BEYOND PROFESSIONAL AFFILIATION:
RACE, CLASS & GENDER DYNAMICS IN INTERDISCIPLINARY TEAMS

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ABSTRACT

This study aims to illuminate the ways that gender, race, and class are experienced and socially constructed on interdisciplinary health teams. The study involves four in-depth qualitative interviews with social workers who are employed members of interdisciplinary health teams within a medium sized city in south-western Ontario. The study documents three levels of inquiry. Initially, it explores social workers' understandings of how gender, race, and class affect interdisciplinary team dynamics. Next, a discourse analysis of the interviewees' accounts reveals how some conceptualizations of gender, race, and class are potentially limiting and at times reinforces the status quo. Lastly, it traces invisible relations of domination and subordination conveyed through the social organization of knowledge around interdisciplinary teams.

The study offers insight into the ways that interdisciplinary health teams are thought to both promote and undermine cultural competency initiatives. It also reveals how gender, race, and class issues on interdisciplinary teams are conceptualized in ways that preserve the status quo. However, the study challenges the notion that education and exposure to difference and diversity alone will foster cultural competency skills. The study concludes that both cognitive and material shifts in power are necessary in order to achieve an effective redistribution of power within interdisciplinary teams.

ACKNOWLEDGMENTS

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CHAPTER 1: INTRODUCTION

You have probably had the experience of listening to a friend or loved one debrief after a long day at work. As they highlight particular parts of their day you may socially experience the ups and downs of their story in ways that makes you feel in sync with the speaker. Similarly, you may have had the experience during a group discussion, where it felt like no one was on the same page, and no matter how many times the subject was rephrased, it seemed that no one truly understood each other.

As a grievance officer for my union local, I frequently observe how gender, race, and class dynamics almost always contribute to the issue in dispute, but rarely become a direct topic of conversation in grievance hearings, or overtly inform resolutions. Gender, race, and class dynamics are rarely accounted for in harassment grievances and sometimes these variables are flat out denied. In one such grievance a supervisor argued that, he could not possibly racially discriminate against his employee, because they were of the same ethnic background, although he did agree that his actions had been discriminatory. Removing race from the incident transformed the entire essence and resolution of the case – the actions were now viewed through a vacuum rather than against a backdrop of racialized social relations. Consequently, the case began to look like an isolated incident, just a clash of personalities between a supervisor and an employee, rather than an employer's false assumptions and stereotypes about an ethnic group, which led to his suspicion, mistrust, and over-surveillance of his employee.

Experiences such as these began to stir my interest about how gender, race, and class dynamics are perceived, managed, and acted upon in our work relationships throughout our day-to-day lives, and how some groups might benefit more from these perceptions and arrangements than others. I also became curious about how discrepancies in perceptions, such as in the case above, get explained and accounted for.

At a more personal level, I began to wonder about how we see ourselves during these daily performances. Indeed, it is only in hindsight that I sometimes realize the many ways that a case could have been constructed to better account for gender, race, and class dynamics that were at play. During these reflections, I may have a dawning of awareness of how I actively participated in the construction and reconstruction of these accounts. By accepting certain bits of knowledge and reasoning at face value rather than questioning taken-for-granted perceptions and thus challenging the status quo. In turn, these small epiphanies drew me to question how we come to understand and explain our own participation in gender, race, and class dynamics.

Interdisciplinary healthcare teams were selected as the medium to explore these questions because I have personally been part of interdisciplinary healthcare teams, during my undergraduate training and, therefore, I felt that I had a good basic understanding of health team functioning and group dynamics. Additionally, I felt that interdisciplinary teams were an appropriate medium to explore gender, race, and class dynamics because they are notorious for having power struggles between team members (McCallin, 2001). I hoped to be able to draw on the experiences and knowledge of power

struggles, and the ways that they are managed and mitigated, as a basis to explore

people's understandings of how gender, race, and class inform their team's dynamics.

THEORETICAL FRAMEWORK

Scholarly literature on interdisciplinary healthcare teams is relatively recent

because they have only existed for a few decades (McCallin, 2001). Nonetheless, the

discourse is already marked by several significant paradigm shifts that seem to be deeply

influenced by prevailing customs and conventions of the particular times and places

(Campbell & Gregor, 2002; Lorbiecki, 2001; Smith, 1987).

The changing terrain of socio-political-economic contexts originally created the

need for interdisciplinary healthcare teams. The rise of neo-liberalism[1] in Western

countries in the late 1980s and early 1990s created an increased focus on the bottom line,

which in turn led to massive cutbacks and restructuring in healthcare (Baines, 2004;

Dominelli, 1999; McCallin, 2001). According to Baines and McCallin, cutbacks and

restructuring forced health professionals into more focused practices creating a spike in

professional specialization. Interprofessional models of care, such as interdisciplinary

teams, were consequently developed to accommodate specialist service delivery trends of

the 1990's by fostering collaboration between specialists.

Initially scholars endorsed a hierarchal team structure; however, they soon began to

observe miscommunications, misunderstandings, and tensions between interdisciplinary

team members (McCallin, 2001). Looking through a neo-liberal prism, a customary

framework at that time, scholars and policy-makers alike viewed these tensions as

indicators of inefficiency and ineffectiveness, which did not complement the bottom-line

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[1] Neo-Liberalism is a right-wing political movement postulating that political involvement in the market is inefficient, and embraces notions of free market and private enterprise rather than public ownership (Ralston Saul, 2005)

agenda espoused by the health field. Consequently, a strenuous effort has been put into researching models to improve communication, collaboration, and participation between team members as part of the agenda to maximize productive labour (2001; Reich & Reich, 2006).

The perceived need for better communications, more productive collaboration, and maximum participation has contributed to the growth of a whole new diversity management industry. The industry is so highly in demand that Lorbiecki (2001, p. 354) notes there is even "a sub-industry of specialized consultants who are brought into organizations to patch up the antagonism left behind by other diversity consultants."

Today, more collaborative models of interdisciplinary teams are endorsed among much of the scholarly discourse and rhetoric on interdisciplinary teams. While these initiatives emphasize more progressive and egalitarian approaches, such as cultural competency, learning and individual growth, legitimacy, equality, accessibility and inclusion, they lack authenticity as they continue to be motivated by the bottom line (McCallin, 2001).

