. The latter, "nursing theories", inform nurses' collection and interpretation of data. Theories are operationalized in "assessment guides". These guides are like a checklist which helps the nurse systematically consider (or "assess") all facets of a patient's physical, emotional, and social wellbeing. Each facet contains numerous elements. Nurses are expected to consider these when conducting patient assessments. Upon findings of their assessment, "nursing care plans" are developed. These written records of the nursing process function to direct and coordinate nursing care for each patient.

Theoretical perspectives influence the nursing process in the emphasis they place on particular aspects of patients' health, and by shaping the way that nurses subsequently impute meaning to assessments. Promoting cultural sensitivity in nursing theory, endeavours to influence nurses thinking and action at the broadest level. Theory, is the first area where culture is promoted in nursing. Leininger, published prolifically since the late 1960's, is widely credited with advancing work in this area. Her first book entitled, Nursing and Anthropology: Two worlds to Blend (1970), lays the groundwork for her theory of Cultural Care articulated in the early 1970's. This theory encourages nurses to identify the universalities and particularities of human behaviour in all cultures in an effort to develop care that transcends the cultural and social biases in western medicine. Leininger (1996) thus claims that the theory is not culture-

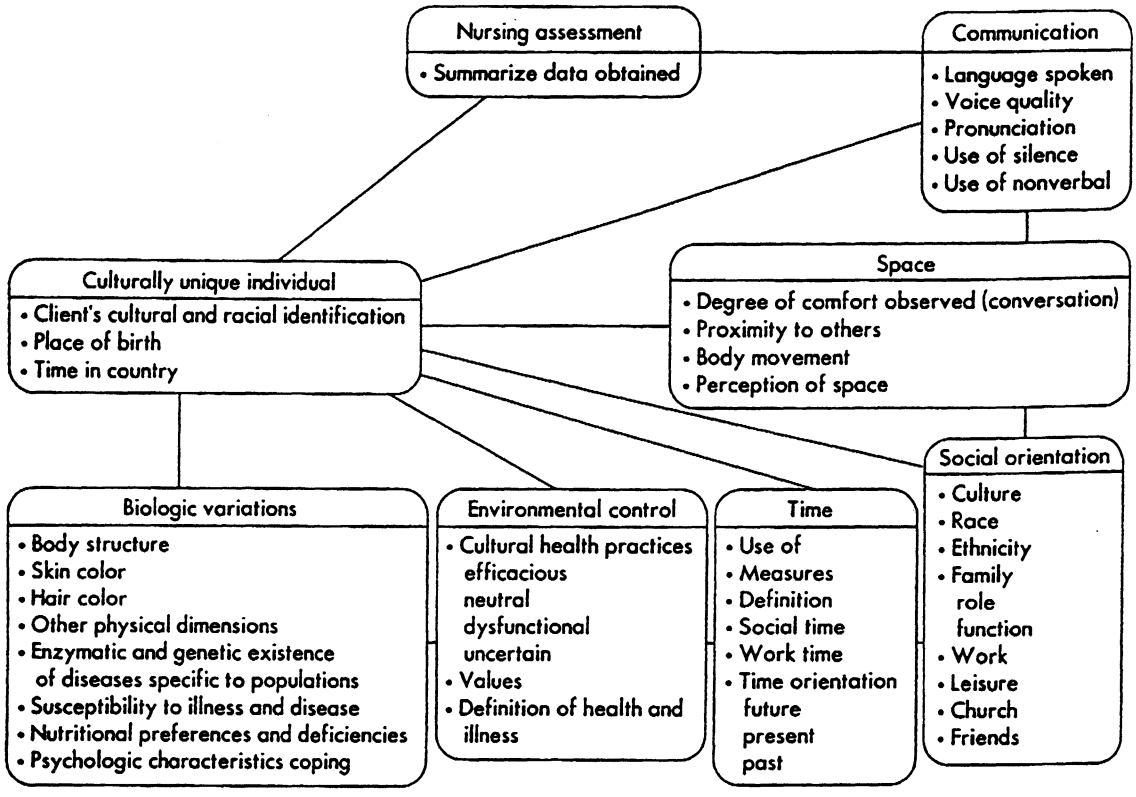
bound and she presents it as a metaparadigm for nursing worldwide[4]. Leininger's theory has been criticized for omitting the influence of class and gender and for failing to acknowledge that cultural values and beliefs change over time (Bruni, 1988), however elements of her theory remain influential.

Since the late 1970's many others have contributed to cultural theory in nursing (Dobson,1991; Giger & Davidhizar, 1990; Orque et al, 1983; Waxler-Morrison, 1990). Giger & Davidhizar (1995) conceptualize cultural behaviour as an expression of six inter-related dimensions: biologic variation, environment, time, space, social orientation and communication. Dimensions are conceived in a linear relationship to the "culturally unique individual" as portrayed in Figure 1. This makes it considerably easier to understand than alternative models, such as Leiningers, and may, in part, explain its appeal for many nurses.

Most literature claims that a key to cultural sensitivity is the generation of 'cultural knowledge' and transmission of this knowledge to nurses. Principal avenues suggested are research that addresses cultural dimensions of care and education of nurses (Giger & Davidhizar, 1995; Leininger, 1976, 1991; Majumdar et al, 1995; Wilkins, 1993). Providing nurses with knowledge of cultural strangers is expected to result in culturally sensitive practise. Giger and Davidhizar (1996) write "when nurses consider race, ethnicity, culture and cultural heritage, they become more sensitive to clients" (p. 5). Although there

[4] It is worth noting that this theoretical work subsequently provided the basis for Leininger to establish transcultural nursing (TCN) as a distinct subspecialty in nursing. This included establishing the Transcultural Nursing Society in 1974. This society holds annual meetings and boasts approximately 300 members (Andrews, 1992). It also established a transcultural nurse specialty certification program in 1988, and launched its own refereed journal (Journal of Transcultural Nursing) in 1989.

Figure 1: Giger and Davidhizar's (1996) Model for Transcultural Assessment



are disagreements in specific approaches to education, two commonly suggested strategies are cultural sensitivity training and the inclusion of cultural concepts in nursing curriculae. The importance of cultural sensitivity training is explained by Majumdar et al (1995):

> The goal of cultural sensitivity training for social and health providers is to foster a recognition and acceptance that individual's cultural identity is integral to all aspects of his / her life...Multicultural factors must be considered in the routine assessment of a client without stereotyping of ethnic cultural groups. The provider must be able to let the client know his or her beliefs and traditions are accepted while creating an awareness of Canadian norms. (p. 210).

Arguments for culture-specific education are often framed in predictions that lack of knowledge will increase inequities in health and barriers to care. Bernal (1993) asserts:

> At least three risks are inherent in allowing nurses to practise without training and support in delivering culturally relevant care: services to the target populations are undermined, nurses are at greater risk for failure and may leave (sic), and an atmosphere of avoidance behaviour for serving the target population may develop. (p. 228).

Efforts to promote cultural sensitivity in clinical practise recognize that cultural data is often missed with standardized approaches to patient assessment. Nursing theories of culture, therefore, place significant emphasis on outlining and advocating the use of cultural assessment guides in practise. These guides direct nurses in eliciting cultural data from clients with the intent that it will be integrated in nursing care plans. Cultural data are seen as necessary "to design health promotion strategies that are more likely to be culturally acceptable, and thus more likely to be effective" (Abramson, 1992, p. 719).

Formal discourse explicitly supports nurses' role as agents of social change (Abramson, 1992; Andrews, 1992; DeSantis, 1991). For example, one of the core assumptions informing the AAN Expert Panel (1992) is "Nursing's mission is to provide more options and better access to heath care for disenfranchised, stigmatized, and discriminated against populations" (p. 278). Another example is provided in a study conducted by the Nova Scotia Registered Nurses' Association (RNANS) (1995). Characterizing the sentiments of several respondents in the study, one nurse is quoted as saying, "As nurses, we have an obligation to promote and advocate to change policies to meet our clients' needs" (RNANS, 1995, p. 30).

Analysis of Formal Discourse

The meaning of cultural sensitivity in health is heavily influenced by historic relations of domination between people of western and non-western cultures. Its meaning is inherently relational. However, it is an unequal relationship where one "provides" and one "receives". The standpoint of "provision" is always that of the health provider which symbolically acknowledges that the burden for restoring historic "insensitivities" lies with those of the dominant culture. When used uncritically, "cultural sensitivity" unconsciously calls forth a history of exploitation.

Cultural sensitivity is used interchangeably with terms like "cultural competence" (Sawyer et al, 1995), "cultural appropriateness" (Giger & Davidhizar, 1990) and "cultural relevance" (Madiros, 1986). Distinctions are largely semantic. Because cultural sensitivity appears most frequently, I use it to encompass all related terms. For all terms, there is a a paucity of explicit definitions in formal discourse. The American Association of Nurses (AAN) Expert Panel, rejects the term cultural sensitivity on the basis that it is too limited. Instead they prefer the use of cultural competence, describing it as care "that is sensitive to issues related to culture, race, gender, and sexual orientation" (AAN, 1992, p. 278). The meaning of "sensitivity" itself was notably absent. The only explicit definition of cultural sensitivity found in formal discourse is developed by the Registered Nurses Association of Nova Scotia (RNANS) from focus groups with nurses and representatives of ethnocultural groups. They claim:

> Culturally sensitive care includes knowing the total patient, which is achieved through the application of a cultural assessment, communication skills, and requires the delivery of care in a matter that is

> respectful, accepting, flexible, open, understanding, and responsive to the cultural needs of the clients and families (RNANS, 1995, p. 14).

The meaning of cultural sensitivity derives from one's view of culture. Health literature formally borrows anthropological definitions of culture, which make reference to a group's shared value and belief systems (Abramson, 1992; CMA, 1994; Dyck, 1989; Leininger, 1991). However, when discussed in relation to specific health concerns, it becomes evident that the meaning of culture is problematic. The RNANS (1995) study exemplifies this disjuncture. Nurses' responses to the meaning of culture reflect three themes; (culture) as a way of life, as a way of viewing things, and as a way of communicating. When nurses are asked to talk about culture in the context of their practise, however, they provide examples such as "language as a barrier to accessing health care, and culture as a source of conflict between health belief of clients and health care providers" (RNANS, 1995, p. 11). Summarizing their responses, the document notes, "It is clear from the data that most of the nurse participants view the effects of culture on health as it relates to implications for health care service delivery, rather than as an important determinant of health" (RNANS, 1995, p. 12). The meaning of culture, as this indicates, varies according to whether nurses are approaching it in principle, or in practise.

The underlying tension in whether culture is something nurses ought to support, or ought to eliminate as a barrier to client's health is reflected by DeSantis (1991), one of the leading proponents of cultural care in the United States, who writes:

> To negate the potentially harmful effects of culture on health, while promoting beneficial ethnomedical (folk) beliefs and practises, nurses and other biomedical health providers need to become adept at

> incorporating cultural factors into health teaching and health care planning (p. 300).

In practise, culture clearly presents a problem for the delivery of patient care. Zola (1966) observes that "with an orientation to problems usually goes a preferred solution or way of handling them" (p. 626). Health discourse, which construes culture as the problem, presents cultural sensitivity as the solution. Justifications for cultural sensitivity are generally framed in appeals to pragmatic and moral considerations. Pragmatically, cultural sensitivity is viewed as a necessary response to the unavoidable diversity in society (AAN, 1992; Andrews, 1992; Lipson & Meleis, 1985; Majumdar et al, 1995; Pope-Davis et al, 1994). Grossman (1994) writes; "our patient's growing diversity forces us to view health, illness, and nursing care from different perspectives" (p. 58).

Cultural strangers not only introduce different meanings of health which make the outcomes of care less predictable, but introduce new problems to which health providers must respond. Calder et al (1993, p. 227) describe this with reference to female circumcision; "Because of increased immigration of African families to Western nations, the practise has become an issue for health care providers, who may not be aware of the practise and its sequelae". Cultural sensitivity is seen to increase nurses' ability to meet the increasing diversity of client needs (Dyck, 1989; Seideman et al, 1994; Tripp-Reimer et al, 1984).

Nurses' role as advocates for socially disenfranchised groups locates appeals for cultural sensitivity in moral concerns such as professional ethics and principles of equality, universality and accessibility in health care. Cultural sensitivity is presented as an inherently desirable enterprise; a means for

achieving the World Health Organization's goals of equity and access to health care (AAN, 1992; CMA, 1994; RNANS, 1995). That fact that pragmatic and moral rationale for cultural sensitivity are often intertwined, reveals the tension that exists between them in formal discourse. The following comment by Leininger (1996) demonstrates this:

> Nursing as a profession is mandated by world societies to serve people in relevant, purposeful, and health promoting ways...nurses have been almost forced to become transculturally oriented (p. 71).

The need to assert nurses' role as agents of social change is supported by arguments that justify cultural care on the basis that it helps nurses overcome feelings of helplessness and frustration with cultural strangers (Leininger, 1991, p. 7; MacGregor, 1976). This tension between the rationale for cultural sensitivity and nurses' role becomes more apparent when examining the implicit meanings of formal discourse.

Patterning of Cultural Sensitivity in Health Discourse

> *"A great many people think they are thinking when they are merely rearranging their prejudices" William James*
> (quoted by Stevenson, 1994, p. 66)

The underlying rationale in formal discourse is the implicit use of cultural sensitivity as a mechanism of social control, pressuring non-western people toward conformity with western norms. Sapir [1994] suggests that most reasons may be little "more than ex post facto rationalizations of behaviour controlled by unconscious necessity" (p. 234). It would appear that the rationale offered for cultural sensitivity masks a deeply embedded western cultural impulsion to exercise control.

Patterns of mastery are reflected in both the epistemology and language of nursing. Nursing theories are formulated to assist practitioners in bridging cultural differences. Those reviewed demonstrate that the extent to which cultural sensitivity seeks to control varies according to the degree of perceived conflict between cultural behaviours and treatment goals (Dobson, 1991; Giger & Davidhizar, 1990; Leininger 1991, 1996; Orque et al, 1983; and Tripp-Reimer et al, 1984).

Leininger's theory appears to be among the most influential in nursing. The nurses that I interview for this thesis who are familiar with nursing theory, most often refer to Leininger's ideas when describing examples of cultural sensitivity in practise. Leininger (1991) states that culturally sensitive[5] care is characterized by three modes of intervention. Since Leininger does not define these modes directly, meaning must be imputed through her examples. The first mode, "cultural care preservation and / or maintenance" is demonstrated in examples such as supporting Chinese-American clients in using herbal teas believed to ease a 'nervous stomach'. "For this generic care practise has worked well in the past and is still held important today by many Chinese-American client's" (Leininger, 1991, p. 42). Another example of this mode, provided by the American Association of Nurses (AAN) (1992), is allowing "culture-bound practises...such as the wearing of religious articles to drive away spirits" (p. 281). These examples suggest that the first mode refers to situations where cultural practises do not jeopardize the efficacy or application of western

[5] Leininger uses the term "culturally congruent care" which is functionally consistent with references to "culturally sensitive care" in formal discourse. I use the latter term to avoid unnecessary confusion.

health care. The nurses' involvement primarily consists of conveying acceptance for behaviour.

Leininger (1991) demonstrates the second mode of nursing action "cultural care accommodation and / or negotiation" with the example of an Arab-Muslim family who "value total family participation when assisting a sick family member" (p. 42). For these families where "the mother is *obliged* and *responsible* to stay with him or her... the nurse would need to plan and make accommodations for the mother and family to provide the most beneficial and satisfying care possible" ([italics in original] p. 42). Nurses are encouraged to modify care in ways that allow family members to take a more active role. Another example of accommodation is provided by Sohier (1976) who describes an experience of caring for a terminally ill Jewish client. On recognizing it "was difficult to comfort a Jew by citing Christ as an example of patient acceptance (of pain)", accommodation involves learning about Jewish ways for coping with pain (Sohier, 1976, p. 72). These examples indicate that the second mode refers to situations where client's behaviours are in low conflict with nursing care. In such cases, the nurse is required to actively integrate knowledge of client's culture with care.

The most obvious examples of the underlying control orientations of cultural sensitivity are demonstrated in cases where the cultural clash or conflict between clients and nurses is greatest. The third mode of behaviour, "cultural care repatterning and restructuring", is explained by Leininger (1991) as follows:

> Repatterning or restructuring of care requires being very attentive or sensitive to the people's lifeways. It also involves assessing how nursing practises may facilitate helping a client maintain wellness, and especially

> when she returns home. For example, nurses may repattern or restructure care related to eating, sleeping, and smoking lifeways found harmful to client(s) by both nurse and client. Together the nurse and the client creatively design a new or different care lifestyle for the health or wellbeing of the client...Care knowledge and skills should always be repatterned for the best interests of the client (pp. 42-44).

This mode describes situations where there is a direct effort to elicit behavioural change. Repatterning involves trying to shape client behaviours that are seen as contrary to the goals of health. Although Leininger acknowledges the need for nurse and client to interact as "coparticipants", it is unclear how clients' best interests are determined in situations where nurses' and clients' values are in conflict. Those who use Leininger's modes of nursing action, indicate that where conflict occurs, nursing beliefs take precedence. This is reflected by Rosenbaum (1995), who provides the following example of repatterning client's behaviour:

> When a client from a Third World country throws his garbage on the street, the community health nurse repatterns this behaviour by teaching him that this practise is not accepted in this society (p. 189)

As this example shows, definitions of theoretical constructs are sufficiently malleable to legitimize nurses' efforts to control cultural strangers. This is highlighted when applying Leininger's framework to the frequently cited "cultural problem" of large extended families visiting relatives in institutions. A nurse could practise cultural care preservation by encouraging large families to visit. Similarly, a nurse could practise cultural care accommodation by planning care around family visits. Or, when family members are believed to intrude on the rest and welfare of the patients, the nurse could practise cultural care repatterning and actively limit the family's access to the patient's room.

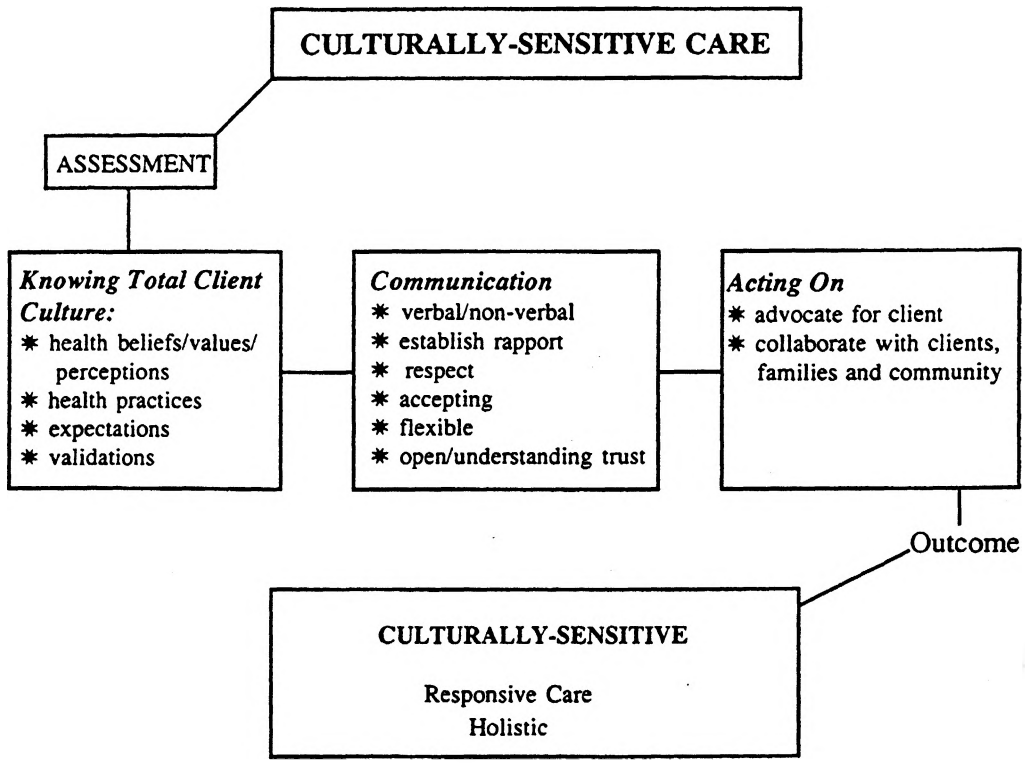
While Leininger's third mode, repatterning and restructuring, provides the clearest example of control, the entire framework rests on western values of objectivity and reductionism. Leininger's tri-modal framework begins with the assumption that classification of cultural behaviours can proceed objectively. As Sapir notes about cultural writing more generally, "there is a pretence of extreme objectivity, of objective control of situation which cannot be [tangibly measured]. To make of society a machine, understand it, and then control it- This is the American idea" ([1994], p. 33). The machine metaphor is reflected in biomedical beliefs that aberrations in behaviour are reducible to objectively observable elemental processes, *and* that these elements can be best understood and controlled when treated in isolation of each other (Freund & McGuire, 1995, p. 215).

The emphasis on measurement of 'objective' criteria neglects to address a number of limitations. First, such claims provide no room for understanding how cultural biases influence patterns of nursing assessment (Donovan, 1986; Health and Welfare, 1988; Helman, 1978). It further neglects to recognize that patients' understandings are often different from those of health workers (Blaxter, 1983; Hunt et al,1989). In fact, the way people attribute meanings to experiences with illness is a dynamic process which varies according to one's background and current life situation (Hunt et al, 1989; Walters, 1993). The mismatch between professional and lay understandings of disease may be compounded by cultural differences. Elfert et al (1991) find that chronic illness among children has very different meanings for Euro-Caucasian and Chinese parents.

Cultural sensitivity as a tool for controlling behaviour is made manageable by reducing culture (in the anthropological sense) from the form giving axis of human consciousness, to merely another biomedical variable of behaviour (Inclan & Hernandez, 1992, p. 252; Newhill, 1990, p. 183). Since the "fuzziness" of individual behaviour does not accord with this, the significance of "culture as a variable" lies in supporting an *illusion* of control.

Reductionism is concretized in the development of cogno-behavioural approaches to culture, such as cultural assessment guides (Giger & Davidhizar, 1990; Orque et al, 1983;Tripp-Reimer et al 1984). Assessment guides are like cookbooks for culture. They provide "practical, easy to understand" taxonomies for classifying cultural behaviour (Giger & Davidhizar, 1990, p. 199). They assume that cultural sensitivity can be achieved by simply incorporating cultural data into western paradigms of health (Orque et al, 1993, p. 8; Rosenbaum, 1995, p. 188). Understanding cultural behaviour demands more than ideological formulas. Knowledge is *not* synonymous with understanding *nor* will it inevitably lead to changing behaviour. Morse (1989, p. 224) comments that structured assessments actually work against intercultural understanding because they force health workers to consider culture in narrow, inflexible terms. The suggestion that an input of cultural data automatically leads to an output of culturally sensitive behaviour, highlights a linearity of thought central to the mechanistic view of culture and health. This is depicted in a diagram of cultural sensitivity produced by the Nova Scotia Registered Nurses Association (1995) in Figure 2. It shows that an input of cultural knowledge (via assessment) leads to an outcome of culturally sensitive care.

Figure 2: RNANS (1995) Definition of Culturally Sensitive Care



Assessment guides construe culture as the sum of individual elements. The synergistic interplay between elements and the less apprehendable, unconscious dimensions of culture are not recognized. Tripp-Reimer et al (1984) state that it is not even necessary for nurses to conduct full cultural assessments to provide culturally sensitive care as "cultural data are embedded in many good (generic) nursing assessment tools" (p. 79). Given constraints of time and cost, they advise nurses to obtain indepth cultural data on an "as needed" basis.

Perhaps the most profound example of reductionism in nursing theories of culture, is in Facione's (1993) application of the Triandis model. This model provides algebraic formulas intended to "capture" cultural variables in a way that can be incorporated into research. Facione presents this as a means to ensure research is culturally sensitive. Nurses are expected to categorize cultural practises according to a framework proposed by Triandis. Through this:

> ... skilful operationalization of...variables, the nurse scientist could hope to separate the effects of race or ethnic grouping from the effects of socioeconomic status in studies of health and illness behaviour (p. 55).

Facione offers reassurance for those who recognize the complexities inherent in the categorization of cultural behaviours:

> [while] this might seem an exceedingly large demand...it is certainly not beyond the expertise of nurse scientists concerned with high-quality, culturally sensitive research (p. 56).

These examples accentuate a fragmented, trait-focussed approach to culture which distorts meanings. "[To remove a trait from context is to strip] the trait of the latent or total cultural content that acts upon it's meaning" (Sapir, [1994], p. 103). It is the ability to discern and interpret patterns which imbue elements of their meaning that is important not the content, or function of specific traits themselves (Sapir, [1994], p. 105).

Underlying assessment taxonomies is the presumption that non-western people are fundamentally "different". The problem of culture becomes essentially a problem of differentness from western, Eurocentric norms. Assessment guides fail to consider that the taxonomies and language used to measure differences are themselves culturally bound. Distortions of culture, through an exclusive emphasis on differences, are further compounded by the

cultural meaning of language used to describe these. For example, nurses are encouraged to identify particular traits, such as religious observances, without recognizing the culturally laden meaning of these terms (Orque et al, 1983, p. 67). In such cases, Sapir [1994] warns, our "terminology is our enemy, for the mere use of the same term ... prevents our seeing differences" (p. 94). To label a behaviour as religious is to impute significance that may be alien to those observed.

An ironic example of this, is found in an article boasting that a new "culturally sensitive diagnostic category" of religious or spiritual problem has been added to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (Turner et al, 1995). The new category was prompted by a need to "offset the tendency of mental health professional to ignore or pathologize religious and spiritual issues brought into treatment" (p 435). Authors report that definitional and assessment criteria for "religious and spiritual problems" have been developed for application to people of all cultures. Types of problems addressed in the new DSM category include; change in denominational membership or conversion to a new religion, loss or questioning of faith, mystical experience, meditation, and separating from a spiritual teacher. Author's effort to remove the cultural bias from psychiatric assessment merely broadens the basis for possible pathology. While the intent has merit, the authors fail to realize that diagnostic categories are socially constructed. Definitions of what is, or is not a medical problem change over time (Conrad & Schneider,1980; Waxler, 1974). Any claim to the universal applicability of a religious or spiritual problem is at best, naive.

Cultural sensitivity as a means to control culture is also bolstered by the perceived truth value of biomedicine. This "truth value" is deemed a sufficient rationale for transmitting western methods across cultures. Stone (1992) refers to it as fostering a "silver platter" mentality which holds that all non-western people "would naturally accept and adopt superior knowledge and technology (p. 409). Consequently, most health workers question neither their right to probe non-western cultural behaviours, nor the legitimacy of subsequent actions that interfere in behaviours considered barriers to care (Dyck, 1989; Rosenbaum, 1995). The parallels to imperialism are difficult to ignore. Where colonists subordinate people in the conquest of land, health workers strive to achieve conquest of non-western people in terms of behavioural change.

Language for domination

As a symbolic referent, language provides pathways for thought and organizes behaviour (Sapir, 1921, p.15). There are several concepts pervading nursing discourse, which when used in conjunction with cultural sensitivity, reinforce formal patterns of control. I specifically discuss how those of "otherness", "needs", "compliance", and "professionalism", support the hegemonic discourse of cultural sensitivity.

a) Otherness

Recipients of culturally sensitive care are ambiguously defined. Categories of race, ethnicity and language are often used interchangeably. For example, Skawski (1987) mixes racial, linguistic and regional groupings in talking about culturally sensitive services among Whites, Hispanics, and Southeast Asians. Ambiguous terminology ignores that Caucasian North

Americans may trace origins to a number of non-western cultures as distinct as Russian and Italian. Spanish speaking people may also represent very different cultural groups (Polgar, 1963, p.413). Sapir [1994] notes that racial categorizations are more emotional than biological (p. 67). Definitions of "the other" reinforce emotional dichotomies between "us" and "them"; between those who belong and those who do not (Hammonds, 1995). Hall (1989) explains:

> ...the English are racist not because they hate the Blacks but because they don't know who they are without the Blacks. They have to know who they are *not* in order to know who they are (p. 16).

Dichotomies which pervade health discourse perpetuate historically derived identities of difference by assuming a false homogeneity within respective groupings. Among non-western people this masks differences of socioeconomic status and education (Quesada, 1976). In fact, affluent educated non-westerners may have more in common with western culture, than with the less affluent among those of their own culture (Bagheri, 1992; Blackhall et al, 1995; Haffner, 1992). Constructions of ethnic or racial identity are not static. They vary according to the demands of particular times and circumstances (Nagel, 1994, p. 154).

Although the categories of "otherness" are ambiguous, the behavioural qualities attributed to non-western people are fairly consistent. Cultural strangers are most often portrayed as passive, dependent, and having few resources. For example, references to aboriginal people often emphasize indicators of ill health and social degradation. They are frequently described in terms of their high rates of suicide, substance abuse and family violence (Buehler, 1993). Rarely does the discussion get beyond these problems to address cultural strengths or resources. As Broken Nose (1992) writes:

> We seldom hear about the strengths of the native American family or the power of (their) deeply felt spiritual beliefs. Their positive values, such as generosity and courage...the strengths and characteristics that help native Americans fight grave social problems are seldom acknowledged" (p. 380).

Stereotyping otherness is by no means limited to native people. Immigrant groups are stigmatized as being highly prone to emotional adjustment disorders[6] (Aronowitz, 1984; Canadian Task Force, 1988; Salvendy, 1983). Bagheri (1992), referring to Iranian immigrants writes, "There is no doubt that this ever-growing stream of immigrants have their own special needs, particularly psychological" (1992, p.7). Carlson and Rosser-Hogan (1993), in a study of Cambodian refugees, find "even ten years after they had left their homes in Cambodia, these refugees are still suffering considerable mental distress" (p. 229). Using various psychological measures, they identify respondents as having exceptionally high rates of post-traumatic stress disorders (86%), depression (80%), and anxiety (78%). Findings from such studies (Bagheri, 1992; Vega et al, 1987) are often used to label entire ethno-cultural populations as vulnerable to psychological disorders.

In contrast, a less common form of stereotyping is highly romanticized characterizations of cultural strangers. An example is provided by Giger and Davidhizar's (1995) characterization of "French Canadians of Quebec Origin":

> Native French Quebeckers are warm-hearted people who express their thoughts and opinions openly. They are quite expressive and use their hands for emphasis when speaking. However they do not use as many nonverbal movements as the Italians, Spaniards, or the continental French. They enjoy social gatherings and celebrating important dates. They have a quick sense of humour and are very resourceful (p. 580).

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[6] Interest in the relation between immigration and adjustment disorders is most pronounced in medical literature. Since medical research is used to inform nursing practise, I have chosen examples here from medical literature.

Portrayals which cast cultural strangers as warm-hearted and cheerful, bear as little correspondence to those which cast others as weak and vulnerable. Negative and romanticized portrayals share a uni-dimensional, static representation of cultural strangers. Regardless of how others are characterized the unbalanced discussion of cultural strangers reinforce stereotypes held in dominant culture (Donovan, 1984).

b) Need

Dominance is also reflected in references to cultural strangers' "needs". Although need can mean various things, in nursing discourse, as in most professional discourse, it is used here in a sense that McKnight (1977) characterizes as: "an unfortunate absence or emptiness in another" (p. 113). Increasingly sophisticated ways of measuring needs transform individuals and groups into deficit entities (McKnight, 1989). The orientation towards individual deficits, which is implied in language of need, provides no recognition of others capacities to engage in their social reality in purposive and constructive ways. It denies that "cultural inheritances hold many positive elements which can be used to improve (cultural strangers') health and lives," (Donovan 1986, p. 133). A study of elderly Chinese women in Montreal, for example, finds that culture and ethnicity enabled these women to "maintain a sense of self-worth and personal efficacy despite adversity and limited resources" (Chan, 1983, p. 49). Need discourse dismisses an individual's "inner strength", which is cited by many immigrants as the greatest resource in their adjustment (Anderson, 1991, p. 106).

The fact that representatives of ethnocultural groups often use fewer health services than resident populations (Canadian Task Force, 1988; Health

and Welfare, 1988; Weitzman & Berry, 1992) suggests that many have not yet internalized medical notions of their needs. Professionals tend to attribute low utilization patterns to cultural factors such as a family's tendency to conceal mental illness (Health and Welfare, 1988, p.21-22). Describing mental illness among people from South Asia, Assanand et al (1990) write:

> ...mental illness is stigmatized and is generally hidden to safeguard the children's marriage arrangements. Many of these beliefs and practices persist in the South Asian community in Canada. Severely ill family members are not ignored or rejected, but may be kept hidden and thus may remain untreated for long periods of time, only to arrive at hospital emergency rooms by ambulance or police care after uncontrollable outbreaks or suicide attempts (p.166).

The culturally-based stigma of mental illness is frequently cited as a major barrier to professional fulfilment of needs (Bentelspacher et al, 1994; Canadian Task Force, 1988). As Carlson and Rosser-Hogan (1993) explain "Even if resources and appropriate treatment were available, however, the reluctance of Southeast Asian refugees to seek treatment for mental health problems would continue to hamper efforts to treat this population" (p.230). Such explanations assume that the "actual" incidence of mental illness among immigrants is high, and that the traditional ways of addressing these are inadequate. Yet, other research shows that low rates of utilization are due to immigrants' dissatisfaction with "over-professionalized" services (Pearson, 1986, p. 112), or fears that by entering the health system they will lose control over their lives (Anderson et al, 1993). Lipson and Meleis (1985), in an article about Middle Eastern immigrants, explain:

> While nurses consider a comprehensive health assessment essential to individualized care, Middle Eastern clients, who value privacy and guard it vehemently, may view the health care interview as intrusive. The more comprehensive the interview, the more intrusive it seems (p. 55).

Health professionals' response to problems of underutilization has been to try and convince people that they have certain needs and that the best way to "fill" these needs is by utilizing professional services (Illich, 1977; McKnight, 1977; Rappaport, 1975). As Carlson and Rosser Hogan (1993) assert, with respect to Cambodian refugees, "The results of the study indicate that there is no reason to believe that these traumatized refugees will ever recover if left untreated" (p. 230).

A common justification for cultural sensitivity, is that it enhances health workers' ability to identify and meet patients' needs (Rankin & Kappy, 1993, p.826). Health discourse is predicated on assumptions about the universality and hierarchical nature of human needs (Orque et al, 1983, p.10). The idea that lower needs for food and shelter must be satisfied before higher needs for love or self actualization can be met, is widely accepted by health workers. Assumptions and ascriptions of need are highly problematic.

> [How are we to be certain that] basic material biological needs are more important that immaterial symbolic needs or aesthetic needs...Do religious needs take precedence over material? Although in our civilization, they don't now, they [once] did (Sapir [1994] p. 76, 79).

Even where the motivations for human behaviour are biological, it is culture that patterns their expression and individual approaches to resolution (Sapir, [1994], p. 80).

Ignatieff (1984) writes, "there are few presumptions in human relations more dangerous than the idea that one knows what another human being needs better than they do themselves" (p. 11). The authority vested in biomedicine makes such claims vulnerable to misuse. This is exemplified in situations where health workers have falsely imputed needs to people of non-

western cultures. Stone (1986), studying primary health care in Nepal, found that expatriate health workers identified health education as a priority need for villagers. Examining indifference to education campaigns, it was found that villagers considered their own concepts of illness prevention adequate and consequently were not interested in westernized health education (Stone, 1986, p. 297).

Identification of need signifies an entitlement to resources (Ignatieff, 1984, p. 10; Navarro, 1984). As the previous example shows, this is a circular logic which buttresses professional dominance since the authority to identify needs and the ability to satisfy them are both claimed by health workers. This is particularly revealing with the term "cultural needs" beginning to emerge in nursing literature. Not surprisingly, it is used in arguments to support the professional obligation to provide culturally sensitive service; "carrying out measures to meet cultural needs is essential to delivering culturally sensitive care" (RNANS, 1995, p. 13). It is difficult to discern what distinguishes cultural needs from human needs. In this study, cultural needs imputed to ethno-cultural representatives concerned problems such as "the lack of explanation from the physician about their conditions", or "technical words used by health care professionals". These could just as easily characterize the needs of all patients.

Need discourse supports professional dominance by portraying people as deficit entities. It encourages dependence on health workers for "need satisfaction". The symbolic significance of needs interlocking with those of otherness deny the fact that "cultural inheritances hold many positive elements which can be used to improve individual health and lives" (Donovan, 1986, p.

133). The concept of cultural need is particularly problematic because it symbolically separates the commonality of experience between people.

c) Compliance

In addition to concepts of otherness and need, the formal patterning of cultural sensitivity is supported by rhetoric of compliance. Non-western cultural behaviour is cited as a factor restricting clients' ability to comply with treatment (Hoang & Erickson, 1985). Most often this is discussed in terms of the client's ability or willingness to change behaviour. Tripp-Reimer et al (1984) provide an example of this with respect to cultural assessments:

> ...the nurse needs to find out if the client's system is adaptive (beneficial), neutral, or maladaptive (harmful) in relation to the possible interventions. If the client's system is adaptive or neutral, it can be incorporated into the plan for intervention...If, on the other hand, *the nurse determines* that the client's beliefs, values and customs are detrimental to achieving the desired health outcomes, *the nurse needs to determine*: *a) ways of persuasion that aid alteration of the client's system if the client is amenable to change*; or b) ways of understanding the client and the rational for not altering the client's system, if the client will not change ([italics added] p. 81).

Rationale for the client's behaviour is only required if they are resistant to change, thereby indicating that the desire to change is deemed both logical and desirable. It is often the client's resistance to change that signals the need for culturally sensitive practise because "when the patient is noncompliant... health professionals become aware that there is a problem that cannot be solved in the usual way" (Tripp-Reimer et al, 1985, p. 355). Abramson's (1992) description of culturally sensitive strategies for breastfeeding support this;

> In communities in which breastfeeding rates are low, there are no visible role models or sources of support for women interested in breastfeeding. In this cultural context, health professionals have not been effective in trying to get other people to do things that are believed to be good for

> them. To promote breastfeeding in vulnerable communities, health care professionals must understand how to address the sociocultural factors that affect infant-feeding choices (p. 718).

Culturally sensitive practise therefore provides a way to increase compliance and desired outcomes of care (DeSantis, 1991, p. 300).

Trostle (1988) argues that compliance is an ideology which supports power and authority of biomedicine in non-western cultures. It reinforces imperialistic notions that the basis of treatment failure are external to the health provider. " What fails to be recognized", Anderson et al (1991) write, "is that what is construed as non-compliance is a function of socioeconomic political factors, and the medicocentric approaches to health care delivery (p. 112). Rarely are problems with therapeutic response attributed to weaknesses or limitations in the clinical judgment process (Dyck, 1989, p. 253; Hagey & Buller, 1983).

d) Professionalism

Concepts of the "professional's role" also impede the ability to work with people of non-western cultures. Hodgson (1982) reports that nurses who work in isolated outposts frequently complained that native residents place demands on them which go beyond the scope of nursing duty. "They are correct, in that these are matters are outside the role of nurses as defined by western society, however the role of healer in traditional native society was not limited or specialized" (Hodgson, 1982, p. 109). Peacock (1986, p. 86) notes that the role of curer, which is oriented toward change, limits the health worker's receptivity to learning from people of other cultures. This view is endorsed by Morse (1989) who writes:

> ...the learned patterns of interaction from our (nursing) education, and the norms of the workplace destroy the opportunity and advantages for open and honest interaction with our patients. We are too busy too listen... (p. 231).

In addition to specific concepts, the ways that language is used in discussing cultural sensitivity reinforces underlying patterns of control. One way is by reversing agency to distort the locus for action and responsibility (Vickers, 1989, p. 47-49). This is most evident in how the limitations of health services are conceptualized and projected onto others in the "problem of culture". The language of cultural sensitivity also contains a hierarchy of meanings that provides built in resistance to intercultural communication. For example, the symbolic meanings associated with "quality care" or "standards of professional conduct" are viewed as a culturally legitimate reasons for over-riding differences in non-western cultures. Madiros (1986), in describing an access program for native students in BC, wrote that "students will be taught in a culturally sensitive manner, but without compromising (the school's) own academic and clinical standards" (p. 15). Biomedical notions of "quality" or "standards" are accorded higher symbolic value than non-western cultural beliefs. Thus, where cultural behaviour conflicts with biomedicine, appeals to "quality" provide a way to bypass the commitment to intercultural negotiation.

Another curious feature of cultural sensitivity discourse, is the contradictory messages between formally and informally stated professional goals. Particularly in references to Aboriginal health, professional bodies now claim to support self-determination (CMA, 1994). Promoting self-determination means allowing non-western people to speak for themselves (Freire, [1990]; Hagey & Buller, 1983). It may also require a commitment to developing a

synthesis between traditional and western practises, as advocated by Willier, a Cree medicine man in Cry of the Eagle (Young et al , 1989). For Willier this means open recognition of the relative strengths and limitations in both traditional and western medicine. "I can't cure diabetes but I can heal the sores and keep it at a level where the blood pressure doesn't go up" (Young et al, 1989, p. 95). The intent of emancipatory goals are undermined by the fact that professionals simultaneously claim to be sole advocates for clients' health needs (AAN, 1992, p.277; CMA, 1994, p.11). Synthesis of western and non-western health systems is mitigated by the legal-political framework of western practise which prescribes and sanctions how services are to be provided (Gostin, 1995). Patterns underlying biomedical ideologies have historically arisen to protect the interests of society's affluent (Freund & McGuire, 1995; Illich, 1976). For this reason the professionalized language of nursing is generally at odds with a social-action view of cultural sensitivity.

The incongruence between formal and informal goals of cultural sensitivity is further reflected in contradictory messages for recipient populations. Non-western people are encouraged to maintain their difference yet are simultaneously expected to acculturate. This tension can be observed in the promotion of cultural sensitivity training. It is frequently advocated as a means for communicating acceptance for client's beliefs and it functionally strives to ameliorate cultural barriers to treatment (Taylor, 1994; Wuest, 1992). As Majumdar et al (1995) write; "The provider must be able to let the client know that his or her beliefs and traditions are accepted while creating an awareness of Canadian norms" (p. 210). Those who advocate cultural sensitivity training, believe that increasing health workers' cultural knowledge will improve their

ability to identify and meet client's cultural needs (DeSantis, 1991; Lyman, 1992; Majumdar et al, 1995; RNANS, 1995). Paradoxically, training health workers to observe "difference" begets more difference. Labels of difference influence how non-westerner's see themselves. As Hall (1989), a Jamaican emigre to Britain, comments:

> ... somebody said to me... - I suppose you're really Black. Well, I'd never thought of myself as Black.. And I'll tell you something, nobody in Jamaica ever did (p. 15).

Where non-westerners did not originally see themselves as others, such terms gradually remind them of their position as marginal members in a dominant society. Health workers are explicitly encouraged to think of the "culturally different" client (Orque et al, 1983), which affirms that the underlying 'norms' are innately Caucasian and Eurocentric (Barker, 1992, p.249).