STATEMENT OF THE PROBLEM

To date, research on interdisciplinary teams attributes tensions and miscommunications primarily to differences in power and ideology between professions. Scholars such as Campbell-Heider and Pollock (1987), Clark (1997), and Hilton (1995) assert that nurses share a worldview, which is different from social workers, doctors, and other health professionals. These scholars suggest that clashes in ideologies between professions result in conflict, miscommunication, and misunderstandings between team members. Other scholars, such as Apker, Propp, and Ford (2005) and Cott (1998) suggest

that these tensions get exasperated when decisions are made using top-down hierarchal approaches according to professional status. Perhaps the most notorious hierarchy within the health field is between doctors and nurses, where doctors are understood to have enormous power and authority over nurses (2005; Kendrick, 1995; McCallin, 2001).

With problems being largely attributed to hierarchies among the professions and differences in ideology, scholars are respectively calling for more collaborative team models to flatten the power structures. Scholars such as Carpenter (1995), Hilton (1995), and Reich and Reich (2006) recommend having a standard theoretical framework for all health professions to adopt in order to decrease misunderstandings and miscommunications. So far these resolutions have not automatically been effective. Current research findings suggest that decentralizing power and responsibility on teams has not altered traditional inter-professional interactions. McCallin (2001, p. 421) offers insight into the failed resolutions by pointing out that "the simple re-allocation of tasks cannot mask potential problems of collaboration that are more complex." What are the more complex problems preventing collaboration? McCallin's review of the literature on interdisciplinary teams reveals an essential ingredient for effective teamwork and communication on interdisciplinary teams: team members need to have a pluralistic understanding of each others' roles and responsibilities.

However, scholars' preoccupations with professional affiliations have meant that differences and power hierarchies associated with other social statuses have not been explored to a great degree. The lack of scholarly literature on gender, race, and class is profound when the demographics of healthcare teams are considered (Sulman, Kanee, Stewart, and Savage, 2007).

> Women make up 46 per cent of the Canadian paid workforce, 59 per cent of public sector workers and more than 85 per cent of unionized workers in health care (Sandborn, 2007, para. 20).

Healthcare also employs a significantly greater level of immigrants and visible minorities compared to the general population. The B.C. Hospital Employee's Union (HEU) reports "more than one out of four HEU members belong to a visible minority, compared to less than one in five in the general population" (Sandborn, 2007, para. 20). Such significant statistics beg the question of why gender, race, and class issues affecting interdisciplinary health teams are not receiving more academic attention (Sulman et al., 2007).

PURPOSE & IMPORTANCE OF THE STUDY

Perhaps the narrow scholarly focus on issues related to professional status is indicative of a wider phenomena occurring within interdisciplinary teams. Is it possible that the relative silence on race, class, and gender issues in the literature is reflective of silences of these issues in practice? If this is the case, how is it that race, class, and gender issues have been largely neglected in the academic community? What are the effects of not having these conversations? How does silence "discursively conceal what would otherwise be so noticeable – the continued huge disjuncture in power/status/life chances" (Macalpine & Marsh, 2005, p. 443) – between white/non-white, male/female, and affluent/non-affluent people?

The aim of this study is to explore people's experiences of how interdisciplinary teams are affected by race, class, and gender dynamics, and to illuminate discourse, schemas, and ideologies that work to reinforce and/or reduce inequalities between gender, race, and class on interdisciplinary teams. In other words, the aim of this study is

to reveal how interdisciplinary teams are socially organized, and how people's lives are ruled by dominant discourse. Overall, it is hoped that this study will begin to fill this gap in the literature, and initiate further discussion on differences in power on interdisciplinary teams beyond professional affiliation.

RESEARCH QUESTIONS

How do race, class, and gender affect the dynamics of interdisciplinary teams in health care, and how do team members understand, experience, and participate in these dynamics? How is knowledge and experiences of interdisciplinary teams described in narratives and dominant discourse? Further, how do these accounts work to serve the interests of some groups and not others? Finally, how are interdisciplinary teams socially organized by knowledge and power?

CHAPTER 2: REVIEW OF THE LITERATURE

This review of the literature contains three sections. Section A, Previous Research on Interdisciplinary Teams, reviews previous scholarly literature on interdisciplinary teams. Section B, Interdisciplinary Teamwork & Team Functioning, provides some background on teamwork and team functioning in order to help readers to better understand the interdisciplinary team experiences described in the Research Findings. Finally, Section C, Diversity Management, summarizes key findings in diversity management research in order to help readers understand the different meanings interdisciplinary team members attach to gender, race, and class.

A. PREVIOUS RESEARCH ON INTERDISCIPLINARY TEAMS

Development of Interdisciplinary Health Teams

Studies on interdisciplinary teams are rare (Cott, 1997; McCallin, 2001; Zwarenstein & Reeves, 2000). This is not surprising according to McCallin who asserts that collaborative interdisciplinary team models have only been around for a relatively short time, so the scholarly community has not had much opportunity to document decentralized interdisciplinary team trends. Historically, interdisciplinary teams were modeled to be authoritarian structures where the physician held absolute power in decision making. In the late 1980's and early 1990's, the nursing profession challenged this model of interdisciplinary health teams. At the same time, hospitals were under enormous pressure to cut costs and they needed to find a way of bringing together all the different health professionals who had moved away from generalist practice to specialized positions (Baines, 2004; McCallin, 2001). In turn, interdisciplinary health teams were restructured with the intention of making them decentralized and more

collaborative, as a way of redistributing power more equally between health professions and bringing together health professional expertise (McCallin, 2001). Noticeably, there was a boom in research on interdisciplinary teams in the late 1980's and early 1990's. The literature produced during this time largely documents and theorizes about how to adjust to job restructuring and how to foster collaboration on interdisciplinary teams.

Current Focuses in Interdisciplinary Health Team Research

McCallin's (2001) and Cott's (1998) reviews of the literature on interdisciplinary teams reveals that most of the literature is largely rhetorical.It describes how to organize interdisciplinary health teams and make them more effective and efficient, but there is little actual research on how teams function or how they impact patient care and outcomes. According to McCallin (2001), the scholarly research on interdisciplinary health teams tends to focus on teamwork, collaboration, professional socialization, and professional hierarchy, especially between doctors and nurses. To a lesser extent, interdisciplinary team research also looks at gender and nursing roles, work redesign in healthcare, and patient-focused care.

Interestingly, McCallin (2001) asserts that there is little evidence suggesting interdisciplinary teams improve patient care or outcomes. Zwarenstein and Reeves (2000) explain that interdisciplinary teams were created to produce fiscal savings, and that patient outcomes were a secondary consideration. There is little evidence to suggest that interdisciplinary teams function efficiently and effectively at all.