Language of difference is a potent depoliticizer of relationships between western and non-western people. References to "cultural needs or beliefs" can keep the real basis of ill health concealed. Angry behaviour among immigrants, for example, may be attributed to a "cultural adjustment disorder" when it is more likely a response to living in a racist society (Rutter cited in Aronowitz, 1984, p. 244-245). Talking about cultural sensitivity in such cases serves the needs of bureaucracies in denying responsibility for socio-structural inequalities among non-western people (Donovan, 1984, p. 668; Stone, 1992).

Appealing to culture may conceal other unconscious motivations for pursuing cultural sensitivity (Stone, 1992, p. 412). "Even an elaborate, well documented theory may...be little more than a symbol of unknown necessities of the ego" (Sapir, [1994] p. 234). Health discourse generally supports the view that more knowledge will lead to better care for non-western people (Majumdar

et al, 1995). The extent to which this may be muddied by professional self interest is seldom considered. Arguments for more cultural knowledge present cultural sensitivity as a frontier for professional expansion. Admonitions for a new cadre of health experts, such as "culturally-trained nurses" (Majumdar et al, 1995), "ethnic-nurses" (Orque et al, 1983) and "nurse-anthropologists" (Leininger, 1979) appear to support this view. These experts claim the right to speak both authoritatively and exclusively on matters of culture health and nursing. Leininger (1979, pp. 4-5) argues that nurse-anthropologists have a more encompassing orientation to health and culture than medical anthropologists or medical sociologists. She adds that collaboration with social scientists is desirable, but their role is secondary to that of nurse-anthropologists (1979, p.21).

Together the theories and language of nursing emphasize mastery and an orientation to "doing", rather than "being" culturally sensitive (Henderson et al, 1992). An action orientation focusses attention on the health provider, in terms of whether and how the act was performed, thereby obviates the need to elicit the recipient's point of view. The non-western client becomes relevant only in terms of how well stated actions elicit intended goals of behavioural change. An action orientation supports erasure of non-western clients by subordinating their experiences to those of the health provider.

The meaning of individual words or concepts is linked to a broader system of symbolic meanings. Examining this relationship reveals the underlying, unconscious aspects of patterning. Western paradigms for health assume a logical relationship between bodily systems and health. For example, the western idea of health is conceptualized as a mind/body duality.

This dualism is reflected in the fact that assessment taxonomies are divided according to mental and physical needs. The words 'mind - body' subsequently pattern the thought and action of health workers as they perform assessments. It is assumed that the client will be able to place the questions asked in a common symbolic framework for health. As Luria (1979) found with his research among peasants in Siberia, notions of logic, in terms of which connections are obvious, are culturally determined. This is also found in health. Relationships between various concepts of health may not be obvious in other cultures. As Meleis and Jonsen (1983) observe in the case of an Arab patient:

> Many questions were asked about such personal things as the patients and the family's health and social status, questions which were regarded suspiciously because the nature of the relationship between the medical problem and personal question was not apparent (p. 892).

Addressing cultural sensitivity therefore involves probing a deeper level of the symbolic meanings and uses of language. It is not a simple matter of translating words for other cultures. The same word, when translated, may have distinctly different regional meanings. Nichter (1984) states that for health services to be culturally sensitive, they must be developed according to local rhetorical styles and language. The inability to reconcile western and non-western symbolic meanings of health present a barrier to effective intercultural communication (Polgar, 1963, p. 413).

An Emancipatory Construction of Cultural Sensitivity

A critique of cultural sensitivity in health does not mean that those who work in western health systems are inherently "good" or "bad". Most health providers are sincerely interested in learning more effective ways of working

cross-culturally. In seeking to understand culture, health workers invariably encounter the concept of cultural sensitivity and grasp it as an intellectual vehicle for developing their inquiry. However, words may act as "fetters" (Sapir, 1921, p. 17). Language may provide pathways that limit an individual's ability to perceive problems clearly and creatively (Preston, 1996, Jan. 16). As words are linked to symbolic patterns, accepting cultural sensitivity noncritically allows its symbolic significance to be unconsciously absorbed. This then shapes individual behaviour in ways that reproduce historic relations of domination.

As a disjuncture often exists between rhetoric and reality, a desire to reorient patterns of domination must include more than the ability to articulate socio-historic antecedents of intercultural relations. Although the formal discourse of cultural sensitivity emphasizes control, there is evidence that counter-hegemonic patterns are beginning to emerge. Those who contribute to this literature recognize the complex, unpredictable dimensions of human interaction. In so doing they recast the symbolic dimensions of cultural sensitivity not as abstract deterministic entities, but as processes dialectically related to individual personalities; as they influence behaviour, so too are they influenced by the complex creative agency of individuals. Bending patterns of domination between health workers and non-western people is necessarily a creative endeavour because it requires being able to understand "old" problems in new ways. Evidence of this is found in recognition of the noncognitive dimensions of relationship as central to intercultural communication. Sawyer et al (1995, p. 563) refer to this as the ability to perceive "the accurate essence" of others . More often this is implied through authors references to the use of humour (Hagey & Buller, 1983), or to the

importance of recognizing the unspoken meanings imputed to behaviours (Buehler, 1993; Lipson & Meleis, 1985). Referring to their work among aboriginal people, Hagey and Buller (1983) explain;

> Unlike non-native societies, natives educate their young about the meaning of of body position and movements. Non-natives may be unaware of the signals they are both sending and receiving. Natives use explicit body language as well to evaluate the truth of verbal messages of non-natives, or the extent to which "the head matches the heart (p. 30).

The authors explain how standard approaches to health care may provoke misunderstanding and alienate native clients.

In contrast to the "quick and easy" approaches to culture, this orientation also recognizes that authentic intercultural communication develops from a long-term process of building trust (Buehler, 1993). This recognizes that the accretion of historic inequities has contributed to a mistrust of dominant culture among some populations (Stevenson, 1994; Ridley, 1984). It is naive to think that developing trust in such contexts is either easy, or attainable.

The emancipatory orientation to cultural sensitivity further suggests that cultural understanding requires a reflexive and critical appraisal of one's own cultural values and biases (Carrese & Rhodes, 1995; Sawyer et al, 1995, p.564). Broken Nose (1992) relates this in her experiences of working with the Ogala Lakota Natives:

> I counselled boys who were chemically dependent and physically abused. I had the opportunity to experience how cultural differences can affect therapeutic interventions, learning that my cultural background (middle - class Irish) often caused me to interpret situations and behaviours wrongly. On a personal level, this was very disturbing - if I couldn't trust my own instincts, what could I trust? (p. 381).

An awareness of one's cultural assumptions, however, does not mean these are necessarily ammenable to change. Hagey and Buller (1983)

comment that it is pointless to advise health workers to avoid making judgments of value. "because all judgments are value judgments of one sort or another" (p. 31). Sharing this view, Rothenburger (1987) suggests:

> We can, however, go in a different direction with our efforts and develop the sensitivity to know that other belief systems can be equally valid to another individual (p. 1208).

A critical awareness of western culture is often accompanied by recognition that resources of non-western cultures may enrich experiences of health providers and clients alike (Carrese & Rhodes, 1995; Sawyer et al, 1995). Embracing a view of culture as resource bearing (form-giving) patterns, inherently acknowledges that cultural behaviour is not static, but dynamic and constantly changing.

Situating oneself *in* , rather than *outside* historically derived configurations of culture, reorients the underlying impetus for cultural sensitivity, from actions for control, to an ontological process which proceeds according to the natural rhythm of each relationship (Buehler, 1993; Henderson et al, 1992; Rogler, 1989). Hagey and Buller (1983) demonstrate this in their description of a Native diabetes project. They introduce the project with a critical analysis of how the assumptions of contemporary nursing perpetuate historic relations of domination in interactions with aboriginal people. Nurses are challenged to "recognize this, and... avoid gestures that imply the supremacy of one's own values, and consequently that the authority belongs with the professional" (Hagey & Buller, 1983, p. 31). The need to reorient care in ways that allow nurses to more closely attend the wishes of clients is highlighted, and nurses' efforts to promote behavioural change are directly challenged:

> The concept of motivation implies that there are right and wrong choices of action and when one motivates another person, one has helped that person to make the right choice. The truth is of course, that motivation can only be self directed; you can never 'make' anyone do anything without resorting to manipulation of some kind (p. 31).

A precondition for relational authenticity is relinquishing control over the process and content of health interactions. "If we want to understand people *as* they are, we have to know *who* they are" (Preston, 1996, Feb.6). This means a rejection of essentialist notions of cultural sensitivity which promulgate the nurse as a 'change agent', and instead an acceptance that one's knowledge is limited - a view supported by a Metis nurse:

> Cultural sensitivity to me means not judging...you can't try and change people. No one has a right or the ability to do that...All you can do is offer information. It's up to (the) people to decide what to do with it.
> (Personal communication, April 24, 1996).

Perhaps, as Rogler (1989, p. 298) suggests, the place to begin is not by promoting a priori standards of health, but rather by assuming that our ignorance is the problem. For "regardless of how much we know about another culture, we can never understand it completely" (Broken Nose, 1992, p. 384). Authentic intercultural communication thus involves a "deprofessionalization" of social services because ideas of professionalism promote a guardedness of self that is incompatible with intercultural convergence (Nichter, 1984, p. 238).

An emancipatory approach to cultural sensitivity therefore, directs attention to the qualities of individual relationships, and ways to catalyze their latent transformative potential. Developing goals that are incompatible with the natural processes of intercultural communication merely perpetuates historic patterns of domination. Relationships between all people are highly variable. They are shaped by unconscious patterns and the unique expression of these

in individual personalities. Relational dynamics will also vary according to history, differences in power, and individual situation. In exploring these, it is important to retain a vision for cultural sensitivity that does not merely shift the "blame" of historic inequities to health workers. Relational authenticity requires that individuals are free to be true to their derived forms. Thus, any strategy which compromises the humanity of either party is unacceptable.

Considering cultural sensitivity as a process means there is no definitive point at which one "is" culturally sensitive. David (1995) refers to this as an ongoing process of "making meaning out of patient's stories"; an effort to attend more fully to the spoken and unspoken meanings of patient's experiences. "In a certain sense we have to become the other person or rather, we let him or her become a part of us for a brief second. We suspend our own identities, after which we come back to ourselves and accept or reject what he or she has said. But that brief second of dawdling communication is the nature of understanding" (Jaynes cited in David, 1995, p. 12). The dynamic of convergence of an intercultural relationship is like an "eternal butterfly... a happening profoundly twofold, confusedly entangled" (Buber, 1958, p. 17).

Given the "confusedly entangled" immediacy of relationship, evaluating cultural sensitivity can only be done retrospectively. As a relational term, evaluation must also be dialogically based. Clearly, the meaning of cultural sensitivity can not be worked out by nurses in isolation. Relationship, implied in the term's definition, must be reflected in its resolution and reformation. Indeed, liberal approaches which fanatically adhere to particular conceptions of "equality", "adjustment", and "self-determination", may be equally inflexible and unable to respond to variations in experiences of cultural strangers. If recipients

of care are excluded from meaning construction, the new approaches will remain functionally similar to the old. The object cannot be to isolate particular acts or phrases as definitive artifacts of sensitivity, but to consensually determine the symbolic meanings of intercultural interactions. It is from these alone that assessments can be made regarding the side of history on which relational meanings lie.

Examples from the margins of mainstream discourse suggest there is potential for creatively reorienting patterns between health workers and non-western clients toward an emancipatory view of cultural sensitivity. Many complex issues have yet to be addressed as there is no simple approach, or easy answer. We cannot change history, nor the side of historic relations on which we are born. A commitment to authenticity involves going beyond a mere "rearrangement of our prejudices". Agar's (1994) comment is central to this view:

> Understanding a new culture...is about making sense out of human differences in terms of human similarities (p. 231).

A review of literature on cultural sensitivity reveals a predominant orientation toward control. This is manifest in the language used to develop the construct in theory, and efforts made to apply it in practise. With this is an emerging trend to redefine cultural sensitivity in ways that promote equality and relational engagement between nurses and cultural strangers.

CHAPTER 4:

Cultural Sensitivity in Informal Discourse: Patterns of Control

The meanings of cultural sensitivity in informal discourse align with the two broad thematic orientations of control and humanism. This chapter will discuss those which reflect patterns of control. Within this are two spheres of meaning. In the first, cultural sensitivity is used to define nurses' relationships with cultural strangers. The object of this standpoint is to control behaviour of cultural strangers in order to enhance efficiency and outcomes of nursing care. In the second standpoint cultural sensitivity is used to define organizations' relationships with nurses[7]. Cultural sensitivity is consequently perceived as an organizational mechanism for controlling nurses' relationships with cultural strangers. When used to influence practise, cultural sensitivity is understood as an obstacle to care with meanings which reflect broader issues of workplace experience and professional socialization.

It is important to realize that orientations and constituent meanings are not fixed referents. Although one sphere of meaning tends to dominate in each interview, others are also represented depending on the specific context being described.

I. NURSE:CLIENT STANDPOINT

The control orientation presents cultural sensitivity as a conduit for transmitting nursing care to cultural strangers. In the following quote it is

[7] Organization refers to institutions associated with professional nursing education and practise, and those of employment. When "organization" is used here, it subsumes nurses who work in supervisory or administrative capacities. Reference to "nurses" denotes respondents.

described as an openness which allows knowledge and skill to flow freely across the cultural divide:

> ...cultural sensitivity is an openness that allows you [to] use knowledge, attitudes and skills to provide appropriate care to people in a variety of cultures. It's an ability to be consciously aware of the impact that culture has on care so that you can take actions to attempt at least to provide care to all patients.
>
> (Interview 3)

Cultural differences are construed as a real or potential threat to nurses' ability to provide care. Providing care to all patients means that barriers to care must be ameliorated or reduced. Cultural sensitivity enables nurses to optimize efficiency while delivering care for ethnically diverse patient loads. For many, like the following nurse, it is a pragmatic response to increasing ethnocultural diversity:

> You are living in a multi-cultural society, you are caring for people of different cultures. To me it is essential that you make cultural sensitivity important in order to provide efficient care.
>
> (Interview 24)

"Efficient care" is a goal directed activity which involves aligning client behaviour with nursing care plans. Since culture is a barrier to care, different strategies are required to achieve professional goals. Cultural sensitivity is a way to conceptualize strategies for ameliorating these barriers to care among strangers. Standard nursing approaches are insufficient to deal with "cultural problems", such as female circumcision. The following example demonstrates how the nurse reconceptualizes strategies as culturally sensitive. Reframing the approach means that the overall aim of behavioural change (in this case, discontinuation of the practise) is more likely to succeed. Reconceptualization

with this example means suspending overtly punitive measures in favour of participatory ones:

> Cultural sensitivity added onto my understanding of community development, and [social] context and social systems would lead me to not see the problems just as, you know, threatening and browbeating the women who have their babies [circumcised] in Mississauga. Setting up punitive systems are going to force them to go underground. Recognizing that if we're really going to change behaviour...that you have to be looking at involving maybe all these male elders in the community, you're going to be involving the women elders in the community, you're going to have to be involving everybody, because you're trying to impose, because you're trying to break a cultural tradition...I think it will help the nurse in the delivery room who feels 'I've got to say something and do something. I've got to know the right thing here so this little baby isn't going to be circumcised'. Recognizing that she's one piece in the puzzle that's going to lead to change.
>
> (Interview 3)

The intensity with which nurses pursue change varies according to the degree of perceived conflict between client behaviours and nursing care, *and*, the perceived limits of nursing authority. In situations where there is a low degree of conflict and nurse's authority is limited, cultural sensitivity consists of persuasion or "soft" approaches to change. This is prevalent in health education where nurses have no way of controlling what clients ultimately choose to do. In the following example, cultural sensitivity consists of strategies which try and hook the parent into accepting advice about breastfeeding:

> When you have an understanding [of culture] you don't just take it for as what they say. As soon as they say, 'I can't do this. I don't have enough milk' then you can step back and say, 'Well have you ever had children in your country?' You talk about their history and how they come to where they are and teach them from there. Instead of saying, 'Oh, OK Here's how to make formula and just sort of saying, 'OK, if that's your choice fine'...I mean we don't have success all the time, but I think [this approach] has really helped us...So we were really looking at this as [what's] best for

> baby, we know this is best for baby. How can we get people to really look at this and make some changes.
>
> (Interview 23)

Where conflict remains low but nurses have greater ability to control behaviour (such as hospital settings), they talk about "accommodating" client practises. This usually means trying to incorporate practises within existing routines. In the following hypothetical example, the patient's family presents a barrier to care of other clients in the room. Options for accommodating the family are presented to the patient. It is noteworthy that the option discussed involves leaving the room; a move which will cause the patient some physical discomfort. The nurse's authority is reflected in the tacit acceptance of hospital visitation policy, and the expectation of patient compliance. Cultural sensitivity for this nurse is exemplified by:

> ...saying that I really understand that you need family around you and... that your immediate family means 15 people and its really important. [I'll say] can we work out a system where all 15 people can participate, but maybe not all at the same time. Maybe they can all be down in the waiting room and ...I can wheel you down there..so you're able to visit with your family as opposed to everyone being here and ... saying only two [are allowed]..The patient saying ...its not as comfortable for me to sit up in the chair, but that's what I'll do because it allows me to visit with my family.
>
> (Interview 8)

Incorporating client priorities into plans of care is often problematic in practise, however when conflicts between agendas do arise it is the nurse who mediates between them. Nurses may thus claim the ultimate veto power over client preferences. In resolving practical difficulties of accommodation, one respondent explains:

> I don't try to be all things to all people. I can't. What I will commit to them is 'Tell me what is really important?', what are some of the important

> things here, and I will work with you to see which ones we can help, which ones we can maintain. That's the best I can do.
>
> (Interview 8)

Cultural sensitivity, in this sense, communicates limits in ways that covertly shape client behaviours to better fit with organizational routines or professional norms. This is clearly supported by the following nurse who asserts:

> We need to help them understand in the hospital so they can pick that [and] internalize it and they can mesh [it] with the culture that they bring to the hospital. Because I don't think the hospital can be all things to all people.
>
> (Interview 29)

Expectations that clients will conform with dominant norms, is most apparent when their behaviours are in high conflict with nursing. These conflict situations are invariably discussed in terms of "harm" which signals little or no flexibility in nurses response to client behaviour. Invoking principles of harm legitimizes active intervention and exercise of nursing authority. Several rhetorical strategies are used to support perceptions of harm. Moral-ethical appeals, as evident in the following quote, are common:

> Lets talk about putting cow dung on the umbilical cord of a newborn child to prevent bad forces from going into the child's belly. As you know, cow dung is full of spores. The child will no doubt get lockjaw. I think that's a harmful practise and...that I would have a moral obligation to dissuade the mom, dad or whoever to do otherwise.
>
> (Interview 17)

Moral ethical ideas of harm are often used to justify approaches to highly emotive behaviours such as female circumcision. This practise is often cited when respondents are discussing the limits of tolerance to culturally strange behaviours. Socio-moral taboos frequently underlie the threshold for tolerance as evidenced in one respondent's response to female circumcision:

> I would see female circumcision...as mutilation...its almost like rape. We don't suffer it for the whites, we don't suffer it for anyone. If I had a way of taking that child out, say if I was in Children's Aid and I knew it was going to happen, then I would work at having that child removed from that situation...I couldn't accept that because [its] mutilation of a person.
> (Interview 22)

Most respondents who referred to this practise, used the more current, derisive term, "female genital mutilation" (FGM). Interestingly, no one condemned the more prevalent practise of male circumcision, or referred to it as "male genital mutilation". This reveals subtle ways that language communicates normative assumptions when condemning practises of cultural strangers.

Another respondent develops an argument for harm by appealing to several ideological bases. Her comment also refers to female circumcision:

> I would have to explain why I can't support it, as a feminist and as a nurse, because I believe that it is harmful. ..I'm prepared to give ..health care..to any client. But if it got to the point where [they] expressed to me that you were meaning to do this to your daughter, I would feel obligated as a professional, as a feminist, and as a citizen to report this as child abuse. [They would] need to know that..so there would be a bottom line.
> (Interview 7)

References to 'rights' frequently reinforce the appraisals of harm. For many behaviours, such as child abuse, a legal framework exists which mandates the nurse to act. In other cases, the legal context of "rights" are more ambiguous. This is demonstrated a the next example; a "right to safety" implies expectations for child supervision. Advocating this right provides a sense of legitimacy for communicating expectations to immigrant parents:

> If I provide this service or teaching to one, why wouldn't I provide this service or teaching to somebody else...If its not OK for an individual from a Canadian family to leave their 7 and 2 year old, [then] its not right for a

> Vietnamese family. Even though that's their background, the children have the same right to safety.
>
> (Interview 21)

When there is no legal criterion, appraisal of harm is a matter of independent nursing assessment. The clinical tone of "assessment", however often conceals an underlying subjectivity. Behaviour accommodated in one situation may be sanctioned in another. Variations in how nurses describe their response to visiting relatives in extended families provide a case in point. Earlier, a nurse talked about how a patient with a large family could be accommodated by being relocated to another area. Another nurse discussing the same issue, does not convey any room for negotiation:

> You can't compromise obviously, people in the same room as the other patient...if you were sharing your room with other people like you can't have - its generally accepted that you have all you family members around the dying person. If that happened to be 30 people, [well] you can't have 30 people ..there has to be some sort of limit.
>
> (Interview 6)

That the same problem is accommodated in one instance and rejected in another exposes the subjectivity encompassed in nursing assessment. The harm principle may therefore conceal individual, professional, or organizational norms. This is demonstrated in the following case, where assessment of harm appeals to the scientific principles associated with infection control. Underlying harm is a normative standard of hygiene and cleanliness:

> If someone was throwing garbage on the floor of the hospital I'd say to them, you know, that can cause infection. It can make you sick and it can make other people sick...I wouldn't accept that so maybe I'm biased. But I wouldn't accept that from a white person either.
>
> (Interview 22)

The truth of biomedicine provides the most pervasive justification of harm. For some nurses biomedicine is unequivocally superior to alternate paradigms for health:

> I don't think everything is relative. There are absolutes and we have to establish what they are...The biomedical model as we know it right now is pretty absolute...the holistic type of approaches aren't necessarily based on the western medical model and I can see alot of holes in that...there's only one logic. You can't start saying there's a logic for this person and a logic for that person. There is *A* logic...other cultures may not see it as logic [but] with logic you can't contradict; you have to make sense. For instance, the holistic logic concentration by dilution, well that just doesn't make sense.
>
> (Interview 6)

The way nurses interpret the truth of biomedicine indicates a distinction between biophysical and socio-psychological bases of health. While respondents differ in how they define the parameters, all respondents believe that biomedicine is superior for health problems attributed to biophysical bases. This is indicated in the belief in absolutes based on one respondent's assumptive understanding of infectious disease processes:

> I believe that there is an absolute...that if a person has pneumonia for instance and it can be demonstrated on a smear and on a slide, they they have this bacterial infection. I don't care whether they're Pakistani or Basuthu or North American. They're probably going to get penicillin and a large dose of it for 10 days. I think those biological facts cut across cultures.
>
> (Interview 17)

Barriers

Cultural sensitivity as a vehicle to promote the efficiency and efficacy of nursing care recognizes two main barriers. First are the behaviours of cultural strangers. Most notably there are problems associated with language. As the next example shows, misunderstandings can easily multiply. This nurse recalls

an experience of miscommunication in Emergency which quickly "grew into a whole shift". It provides a dramatic illustration of how language difficulties are attributed to cultural strangers:

> One night we had an oriental man who couldn't speak English and we were really, really busy...the oriental man had run over somebody and had killed him... he was not at fault.. [but] he was quite shaken. We got his wallet out and we called this number that was on it and we got a very oriental speaking woman and we assumed it was his wife. She came and...they explained to her through an interpreter finally, after hours, that her husband had killed someone. She was very upset. [She] went into the man and it wasn't even her husband. And he was all upset. Who was this woman now and why was she yelling at him...It was just awful but nobody sat down long enough to spell it out. Nobody took the interpreter into the man first to talk to him to see what he wanted or how he felt. And no-one found out [before calling] who this person was [which] they would have found out from him...everybody was just so angry that he couldn't speak English. And they got angry at him for not speaking English, rather than getting angry at us for not slowing down long enough for ... getting him an interpreter in the first place...It was very bad..It grew into a big thing which, if we'd done it right in the first place [would have been sorted out]...really it was our fault, but he got blamed for it.
>
> (Interview 11)

In addition to spoken language, communication was often frustrated by differing expectations of care. A nurse working in an abortion clinic explains that cultural strangers may cooperate with pre-treatment counselling, then suddenly refuse treatment when a male physician arrived to perform the procedure:

> [Nurses] get frustrated and ...think 'why didn't you say something before you got to right here...but most of the time you just let it go and deal with it when it happens.
>
> (Interview 28)

Problems of intercultural interaction may thus increase the psychic burden of nursing work. For example, nurses sometimes perceive help-seeking

behaviours as overly demanding. Several nurses in outpatient settings describe the difficulty of responding to client requests for appointments:

> Especially those that have just come over, when they call and want some attention, they want it *right now.* ! They don't understand the concept of 'that's not an emergency, so that can wait'.
>
> (Interview 15)

Frustration was also expressed when cultural strangers were seen inappropriately utilizing service. This increases workloads and provokes resentment. A nurse who had spent several years working in an aboriginal community describes this:

> I can recall that young mothers coming in with their infants and the story was always 'the baby's really sick, vomiting and diarrhea' and I guess that's where my prejudice or whatever came in; that they wanted a babysitting service for these infants for the weekend so they could go and party...that was frustrating to deal with. I found it very frustrating. It invariably happened every weekend.
>
> (Interview 15)

Another problem, is that cultural strangers' expressions of illness may inadvertently challenge values integral to "good nursing care". For example, there is a professional value that nurses keep clients comfortable and pain free. Management of pain is predicated on western norms concerning appropriate forms of expression. These norms subsequently provide the basis against which nurses evaluate the efficacy of care. When client behaviours derive from a different set of assumptions, nurses may think their responses are exaggerated, frustrating efforts to provide good care. This is demonstrated in the following example which describes a nurse's response to an Indian client's expression of pain:

> [I remember] an East Indian family...and this one young man who had broken his arm... we'd say 'He's not dying. He's only got a broken arm.

> And you know, you get frustrated because they've got these long faces and you know, its sort of like this person - that person broke down and would be moaning and like - you know he's only got a broken arm.
> (Interview 27)

The tension between patient behaviours and nurses expectations reflect a deeply held professional ideal of 'knowledge based practise'. The belief that nurses can manage pain implies mastery of a requisite knowledge base. A lack of knowledge is a barrier to care because it makes nurses unsure of their role and competence. A lack of cultural knowledge is implicated by several nurses as a barrier to care for cultural strangers. As one nurse comments, "sometimes these people can be intimidating...they might know more about different things than we do" (Interview 23). Another nurse adds "I do feel uncomfortable with [ethno-cultural] patients because I don't understand them" (Interview 8). If inadequate cultural knowledge is associated with inadequacy, then acquiring cultural knowledge allows the nurse to retain authority when providing care to cultural strangers. One nurse, an ardent advocate for cultural knowledge, describes its importance as follows:

> Cultural knowledge...I really value that now. What it does is it broadens up your mind as a practitioner, as a nurse. It gives you a wider range of hypotheses to work with your patient than if you don't have it....if you don't have the knowledge you can't begin the conversation.
> (Interview 8)

A wider range of hypotheses implies a greater basis from which to understand and influence behavioural outcomes. Cultural knowledge in this sense, necessarily precedes interaction and is acquired outside nurse/client relationships. It consists of identifying general cultural characteristics for ethno-cultural groups. A nurse-educator discusses how general traits are incorporated into nursing curriculae:

> We really should be looking at what are the major cultural groups, what are the major health care problems...We live close to a very large Native Canadian community...so we [said] OK. What are the major problems for native Canadians? And one was adolescent suicide...so we designed a scenario around adolescent [suicide]...[so] we have a scenario where it's a young couple in a community in Northern Ontario [who] move to Toronto, live with a brother -in-law, and they have a baby and he loses his job. There's some drinking (built into the scenario) and a number of issues that are fairly...prevalent (among the aboriginal population).
>
> (Interview 3)

Nurses who advocate formal transmission of cultural knowledge recognize the potential for stereotyping. Citing two examples where student-nurses from minority groups complain of discrimination, respondents attribute the problems to inadequate introduction of the material or to student's attitudes, rather than to the utility of generalizing cultural knowledge itself.

Many respondents comment that it is impossible know everything about client's culture. Two nurses interpret this as a justification for specialization of cultural care in nursing. The following respondent strongly supports this view:

> My dream is; I really believe that the whole, this whole culture thing is a specialized body of knowledge...that every nurse needs to know the basics about it, but I also think that you need advanced practitioners who can get to these levels. I wouldn't expect every staff nurse to get to these levels, but I do hope that we've got some resources somewhere along the way to develop them...it can make a difference if we had that. If we carry that knowledge with us, we can make a difference.
>
> (Interview 8)

Those who believe cultural knowledge is a precursor to cultural sensitivity, tend to support it's promotion through educational, professional, and workplace forums. In this sense cultural sensitivity becomes a mechanism that organizations adopt to influence nurses practise. For simplicity, I refer to this as

the organization/nurse standpoint. It is the second major sphere of meaning associated with the control orientation.

II ORGANIZATION:NURSE STANDPOINT

When used to define the organizations relationship to nurses, cultural sensitivity is understood as something negative. Although professional socialization mediates meaning, the degree of negativity tends to most closely correspond to the climate of workplace relations and nurses primary association of the term. When workplace relations are poor and nurses introduction to the term is in the context of these relations, meanings are most negative. For these nurses, cultural sensitivity signals a prejudgment of care. An emergency room nurse explains:

> I always thought of cultural sensitivity as...somebody else's feelings getting hurt because you did something wrong to them, [but] not knowing it was the wrong thing...cultural sensitivity to me is having to worry about what you did to this person...I would think of it more as a problem; as in a problem for me to have.
>
> (Interview 11)

Cultural sensitivity for this nurse is synonymous with blame. Others associate the term with academy-based nursing which is considered out of touch with realities of patient care. For several nurses cultural sensitivity is a "jargon" word which fails to resonate with practise. A respondent with extensive experience among immigrants, is particularly disdainful of academic nurses who promulgate the importance of cultural sensitivity. Based on involvement with academic nurses, she comments:

> I always wonder [about] these people that have coined these words - if they have actually worked one to one with the people they talk about...these [clients] have basic needs...yet somebody in an ivory tower

> is arguing over semantics...I don't know if they would recognize an individual if they found one!
>
> (Interview 21)

"Academization" of interaction with cultural strangers is clearly seen as empty rhetoric. For nurses with limited exposure to the term prior to interviews, ambivalence toward cultural sensitivity is also linked to associative meanings of constituent terms. With this standpoint, culture signified negative differences. For many, like the following nurse, culture is synonymous with race; "When we talk about cultural sensitivity we talk about a race thing and we get a vision of skin colour" (Interview 21). This leads to broader associations with distinctly negative connotations in comments, "like those guys that put the white sheets over their head...like really negative stuff" (Interview 11). Negative associations with culture are not only expressed by nurses uneasy with the concept. An immigrant nurse who speaks easily about culture in the interview also comments, "Even I don't like that word. [It's] scary...[I think] does that mean I am a racist?...The word itself makes me defensive" (Interview 25). When organizations introduce *cultural* sensitivity it thus becomes analogous to asking nurses to describe how racist they are in practise. One nurse says, as soon as she hears the term she thinks, "Right! here we go - I'm going to be told that I'm a bigot!" (Interview 11).

The word "sensitivity" is also problematic. For several respondents it implies cultural strangers are weak and in need of patronizing protection. One nurse says, "I see this membrane...and someone very gently puts a feather on it to see how it responds" (Interview 17). For another nurse it signals latent danger as evidenced by drawing on familiar medical analogues for sensitivity:

> You should be sensitive...meaning that...it's hard to say. Sensitive meaning that you react to it like a reaction to a strawberry...Hopefully it would be a positive reaction or something like that, but...it could also be a negative reaction too.
>
> (Interview 10)

Likening cultural sensitivity to an allergic reaction implies that interactions with cultural strangers are volatile and threatening. Although some respondents dislike the term cultural sensitivity, they agree there is value to intercultural interaction. The basis on which they reject the term reflects the workplace and professional contexts in which it is used.

Many respondents describe several workplace barriers to cultural sensitivity. The first barrier concerns organizational policies and procedures. One nurse explains that these "do tend to make you very focussed and very non-flexible" (Interview 15). These policies are not acknowledged as barriers by organizations. The following nurse explains her frustration with this:

> You so often hear that we have to be more understanding and we have to allow people to express the culture and then all these rules and policies are in place. Especially in a hospital like setting that actually forbids you to follow through on some of those issues.
>
> (Interview 15)

Nurses are being told to be more culturally sensitive by the organization, yet organizational policies actually prevent it. Employers are thus seen as insensitive to nurses' difficulties in providing care. These sentiments are most apparent with respect to the problems caused by cutbacks and restructuring.

Communicating with cultural strangers often involves more time. Cutbacks increase patient loads and thus reduce nurses' time for communication. This intensifies the challenges of providing care for cultural strangers. An emergency room nurse explains:

> People are rushed for time...especially now with the cutbacks and you don't understand what they're saying and they're talking in broken English and they're talking to the people that come with them, and they're changing all the words back to English...but they're only talking broken English too so you don't know, and the story changes every time you ask the same question...its very frustrating because you don't have time.
>
> (Interview 11)

Though translators may be required to assist with communication, resources are grossly inadequate to meet the demand. The lack of translation support services, as the next nurse explains, directly impacts the ability to provide care for cultural strangers:

> There are 127 languages being spoken [here]...I can't get resources - there [are a few] bi-cultural interpreters [but together] they have only 27 languages being spoken...for the person who is from Chad, there is no person who can speak..so the big problem is resource [because of that] they have been neglected.
>
> (Interview 25)

Telling nurses to be culturally sensitive and then denying resources to accomplish this, engenders considerable cynicism. Several nurses believe that the organization is using cultural sensitivity for political purposes. The image of a "culturally sensitive workplace" benefits the organization, as one nurse explains:

> Hospitals are engaged in fundraising and realize a whole cadre of potential donors out there and they won't [be successful] unless they can make themselves relevant to the population.
>
> (Interview 7)

The superficiality of organizational promotion of cultural sensitivity is supported by several factors. Several respondents challenge the organization's commitment on the basis that ethnocultural diversity is not reflected in staff or administration. An ethnically diverse staff is practically and

symbolically important to many respondents. One nurse sees it as a way of interjecting new perspectives and creative approaches to familiar problems:

> If its all the same people, saying what's important with all alike minds saying...all able-bodies, all non-homosexuals, all white people saying this is what's important, you're going to get the same decisions over and over and over again.
>
> (Interview 29)

The lack of diversity in staff is thus associated with the perpetuation of insidious discriminatory barriers. An immigrant nurse observes "there are many areas...where people eventhough they have the qualifications, they are not given a chance" (Interview 24). In addition to discriminatory biases, a few respondents express frustration that when they did make a commitment to cultural sensitivity, their initiatives were not taken seriously by administration:

> I'm very acutely aware of the fact that although the organization says they value diversity in terms of culture...I don't see that they're practising that..we organized an educational session of managers and executives and it was attended...half heartedly because those that showed up, attended for half the session or showed up, put in an appearance and left.
>
> (Interview 29)

It led this respondent to express disillusionment:

> [There's] a sense of being undermined. Of the self being undermined by the organization...because when we're asked for examples of what is important for us, and we give an opinion...I don't always see that it is followed up...It seems to me that ...the budget is always being rejuggled
>
> for making room for other things that are not, or may not be, important to what the nurse says is important.
>
> (Interview 29)

The disjuncture between what organizations say and do, is also noted in the professions response to cultural sensitivity. All but one nurse who trained in

the past 10 years, comments that cultural dimensions of care receive superficial treatment in nursing education. For example, one nurse recalls that "culture was in the second module of the program in our first year and it was never really dealt with again" (Interview 6). This indicates an unwillingness among institutions to address more fundamental issues of caring for cultural strangers. Nurses who are unsatisfied with how culture is handled in their programs subordinate concerns in order to "get through" the program. The following nurse recalls:

> I saw the racism. I felt impotent about what to do about it. But I saw the racism when I came into nursing. We had all these little very obviously white middle-class type discussions about what is illness and what is a patient. And [I was] thinking 'wait a second here. I have to get through nursing so I'm going to learn all this stuff - but I know alot of it isn't really, that that isn't how alot of people really see the world.
>
> (Interview 3)

Cultural sensitivity is discussed in ways that fail to accord with values in practise. Nurses learn that primacy is placed on efficiency, and that success is contingent on fitting in with existing routines. As the following nurse indicates, this is necessary if one wants to avoid sanctions:

> **Respondent**: They always give you these, 'Well if you came around the corner and you saw so and so, what do you do?' Well that doesn't teach you anything. It doesn't teach you anything about how to respond to somebody that likes to get washed at night instead of the morning. But you expect everybody to get washed in the morning. And when you go on the wards that's what's ingrained. Everybody is washed and ready by noon.
> **Interviewer**: And if they don't?
> **Respondent**: You're in trouble because you lost out somewhere there. And if you went to your teacher and said to them, 'No he doesn't want to get washed up until supper' [they'll say] 'Well maybe you should get him cleaned up anyway'. You know, 'you should deal with that' and it would be your problem again...Where actually the student who didn't make him

> get washed up out of his cultural beliefs is doing better [nursing]...that wouldn't be respected.
>
> (Interview 11)

Nurses consequently learn to expect that cultural sensitivity will not be taken seriously. Indeed, underlying the formal valuation of diversity is a reality that is intolerant of difference. This not only applies to cultural strangers as clients, but also to cultural strangers as students and nurses. An immigrant nurse reflects this when recalling experiences in a nursing program which ironically claimed to have cultural sensitivity integrated into its curriculum:

> The school changed my attitude and also my culture. What the school did was ask me to be what they wanted me to be. I was one different person [before, and] when I went in they changed me. They changed the way I used to act because I am a different culture. But they told me you have to give up your culture in order to survive...Unless I know about Canadian society I cannot survive. My whole culture is irrelevant...in my culture we never talk, just listen. That being quiet is not acceptable here...Unless I say something they don't know what I know... That led to some biases in my mark. They were telling me always that you can't be quiet. You have to speak up loud. That's the message. I have a hard time to change it. Every time I say something, I felt like I'm rude. I felt like I'm competitive.
>
> (Interview 25)

The inability to recognize and respond to diversity among students, attests to the spurious nature of cultural sensitivity in nursing education. There is clearly a gap between what is professed in theory, and what is desirable in practise. The presentation of cultural sensitivity may communicate standards which are completely unattainable in practise, as another nurse observes:

> You're saying that you could have done so much more...so you raise people's expectations of [their] efficiency and effectiveness in working with people, but then you put them back in a system, like an emergency

> room where they've got 3 minutes to do a triage and assessment...how much can be done in that kind of setting?
>
> (Interview 3)

The disjuncture between discourse of cultural sensitivity and practise is also objectionable for other reasons. To some respondents cultural sensitivity is understood as a directive; implying a special body of knowledge must be acquired before caring for cultural strangers. From this standpoint, cultural knowledge becomes a mechanism for controlling nurses rather than cultural strangers. Nurses who reject formalized approaches to cultural sensitivity often do so because of its lack of relevance to values and experience of practise. A respondent with over 20 years experience explains:

> When I went into nursing it was to help people and to be of service, regardless of who they were. It was to help people with their health care and it didn't matter who that person was. So I guess I have a hard time to put everybody into a category. If someone's here and they need help its silly to think that sorry I can't help you because I don't understand what your culture's about kind of thing.
>
> (Interview 15)

For this nurse, and several others, cultural sensitivity obstructs the provision of care. The disjuncture between rhetoric and reality produces obvious tension. However, what is equally apparent is the nurses' sense of helplessness in openly questioning this gap. As they recall experiences as students and as employees there is a consistent underlying theme of fear.