Focus on Efficiency & Effectiveness in Interdisciplinary Health Team Research

The literature on improving efficiency and effectiveness within interdisciplinary teams is likely propelled by several interconnecting factors, including: the need to cut

costs and get higher returns on investments, the desire to reduce duplication, the motivation to improve patient care and outcome, and the imperative task of resolving the long standing tensions between health professionals on interdisciplinary teams. Noteworthy, however, is the abundance of research documenting animosity and conflict on teams (Cott, 1998; Garcia-Prieto, Bellard, & Schneider, 2003; McCallin, 2001; Sulman et al., 2007). Conflicts between doctors and nurses are well-documented (Beattie, 1995; Campbell-Heider & Pollock, 1987; 2001). There is little research that actually finds mutually supportive relationships between team members.

Research on interactions between interdisciplinary team members suggest that teams' effectiveness and efficiency are impaired by miscommunication and misunderstanding (Cott, 1998; McCallin, 1999, 2001; Sulman et al., 2007; Wilmot, 1995). To date, scholars such as Apker, Propp, and Ford (2005), Cott (1998), and Hilton (1995) understand differences in ideology and power inequalities between professions, as the primary cause of discrepancies in communications and understandings between team members. Such differences have led health professionals to have a poor appreciation of each other's responsibilities, expertise, and expectations (Cott, 1998; Fagin, 1992; Farrell et al., 2001; 2001).

While the documentation of animosity and breakdowns in communications between health professionals is useful, also important is Cott's (1998) observation that past studies on interactions within interdisciplinary health teams have been limited to team meetings. More research is needed on what happens outside of formal interactions.

Research on Power Differences in Interdisciplinary Heath Teams

Scholars such as Cott (1998) have documented the existence of professional hierarchies on interdisciplinary teams, where health professionals with more education, such as doctors and registered nurses, have more decision making power than professional staff with less education, such as health care aids or registered practical nurses. Differences in power between health professionals are deemed a significant cause of animosity on interdisciplinary teams (Beattie, 1995; Campbell-Heider & Pollock, 1987; Cott, 1998; Hilton, 1995; McCallin, 2001). Interestingly, Cott found that a health professional's interpretation of power differences between team members depended upon where that person was positioned within the professional hierarchy. Those occupying higher positions of power and authority tended to perceive a flattened hierarchy, while those at the bottom of the hierarchy understood there to be enormous differences in power between team members.

Professional hierarchies are thought to have their roots in historical medical structures, which awarded most of the decision-making power to physicians. While traditional interdisciplinary health team models were restructured in the past few decades to be more collaborative, scholars such Carpenter (1995), Clark (1997), and Cott (1997, 1998) revealed that role socialization continues to reproduce and maintain professional hierarchies in healthcare settings. Professionals are socialized to see the knowledge and expertise of a physician as superior to the knowledge of other health professionals. These perceptions are maintained and reinforced in the ways that health professionals interact with each other, such as actual decision-making structures, professional practices, and norms and traditions (Carpenter, 1995; Clark, 1997; Cott, 1998).

Difference & Diversity in Interdisciplinary Health Teams Scholarship

Discourse on diversity in interdisciplinary health teams has been largely focused on the differences in roles and professional affiliation between team members. In Reich and Reich's (2006) study of cultural competence in interdisciplinary collaborations, the definition of diversity only accounts for the differences between disciplinary cultures. While the study aims to better understand cultural competency on interdisciplinary teams, and it makes no mention of race, class, or gender dynamics – notions that are essential components of the cultural competency framework (King, Sims, and Osher, 2001).

While there has not been much research on how gender informs interdisciplinary team dynamics and vise versa, numerous studies have documented gender role relations in healthcare, especially between doctors and nurses. Indeed, ethnography researchers have portrayed physician-nurse interactions as a "metaphoric 'family' composed of physician-fathers, nurse-mothers, and patient-children" (Campbell-Heider & Pollock 1987, p. 424).

Campbell-Heider and Pollock's (1987) review of the literature on physician-nurse collegiality highlights extensive scholarly research on how sex stereotyping works to maintain the physician's dominance and the nurse's subordination. Sunar (in Campbell-Heider and Pollock, 1987) documented how sex stereotypes function in interdisciplinary teams. It appears that the doctor's dominance is reinforced by nurses' passive, dependent behaviours, despite their clinical expertise or changes in the legal scope of responsibilities and practices of nurses. The behavior derives from the long standing belief that only physicians can diagnose medical problems and a powerful pressure to accept and confirm to the team's own hierarchal image. Harrison (as cited in Campbell & Pollock, 1987) argues that "even in a setting in which 'equality' between men and

women is a principle symbolic dimension of everyday life, ritual can recast this social reality in hierarchal form (p. 244)." Indeed, Campbell-Heider and Pollock (1987) point out that legislative changes to expand nursing practices have not been initially effective in eliminating resistance to collegiality. They conclude that hierarchies in healthcare settings are unlikely to be altered until doctors and nurses come to the realization that such relationships can reduce the options of both groups.

Similar to the lack of research making explicit how gender affects contemporary collaborative interdisciplinary team dynamics, there has also been relatively little research on how race and ethnicity affect interdisciplinary health team dynamics (Sulman et al., 2007). Das Gupta's (as cited in Sulman et al., 2007) study revealed that racial or ethnic minority employees report overt racism. As well, Gupta suggests that racial and ethnic minority employees may also face subtle or systemic racism. Noticeably, none of the reviewed literature for this study looked at the implications class has on interdisciplinary teams.

In Sulman et al. (2007) review of the literature, diversity initiatives in healthcare were found to be more responsive to the needs of patients than employees, and the lack of diversity management strategies was believed to have undermined teamwork and patient care. The researchers further concluded that health organizations are taking little initiative to implement diversity management strategies.

Gaps in Current Research on Interdisciplinary Health Teams

The literature on interdisciplinary teams leaves much unanswered and raises many important questions. Much more needs to be known about the effect interdisciplinary teams have on patient care and outcomes. Reports that team members lack sufficient

knowledge about each other's roles and responsibilities should raise an alarming flag. They appear to lack other important knowledge necessary for bringing diverse groups together, such as cultural competency skills that include gender, race, and class awareness. Undoubtedly, our understandings about interdisciplinary team dynamics need to be broadened to include diversity issues beyond professional hierarchies and differences. Perhaps most importantly, we need to critically ask ourselves how is it that our scholarly community has so narrowly focused on interdisciplinary team dynamics for so long. The answers to the last question can probably be answered by further asking ourselves about the gender, race, and class dynamics that are at play within the scholarly community, and how these dynamics have systematically resulted in the production of interdisciplinary team research that largely concentrates on professional affiliation.