Respondents earlier describe how the ability to perceive the latent meaning of instruction is critical to survival as a nursing student. This reflects a tacit understanding of behaviours deemed acceptable for a nurse, and the sanctions associated with infractions. The nurse in the following example recalls a situation where the realities of a cultural stranger evoke a personal,

emotional response. Concerns about the sensitivity of health services are quickly subordinated to fears of being caught and punished by her instructor:

> I was a nursing student in my third year...I remember going in to take a letter to an Inuit woman...It was a letter from a daughter. An 18 year old daughter - [the woman was unable to read] and I went in to read the letter to her. She told me this was the daughter she had never seen and she had delivered the baby and then come out [from her isolated community to] the [TB] hospital...and she'd never seen the daughter - she'd been in hospital for 18 years...We take people away from their families...and I remember thinking you know, there's got to be more to health care and then I ...and I can remember, we've been socialized you know - you mustn't do anything personal with the patient. And uh, shouldn't sit on their bed, you should be busy and I remember sitting down and I was holding her hand. And she was crying and I was crying, and [I was] thinking you know 'what if my instructor comes in; I'm going to be in trouble for doing this you know. I'm going to get a failing grade on my clinical.
>
> (Interview 3)

Performance fears are also expressed in terms of adequacy. Cultural sensitivity evokes fear of incompetence for several nurses. As one nurses explains:

> There is some fear there...because its something new...new things make everybody uncomfortable...'I don't know if I will be capable of doing it, I don't know if I'm going to be able to understand it...I don't know if I'm going to be good at it.
>
> (Interview 4)

Fear that one may not be able to understand indicates that the terminology associated with cultural sensitivity is confusing for some nurses. Comprehension, as the previous comment suggests, is closely associated with competence. Questioning the meaning of the term may be seen to invite questions of one's personal or professional competence. The following respondent exposes concerns of adequacy when explaining her frustration with the term:

> [It's] an airy fairy word...I've got no idea what you're talking about now and you're confusing me. So either put a definition on it and tell me about it, or don't use the term. I find it very confusing. Maybe its because I'm not good at that stuff...I have a very hard time touching it.
>
> (Interview 11)

The fear of blame inculcated in nurses' education, is also reproduced in workplace responses to cultural sensitivity. Understanding culture as race, means that references to it may be perceived as an accusation of racialist bias in one's practise. The following nurse reveals this in her response:

> If we got a memo saying that "We're going to have a meeting today on cultural awareness' I'd think, 'Oh here we go. Its all my fault again.'..and I might deal with some of them wrong but I deal with some Caucasians wrong too and why aren't we dealing with that.
>
> (Interview 11)

Differences in status between employers and staff, also inhibit nurses from expressing their frustration with cultural sensitivity campaigns. "You're going to say what you want them to hear...you know it's your job, it's your livelihood and you don't want to mess that" (Interview 11). Inability to trust employers discourages some nurses from reporting discrimination when it is observed in practise. A nurse who identified a pattern of prejudice in her work setting comments:

> I've never said anything because [employer] who speaks good English [would] be very angry. He's very sensitive about that. And if it's
>
> mentioned he'd be checking [nurses]...he'd become obsessive about it, and I think it would grow into a bigger problem.
>
> (Interview 11)

Fear that a bigger problem may result, constrains nurses in addressing concerns among colleagues. Several nurses from witness incidents of

discriminatory behaviour. Their response is mediated by fears of ostracism. The following nurse reconciles this by adopting a strategy of avoidance:

> You don't want to be unpopular when you're working some place. You put it aside..if something came into my way, a difference, just put it aside and go do the main thing. Go around.
>
> (Interview 16)

Avoidance is used more generally to resist formal cultural sensitivity campaigns in the workplace. Although several nurses express frustration with these initiatives, they also know that ignoring it is unlikely to precipitate sanctions. As the next nurse understands, it is the standard task oriented work that remains the priority:

> You don't get too many brownie points for doing anything extra right, so as long as you didn't do anything wrong, [you won't be caught out]. That's what charting is all about, to make sure you didn't do anything wrong. [So you can say] 'It's right here. I did all the things that I had to do' - maybe didn't go any further, but I didn't do anything less either.
>
> (Interview 28)

In addition to fear, another prominent reaction to organizations' endorsement of cultural sensitivity, is that it invalidates nurses' personal and professional experiences. As one nurse asserts, "I mean, we're something too!" (Interview 11). Another nurse expresses concern that resident needs will be overlooked:

> I guess I have reservations in...that if we start defining this, that maybe we're focussing in so much on what this other cultural ethnic or cultural
>
> group wants and needs and forgetting what Canadians as a whole need or want.
>
> (Interview 15)

The presentation of cultural sensitivity focuses on what the nurse does in relation to cultural strangers. One nurse vehemently rejects the implicit uni-

directionality of this, claiming that it invalidates the racism and abuse incurred from patients:

> If a patient is rude and often just down right ignorant, they curse, they swear, they will tell you like I pay your wages so you just have to listen to me - nobody hears those complaints of the nurse and fields those complaints...to the nurses satisfaction. So [the] nurse is now feeling, why should I have to listen to this too, on top of it. You know, why would I have to be culturally sensitive when this person comes around and tells me that this is the way it is, end of conversation; close the door.
>
> (Interview 29)

For this nurse, advocating respect for others can only proceed once nurses feel respected themselves. Organizations' failure to do this insults nurses professional and personal worth:

> Nurses come to the room, to their situation already feeling [there's] one against them...yes they are willing to perform their duties to the best of their ability...openly and honestly, all of those times, but if you confront them with something else, it's you know 'this just burns me because I have to listen to so and so...tell me that I'm lazy and that I take too many coffee breaks and don't give them good care, and they waited 20 minutes for a bedpan...so [nurses] are equating that disrespect with now being asked to show respect to this person who, just because they need special food or...want special religious privileges, why should they be any different from me when I'm asking for x, y, and z.
>
> (Interview 29)

This comment reveals the unfortunate irony that directives to respect the needs of cultural strangers subordinate respect for nurses in the process. Admonitions to be culturally sensitive heighten awareness of insensitive workplace environments. While many nurses express frustration with workload and funding issues, there are particular ways that the discourse of cultural sensitivity invalidates nurses who represent minorities. Several minority nurses describe experiences of marginalization. An Indian nurse explains how her ethnocultural identity is invisible to a colleague:

> I was sitting [in the nursing station] and there was another nurse...and she [said to a friend on the telephone] 'You know, that East Indian patient I had, she has all of her relatives sitting around her and they're a pain in the you know what'. And she's going on and on and I'm sitting there. I'm an Indian nurse sitting there and she's a mainstream white. And she [tells the person on the phone that she has said] to the patient 'Well you are only two relatives allowed' and she said, (parroting the patient's reply) 'They've come all the way from India to be with her...and you know we're not disturbing anybody, we have the drapes closed and we are not talking loud' and she's telling this to her friend on the telephone...And she was going on and on...and I'm sitting there listening to this.
>
> (Interview 16)

Several immigrant nurses feel invalidated by the lack of recognition for work experiences prior to arrival in Canada. These respondents, all from developing countries, comment on the ethnocentrism of their Canadian colleagues. The desire to have professional experiences recognized may be misunderstood by colleagues as demonstrated in the following recollection by an immigrant nurse:

> I was talking to some nurses [who complained] 'Oh my God, I have 10 patients! I would say 'oh that's nothing compared to Ecuador where we have 40-60 patients to look after in one shift. Their immediate response was 'well the level of care couldn't be good if you has so many people' No - the level of care is equal for everybody. ...It doesn't mean that because you have 40-60 clients that we are neglecting one.
>
> (Interview 4)

While both the immigrant and Canadian nurses indicate a need to have their professional experiences recognized, the comment is interesting because it shows the subtle ways that experiences of minority nurses are dismissed. By suggesting that care in Ecuador is sub-standard, her colleague questions the competence of the immigrant nurse herself.

The individuality of minority nurses is also invalidated by expecting them to care for clients from similar backgrounds. Such ghettoization is rationalized by peers on the basis that it promotes recognition of minority nurse's "cultural resources". As a Euro-Caucasian nurse comments:

> I think...that we should be looking as a society at maximizing the resources that we have. So, for example, if we have a nurse who is bilingual and bi-cultural, that rather than ghettoizing her practise that [recognizing] she's somebody that can be used as a resource.
>
> (Interview 3)

There is no question that minority nurses *do* view their backgrounds as a resource. What they reject is when colleagues use it as a marker for "otherness" which overrides all other aspects of their identity. They reject the logic of this which assumes it is natural and obvious to assign minority nurses to cultural strangers. A Buddhist nurse argues:

> I remember working in the hospital and them saying 'Who wants to take care of the Buddhist lady in Room 215?'. And I'm thinking, why should it be any different taking care of this person in this room because of her religion?...You are not going to say,'there's a Protestant lady in 205, who want's to take care of her?' So what were they meaning when they said that?
>
> (Interview 21)

Rationale may be predicated on assumptions that minority nurses can provide better care. However, there is also a sense that these requests derive from a desire to pass cultural problems onto minority nurses. When asked to identify the most common 'cultural' question asked by colleagues, a Polish-Canadian nurse replies:

> Can you take this case? Here, do you want this case? They are Polish speaking...You'd probably do a better job at it and it probably wouldn't need as much coordination to get the family there.
>
> (Interview 18)

Responses to minority nurses indicate a tendency to homogenize difference among cultural strangers. Broader social divisions among ethnocultural groups, such as class, are ignored. Assuming that cultural resources are the unique property of minority nurses, denies their individuality. As a black nurse explains:

> Just because I happen to be born in a different country, born with a different ethnic label, a different skin colour, a different language, and different beliefs doesn't necessarily make me culturally sensitive.
> (Interview 28)

The discourse of cultural sensitivity, which formally espouses culture as a resource, may thus exacerbate ghettoization of minority nurses by assuming they will want to contribute knowledge in certain ways. The following nurse explains how such expectations led to concentrating her research among her ethnocultural community:

> [Initially] when involvement in cultural sensitivity was suggested] I said no. I don't want to take on anything on multi-cultural or racism. I don't want to take anything that has anger in it, and second, I don't what to categorize myself. I want to do things (that) are generic...more generalist...So I took more [courses] in education and look at me. All my research subsequent to that has been among [my ethnocultural community]. I didn't want to ghettoize myself, but circumstances were compelling and I had to move into it. I had to find a niche for myself. And people were only willing to listen if I had this kind [of expertise].
> (Interview 16)

Like the Polish nurse who is asked to take cases because she would provide better care, the reasons presented to this nurse are "compelling". It suggests that forces which lead to ghettoization appeal to reason and are not blatantly discriminatory. This comment also indicates that cultural arguments which restrict nurses' practise in some ways, are also the vehicle by which some nurses subsequently gain visibility. The discourse on cultural sensitivity

provides one place where the experiences of minority nurses are recognized and listened to. This is clearly the case for the following nurse's interest:

> I am visibly not of the dominant culture and...this is not going to go away...if I don't [get involved] I...don't have a voice to speak. If you're not doing something to make an improvement, then you're only part of the problem
>
> (Interview 29)

Synthesis

The control orientation to cultural sensitivity reflects two standpoints. The first uses cultural sensitivity to define nurses' relationships with cultural strangers. Cultural sensitivity is viewed as a mechanism for increasing efficiency and promoting positive outcomes. In the second, cultural sensitivity defines the organization's relationship to nurses, specifically by using the construct to shape their relations with cultural strangers.

The two standpoints are distinguished in several ways. In both, nurses' primary concerns are on increasing the efficiency and outcomes of care. In the first standpoint, cultural sensitivity is desirable; a means of enhancing care. From the second perspective, organizational promotion of cultural sensitivity is clearly undesirable; something which signals blame and presents an obstacle to care. Both standpoints approach cultural differences as a barrier to the process and ends of care. Language is commonly recognized as a barrier to be overcome, however the first perspective considers cultural sensitivity as a means to ameliorate this problem, and in the second it merely intensifies frustrations encountered in providing care.

Culture is otherness in both orientations. The first standpoint discussed this generally as 'difference' and accords it less value. In the second view, culture connotes race and potential danger. Responses are generally

characterized by fear. Minority nurses for whom otherness and culture are familiar, adopt cultural sensitivity as a strategy redressing workplace inequities and professional marginalization.

The final significant distinction concerns the nurses' relationship to organizational and professional structures. The first stance presumes a tacit acceptance of organizational and professional norms. Although professional norms are also accepted in the second orientation (as evidenced by the principal focus on efficiency), there is an emerging critical awareness of the way that social structures constrain nurses work. Nurses' abilities to effect change in structures are perceived as limited.

CHAPTER 5:
Cultural Sensitivity in Informal discourse: Patterns of Humanism

This chapter discusses the meanings of cultural sensitivity which reflect themes of humanism. I begin by reviewing humanist meanings of cultural sensitivity. These stress relational engagement and mutual growth. The object of cultural sensitivity is to perceive the life-world of others. This leads to consideration of human difference and similarity. The next section discusses personal characteristics and communication skills needed to promote cultural sensitivity. Finally, I address the barriers to a humanist-orientation of cultural sensitivity. These include the rigidity of dominant health paradigms, individual traits, and the role of social structures.

Cultural sensitivity from a humanist orientation, is also used to define nurses' relationships with cultural strangers. By focussing on mutual understanding and individual's generative capacity cultural sensitivity is seen as something which enhances relationships. This view acknowledges that nurse and client each bring resources to their relationship. Many respondents summarize this as a view which assumes "people are people". As the following respondent claims:

> I can't take what I believe and put it to a word. All that it is, is what I am. And people are simply people to me. And that's very concrete. People are people. And it doesn't go any further than that. I have a problem with people taking them into subgroups...they're just people.
> (Interview 11)

This comment reflects how humanist meanings build from an explicit rejection of 'culture as difference' implicit in formal discourse on cultural sensitivity. Several respondents believe that formal use of the term detracts

from what naturally occurs in relationships. One nurse indicates that it diminishes the value of experiences with cultural strangers:

> ...being sensitive to...it doesn't sound right. Like I'm within my culture and reaching out...There's a fundamental inequality in the term that doesn't sit right with me. When I think of working with immigrants I think of forming relationships, getting to know people; not '*being sensitive*' to them.
>
> (Interview 2)

Respondents also find the concept of 'culture' problematic because it imposes an artificial sense of homogeneity over a reality of human diversity. Interaction occurs between individuals, not generic representatives of a profession or culture. A nurse summarizes this:

> To me cultural sensitivity is human sensitivity - to me that is the bottom line and in fact socially we would have culture out. That the word would be taken out of all the text I can see. It should be sensitivity toward another human being within the Canadian context. I mean there is such a variation. I mean I am nursing all my life and I can't see two Canadian patients who are identical. Every Canadian home is different. Every Canadian context is different.
>
> (Interview 16)

By clarifying what cultural sensitivity it *not*, humanist meanings provide a way to re-orient cultural sensitivity according to what *is* nurses' experience of intercultural communication in practise. Several nurses comment that the description of cultural sensitivity is constrained by the use of words which are inadequate to capture something they feel or intuit. An eloquent effort to resolve feeling with words, is provided by a nurse who works almost exclusively with cultural strangers:

> [My definition] has changed over the while...[now] I'm bombarded with images rather than words. I see alot of families that I've dealt with and I see faces now more than words. I think of the experiences that I've had going into the homes and seeing or feelings that I'm getting...and even the individuals that I've been in contact with. I don't know if I can put it

> into words any more, whereas I would have had a pat definition of it before ..[now its beyond words] to images and faces... If you were to ask for a definition of what a typical Vietnamese woman was I wouldn't be able to say. I'd be able to say, 'well this is Phong' and this is ___. These are the experiences and these are the people, and the warmth, and its varied.
>
> (Interview 21)

The motif of 'stories' emerges in several interviews. In fact, one individual thinks "cultural story-telling" a more apt descriptor for her experience than cultural sensitivity. In spite of the challenges to express it, these examples reveal that one object of cultural sensitivity is to perceive something of others' realities. This acknowledges different world views among both nurses and cultural strangers. As the next respondent explains:

> Don't tell me that my reality is the same as your reality...the reality of a wheelchair bound person is not the same as my reality who can walk. ..the person who speaks to you with an accent speaks to you with a different reality. And my sitting here as a Black nurse, my experience as a nurse. The skills and knowledge base that we share is the same but the experience is a different thing. A different reality that I have.
>
> (Interview 29)

Acknowledging multiple realities also recognizes differences in the logic which informs human behaviour. Examples provided by respondents show that cultural sensitivity involves using one's imagination to temporarily step outside their worldview in an effort to perceive the logical ordering of another's. The following example demonstrates this. The nurse briefly transcends a worldview which judges behaviour of others, to consider how such behaviour is logical within others' realities:

> I think that people who are born in helpless or hopeless situations learn ways of behaviour to perpetuate that...[like] what I would call a culture of poverty. People on welfare that go out and buy a case of beer or pack of cigarettes and smoke a pack a day - that [externally appears] irrational.

> [But] Its not an irrational thing in the culture of poverty. [It's] very rational. Where else are you going to get any kind of satisfaction.
>
> (Interview 17)

Another example juxtaposes the nurse's understanding of multiple realities against the rigid application of a biomedical model. It reveals how different paradigmatic orientations shape responses to cultural strangers:

> A Haitian woman came into the Emergency Department and she was very distressed...her expression of what her problem was ... that she was alone with two toddlers ... and she felt that they had been watching television and had been influenced by the devil...and were now misbehaving...She had come for help for what she perceived to be a possession problem [among] her children. [She] was immediately labelled by psychiatry as schizophrenic and delusional and Children's Aid was called... I tried to express to the psychiatrist that this might be culture bound syndrome; that here was an [immigrant woman] in Toronto, with a husband and toddlers [and no social support] who was in fact expressing that she was having difficulty coping with [the responsibility] and isolation and the way she explained it was in terms of possession...I didn't get anywhere with the psychiatrist, but the fact that I thought about the problem in that way seems to me to have been one of those significant moments in my practise. I still feel very badly.
>
> (Interview 7)

Most nurses describe critical incidents that subsequently spark their interest in trying to understand health issues through the eyes of others. It reveals the highly experiential dimension of humanist meanings. As one respondent explains:

> Isn't that what brings down barriers? Talking to people and touching them, and seeing what they do and why they believe what they believe.
>
> (Interview 11)

One respondent described moments where she perceives logic of other cultures as "cultural bumps"; something which jarrs her existing assumptions about the world:

> Culture bumps for me...is of every surprise moment I had (she offers a reflective) 'Ah', this sort of 'Ah-hah! - this is something to note'. That's how I knew about culture. Because I knew that it was a bit unusual, a bit of a surprise ...[such as] 'This is something about pregnancy - and how many days after pregnancy would you expect somebody to care for you?'. And [the reply]...would be different from my understanding, so 'Ah-hah' well that's something about culture. Something that makes me aware of what my culture is...I suppose learning as much about me as about the other so that's a culture bump. Something about the surprise moment.
>
> (Interview 2)

The surprise moment represents the familiarization of difference. Although recognition of multiple realities presumes 'difference', the discussion of cultural traits provokes considerable unease for many respondents. This affirms their rejection of approaches to 'otherness' as difference in formal discourse. One respondent explains "all generalising does is lose sight of that individuality. It loses respect for the individual" (Interview 17). An Indo-Canadian nurse adds:

> I can bring you 10 Hindus and they will be doing 20 different things. But no two of us will be doing those things. There are so many factors plus economic background, educational background, subset within Hinduism, which cast...which subcast, which part of India you come from...There is no one profile of a Hindu so to me that breaks down right then and there. A total waste.
>
> (Interview 16)

Nurses do not deny that differences exist. What they recoil from is the pejorative valuation of these differences which fails to ground discussion of culture in an understanding of individuality. They assert instead that everyone has culture; that "culture is us" (Interview 10). One respondent explains:

> I think you should treat each person as an individual being aware that each of us has culture. Whether it is a Canadian culture, or an Italian

> culture, or a Bahamian culture. Each of us has culture and everybody is an individual.
>
> (Interview 24)

Cultural difference is thus understood in an overarching framework of human similarity; "We are similar in that we are different". This leads to valuing and accepting difference as something essentially human. What differs from formal discourse is that the discussion of cultural differences derives from nurses cumulative experiences with individuals. As experience provides the substance, it also provides a frame within which patterns are discussed. Identification of cultural difference emerges from, and is particularized to, the nature and context of nurses work. For example a nurse describes cultural patterns observed during her work as a contraceptive educator:

> In alot of different cultures women aren't comfortable touching their body - that it's taboo. So what's the point of us giving them spermicide, 'here's an applicator or a vaginal spermicidal suppository' it's not going to work. They just don't do it...you don't have to say 'are you comfortable?' ...it's like what this is 'is this something that you can see yourself doing' and if they scrunch up their face and say, OK 'next!', we'll try something else.
>
> (Interview 28)

Nurses whose work emphasizes patient education are most comfortable discussing culturally patterned behaviours. A nurse-educator describes cultural patterns that derive from experiences with immigrant students:

> One of the things I learned through [working with immigrants, were differences in learning styles]. For example, Polish students, they had no more language than anybody else, and they would come to see me because...they would need more homework. They would say to me, 'I don't like her (other teacher) because she shows too many movies. I want to learn'... [in contrast students from] the African cultures...who were refugees and had spend 4 to 5 years in a refugee camp where they didn't have any formalized structure for life...found that they loved [group discussion] and wanted to go slower...[and students from] Spanish cultures that I had, were very non-time conscious, manana - Like

> tomorrow, if you had a 2 o'clock appointment, then maybe you'd come at 4:30.
>
> (Interview 14)

Respondents stress that identification of patterns does not supplant the need to keep one's primary focus on individuals. Experiential knowledge provides a foundation upon which experience from successive interactions are inscribed. Thus, understanding of cultural differences constantly evolves as a reflection of ongoing experience with cultural strangers. Keeping the focus on individuals recognizes culture as only one, albeit important influence on interaction. The following nurse cautions that personality can not be neatly reduced to culture:

> They have certain things that I like about them and certain things that I don't...but everybody does. There are Caucasian people too that drive me nuts.
>
> (Interview 11)

This suggests that sometimes the relative "success" of interaction is best explained as a reflection of personalities. Many respondents believe that nurse and client share responsibility for the 'cultural sensitivity' of interaction. As explained by one nurse:

> We're equally able to practise injustices...within [a] culture people aren't homogeneous on their thoughts [about] people...we are equally able to practise racism, practise sexism, practise 'ablism'.
>
> (Interview 29)

Although responsibility is shared, two factors believed to influence nurses' ability to be culturally sensitive are their personal characteristics and communication skills.

Nurses frequently comment that it is hard to "put words" to something that is felt, rather than consciously or cognitively perceived. As one explains, "it has

to come from the heart, rather than from the policy or the code book, or the skills learned" (interview 1). Viewing cultural sensitivity as an expression of something "from the heart", loads the term with personal significance. A nurse who works with refugees explains the importance of cultural sensitivity for her; "the rewards are greater for me; [it's] to get something out of it that's personal to develop myself; to feel good about it, to make a friend, to explore the world" (Interview 2). The idea that intercultural interaction contributes to one's self-awareness and personal growth is shared by many nurses:

> [Cultural sensitivity is important] because otherwise you risk losing knowing yourself. It's important because it gives you an opportunity to see yourself in a fuller view and when you do that, when you can utilize the fuller part...then you get to see kind of all the contours of other people. (Interview 1)

Knowledge of personal resources and limitations is believed to increase nurses ability accept these in others. The previous nurse continues to explain:

> ...acceptance is just self-love...so its just learning about yourself and ... to work out of a loving way. And I don't mean that in a charitable loving way, its like out of a loving spirit. It doesn't mean that you have to like everything about somebody, but to me you can't do that really open way unless you really, really, are in touch with all the kinks in yourself...unless you can look at that and love that, how can you expect to work with somebody else in a loving way and accept all the paradoxes that they have?...that's very key to the core issues in cultural sensitivity. (Interview 1)

This comment suggests a distinction between one's "authentic" and "false" self. Being "in touch with all the kinks in yourself" and accepting these in others indicate a desire to relate to others as equal. One nurse describes this as trying "to get out of your own perfection". She then quickly adds that "it's hard because we're all tradition bound and culture bound. So it's really hard to get out of those assumptions" (Interview 3). The means by which one comes to

know one's self are limited so knowledge of oneself and another is always partial. Self-knowledge therefore encompasses awareness of one's ignorance.