B. INTERDISCIPLINARY TEAMWORK

The reported findings on interdisciplinary team experiences are perhaps better understood when contrasted and compared against the scholarly understanding of an ideal interdisciplinary team. Ideally, interdisciplinary teams are work groups composed of multiple health professionals that collaborate their knowledge, skills, and expertise to provide holistic care to patients (Leathard, 1994; McCallin, 2001). Sorrells-Jones (as cited in McCallin, 2001, p. 420) compared interdisciplinary teams to other teams, such as multi or trans-disciplinary teams, and suggested that interdisciplinary teams have

> [A] deeper level of collaboration in which processes such as evaluation or development of a plan of care is done jointly, with professionals of different disciplines pooling their knowledge together in an independent manner.

A review of the literature reveals that collaboration is believed to be the single most important characteristic that defines interdisciplinary teams. Indeed, a vast amount

of the literature on interdisciplinary teams concentrates on collaboration. Scholars suggest that effective collaboration on interdisciplinary teams involves communication, cooperation, participation, joint thinking, common goals and purposes, and shared expectations of professional contributions (Campbell-Heider & Pollock, 1987; Chapman, Hugman & Williams, 1995; Field & West, 1995; McCallin, 2001; Zwarenstein & Reeves, 2000). Noticeable in the literature that speaks to successful teamwork and collaboration is the emphasis on having a shared, unified vision. Without a shared vision it is believed that team members will work towards opposite goals and risk undermining each others' work and effort (Campbell-Heider & Pollock, 1987; Chapman, Hugman & Williams, 1995; Field & West, 1995; McCallin, 2001).

Surprisingly, despite all the theoretical concern on what constitutes collaboration, there is little research done on interdisciplinary teamwork (Cott, 1998; McCallin, 2001). McCallin's review of the literature reveals that some scholars, such as Poulton and West (in McCallin), suggest that collaboration on teams improves with time; McCallin argues that there is no evidence to support this claim. Another example is how interdisciplinary teams did not initially prove to be effective in decentralizing power differences between health professionals. Indeed, Keatinge (in McCallin) points out that deeply internalized role socialization has hindered the ability of decentralizing structures, like interdisciplinary teams, to dismantle traditional inter-professional interactions in healthcare.

Perhaps some of the more grounded research has been on the environments and value systems that interdisciplinary teams operate in. As noted earlier, interdisciplinary teams sprung out of cost-saving initiatives. Chapman et al., (1995) suggest that

collaborative practice is affected by an intense clash between the business culture

healthcare that it is currently attempting to espouse, and its traditional culture of care.

Business models focus on the bottom line and have historically resulted in massive

cutbacks and restructuring in healthcare (Baines, 2004; McCallin, 2001). Such initiatives

have not always been concerned with traditional notions of quality of care and patient

outcome (2001). Berwick (1996) builds on these concerns stemming from the business

culture, and suggests that the medical model only endorses a single notion of excellence.

Such a notion rules out the possibility of pluralistic understandings of excellence that are

necessary to foster collectivity during teamwork. In other words, a singular notion of

excellences does not grant space for difference and dissent. Team members whose

ideologies differ from the status quo may thus become alienated from the rest of the team.

The gaps in the literature on teamwork in interdisciplinary teams raises some

important questions about what teamwork looks like in practice, whether interdisciplinary

teams are effective structures of decentralizing power, and if teamwork is even able to

thrive in the medical-business environment. Most importantly, further envisioning of

teamwork is required in order to account for a culturally diverse workforce. If indeed

having a unified vision is a prerequisite for successful teamwork, we need to ask whose

vision is prevailing and who is doing most of the giving up. We will have to ask

ourselves if a unified vision is just another discreet way of re-enforcing the status quo.

C. DIVERSITY MANAGEMENT

Diversity management is an important concept that needs to be explored in

interdisciplinary team research beyond just differences in professional affiliation. This

section highlights some of the insights gained from other disciplines on diversity

management, in order to provide a backdrop to understand better the research findings on the experiences and meanings of gender, race, and class issues on interdisciplinary health teams.

Current studies in the field of human resources are marked by a growing discussion on how diversity issues and initiatives are being met with resistance in the workplace. Lorbiecki (2001) states that the promotion of a diverse workplace is not new. However, the meaning and methods of managing diversity have changed over time because most initiatives have previously failed, and many initiatives have been met with resistance from dominant groups. Studies by Henry, Tator, Mattis and Rees (2000) and Bishop (2005) support this finding. They suggest a number of reasons why diversity initiatives have failed, including lack of commitment, inadequate training and policies, lack of representation, limited access to resources, lack of individual and organizational accountability, tokenism, and deceptive dominant discourse.

In a study by Macalpine and Marsh (2005), power relations and material inequalities are attributed to the construction of whiteness in organizations. Data collected through a focus group discussion reveal taken-for-granted whiteness, difficulties in finding the language to talk about whiteness, discomfort in discussing whiteness, whiteness only made visible by contrasting it to non-whiteness. Discussions about diversity issues could provoke conscious raising of white power and privilege, and resistance to diversity discussions.

Other scholars have also begun to map out white culture and hegemonic discourse. Kenny (in Twine & Warren, 2000), found in her study of white, teenage girls that language making race and class relations explicit was avoided, and substituted with

language that identified gender differences. For example, during a basketball game race

was not mentioned even though the racial make up of the two teams was strikingly

obvious. One team was completely composed of white, affluent, suburban girls and the

other team was composed of black, working-class girls from a ghettoized community.

The parents of the white, suburban girls made comments about the differences in the

girls' body sizes, where the white girls were said to be so skinny compared to those big

girls. When a foul was finally called against the black girls' team, the white "crowd

[stood] to its feet cheering, and the mother of the best player on the team shouted: 'It's

about time ref. I was beginning to think you were colour-blind'" (2000, p. 112). In effect,

race and class issues were rendered invisible and white, teenage girls and their role

models, including white teachers and parents, could avoid confronting their power and

privilege associated with their white status.

Warren's (in Twine & Warren, 2000) study also produced some interesting

findings. He noted that the invisibility of racial tensions and inequalities in Brazil led

many people to believe, including local residents and especially visiting Americans, that

racism did not exist in Brazil. However, as Warren explains, the demographic makeup of

the workforce and poverty levels demonstrate significant inequalities between black and

white populations, such that positions of power, prestige, and affluence are

predominantly filled by white people, while the working poor and the poor are

overrepresented by black people.

The research on diversity management raises some important considerations for

this study, including the difficulties in talking around diversity issues because they are

not politically correct topics, because people fail to see them, and because it is generally a

negative experience linking your own power and privilege to the subordination and

oppression of others.