This approach to cultural sensitivity does not mean that nurses no longer experience difficulty interacting with cultural strangers. Instead, it allows them to conceptualize the relationship in ways that accept and work with one's limitations. Identifying instances that generally cause frustration are used to develop anticipatory coping strategies. A visible minority nurse describes several instances where patients were physically or verbally abusive. Initially these left her confused and wondering what she had done to provoke them. Realizing she was not at fault allowed her to develop an alternate response for future instances. As she explains:

> Nurses need to have a healthy respect, a healthy understanding of who they are. So that when they go into a room that they can have the esteem, the dignity, they can go in and say, 'Geez!, I can't manage this situation' excuse themselves from it and come back with a new set of strategies.
>
> (Interview 29)

Self knowledge encompasses more than understanding ones limitations. As much or greater emphasis is placed on recognizing and utilizing resources one brings to relationships. One respondent notes:

> There's something funny about the relationships we've had between nurses and clients in the past where we assume that we don't bring anything to this but knowledge.
>
> (Interview 7)

Many respondents provide examples which demonstrate how personal resources enhance interaction. Experiences of prejudice, or being part of a minority, provide a basis for developing empathy with clients. A holiday abroad allowed one nurse to realize "...not being understood...is kind of a scary thing"

(Interview 6). For others, resources are grounded in experience with health care in Canada. An immigrant nurse recalls:

> I was a refugee, I have some type of psychological problem... When I came to the doctor (in Canada), nobody referred me for counselling or [ask] just what's the problem...nobody approached me. They assumed that I came here to have a good life. I came here just wanting something.
> (Interview 20)

For this nurse, like others, the experience of being an immigrant exposes commonly held assumptions among Canadian service providers. Learning to function within two cultures generally increases insight about how cultural assumptions manifest in expectations, behaviour, and institutional routines. For example, Euro-caucasian nurses commonly identify frustrations with the number of visiting relatives in extended families. The following example illustrates how an immigrant nurse draws on her cultural background to understand conflicts with visitor restrictions:

> [Here] there are certain times the patient is allowed [to have visitors] between 8 until noon, or until 2 PM in surgery. But for me (in my culture) I'm going anytime to see my family - I can not be rejected. So (here) when they tell me not to go in, I will be angry; I will say they are rude because they didn't (let me visit). Or if somebody die in the hospital, I might cry out loud and they are not familiar in this way. And they call the police to move me from that area, so that also disturb me.
> (Interview 20)

Using assumptions from her cultural background, the nurse is able to impute meaning underlying patient behaviours. Another commonly identified frustration, is the perception that men in other cultures are overbearing with women. An Indian nurse explains how cultural expressions of care between spouses may be misinterpreted. She describes how her husband would respond to news that she has a doctor's appointment:

> [He would say] 'Don't you want me to go with you?' He hates health care, he hates hospitals, he doesn't understand the language. But what he's saying, and I know this, is 'shall I come with you?' I know what this means for him...I know what it means for him to walk into a hospital and feel like his wife is in danger somehow and he's got to be here to protect me. And yet he feels totally uncomfortable. That's an expression of caring where somebody else will say 'Ah- Ha! that's a sign of control'. But its our (western) assumption.
>
> (Interview 8)

Although the humanist ideal of cultural sensitivity is to achieve understanding, it also recognizes the reality, which is that individual resources fluctuate. As one nurse explains, "sometimes lets face it, we're not all that sensitive" (Interview 28). She continues:

> I know there are days where...I'm going through the motions and people know that. And I don't know how people know that. But they know. As opposed to other days where like, I actually care about what happens to you today. And there's other days where you're not giving a 100% and even though you're saying the same words, it just doesn't come across... so you're getting back what you give in...garbage in, garbage out.
>
> (Interview 28)

This view recognizes the emotional cost of caring and the fact that sometimes nurses' emotional energies are low. It also recognizes the importance of taking measures to keep their emotional resources replenished. An intensive care nurse explains:

> There are sometimes...You just don't want to get so involved with the family and the patient. [so you might] close yourself off a little bit to protect yourself...Sometimes I get more involved with the family and sometimes it hurts to be that sensitive...for some people its too much because its so draining all the time. But for me, I'm aware...that even in the past dealing with a baby that I've looked after for 8 or 9 months, I've said, 'I want a break'...because I knew for myself to dive right into a situation again where you're dealing with somebody that's going to be here for 6 months or whatever, that I would probably close myself off emotionally...I haven't had a chance to recuperate.
>
> (Interview 27)

The ability to state, 'I need a break', reflects an awareness of the nurses' boundaries. It is also demonstrates the ability to communicate clearly and effectively. In addition to general characteristics of the nurse, the second major factor in nurses ability to be culturally sensitive is communication skills. Interactional experience is contingent upon them. One nurse summarizes:

> I think it really comes down to being able to communicate because you can't ever know all [about] Chinese cultures, or oriental cultures...just being able to communicate about what I'm doing, about what you're doing. What does this mean to you? What does this mean to me?
> (Interview 19)

Several nurses acknowledge that communication is shaped by assumptions, and that one must consider both verbal and non-verbal language. As one nurse explains, "sharing a common language sometimes leads us to make the assumption [of shared understanding] and take everything at face value" (Interview 3). But using the same words may lead to "talking about concepts that aren't even real in other places" (Interview 14). A nurse who worked internationally recalls:

> One of the things I thought alot about in Guatemala was the whole term..mental health. I mean we were living with these people who are Mayan...and they don't have 'mental health'..those words within the Mayan Vocabulary, yet they are talking like health promoters are talking about health..(a local doctor told me) there was somebody that was doing a study on mental health a few months back... (So) I would say to people, 'well what do you mean when you say that?, What does it mean?' 'Well, it means that you just have a disease in your head instead of your body'.
> (Interview 1)

Perceiving the logic of other's behaviour thus involves going beyond limits of spoken language. By attending non-verbal aspects of communication, or 'silent language' nurses try to locate meaning in clients behaviour and the dialectical context of a relationship itself. This assumes "that people are

intelligent...(and) that people are going to be able to express themselves if given the time and support" (Interview 3). These assumptions replace professional claims to know the needs of others with the more personal belief that "people of different background and cultures do know what's best for them" (Interview 17).

Nurses' emphasis on competencies is not accepted as a call for relativism. Relativism is viewed by many nurses as a negation of nurses responsibility and as a covert mechanism which undermines competence of cultural strangers. A nurse with extensive international work experience, explains:

> ...one of the things that we do that we think is culturally sensitive and isn't, is we always want to give them the benefit of the doubt....and that's really great but when it gets to the crunch and what's [supposed to] be produced isn't what you want, ...then there's kind of a feeling that 'people here aren't as capable'. Either that, or 'they're not listening to my directions'...if the project or whatever you're doing...doesn't kind of meet this outcome, that maybe the person (expatriate) has thought that it would, they then [use it to] blame that other person (cultural stranger). Whereas if they had been more critical all along in the process, then the outcome would have been different. So it's like abdicating your duty, your inner duty. Abdicating your responsibility [which is] to be critical and to treat people like they have brains.
>
> (Interview 1)

Recognizing that everyone has strengths and limitations, accepts that sometimes people may try to manipulate situations to advantage. Nurses who mention this, describe their response as offering support in ways which utilize and reinforce client competencies. An example is provided by one respondent:

> Sometimes individuals use it (their cultural background) as an excuse, like I can't do anything. I'm immobilized because no-one will allow me, or I can't do it myself so you have to do it for me. No one will trust my judgment...they want you to call agencies for them, or to make telephone

> calls for them, or make appointments for them, and I'd say no, you've got to do it yourself. And you can do it!
>
> (Interview 21)

Closely linked to the idea of competencies, is the need for mutual respect. Though nurses conceptualize this in different ways, generally it refers a patient, non-intrusive acceptance of other's values and beliefs. One nurse describes it in terms of humility:

> I think...that humility is a key characteristic, uhm it doesn't have to be really blatant'...[like] when you see people in a conversation and you know...they know something and they're talking to somebody else, and...they could easily say that they know and speed up the conversation and make their point, and get on, and they don't do that. They just kind of let...the other person talk...it's like there's nothing lost in letting the other person, so it's, it's giving somebody space to express their attitude around what they feel and then kind of receiving what that person's going to give back to you and that's what you work with as a shared thing...So its not somebody whose so keen to let somebody know they're knowledge...[it's a way that] everybody, or more people get to use what they have
>
> (Interview 1)

Respect in this sense is an ability to moderate one's intellectual and relational intensity so that the other has equal room for self-expression. For most respondents it also means modifying behaviour and implicitly communicating acceptance of others values. A nurse living in a remote aboriginal community illustrates this when describing her response to the local practise of hanging meat in homes:

> When I go into a house where there's meat hanging, I can't stand the smell. But you know, I try really hard to be neutral about it. Not that I want to cover my true self, but I don't want to be really obvious about it...because dry meat is a prized thing up there...so a person who is culturally sensitive wouldn't look down on something or try to change it.
>
> (Interview 30)

Respecting others is inextricably linked to respect for self. Not insulting or demeaning other's practises, frees the nurse to expect the same for herself. The next nurse demonstrates this in describing her expectations of patients:

> ...it sounds really rosy, and I know its coming off sounding really cheery like sunshine, but I think that they need to understand my values are going to be different from them. But if they treat me with respect, and they should demand and expect respect back from the nurse, that they should expect that I will treat them as an individual as I expect them to treat me. Not 'well the nurse before you didn't do it that way'. Well, there's more than one way to skin a cat...I want them to value the answer I give them, and not just look at it like, well you're a black young female, so maybe its not as important as if it were a 50 year old white male.
>
> (Interview 29)

Examples of respect reflect nurses' attunement to the nonverbal dimensions of behaviour. Reflecting the sentiments of many, an Indo-Canadian nurse says that "in terms of kindness, compassion and empathy...culture needs no language" (Interview 16). Central to this is one's ability to observe and listen. Observation provides insight about the experiential realities that lie hidden beneath limitations of language. A nurse who works with refugees, gains insight on the psychological trauma of torture when observing one women's behaviour:

> I was...in one of the classes [with] a woman...and we were talking...and (an) announcement came across the intercom and the look of sheer terror of the woman who had a machine talking to her in a small enclosed room and the sense of absolute sheer terror in that sort of technology.
>
> (Interview 2)

An everyday event for this nurse has dramatically different meanings for a cultural stranger. Several nurses describe situations where observing client responses enables them to modify approaches and offer better support. In the next example the nurse describes a situation where a family is grieving the

sudden, unexpected loss of a son. The nurse's ability to provide support derives from observing their response to a spontaneous and simple gesture:

> I just went around to people and passed out wet wash cloths...it seemed to be well received, so I just went and got one [after another]. People were emotionally distraught, they were vomiting, they were in tears, it was really very sad...On their way out though, I received so many positive comments about how helpful I had been. Even though I just felt that I had been there and hadn't done anything but permitted this to happen.
>
> (Interview 7)

Several respondents provide examples where communication transcends limitations of spoken language. Taking client's concerns seriously and committing one's professional resources to address these are common to all examples. When language is limited, communicating concern for the client is deemed vital to providing care. A nurse demonstrates how this is applied in practise. She recalls a situation when a Dene parent brought an infant into the nursing station with an extremely high temperature:

> [I said we] have to get the water on the baby's head because the head cools [fevers] down quickly...She's on her knees and I'm on my knees and we're both hanging over in the bathtub giving the baby a tepid sponge bath...So we were doing something together physically. We had a relationship [because] this child was hot. He has a suppository to help and a shot of antibiotic, but that was a trust thing. Because she wasn't going to let me put a needle in this child's thigh. She didn't know what was in the needle [but] I knew...so she had to trust me...I wasn't fluent in Dene and she wasn't fluent in English, but we communicated pretty well I'd say.
>
> (Interview 17)

Another communication skill integral to cultural sensitivity, is the willingness to hear what clients are trying to say. A community nurse describes her approach to this in practise:

> When I have a referral or some type of problem to deal with, before I go in [I ask myself] how do they think? How do you define the problem? Then

> I go in without saying any words. What does this mean? And they will explain to me. And then without saying anything, I will come back and research it. So with some type of common understanding...the next visit yes, at that time we interact...I am feeling them in terms of the way they think.
>
> (Interview 20)

However, nurses do not work in the best of all possible worlds. Listening requires the nurse to suspend agendas long enough for patients to express themselves. The demands of some settings clearly impinge on nurses ability to accomplish this. When it is possible to communicate verbally, several nurses say it is important to begin interaction by asking questions which elicit client's perceptions about the meaning of their illness. As the following nurse explains:

> I have some sort of stock questions...'What do you think caused your illness?', 'what do you think needs to be done for you to get better?' and 'who else should be involved in decision making?'...just a few things that help me to get a sense of this person...of how they are oriented toward time, activity, and what needs to be done.
>
> (Interview 7)

The way questions are asked is viewed as important as the questions themselves. It is not just the acquisition of information about client's meanings, but one's ability to communicate sincerity and interest in the process.

Initially, interest in cultural sensitivity may be motivated by pragmatic concerns, such as the realization that standard approaches are ineffective with cultural strangers. Although the original impetus may derive from a desire to maintain efficiency, the process of interaction causes them to see their professional roles, and relations to clients in new ways. This reflective-thinking and reorientation of self in relation to others is characteristic of a humanist approach to cultural sensitivity. The following example demonstrates how

interaction inspired by pragmatic concerns over a "difficult patient" led to a different understanding of the nurse's role:

> I remember this particular East Indian woman...who we had for a long long time...it was a constant battle on the ward...it was very much an us and them; the family and her [against] the staff...a constant battle of the wills and it was horrible for everybody...I thought I can't do this. I've got to do something else because this isn't working...I can't work like this every shift...So I said [to her], 'This isn't working, you're not happy with us, let's be honest, and that certainly goes the other way too, so let's try and do this differently'...We worked it out quite nicely. I don't think she was ever anyone's favourite, but we actually said there's a problem and let's figure out what the problem is and what you can live with and what we can live with...you just can't shove a square peg into a round whole...[we knew] we weren't going to institutionalize this one woman...It was part of her personality, part of her culture, and the whole thing...[And when] we bent and gave, then she relaxed too. It was a much smoother road for everybody...If bending a little bit to what she wanted made her so much easier to deal with, maybe if you sort of asked everybody that it would be alot smoother..if you started going that up front instead of waiting until it was so horrendous...[then maybe] people wouldn't be ringing their lights and nobody would be answering..that's no way to go through life...especially when you've got cancer and you're sick and scared.
>
> (Interview 28)

Interaction clearly involves a process of trial and error. Most comment that they have learned most through "mistakes". These could as easily derive from ignorance, as they could from a deliberate effort to be culturally sensitive:

> You can't know everything about everybody. But you can know that there are differences...[and] you can also go overboard by trying to show that you know.
>
> (Interview 26)

Starting with cultural sensitivity as a personal goal may undermine communication by invoking a set of expectations about how interaction ought to proceed. This is demonstrated by the following nurse as she recalls working with a midwife in Central Africa:

> I decided when I worked with her that I would just let her lead and invite me to participate. I would just give her complete liberty to invite me to participate...I thought I'm just being culturally sensitive, waiting for her to invite me. One of the [local] health promoters said, 'What are you going to do next week?' I said 'What do you mean?' And he said, 'Well you have to make a work plan'. He said, 'You have to work with these midwives you have to have a workplan'. And I thought, 'Doesn't he realize I'm being culturally sensitive in letting them invite me along in their own pace?'. I thought 'No'...He was sort of saying 'Look, you have some knowledge these women need. You're here to improve their work and you have something to offer, so put out!'...I was kind of disappointed in a sense that he hadn't kind of realized that here I was being so culturally sensitive that I was just letting them invite me into what they were doing.
>
> (Interview 1)

Each nurse's understanding of cultural sensitivity is a reflection of her cumulative experience with cultural strangers. The experiential core and dynamic flux of this orientation, precludes delineation of generic, culturally sensitive approaches. Success with one cultural group may boost nurses confidence, but several nurses emphasized that each new setting demands a critical, reflective approach to interaction. One nurse explained:

> The process of having experienced a cross cultural learning may make me more open and sensitive, but I don't see it as sort of this generic expertise...the very skills we're appropriating in one setting may not be the best skills in another.
>
> (Interview 3)

Cultural sensitivity is a process. As another respondent explains, "it's not something that you attain, it's something that you are always developing" (Interview 18). For many, like the following nurse, cultural sensitivity represents a relentless commitment to deeper understanding of one's relationships with others:

> There's always something, like its one more layer that [I] try and think, Oh, I thought I knew that' [and] I may have known that intellectually, but I really

> haven't incorporated that into my heart, or into my actions, or kind of my subconscious.
>
> (Interview 1)

The dynamic nature of cultural sensitivity is reflected in the self-questioning responses of several nurses. Questions reflect the complexity of trying to make sense of others behaviours. For example, the confusion in discerning between culture and other explanations for behaviour. As one nurse asked, "Is it the culture thing that I'm hearing? Is it a nursing belief? Is it an individual belief?" (Interview 21).

Movement forward in a relationship seems to coexist with the need for a reflective distancing of self. The tension between engagement and disengagement exposes several considerations which nurses address as they formulate meaning of cultural sensitivity. When interaction is mutually satisfying, the client may want to continue the relationship on personal terms. This leads to reconsideration of the following nurse's professional and personal boundaries:

> I like this woman, but that doesn't mean that I want to have a friendship with her. Do I want to put the time into creating a friendship with her [when] she says to me what she needed is a friend. And I believe that, but am I that friend? I don't know.
>
> (Interview 1)

For others, interaction causes them to critically reflect on the meaning of health services. What, as the next nurse speculates, do concepts like equality really mean when talking about cultural sensitivity?

> We want people to have equal access to health care services...What does that mean? Do we provide the same thing to everyone. Or do we do things differently for different cultures?
>
> (Interview 23)

Questioning concepts of health service reflects broader and more pervasive reevaluation of nurses professional belief system. The values of dominant paradigms for health become highly problematic for many nurses. This leads some, like the following nurse, to redefine roles in a way that fit the realities of working among cultural strangers:

> If you set out that your goal is to change behaviour, then you're going to be running up against a brick wall every time...I have seen alot of nurses...burn themselves out because they can't accept that...they go out [to aboriginal communities thinking] I want to make a difference, I want to make a difference...who are we in the first place to say how or not that behaviour should be changed?
>
> (Interview 30)

Questioning the professional mandate to impose change reflects a fundamental shift in paradigm. This is well summarized by another nurse; "I guess my philosophy changed from people have to fit the system, to the system should fit people" (Interview 7). A parallel distinction was made regarding the connection between health and culture:

> ...health fits into the framework of culture and not the other way around. And that's how nursing models are generally defined. That [there's] all these little pieces that's a part of health. But I think health should be [defined] the other way around. That your culture is who you are and health is a part of that.
>
> (Interview 5)

This broader shift in paradigm impacts the meaning cultural sensitivity as one nurse explains:

> [most orientations to cultural sensitivity]...deny the nurse-patient engagement...the [predominant] intent is compliance...to get to know you so we can put it into the nursing care plan so I can get you to do what I want you to do - [but] that isn't my interpretation of it. Mine is getting to that nurse-patient relationship where you make this connection, where the two of us are in agreement about how we want to proceed.
>
> (Interview 7)

Meanings of health derive from culture. Working with cultural strangers, as this comment suggests, requires nurses to expand frameworks of health that can accommodate numerous perspectives. A nurse who finds biomedical approaches inadequate for addressing problems among indigenous people comments:

> From a narrow medical definition, which I think I believed whole heartedly when I graduated from nursing school; that illness was caused by germs, the germ theory.. [I came to an idea of] social pathology...if people are operating on a different definition of health, it requires a different set of questions and those questions require insight. And I think that insight and experience comes from experience and changing one's model and definition of health.
>
> (Interview 17)

Dominant paradigms of medicine and nursing clearly present obstacles to a humanist-orientation of cultural sensitivity. Although all nurses convey some acceptance of biomedicine's truth value, they do so selectively and within a broader understanding of its limitations. One respondent shares her assessment:

> There's nothing about western medicine that makes it superior to any other type of medicine in terms of people. Most of what it does is superior in treating trauma. It's superior in terms of treating children's behaviours like dehydration and some infectious diseases...but there are an awful lot of things that we're not very good at.
>
> (Interview 7)

The limitations identified with biomedicine parallel those subsequently associated with nursing. Biomedicine is unacceptable to many nurses because it reduces health problems to biophysical processes, and therefore ignores the broader social context of illness and disease. Many, like the following nurse, criticize formal nursing discourse for being similarly reductionistic in approaches to culture:

> I've read Leininger and all her Sunset Model and all of that...and [a] nursing care plan and assessment plan in the Canadian nurse a few years ago. And I was thinking, [that] these are the things you could ask of anybody. It doesn't matter what their culture...stop separating culture and stop identifying culture as something that makes the person...so many things make the person.
>
> (Interview 26)

Several respondents support the view that the principles of cultural sensitivity are simply good nursing care. Many, like the next nurse, also thinks that atomizing human experience actually increases ethnocentric approaches to care:

> We wouldn't teach a course separately on any other aspect of being human. So by virtue of setting it apart we're saying that this is something weird [or] exotic...those same principles apply to nursing the poor [or] nursing any marginalized group.
>
> (Interview 7)

The realities of intercultural communication demonstrate the need for flexibility in thought and practise. Efforts to remove 'cultural knowledge' from the context of relationship undermine this by promoting rigid, formulaic approaches to cultural strangers. The following respondent provides her critique of formal discourse:

> There's none of this reflective thinking. [Nurses are] like amateur anthropologists reading ethnographies [thinking] 'Isn't' this interesting?'... If you're coming to your practise with this whole set of ideological thinking about western kind of medicine as the absolute best...then you get into this whole issue of compliance; how to make people compliant.
>
> (Interview 7)

Ideological thinking, as this nurse explains, conceals a covert agenda of promoting conformity among cultural strangers. Focusing on culture as otherness removes discussion of cultural sensitivity from personal and social contexts. The following nurse, who has worked extensively in aboriginal

communities, suggests that the ahistoric focus on otherness must by replaced by locating relationship within socio-historic antecedents:

> What upsets me [is] the insensitivity and total ignorance of the history of aboriginal people - that to me speaks volumes about cultural sensitivity. And I don't know so much about 'sensitivity' to native culture...Its the ignorance of the history of 500 years of colonialism. Why are the Indian people experiencing difficulty? It's almost the development of 'sensitivity' rather than 'cultural'.
>
> (Interview 17)

Emphasizing the development of sensitivity centres discussion on nurse's self awareness and agency, both of which are fundaments of the humanist view. However, this reflectiveness is seen as missing from efforts to formally promulgate cultural sensitivity. A nurse who attended a two-day workshop on cultural sensitivity, explains how discussion of the topic keeps social bases concealed:

> Its not what gets discussed, its in what doesn't get discussed. So you know, we don't talk about being racist, we don't talk about the power that we have, we don't talk about what we represent to people who walk through the door. It's those things that we need to look at but we don't.
>
> (Interview 1)

Several nurses are severely critical of the denial of class and power in formal discourse. Referring to the nursing literature, a respondent exclaims, "they're saying they are culturally sensitive and in the next paragraph there is a mainstream intervention!" (Interview 16). Failing to acknowledge the class bias in health literature maintains the status quo:

> You look around at the addictions literature and [its written by] middle class people trying to tell others how to live their lives because its convenient for them. They want [an] aesthetically nice city, they want nice parks, they don't want any bad men or bad ladies standing around, [no] beggars [or] poor. They don't want smoking but they want to protect themselves. It is all self-centred, convenient lifestyles of the middle class.