CHAPTER 3: RESEARCH METHODS

QUALITATIVE PARADIGM

This study implements an institutional ethnography methodological approach and therefore utilizes aspects of one qualitative paradigm: critical science. Drawing on this paradigm, the study explores the social world of interdisciplinary health care teams. It attempts to critically understand how these teams function and subsequently, how social workers arrive at certain meanings and understandings about interdisciplinary teams. The study strives to map out social relations of power that are acting on and operating within interdisciplinary teams. Mapping entails combing through the narratives to reveal how social relations of power structure inform knowledge and discourse about interdisciplinary teams (Campbell & Gregor, 2002).

This study is also reflective of the critical science approach in that it seeks to produce social change. Contrary to traditional goals of the critical science paradigm, this study does not aim to empower the oppressed. Rather, it attempts to offer privileged and powerful ruling groups an alternative way of interpreting their day-to-day lives so that they can become accountable for their part in the subordination of others. In this way, it is hoped that by recognizing social relations of power and oppression we can become more proactive in dismantling them (Campbell & Gregor, 2002; Neuman & Kreuger, 2003).

QUALITATIVE METHOD: INSTITUTIONAL ETHNOGRAPHY

Institutional ethnographers reject the notion that everyday experiences are natural. The researcher collects information on everyday experiences and the ways that they are understood and then interprets the data as problematic. Data are deemed problematic in

that it is not taken for granted as natural or disinterested. Ladson-Billings (in Brown &

Strega, 2005, p. 201) states that

> How one views the world is influenced by what knowledge one possess, and what
> knowledge one is capable of possessing is influenced deeply by one's world view.
> The conditions under which people live and learn shape both their knowledge and
> their world view... [S]chools, society, and the structure and production of
> knowledge are designed to create individuals who internalize the dominant world
> view.

The institutional ethnographer does not use the data to develop theory. After pulling

out the narratives around certain experiences or phenomena, the researcher performs a

second analysis to map out how social relations are organized, such that particular

phenomena are produced and experienced in specific ways. Mapping involves connecting

discourse and narratives to relations of power and subordination. The institutional

ethnographer comes from the understanding that experiences will be framed in such a

way as to serve the interests of the ruling or dominant group.

The institutional ethnographer positions herself within the research because she

understands herself to be in a dynamic relationship with the research rather than an

omnipresent observer. Indeed, the researcher admits that her own pool of knowledge and

ideology is very much informed by the dominant world view. The researcher recognizes

that her research and particularly the discourse analysis will be limited by her ability to

reflect critically and develop a worldview that differs from the status quo.

The aim of the institutional ethnographer is to further democracy at the individual

level as we are actually located in space and time. The research is intended to be used as

a resource for people wanting to establish greater equality in their lives. The research can

be used as a tool or a starting block, empowering people to think more critically about

what we know and experience. In effect, it is hoped that a critical reflective praxis will be

put into motion, where individuals continuously reflect on the social organization of power within their lives, and in acknowledging relations of power and oppression; they begin to dismantle them (Brown & Strega, 2005; Campbell & Gregor, 2002; Macalpine & Marsh, 2005; Smith, 1987; Twine & Warren, 2000).

DATA SOURCE

This study drew on the knowledge and experiences of social workers who were employed members of interdisciplinary health care teams within Hamilton Ontario. Although all identifying information about the interviewees, their coworkers, and patients has been changed, it is important to note that interviewees came from three medical sites, including two hospitals and one family clinic. The participants that worked in hospital settings were a part of specialized teams providing ongoing care. Both interviewees stated that their clientele tended to be from the lower working class. The participants employed in the family clinic suggested that their services largely catered to a poor and immigrant community. Two interviewees declared that they practiced from an anti-oppressive practice (AOP) framework – a framework that is in sync with the theoretical framework of this study, as it acknowledges relations of power and oppression relative to social location, such as gender, race, class, sexual orientation, and (dis)ability, just to name a few.

Of the four participants, all of them were female and they all had graduate degrees. Three participants self-identified as middle-class and white, two participants referred to themselves as European, and one participant identified herself as a racial minority. Taking the social statues all together, the participants tended to be from relatively privileged and powerful social locations.

DATA COLLECTION

After gaining approval from the McMaster University Research Ethics Board to conduct the study, the recruitment process was initiated. The study was initially limited to four sites, including two family medical clinics and two community health centers. The study sought four to six participants and intended to select a maximum of two participants from each site. The administration staff at the four sites were sent an email containing a letter of information (appendix A) detailing the study. The administrative staff in turn forwarded the email and letter of information to the social workers employed at their workplace. After a low response rate, hardcopies of the letter of information were given to the administrative staff at the four sites to put into social workers' mailboxes. Unfortunately, only two participants were recruited through this technique.

To increase the response rate, the sample was widened to social workers that were employed in hospital settings in the Hamilton area. Three social work faculty at McMaster University who are also members of the clinical social work community in Hamilton were asked to act as intermediates and to email letters of information to their contacts. Two additional participants were recruited to the study using this technique.

Participants took part in one face-to-face tape-recorded in-depth interview. At the beginning of the interviews, participants read and discussed a letter of consent (appendix B) detailing participation in the study. Interviews lasted between forty-five minutes to one and a half hours. Three interviews took place at the participant's worksites and one interview took place in the interviewee's home. Interviews consisted of open-ended questions guided by a tentative theme-based interview schedule (appendix C). As is common to qualitative research, the research design was shaped by the research findings.

Each interview involved many unique and improvised questions; however, they tended to

focus on:

- How interviewees understood gender, race, and class to be impacting
  interdisciplinary team dynamics (structurally and in daily interactions)

- How gender, race, and class got discussed on interdisciplinary teams, and
  whether it was regarding patients or themselves

- How diversity was managed on the team, including inclusive and exclusive
  practices

- Experiences of gender, race, and class discrimination (overt, discreet, systemic)
  experienced as a witness or as a victim

- How the team responds to overt discrimination

- How the interviewee responds to discrimination within her team

DATA ANALYSIS

As previously discussed, the study uses an institutional ethnography methodological

approach. Two levels of analysis are used to examine the data. The first level of analysis

highlights common, reoccurring, and unique experiences of interdisciplinary teams in

health care. The first level of analysis also highlights the meanings interviewees attach to

these experiences. When some interviewees talked about overt discrimination in their

workplaces, (the experiences) they also recalled the shock and disbelief (the meaning)

they felt when the incident occurred. Yet all the interviewees declared that they generally

had positive or indifferent (the meaning) experiences of their interdisciplinary teams (the

experience).

The second level of analysis moves beyond just describing experiences and involves a

discourse analysis called mapping. It attempts to describe how and why something

happens. The narratives around experiences and meanings identified in the first level of

analysis undergo a second critical analysis, to reveal how the subject's experience is organized in ways that serve the interests of the ruling class.

A broader question asked during the second level of analysis is "what are the connections across and beyond the boundaries of this setting and how are they enacted by actual people?" (Campbell & Gregor, 2002, p. 61). When interviewees described times when their coworkers made racist or sexist comments, the offense was attributed to the coworker's ethnic or racial background only if the coworker was thought to belong to a visible minority. In effect, racism and sexism is not attributed to having white skin so white people, as a race, are not charged with taking responsibility for the racism and sexism imbedded in their culture.

The second analysis reveals the ways that specific activities are made visible, while others activities are made invisible. Critically analyzing hegemonic discourse reveals relations of power that are hidden and disguised by notions of truth, normalcy, and notions of common sense (Brown & Strega, 2005; Campbell & Gregor, 2002; Macalpine & Marsh, 2005; Smith, 1987).

SCOPE & LIMITATIONS OF THE STUDY

The study is intended to investigate the social organization of interdisciplinary teams in health care, by identifying different knowledge and experiences of how gender, race, and class influence interdisciplinary team dynamics, and by exploring how knowledge of interdisciplinary teams inform relations of power and visa versa. Due to the exploratory nature of this study, it is only able to offer a glimpse into the ways that gender, race, and class are socially organized, more over, experienced, imagined, and understood on medical interdisciplinary teams.

To explore the major questions of this study, the data needed to be rich and detailed. In addition, the collection process needed to be flexible as there is relatively little previous research in this area (McCallin, 2001; Sulman et al., 2007). Institutional ethnography methodology was chosen for the study so that rich, detailed, and meaningful data could be collected. In effect, the data collection was limited to four face-to-face in-depth interviews to allow interviews and the research to discuss and investigate the topics with liberty.

The study was also restricted by limited funding, resources, and time. The study only included one principle investigator; it did not have any funding, and it had a specified time limit as the study was a partial fulfillment of the requirements of the degree of Master of Social Work. Given the qualitative and exploratory nature of the study, and the limitations on funding, resources and time, a small sample size was appropriate.

Given the many limitations of this study, the findings lack reliability and validity, and therefore cannot be generalized to the larger community of interdisciplinary teams in healthcare. However, the intention of the study is not to make generalizations, but to provide exploration and analysis of interdisciplinary teams from an alternative framework, and to initiate future discussion in these uncharted areas. Therefore, regardless of the study's inability to be generalized, it makes a significant contribution to the scholarly literature on interdisciplinary teams in healthcare.

VERIFICATION

In an earlier section, the study's many limits were laid out and described, such as a time limit on completing this study and a small sample size. Nonetheless, the study is very much substantiated considering its qualitative methodology. First, limiting the data

source only to social workers has allowed for the collection of rich and condensed data, by zeroing in on the specific experiences of a specific group, and in turn allowing for a rich and more complex data analysis. Had the data source been opened up to include multiple professions, the data would have likely become too wide to make any meaningful comparisons.

Second, the small sample size gave me the possibility to conduct lengthy face-to-face interviews. In turn, rich and meaningful data was collected. A large sample size would have significantly limited the study's ability to collect rich data because the study only had one investigator and it had time restraints.

Third, the flexibility of the interview schedule allowed for a more collaborative relationship between the researcher and the informant to emerge, whereby the informant had more control over the direction of the research. In effect, the study was able to explore the informant's experiences in more detail and was better able to capture these experiences from the informant's point of view, as opposed to a check list. Most importantly, the flexibility of the interview schedule allowed for spontaneous discussions about the topics to erupt, including topics that were not previously questioned or identified. The study was able to undergo a reflective process, whereby the research informed the research design, and thus allowing for the collection of richer data.

ETHICAL CONSIDERATIONS

SAMPLING

The non-probability sampling method creates several human diversity issues.[2] The study limited interviews to only social workers – a profession that is dominated by

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[2] Research creates human diversity issues when the research lacks validity with diverse populations; when there can be different cultural interpretations of the research questions and the different interpretations

white, affluent, heterosexual, females. Indeed, research participants were all female, and the majority self-identified as middle class, white and/or European. One interviewee stated she was Aboriginal and one interviewee stated she was a lesbian. While the participants possibly reflected a greater level of diversity than is the norm of Ontario's social work community, minority groups were nonetheless under represented in the research. Therefore, the research runs the risk of reinforcing the knowledge and perspectives of dominant society, and in effect, it risks contradicting or mitigating its purpose to create alterative perspectives of interdisciplinary teams. Additionally, there is the risk the content may lack relevance to diverse populations (Marlow, 2005; Neuman & Kreuger, 2003).

DATA COLLECTION

The data collection also contains several ethical issues. As noted in the review of literature, race, class, and gender issues are difficult and uncomfortable to talk about. In fact, while discussing possible interview questions with a friend during the preliminary stages, my peer said, "I don't like talking about this (on what it is like to be a white, heterosexual, male), because it feels wrong – because I don't see myself as a racist, and this conversation kinda makes me feel like I am" (personal communication, April 7, 2008). It is likely that the discomfort involved with talking about race, class, and gender issues may have been an emotionally stressful experience for interviewees. To be sure, interviewees seemed to have difficultly talking about their own passivity and silence around race, class, and gender discrimination in their workplace.

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to be identified and/or discussed; and when the social location of the researcher is understood to influence the research due to the researcher's personal biases and stereotypes that manipulate the interpretation of the

Such ethical dilemmas were handled proactively by informing interviewees of their right to withdraw at any time, and during the interview participants were given enormous control over the direction of the interview. Participants were surveyed throughout the interviews for signs of distress, and the need to be reminded about the possibility of withdrawing from the study. However, none of the interviewees seemed to require this reminder. Some interviewees seemed to struggle to answer questions because they had not previously considered the issue. During these moments interviewees were given the opportunity to skip that question or come back to it later.

While these difficult and uncomfortable discussions presented ethical issues, it should also be noted that they fostered opportunities for social change. As Macalpine and Marsh (2005, p. 446)) describe, the discomfort is part of "helping people to see what they currently don't see [by] expos[ing] the emperor's lack of clothes and the self-evident inequalities at work.... It gives them the opportunity to recognize their own whiteness."

DATA ANALYSIS & RESEARCH WRITING

The data analysis and research writing also has raised ethical and human diversity issues. First, my privileged social location limits my ability as a researcher to move beyond dominant discourse and ideologies. According to Marlow (2005, p. 233), "personal, intellectual, and professional biases are more likely to interfere with qualitative data analysis." Human diversity issues arise out of the fact that my upbringing and social environment shape my thoughts and actions, and in turn, I may unconsciously exclude certain groups or alternative ways of thinking (2005). To address this human diversity issue, I have positioned myself within the research, in an effort to make explicit my active role in shaping the research in a way that maintains relationships of power.