> The nurses are mainly from the middle class so they impose their values, 'we have a right to...'
>
> (Interview 16)

Inability to address the class-bias in health services is identified by many as a significant barrier to intercultural communication. Focusing on individuals ignores the impact of social structures on clients lives. However, respondents who talk about socio-structural factors differ considerably in how they understand it in practise. Several who work in community settings claim they are beginning to address these issues through increasing collaboration with agencies and interest groups. They describe these efforts as "community development". While they speak readily of class they seldom contextualize it in the substantive basis of practise. For example, client participation in health education is identified as a way of equalizing opportunities for involvement, but the influence of class in the topic and content of instruction is rarely considered. Others, like the following nurse, are more cynical of class awareness in nursing:[8]

> One of the things that I think is a real problem about the way that we think about public health, is that we have very much a blame the victim approach to it. And we're off loading all the responsibility to individuals...[with] a feeling that everybody has the same choices. Well, in reality, if you're an immigrant, or you're poor, or whatever, your choices [are limited]. We're all brought up with the history that cleanliness is next to godliness, almost a religious zeal. You know, what we are going to do with these people is to clean them up and fix them up.
>
> (Interview 8)

Understanding the limitations of formal discourse in the context of intercultural interaction clearly involves more than identifying latent biases and

[8] Reference to class is included with themes of humanism because of its influence on the symbolic resources that one brings to relationship. Also, most nurses are from a middle-class background. Awareness of how class shapes their behaviour individually and professionally will influence the way that they interact with socially marginalized clients.

socio-historic antecedents. The humanist orientation centres on a capacity for self-reflection and openness to seeing familiar things in new ways. One respondent explains:

> [Its an] individual journey...one that must challenge your own thinking and your beliefs. Because until you've done that, there's no way you'll ever become culturally sensitive.
>
> (Interview 7)

Although nurses recognize the necessity of challenging oneself, many also acknowledge that individual capacities for this vary. Cultural sensitivity, to many nurses, is an expression of something innate. "If you're culturally sensitive, you're culturally sensitive. Some people just have that" (Interview 30). These nurses reject the idea that cultural sensitivity can be taught. The following nurse explains:

> Some people make good nurses and some people don't....years ago we used to recognize that people brought certain things to their nursing school and in the old nursing schools the Director would say 'Honey, you don't have what it takes' and you'd be gone. And now we seem to have a feeling that we can teach everybody everything, including in the affective domain. And I don't think that's possible. I think that some people come with very rigid world views because they need them as a structure to be able to function... and to me, those people who are rigid about cultural
>
> issues are rigid about a whole bunch of other things and consequently, they don't belong in the profession.
>
> (Interview 7)

Cultural sensitivity is an expression of one's personality; something that emerges from within towards the other. Most nurses describe it occurring spontaneously without conscious consideration. This provides another basis for resistance to deliberate approaches. This is reflected in the comments provided by one nurse:

> When someone says, 'do you practise it?', I don't think its something that you practise as such. I mean, I don't think it can be trained into you...I hope its just something that's a natural thing...(consciously thinking about it) would make me very uncomfortable; very strained. [Like] I'd have to put this mode up in my brain, like I'm flipping pages looking for my Indian page. 'How do I behave with an Indian person?'. It wouldn't be comfortable at all...I think they'd feel I was a phoney.
>
> (Interview 10)

While several nurses think cultural sensitivity training may not do any harm, only one respondent believes it could soften individual attitudes. This respondent has observed a gradual transformation in a colleague over several years. A concerted approach to cultural sensitivity has been undertaken in their workplace. While it is not possible to demonstrate a causal relationship, she believes the workplace approach has been beneficial.

All nurses convey some recognition that interaction occurs in a socio-structural context. Organizational considerations, such as policies and procedures, are thus the other significant barrier to interaction. While these are recognized as having a western bias, nurses realize that openly challenging them could provoke sanctions from superiors. A nurse working in a hospital describes one example of a culturally insensitive policy:

> It's OK to have a Chaplain and have a little prayer ceremony around the bed, but it's not OK to burn sweetgrass, or its not OK to burn incense, or its not OK to have something else. But our policies don't cover that...we've got a list of excuses why we can't do that. Because it means doing something different, and [reflects] our ability as professionals to take a risk.
>
> (Interview 8)

For nurses in community settings, cultural sensitivity is often constrained by the dictates of several organizations. A nurse working among new immigrants has extensive involvement with governmental and community

agencies. Bureaucratic delays in processing requests for assistance often place families in precarious situations. The significance of structural constraints to culturally sensitive care is demonstrated with respect to one family's circumstances:

> A week after they came (to Canada), their middle child was hospitalized with severe respiratory problems, [and] no hospitalization [coverage]...so a week later [they] had this massive bill. So the husband had taken off to live with somebody else in another country...this woman now, has twenty dollars to her name and 5 children plus a large hospital bill. When I tried to work it through with the family and with the agencies involved, the attitude was, 'her husband came in and he had lots of money, let him take care of her'. Meanwhile, we've still got 5 children and they're living alone on 20 dollars. So we referred them to Welfare and Welfare said they'd be out in 4 days. Welfare came and rang the buzzer and nobody answered; they had the wrong number and nobody answered - nobody's home. Meanwhile these people, the mother and 5 children were home all along. So when we worked through it again. The attitude when we called again on Monday and said, 'Look, nobody's come to see this family - they now have 3 dollars and still [have] 5 children' [Welfare responded] 'Well you know, this report has gone in today. We'll have to respond to it in 4 days'...regardless of how the family came in, the circumstances changed. Maybe there is some fooling around going on, and maybe the husband is just hiding. But what if he isn't? We've still got 5 children and the mother with 3 dollars and no food?
>
> (Interview 21)

For this nurse, resolution is ultimately sought by breaking established policies. This is assumes that if rules or structures present a barrier to clients, then strategies for change are justified.

A humanist orientation to cultural sensitivity is predicated upon relational experience. While individual meanings vary, all nurses share a view that there is inherent value to intercultural interaction. For many, cultural sensitivity represents a more personal process of self knowledge and growth. Professionally, the object of cultural sensitivity is to perceive something of the

logic of others. This accepts and gives legitimacy to multiple perspective. Being able to see the world through the "eyes of the other" provides the base for developing a mutually agreeable plan of care.

A central theme of the humanist view is that "people are people". This recognizes that both nurse and client bring personal resources and limitations to their relationship. Implicit in this, is a belief in the intelligence of cultural strangers and the underlying inchoate logic of human behaviour. As individuals, both nurse and client share responsibility for relationship and the need to communicate respect. In addition, nurses describe various communication skills that enhance their ability to interact across cultural divides. These generally recognize the importance of both spoken and silent language.

Meanings of cultural sensitivity are constantly evolving in response to ongoing experience. Learning occurs through a process of trial and error. In spite of the personal aspects of this, there are three commonly identified barriers to intercultural interaction. The first concerns the biases and assumptions embedded in formal discourse of biomedicine and nursing. The second, concerns the personal characteristics and behaviour of nurse and client. It is generally agreed that the attributes of cultural sensitivity are innate. The third barrier, recognizes the structural constraints on relationship.

Summary

This chapter has discussed humanist-oriented meanings associated with cultural sensitivity. There are numerous subtle distinctions between orientations, and for the purpose of clarifying where they fit in the 'big picture', I

will briefly explain how the humanist view is distinguished from those previously discussed.

Each orientation addresses the specific meanings associated with the term cultural sensitivity, the role of language, and nursing values. There are also similarities in focus between individual orientations. The control, nurse:client (N:C) standpoint and the humanist orientation, both understand cultural sensitivity as something which defines the nature of nurses' relationships with cultural strangers. And the organization:nurse (O:N) standpoint and humanist approach both address how social structure intersects relationship.

Like the organization:nurse (O:N) standpoint, the humanist orientation rejects the formal construction of cultural sensitivity. Where the O:N standpoint rejects cultural sensitivity because of its association with racism and danger, the humanist orientation rejects it due to an implicit inequality and lack of relevance to how nurses experience intercultural interaction. Nurses with the O:N standpoint submit and internalize formal meanings, but with the humanist view, they actively recreate meanings in ways that reflect their experience.

Where other orientations view culture as otherness and pejorative difference, the humanist approach understands culture as "us"; it does encompass difference, but within a framework of human similarity. Consequently, it conveys nurses' acceptance of difference and desire to work with resources that each person brings to culture.

Where other approaches view language as a barrier to be overcome, a humanist view acknowledges limitations of spoken language and seeks to work with these. This is done by recognizing the importance of non-verbal language,

trying to suspend extraneous agendas, and centering one's full attention on the relationship.

Another important difference concerns the nurses' agenda. With the control orientation, nurses give primary value to efficient execution of tasks and behavioural change. Toward these ends, cultural sensitivity is seen to enhance the goals of a N:C standpoint and to present an obstacle to the O:N standpoint. However in both control standpoints, relationship with cultural strangers is a means to an end. With the humanist view, relationship is a means and an end in itself. The primary object is understanding; to perceive the world through the eyes of the other. Cultural sensitivity is used to define nurses' relationship to others. As a process of understanding, it stresses mutuality and the generative capacities of individuals. Although responsibility for interaction is shared, nurses' ability to be culturally sensitive is contingent upon personal characteristics and communication skills. Unlike the N:C standpoint, which promotes decontextualized knowledge of culture, humanist meanings are grounded in ongoing relational experience.

In the control orientation, nurses' behaviour derives from tacit acceptance of dominant values in health services. The importance of perceiving realities of others in the humanist orientation, is predicated upon a critical understanding of biomedicine and nursing science. Similar to the O:N approach, in humanist meanings the nurse understands how structures impact on relationship, however with it, she sees herself as creatively interacting with structures. Also, with the O:N view, structures promote rigidity. In the humanist orientation, critically acknowledging the influence of structure becomes a catalyst for action.

So the meaning of cultural sensitivity is relationally-centered but it is located within an overarching understanding of socio-historic forces.

CHAPTER 6: Conclusion

This thesis has discussed the emergence and meanings of cultural sensitivity in both formal and informal nursing discourse. I have addressed four main questions: What are the meanings imputed to cultural sensitivity in these discourses? What are the similarities and differences in meanings between these discourses? What factors may be suggested to account for these similarities and differences? And how are various constructions experienced by nurses?

In this chapter I will briefly summarize the tensions that emerge in discourses on cultural sensitivity. I highlight themes which reflect patterns of control and humanism. Next I discuss the implications of this research. I begin by briefly stating how the data reorients my own assumptions of cultural sensitivity. I address the substantive contributions and use these as a basis to consider the implications of this study for social constructionism. Finally I discuss the social policy implications of my research.

Tensions

Analysis of the meanings of cultural sensitivity in nursing discourse exposes several divergent tensions. The first concerns tendencies of control and humanism revealed in both discourses. The control orientation encompasses themes which reflect how cultural sensitivity is used to promote behavioural change. It reinforces differences in status between participants by presuming an active provider and passive recipient of culturally sensitive care. The humanist orientation encompasses themes which place primary emphasis

on the quality of the nurse:client relationship. The goal of this orientation is mutuality in understanding and personal growth. It supports equality between nurse and client. Meanings are highly experiential and dynamic, and are derived from the ongoing flux of active engagement between participants

The second tension concerns divergent meanings associated with the two standpoints of the control orientation. When cultural sensitivity is framed in the context of nurse:patient relationships, control is expressed in efforts to optimize efficiency in nursing care. From this standpoint, the nurse is an active arbiter of meaning. However, when cultural sensitivity is framed in the context of organization:nurse relationships, cultural sensitivity is viewed as a tool the organization uses to control the practise of nurses. From this standpoint, nurses feel they have little ability to shape meanings.

The third tension concerns the differential emphasis on patterns in formal and informal discourse. A control orientation predominated the formal discourse and a humanist orientation predominated the informal discourse. There is also considerable variation in patterns between nurses and within each interview.

Themes

a) Control

Themes associated with the nurse:patient standpoint of the control orientation, reflect an uncritical acceptance of the professionalized discourse of nursing and the truth value of biomedicine. It assumes that culture presents a potential problem to the delivery of nursing care. Various rhetorical devices are used to assert professional authority over cultural strangers. Examples include

references to need (and cultural needs specifically), compliance, and harm. Rationalizing cultural sensitivity with references to these terms, provides pseudo-scientific legitimation for promulgating Euro-centric norms among cultural strangers.

The most prevalent device used to support a control orientation was the rhetoric of harm. All respondents describe examples where culturally sensitive care would involve actively discouraging the client's behaviours. Moral-ethical appeals are often encompassed in emotive terminology used to support claims of harm. For example, female circumcision is consistently referred to as female genital *mutilation*. Determinations of harm vary considerably among nurses. Behaviour deemed harmful by one nurse, could be seen as idiosyncratic by another. This reveals how the objectivity of nursing practise is, in fact, informed by subjective considerations. It also indicates ways that approaches to cultural strangers may reproduce nurse's personal and socio-cultural biases.

This standpoint emphasizes differences between nurses and others. Difference is controlled through the acquisition of cultural knowledge. The function of this knowledge is to increase the nurses' ability to influence client behaviours, and to ultimately achieve the ends of care. Claims regarding the importance of cultural knowledge support the expansion of cultural sensitivity as a distinct speciality within nursing. It promotes a view of cultural sensitivity as a skill which, like others in nursing, can be mastered with sufficient knowledge and training.

Cultural knowledge provides a way of measuring and functionally increasing perceptions of difference. More knowledge provides more effective ways of defining difference. This standpoint, by accentuating the strangeness of

cultural strangers, ensures that social distance between nurse and client are maintained.

Negative meanings which characterize the organization:nurse standpoint only emerge in informal discourse. Constituent terms of culture and sensitivity are associated with racism, prejudice and latent danger. Organizational promotion of the term is perceived as a prejudgment of nurses' care. That employers would judge nurses while simultaneously reducing resources needed to deliver basic nursing care, is offensive and has the effect of increasing resistance to the term. Pressuring nurses to be culturally sensitive reinforces a fractious work environment where employers are perceived as indifferent to nurses' needs.

There is considerable cynicism regarding the organization's interest in cultural sensitivity. A disjuncture between rhetoric and reality is frequently observed. Organizational endorsement of cultural sensitivity is perceived by several nurses to be a political expedient for soliciting funds from affluent minority groups. Support for this is derived from observations that the commitment of administrators to cultural sensitivity is often weak or lacking. Consequently, nurses feel doubly exploited: undervalued as labour, and used as a ploy to support marketing campaigns.

A disjuncture between rhetoric and reality is also reflected in the fact that one of the most frequently cited barriers to cultural sensitivity is the organization's inflexible policies and procedures. Nurses are being given contradictory messages: on the one hand they are told to be more culturally sensitive, and on the other hand, they are prevented from being culturally sensitive by structures governing their work.

Nurses openly resist challenging this discrepancy because it makes them vulnerable to sanctions by employers. Indeed, nurses ability to perceive latent and manifest meanings is often described in the context of their professional socialization.

For nurses from minority groups, the control orientation of cultural sensitivity often results in ghettoizing their practise among cultural strangers. Interestingly, this discourse which promotes ethnocultural invisibility among professionals by associating cultural difference with otherness, also provides the mechanism for redressing professional invisibility to a limited degree. Several minority nurses use cultural sensitivity as a conduit for gaining professional recognition otherwise denied.

b) Humanism

The other predominant tendency in both formal and informal discourse reflects patterns of humanism. Humanism, conveyed in the moral, relational dimensions of 'care', occupies a marginal role in the formal discourse. This may be partly explained by the critical stance humanism takes of the professionalized approach to cultural sensitivity. It explicitly challenges the assumptions that gird professional authority by acknowledging that nurse and client bring equally important resources to interaction. A humanist view also critically appraises the truth value of western paradigms for health, and it acknowledges other ways of seeing the world as valid. This enables nurses to situate themselves socially and historically in relationships with cultural strangers. Thus, a white nurse interacting with a visible minority client, will have some awareness of the ways that historically patterned inequities and biomedical hegemony impinge on interaction.

The primary emphasis of this orientation is not to change, but to perceive the inchoate logic that underlies individual behaviour. Interaction is seen as inherently valuable, and as an end in itself. An important theme of this orientation is knowledge of oneself. Many nurses emphasize that mutuality in interaction proceeds from knowledge and acceptance of one's particular strengths and limitations. This is deemed a co-requisite for understanding and accepting others. The prevailing sentiment of this orientation, is that "people are people". This finds the essence of human similarity in the inevitability of human difference, or simply, that everyone brings culture, in addition to other resources and personal traits, to relationships.

Cultural sensitivity with this orientation is experientially derived and its particular contents dynamic. Implicit in the orientation is the recognition that ideals of relationship are fleeting and at times elusive. Given the primacy of relationship, it is not surprising that many themes reflect facets of communication. For example, the importance of listening and attending the non-verbal language of interaction. Nurses also stress the need to openly question their assumptions of others. This requires nurses to take risks; to risk asking the obvious, and most importantly, to risk making mistakes.

A humanist orientation supports development of a critical rationality: a constant reflecting and challenging of assumptive truths of one's self and others. The ongoing generative nature of a humanist-oriented meanings indicates that cultural sensitivity is a process of becoming, rather than a static state or skill to be achieved.

Cultural sensitivity within a humanist framework is generally believed to function at an unconscious level. In fact, several nurses felt that consciously

striving to be culturally sensitive is the hallmark of insensitive behaviour.

Implications

a) Substantive

The formal discourse on cultural sensitivity in nursing presumes a high degree of consensus on the meaning of cultural sensitivity. This research contributes to the substantive literature by showing that meanings of cultural sensitivity are variable and highly contested. Data also show the multifaceted nature of meaning construction. Although the study's focus is on describing, rather than explaining the meanings nurses attach to the concept, the results raise questions on several levels about the process of meaning construction. These warrant further investigation and are summarized as follows:

First, there is the associative meaning of culture. Most respondents are extremely comfortable with the concept of culture. For these individuals, culture is informed by their experiences as immigrants, as members of visible minorities, or by their family background. For example, several nurses have grown up with parents who are immigrants or have experience living among minority groups in Canada or overseas. One nurse, who could trace no particular antecedents, claims she has always been interested in how other people lived. Apart from differences in how they trace interest in cultural sensitivity, all these nurses indicate that an interest in culture preceded their career in nursing.

In contrast, nurses who ardently reject the construct of cultural sensitivity identify no positive or familiar referents of interest. Associations for meaning are drawn from sensationalized portrayals of difference in popular culture and from

impersonal encounters with cultural strangers. Cultural sensitivity is associated with racism and fear. Efforts to discuss cultural sensitivity are thus perceived as asking nurses to specify the parameters of their prejudice in practise.

Regardless of nurses' familiarity with the concept of culture, many respondents think that the term cultural sensitivity does not accurately capture the experience of intercultural communication. A variety of terms are suggested as alternatives. These include: cultural story-telling, culturally fair care, cultural competence, racially and culturally sensitive care, and human or people sensitivity.

A second factor that seems to influence meaning concerns the referents used when discussing cultural sensitivity. When cultural sensitivity is presented in the context of organizational:nursing relationships, meanings imputed to the term reflect how nurses experience their occupational environment. Where these relations are generally felt to support nurses in their work, meanings of cultural sensitivity remain fairly positive. When employers are not viewed as supportive of nurses, the meaning of cultural sensitivity is imbued with considerable negativity and cynicism.