Needless to say, this effort can only mitigate this human diversity, but can not absolve it entirely.

Second, the study lacks the funds and resources to widely distribute the findings to the public in an accessible, understandable, and meaningful way. Possible methods of inexpensively transferring the knowledge to the public, and especially to interdisciplinary health teams, includes publishing findings in an academic journal or appropriate informal publications (such as McMaster University's school of social work's newsletter *Challenging The Silences)*, distributing pamphlets, and presenting the findings at conferences.

Third, I am concerned about the possibility of making matters worse on interdisciplinary teams by sharing the findings. Past studies have illustrated that people can become very defensive and destructive, when their worldview is challenged or when they are faced with uncomfortable topics such as gender, race, and class issues. Lorbiecki (2001) notes how dominant groups sometimes claim to be victims of reverse discrimination, and that their rights are being threatened, when minority rights are being protected and expanded through initiatives such as affirmative action.

Past studies also warn that workers of minority status have been left feeling deeply resentful when promises of a more inclusive workplace were not fulfilled (Lorbiecki, 2001; McCallin, 2001, Pelled, Eisenhardt, & Xin, 1999). Alarmingly, workers of minority status have often felt further marginalized after diversity management practices were introduced to the workplace (2001; 2001). Consequently, dissemination of the findings will have to stress concerns about igniting resistance and resentment in the workplace.

CHAPTER 4: RESEARCH FINDINGS

This chapter is divided into three sections. Section one, Experiences & Meanings, includes a basic account about what interviewees talked about and said, and focuses on the major topics of discussion explored in the interviews. Thusly, interviewees' observations and experiences of how gender, race, and class affect interdisciplinary team dynamics are highlighted. Additionally, this section discusses some of the meanings interviewees' attach to those experiences.

Section two, Discourse Analysis, includes a discussion about the researcher's observations of how interviewees talked about gender, race, and class dynamics. Discourse analysis is an essential component of institutional ethnography, and thus serves as the basis for a third, broader analysis conducted in section three.

Section three, Mapping the Social Organization of Knowledge in Interdisciplinary Teams: silences, gaps, and discrepancies' constitutes the third section of analysis, in linking findings to broader relations of power. This section illustrates the ways that interviewees' discourses, highlighted in section two, reinforce relations of domination and subordination.

While sections two and three stray from traditional qualitative styles of analysis, in that they read deeper into discourse and draw conclusions beyond the observations of informants, they nonetheless offer valuable insight into the world of interdisciplinary health teams.

> The ultimate purpose of the institutional ethnography is *not* to produce an account *of* or *from* those insiders' perspectives.... [T]he institutional ethnographer attempts to explicate how the local settings, including local understandings and explanations, are brought into being – so that informants can talk about their experiences as they do.... This kind of analysis uses what informants know and what they are observed doing for the analytic purpose of identifying, tracing and

describing the social relations that extend beyond the boundaries of any one informant's experiences. Translocal and discursively-organized relations permeate informants' understandings, talk, and activities (Campbell & Gregor, 2002, p. 90).

SECTION I: OBSERVATIONS, EXPERIENCES & MEANINGS

While discussions with interviewees were organic and flowed freely, there were three major areas of discussion: (a) observations and opinions about interdisciplinary team functioning in relation to gender, race, and class dynamics; (b) observations and interpretations of discrimination; and (c) the social worker's understanding of herself in relation to team functioning and gender, race, and class dynamics.

A. Interdisciplinary Teams

Interviewees talked about interdisciplinary teams in terms of (i) how team dynamics were impacted by diversity; (ii) how teams talked about gender, race, and class; (iii) how teams managed diversity; and (iv) how they interpreted the outcomes of diversity management.

i.   How Team Dynamics are Impacted by Diversity

Gender

Interviews were started off with the researcher asking interviewees the broad question – how does gender, race, and class impact your team's dynamics? Interviewees understood diversity to impact their interdisciplinary health teams in a number of different ways. For the most part, interviewees did not perceive gender to impact team dynamics because the teams were primarily composed of women. As one interviewee concluded, "Because we're such a female dominated unit I don't see gender as an issue". Another interviewee also stated that gender did not impact her team's dynamics because the team was almost exclusively made up of women. The interviewee concluded,

however, that the imbalance between male and female employees was viewed as problematic. That said, gender became an issue for her and her team in regards to making a conscious effort to hire more men.

For another interviewee, gender impacted team dynamics when male coworkers from racial and ethnic minorities interacted inappropriately with women, and exercised sexist attitudes and beliefs towards female colleagues. This interviewee felt that these men touched their female colleagues in an inappropriate way for a professional relationship. The interviewee interpreted these acts as men not treating or thinking about their female coworkers as equals. In another reflection, the interviewee suggested that she felt like she had to prove herself to a male coworker, stating, "I think I had to actually gain the confidence of that person. So I think now I'm more respected than initially." While the interviewee identified differential treatment and sexism as gender issues influencing team dynamics, the interviewee gave the impression that had these men from racial and ethnic minorities not been present on the team; gender would not have been an issue. Indeed, the interviewee made it clear that she did not feel like she had to prove herself to her other male colleagues.

Another interviewee also described how female colleagues received differential treatment compared to the men on her team; however, her accounts suggested that everyone on the team participated in the differential treatment of men and women. The interviewee described several instances where female colleagues were not given the same attention and respect in comparison to their male colleagues. The interviewee also noted that female coworkers where given greater attention and respect when they demonstrated traits traditionally considered to be masculine, such as leadership skills, being assertive,

using medical jargon, as well as, talking in rational and scientific terms. In contrast, the interviewee observed that when female coworkers exhibited traditional feminine traits, such as acting passive and using holistic and emotional speech, the team would ignore and cut off their female colleague. As the interviewee recalls

> Whatever she said, it was just ignored. I thought it was completely rude. [Whereas with the other coworker], it was far different. She was given air time [and the rest of the team made comments like] 'Oh lets talk to Kathy about that' or 'I think we should call Kathy in on that.'

Race

Interviewees shared many differing experiences and opinions, when they spoke about their perceptions and understandings of how race impacted their team's dynamics. Several individuals commented that their teams were considerably diverse. In fact, one interviewee began her interview by listing off her coworker's different ethnic and racial backgrounds. For this interviewee, the diversity of her coworker's heritage represented a progressive and inclusive atmosphere towards difference and diversity. The interviewee felt that the diversity of her team had a positive impact on the team's dynamics. The interviewee believed that the sheer diversity of her workplace improved the team's knowledge about different cultures, led to better cultural competency skills, and made the team more sensitive of difference. Indeed, the interviewee suggested that

> [I]t's harder to be racist when there's only 50% white, right…. The best way I think to combat racism is to have intimate relationships with not-white people and that's what's created in [our cultural competency training sessions]. When you get to know well, really well five other people that are from ethnic minorities it blows stereotypes out of the water.