Shifting the referent to nurse:client relationships, variations in meaning reflect the extent to which nurses accept professionalized constructions of cultural sensitivity. Nurses who generally accept meanings of formal discourse, speak about cultural sensitivity in ways that emphasize patterns of control. That is, they talk about cultural sensitivity as a vehicle for enhancing the efficiency of care, and frequently refer to limits in their ability to accommodate cultural strangers. They are also more likely to advocate the expansion and development of cultural sensitivity in nursing.

Conversely, nurses who reject professionalized constructions, place emphasis on the relational dimensions of care and talk about the value of intercultural communication and understanding as an end in itself. Even nurses who unequivocally reject the construct of cultural sensitivity, freely describe meaningful interactions with cultural strangers. Examples show how intercultural communication leads the nurse to a deeper, critical understanding of herself, and her professional role. It is important to note that the referents for meaning are not static, but change during interviews depending on the particular aspects of cultural sensitivity discussed.

A third factor reflects the emphasis on relational aspects of care in nurses' particular practise setting. For those who work in intensive care and emergency settings, relational considerations are often subordinated to technical dimensions of care. While these nurses do not dispute the importance of intercultural communication, they complain that there is often insufficient staffing, time or resources to support it. For a few of these nurses, cultural sensitivity presents a barrier to completing care because it adds one more consideration to an already overburdened workload. Conversely, all nurses who work in community settings, view relationships as an integral component of practise.

It is worth noting that 8 of 11 nurses who work in clinical settings (hospitals and clinics) were interviewed on their personal time. In contrast, 16 of 19 nurses who work in community, teaching or other non-traditional settings, were interviewed during hours of employment. I believe this reflects differences in organizational support for cultural sensitivity in these settings, and the degree of autonomy nurses experience in their work. Work in clinical settings is

routinized and demands performance of the technical dimensions of care to maintain organizational operation. Further, in these settings, work tends to be closely scrutinized by supervisors and peers who may challenge time spent "just talking". Nurses who define cultural sensitivity in negative terms, describe feelings of powerlessness in their occupational settings and a guarded trust of employers. Community and other non-clinical settings provide greater professional autonomy and freedom from scrutiny by employers. There is an implicit sense in these settings that employers will understand the importance of research and support nurses ability to contribute.

A fourth factor concerns nurses professional resources. The educational preparation of nurses in this study ranges from diploma to doctoral level. Although there are nurses in each educational strata whose responses strongly accord with themes of humanism, an interesting difference occurs with how patterns of control are expressed. Respondents who most forcefully endorse professionalized meanings of cultural sensitivity have baccalaureate or master's degrees. Nurses who most ardently reject cultural sensitivity, are diploma prepared. This suggests that nurses who are diploma prepared are less likely to see themselves as active creators of meaning and are more likely to feel victimized by professionalized constructions. Degree prepared nurses, in contrast, are more likely see themselves as active creators of meaning whether this is based on an acceptance or rejection of professionalized constructions. This highlights differences in the cultural resources necessary for entering the arena of formal claimsmakers. It also provides insight regarding the barriers that may prevent nurses from launching claims about the negative meanings associated with cultural sensitivity.

b) Theoretical

Data from this study contribute to constructionist theory both by affirming particular contingent truths of this approach to social problems, and by raising areas for further consideration. Most significantly, tensions in meanings of cultural sensitivity affirm constructionism's premise of "multiple realities". Informal discourse raises provocative questions about hegemonic assumptions of formal discourse, specifically, which nurses define cultural sensitivity, and generally, what is it that enables these nurses to enter the arena of claimsmakers and not others? There is not a high degree of consensus about the meanings of cultural sensitivity.

These data also demonstrate the problems that arise when one party assumes the 'truth value' of particular claims, and endeavours to impose these on others. Negative meanings of cultural sensitivity are, in part, a reaction to employers who fail to question their assumptions and seek to impose their views on others. Constructionism's refusal to judge the worth of claims allows previously unidentified meanings of cultural sensitivity to gain expression. However, it is also in this area where the data reveal some of the limitations of the social constructionist approach.

Differences in claimsmaking styles in informal discourse are non-competitive. Variations in the professional resources of some respondents, relegate them to the margins of claimsmaking. This study suggests the need to expand constructionism's understanding of claimsmaking behaviours to encompass styles used by groups who are socially or professionally marginalized. The study also raises questions about the strict constructionist's tendency to focus on text alone. In this study, important insights are derived

from non-verbal cues provided by respondents. There must also be ways to account for the intent of people's claims because the meaning of "politically incorrect" terms (as one example) reflect differences in individual's access to symbolic resources of culture.

Admittedly, this introduces additional questions for consideration; what happens when the researcher perceives motives that are at odds with those espoused by social actors? While examination and resolution of these is beyond the scope of this thesis I believe we must think more carefully about the need for a limited relational engagement between analyst and social actors. Throughout this research I have increasingly recognized the importance of detachment as an ideal. In terms of what can be achieved within the limits of human possibilities, I think that a more meaningful goal may be to talk about achieving "authenticity" with research processes and results. Authenticity as it relates to the research process reflects an effort to make assumptions explicit and to recognize where our own meanings may intrude. Authenticity when it comes to results has to do with the extent to which respondents see themselves mirrored in the thesis.

The parallels between constructionism and discourses on cultural sensitivity point to broad cultural forces which pattern efforts to understand our social reality. The tenacity of patterning lends support to alternate explanations of the generative nature of meaning. It also questions whether the parallels in patterning between theory and construct of cultural sensitivity are merely a peculiar artifact of this study, or may be more commonly found.

The final contribution this thesis may make to constructionism is in highlighting the importance of eliciting the experiential dimensions of claims.

Cultural sensitivity is a highly relational term. Thus its meanings are most fully understood with representation from both parties in the relationship. Although this study cannot comment in the way that cultural sensitivity is experienced by cultural strangers, it does provide insight for how it is experienced by nurses. Standpoints of the control orientation situate nurses both as proponents and recipients of culturally sensitive care. Several nurses indicate that the control orientation is experienced as constraining their potential.

There is one related note for constructionism. Factors which appear to influence meanings of cultural sensitivity highlight the ways that claims intersect with broader social forces. Level of education and membership in minority groups *do* seem to influence how nurses construct and promote meanings.

c) Policy

Given the disparate meanings of cultural sensitivity, endorsing cultural sensitivity en masse will likely elicit divergent and unpredictable results. These data suggest that efforts to promote cultural sensitivity are, at best, misguided. The formal discourse on cultural sensitivity understands the barriers to intercultural communication as individual problems. While the importance of micro-level interactions cannot be denied, this study points to the need for policy initiatives which target the structural contexts in which nurse:client interaction occurs.

If the intent of discourse on cultural sensitivity is to promote intercultural communication, then the place to begin is in promoting organizational environments that communicate respect for nurses. The control orientation shows that initiatives which compromise the humanity of cultural strangers by trying to manipulate behaviour, also compromise the humanity of nurses.

Nurses' assertion that people are people, may be understood as a plea to have their own differences and contributions recognized. It is a contradiction to talk about respect for cultural strangers in ways that do not simultaneously communicate respect for nurses. Hearing what nurses have to say about the challenges currently encountered in their workplaces, and developing supports accordingly seems a reasonable and necessary point of departure. Rhetoric that continues to deny the organizations' agency with intercultural care, can hardly be expected to win nurses' trust.

It is instructive that nurses who see cultural sensitivity as "a good thing" developed interest of their own accord, not as a result of exposure to formalized approaches within nursing. Initiatives directed at changing nurses' behaviour, suggest that meanings and interest can be applied from without. Using cultural sensitivity to influence behaviour can, as this study shows, increase resistance. Those who define cultural sensitivity negatively, communicate a desire to be left alone, to fulfil duties as they were trained. In spite of this, all nurses retain the belief that there is value in promoting communication across divisions of difference. Nurses who recall memorable exchanges with cultural strangers, talk about interactions with individuals, not with categories of difference. The construct of cultural sensitivity may provide a useful heuristic device for some nurses to reflect on relationships with cultural strangers. To catalyse nurses' value in promoting intercultural communication, it would appear more viable to suspend reference to the term cultural sensitivity and use rhetorical devices that demonstrate understanding, respect and acceptance for diversity in nurses own personal, social and cultural background. The control orientation shows, that initiatives which compromise the humanity of one, compromise the humanity of

all. Even if there is consensus on the meaning of cultural sensitivity, it is doubtful that nurses can improve care selectively for clients. Although further research involving cultural strangers is needed, one way of interpreting these results, is to recognize that to improve the care for one socially marginalized client (whatever his/her ethno-cultural background), will lead to improvements in care for all.

Appendix A

LETTER OF INTRODUCTION

CULTURAL SENSITIVITY STUDY: BACKGROUND

Dear Nurse:

My name is Lesley Cerny. I am currently conducting a study to learn how nurses understand and use the concept of "cultural sensitivity" in practice. This research will be used for my Master's thesis in Sociology at McMaster University. For this study I will be speaking with nurses who identify a particular personal / professional interest in cultural sensitivity.

The purpose of the research is to develop an understanding of cultural sensitivity that is grounded in the experience of nurses, and contrast this to the construction of cultural sensitivity in health literature. A preliminary review of this literature reveals general support for the concept based on the need to provide health services to culturally diverse populations. While the concept of cultural sensitivity is widely used, it is, however, seldom defined.

Having worked as a nurse in both hospital and community settings, it has been my experience that nurses are often uncertain about what is meant by "culturally sensitive care". This research, by addressing both theoretical and practical dimensions of cultural sensitivity, will provide a better understanding of how the term is currently understood and used by nurses. Findings from this study are expected to provide a definition of cultural sensitivity that is congruent with nurse's experiences, and, to provide insight about how care may be adapted to better "fit" cross-cultural contexts.

I would appreciate your help in finding nurses interested in being interviewed for this study. The attached copy of the interview guide will provide a rough framework for the discussions. Interviews will take approximately one hour, and would be arranged at a time and place of each nurse's convenience. Please note that this research adheres to the guidelines set out by the McMaster University President's Committee on Ethics of Research on Human Subjects. This means that all information will be strictly confidential and used only for the purposes of research. No details which may identify a specific participant or her agency will be used. Also, participants may refrain from answering any question. A summary of the research findings will be available to all participants and supporting organizations upon completion of the study.

If you, or anyone you know, is interested in participating please contact me at; 905-627-4953, or e-mail; g9526230@mcmail.mcmaster.ca. Also, if you have any general questions or comments, please do not hesitate to call me at any time. I look forward to hearing from you.

Sincerely,

Lesley Cerny (RN, BSN)

Appendix B

SAMPLE INTERVIEW GUIDE
(excluding probes and shared with respondents)

1. Can you tell me how you became interested in "cultural sensitivity"?

2. What, to you, are the characteristics of someone who is culturally sensitive?

3. In your view, why is it important to be culturally sensitive?

4. What do you see as the factors, or assets that increase one's ability to be culturally sensitive?

5. Can you provide examples, based on your experiences, that illustrate how your nursing care was made more sensitive?

6. What would "cultural sensitivity" mean in specific nursing contexts; such as rural vs urban, or clinical vs community settings?

7. Are there some situations where nursing care is the same for people of any cultural background?

8. How do you know whether you've been culturally sensitive or not?

9. Do you think the meaning of "cultural sensitivity" would differ according to the ethno-cultural background of a particular nurse?

10. What things have helped you to become more culturally sensitive?

11. How does "cultural sensitivity" - as presented in nursing school or in the literature, get played out in "real life"?

12. How would you go about increasing the cultural sensitivity among nurses or in health care generally?

13. Nursing literature uses a number of terms to address the concept of cultural sensitivity, such as cultural appropriateness, cultural relevance, and cultural competence. In your opinion, are the meanings of these terms the same or different from cultural sensitivity?

14. In general, how do you define your role as a nurse in health education or health promotion? Does this change if talking about education or promotion initiatives among specific cultural groups?

15. When thinking of your work, what cross-cultural experiences stand out the most in your mind?

Appendix C

CONSENT FORM

CULTURAL SENSITIVITY STUDY, 1996
CONSENT STATEMENT

I agree to participate in a study to address the understanding of cultural sensitivity among nurses.

This research is being carried out by, Lesley Cerny, a nurse with experience in rural hospitals and in public health. She will use this information for completion of her Master's thesis in Sociology at McMaster University. She will answer any question I have concerning this study and may be contacted by: telephone at 905-627-4953, by e-mail at: g9526230@mcmail.mcmaster.ca., or by message at the Sociology Department, 525-9140 ext. 244481. Dr. Dorothy Pawluch, the Faculty Supervisor for this study, may be contacted at the Department of Sociology, 525-9140, ext. 23618.

The purpose of this research is to learn more about how nurses understand and apply the concept of "cultural sensitivity" to their practise. The study is designed to evaluate how the construction of cultural sensitivity in health literature influences the thought and practise of nurses.

I agree to take part in one interview with Lesley Cerny as part of the study described above. I agree to provide an additional interview if there is a need for further clarification or information. Each interview will last approximately one hour, and will be arranged at a time and place of my convenience. I also agree to allow this interview to be audiotaped.

I have been assured that all information which I provide will be treated with the utmost confidence. I understand that all identifying criteria will be removed from the interview material and that this information will be used for research purposes only. No individual will be identified in any way in the research report. A summary of research findings will be sent to me when the study is complete.

I understand that I may refrain from answering any questions asked in the interview or on the demographic questionnaire, and, that I may withdraw from the study at anytime. If I decide to withdraw, all notes and tapes concerning my interview will be destroyed.

I give my consent to participate in this study.

_____

Signature Date

Appendix D

EXECUTIVE SUMMARY
CULTURAL SENSITIVITY STUDY, 1996/7.

Background

While "cultural sensitivity" is increasingly used in nursing policy and practise, the term, however, is seldom defined. The purpose of this study is to analyse the meanings of cultural sensitivity in nursing literature and practise. Toward this end, I conduct an extensive review of nursing literature and indepth interviews with 31 nurses[9] .

Findings

Two tendencies[10] characterize the way that cultural sensitivity is presented in nursing literature and practise. The first is a 'control' orientation which understands cultural sensitivity as something to promote the efficiency and efficacy of nursing practise with cultural strangers. The second, is a 'humanist' orientation which understands cultural sensitivity as something which describes the quality of interactions between nurses and cultural strangers.

a) Nursing literature

Although these tendencies are evident in both literature and interviews, their expression varies. Nursing literature tends to emphasize a control orientation. Culture is understood as problem; something which presents a barrier to nurses' ability to provide care. Cultural sensitivity is presented as a solution - something to help nurses alleviate or overcome cultural barriers to care.

A control orientation is expressed in nursing theories, assessment guides, and the language of professionalism. For example, assessment guides presume that nurses have the ability to accurately assess clients' cultural behaviours and to incorporate this information into practise. They offer little recognition of cultural assumptions held by the nurse, or how these more broadly shape nursing theory and practise.

[9] Constructionism provided the guiding framework for this study.

[10] The two orientations noted in this thesis align with Erich Fromm's (1976) 'potentialities' of being discussed in To Have or To Be. Fromm believes that these are found in all cultures, and that their relative emphasis is in constant flux. Normative evaluations are based on the extent to which their expression in culture allows individuals' potential to unfold. In this study, orientations of control and humanism are relevant in terms of how they shape meanings of cultural sensitivity, and to the extent resultant meanings allow nurses' potential to unfold.

Within the literature is an emerging 'humanist' orientation to cultural sensitivity. This is demonstrated by nurses who critically challenge assumptions vested in professional authority and more generally in nursing practise. Humanism is also reflected in articles which stress that the nurse and client bring equally valuable resources to interaction. From a humanist view cultural sensitivity is a process of mutual engagement and personal growth.

b) Nurse's Interviews

In nurses' interviews, patterns of control are expressed in two different meanings of cultural sensitivity. When cultural sensitivity is used in the context of nurse:patient relationships, control is reflected mainly in references to 'harm'. Several nurses use the example of female circumcision to demonstrate this. Assessments of harm legitimize nurses' efforts to change clients' behaviour. This expression of control is a minor emphasis in the interviews. More often, the control orientation is manifest in the context organization:nurse relationships. From this perspective, cultural sensitivity is viewed as something the organization uses to control nurses' interactions with cultural strangers. This meaning of cultural sensitivity tends to be negative. For a few nurses, it means the organization has labelled them as racists. References to cultural sensitivity in the context of employer:nurse relationships negate the fact that organizational policies and procedures, and increasing workload demands present significant barriers to patient care. Organizational promotion of cultural sensitivity often fail to respect the needs of nurses. Cultural sensitivity represents one more thing that nurses are expected to consider, and as such, becomes an additional barrier to care.

A humanist orientation is clearly the greatest emphasis in interviews. Humanist meanings of cultural sensitivity derive from a critical awareness of professional authority and biomedical science. This orientation places emphasis on mutual understanding and personal growth. Humanist meanings recognize there are multiple realities, and that the nurse and client both bring strengths and limitations to relationship. Meanings of cultural sensitivity are highly experiential and dynamic. Nurses emphasize the importance of self-awareness. The need to identify and accept one's own strengths and limitations are deemed a prerequisite to accepting these in others. In addition to the nurse's personal characteristics, the humanist orientation stresses communication skills. Specifically, the ability listen and attend the non-verbal dimensions of interaction. Several nurses explain the importance of taking risks in asking questions, and in accepting mistakes as an inevitable source of learning about intercultural interaction.

Summary

Nursing literature assumes there is a shared understanding of what cultural sensitivity means. Findings from this study show that the meanings of cultural sensitivity are highly varied. Efforts to promote cultural sensitivity by focusing on individual nurses (as with cultural sensitivity training) may thus elicit divergent results. If cultural sensitivity is understood as a means to facilitate communication between nurses and clients, then it may be more effective to consider strategies which concentrate on creating environments that communicate respect for all people.

Appendix E

INTERVIEW GUIDE
(working copy including probes)

1. **When did you first start thinking about, or become interested in "cultural sensitivity"?**
   * basis of interest? why is it important?
   *certain things you personally hope to achieve by it?

2. **What to you, are the characteristics of someone who is culturally sensitive?**
   * what contributes to, or acts as a barrier to this?

3. **Can you provide examples, based on your experiences, that illustrate how your nursing care was made more sensitive?**
   * how does"culturally sensitive" care look different from "generic" approaches?

4. **Does the meaning of "cultural sensitivity" change in different contexts; such as rural vs urban, or clinical vs community settings?**
   * Would it depend on whether you were talking about a physical or mental health problem?

   * situations where nursing care is the same for all people

5. **How do you know whether you've been culturally sensitive or not?**
   * Are there particular experiences that come to mind of when you'd been sensitive or insensitive - how did you know this?

6. **Do you think nurses from non-dominant cultures have any advantage, or additional insight understanding or providing "culturally sensitive" care?** (ie: rationale for all native health providers)

7 **How does "cultural sensitivity" - as presented in nursing school, or in the literature, get played out in "real life"?**

8 **What things would you say to a new nurse who wanted to know how to become culturally sensitive**?

   * Is there anything you wished you had known when beginning your career?

9. **How would you go about increasing the cultural sensitivity among nurses or in health care generally?**
   *In a position of authority what things would you do to increase cultural sensitivity - among your "recruits", or among those under your jurisdiction?

10. Nursing literature uses a number of terms to address the concept of cultural sensitivity, such as **cultural appropriateness, cultural relevance, and cultural competence.** In your opinion, are the meanings of these terms the same or different from cultural sensitivity?

* does the term "cultural need" have any meaning to you?

11: There seem to be **different motives for development of cultural sensitivity** in nursing - ie: "professional" such as those who wish to establish is as a clinical specialty, and "personal" -as part of an altruistic commitment to humanistic care which argues against separate treatment. -

Is this a fair characterization for how you see it developing in nursing?

Do you think the motivation (professional/personal) is significant to manner in which care is ultimately provided?

12: Talking about "cultural care" presumes that nurses are able to discern or differentiate between personality traits, class and culture. **Have you some way for distinguishing between what is cultural, and what may be attributable to other factors?**

13: Approaches to culture in health literature emphasise a cognitive approach (ie: acquisition of knowledge and cultural "facts").

What kind of knowledge do nurses need?

Are there limitations of emphasizing the cognition dimensions?

14. I've spoken with a number of 'general duty' nurses who perceive cultural sensitive as inherently negative, and are uneasy discuss it:

Does this surprise you?

How do you think ideas of "political correctness" affect nurses?

15. **When thinking of your work, what cross-cultural experiences stand out the most in your mind?**

* Those that you learned the most from, or, that were particularly good or bad.

Appendix F

QUESTIONNAIRE

Primary Area of Nursing Responsibility

acute care / community _____
research/teaching_____
other _____

Hours Full Time ____ Part Time ___ Casual ____

Setting Rural ____ Urban ___ Other ____

Years of Experience (number) _____

Context of Employment

Federal health service (ie: MSB) _____
Municipal/ City health service (ie: City of Toronto)_____
Provincial health service (ie: Ministry of Health)_____
First Nation _____
College / University _____
Research Institution_____
Other _____

Sex M ____ F ____

Age Range

less than 20	____	40-49	____
20-29	____	50-59	____
30-39	____	60+	____

Languages Spoken _____

Ethno-cultural Background _____

Clientele in Current Nursing Position

primarily Euro-caucasian ____
mixed ethnicity ____
Primarily non-eurocaucasian ____

Which ethno-cultural groups have you worked the most with?

_____

General Nursing Educational Background (please include all that apply)

Diploma_____

Degree Baccalaureate___, Master's___, PhD___

Other ____

Formal Education Pertaining to Cultural Sensitivity (ie; special in-services, courses)

_____

_____

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