The interviewee noted that team members sometimes held discriminating or stereotypical judgments about their patient's or coworker's ethnic or racial background. However, the interviewee believed the team's heightened cultural competency skills

enabled team members to better identify and challenge discrimination and false

stereotypes. In turn, the interviewee felt that these moments made the space feel safer and

supportive for everyone. The only major concern this interviewee expressed was the

following:

> We [Canadian professionals on her interdisciplinary team] have done a very bad
> job of giving them [health professionals from foreign countries] the opportunity to
> share their wisdom. We teach them but we haven't let them teach us much.

For another interviewee who also found her workplace to be exceptionally diverse,

race and ethnicity were also seen as having a major influence on team dynamics.

Contrary to the previous interviewee's view, this participant felt that difference and

dissent were not tolerated even though the team's racial and ethnic make up was diverse,

and diversity and multiculturalism were supposedly valued in her workplace. For

example, the interviewee recalled how two coworkers where treated differently

> She was not from Canada, so sometimes when she was talking she's trying to find
> that word and how to say it in English. And it was almost like there was no
> patience.... [Jean] was able to I think navigate more in that medical jargon.

The interviewee cited two issues that she thought contributed to the lack of full or

authentic inclusion on the team. One issue was that team members lacked knowledge and

awareness about different cultures, and in turn, they drew false and stereotypical

judgments about other members. Indeed, in an appalled voice, the interviewee recounted

how some doctors on her team had asked patients who had immigrated to Canada,

whether Cambodia had doctors or if residents of the Solomon Islands still lived in trees.

The second issue that the interviewee observed was that the team only seemed to

value certain kinds of contributions. She recounted how two coworkers who had the same

purpose and role on the team were valued and treated differently. One coworker had

trouble speaking English, and used more holistic terms to describe what she wanted to say, "more about 'I don't want to offend' or 'this is what I'm feeling.'" The interviewee noted that this coworker was frequently disrespected, ignored and cut off. Conversely, the other coworker "was able to think and navigate more in that medical jargon. Like they [interdisciplinary team] didn't have to work harder to understand [her]." From this account, it seemed like the interviewee's team only valued contributions that reflected rational, objective, and Western notions of medicine. Overall, the interviewee's accounts implied that there was little room for difference and dissent from the status quo.

A third interviewee also described her team as being diverse in racial and ethnic background. In her opinion, race and ethnicity were also seen to gravely affect the team's dynamics negatively. The interviewee suggested that team members did not have a shared vision or standard on what was considered acceptable cultural practices when it came to a patient's care. This interviewee recalled how her team argued over whether or not a patient's wife should be allowed to continue caring for her husband in a certain way. Some team members believed that her activities interfered with the patient's care, while others felt that her behaviour was appropriate to and reflective of their cultural background.

The interviewee noted throughout the interview the many differing and sometimes conflicting opinions of her teammates, and often attributed these differences in opinion to her coworkers' racial and ethnic backgrounds. Interestingly, this interviewee also noted that her team tended to endorse Western, Eurocentric, and White ways of doing things. The interviewee reflected on how a patient had to get permission from the hospital to have a native healer come visit him, and while the hospital gave its consent, it did not

really approve of the practice. The interviewee also reflected on how a black colleague's style of practice was criticized extensively. She commented that, "I wonder sometimes if they're just not accepting of colour. You know if this person was, and I don't want to be disrespectful, but Caucasian. Maybe they'd be ... OK." This interviewee's overall stance was that differences in race and ethnicity interfered with the team's ability to have a shared worldview, which at times appeared to lead to animosity and criticism of different approaches to practice.

Interestingly, a fourth interviewee did not perceive race or ethnicity as having any impact on the team's dynamics. The interviewee asserted that everyone on the team, regardless of his or her racial or ethnic background, were treated the same way and had the same opportunities to contribute to the team's work. She pointed out that,

> I don't see it [race and ethnicity influencing team dynamics] because it seems like we function just as well as a team and the conversation happens regardless of who is on and who isn't. [Everyone] has the same opportunity to voice and to express yourself and your concerns.

On the whole, the interviewee felt that her team dynamics were not influenced by race and ethnicity, because her team operated smoothly and effectively regardless of who was present.

Class

Conversations and observations of class informed team dynamics the most infrequently and briefly. Interestingly, all but one of the interviewees concluded that class did not influence their team's dynamics because all of the team members belonged to the same class. When one interviewee was asked how she knew there was equality on her team in regards to gender, race, and class issues, the interviewee instantly responded, "we're pretty much similar kinds of class.... Everyone has a living wage.... So we're not

going to have people who use the food bank that work here." The interviewee concluded

that when people are of the same class they are equal.

Interviewees described class solely in regards to income and education. Two

interviewees suggested that there were minute differences between team members'

incomes. As one interviewee commented,

> [W]e're certainly aware of it [class]. Some of us drive nicer vehicles and live in maybe more affluent parts of the city or province. So we know it's there. But I don't think it determines how we interact with each other.

Noticeably, the interviewee infers the ambiguity of class when she says, "we

know it's there", as though class, unlike race and gender, is an invisible force in their

lives that manifests into concrete differences in material goods like automobiles and

homes.

> For another interviewee, class was closely associated with education levels.

> The only people we are going to deal with are middle and upper because, in terms of professional staff, even the reception, there's a certain level of education that one is going to have. They're not going to be poor.

Interestingly, a higher education is perceived as a guaranteed protection against

poverty. Not all interviewees shared this view. Indeed one interviewee thought that her

coworkers

> [M]aybe [were] able to relate to that [working class] more readily because some of them are in that same situation. You know, even though they earn money maybe they can relate to it [working class] a little bit more.

For this interviewee, income alone did not determine a person's class.

Unfortunately, her thoughts in this area were not further explored to find out what she

thought class all entailed.

ii.   How Teams Talked About Gender, Race & Class

Gender

When asked how interdisciplinary teams discuss gender, race, and class, interviewees provided a wide array of responses. For one interviewee, gender was only discussed on the team when the team was hiring. "Gender, I think does come up because of the importance of having more men in family medicine. You don't want to segregate it as a female only discipline." Alternatively, another interviewee said that gender was discussed on the team on a daily bases in regards to clashes between professional and parenting roles.

> We talk a lot about our responsibilities to our families as full time working women.... We talk about the balancing act of trying to be a good mother, be an involved parent and still work full time and experiencing similar feelings of guilt.... You know someone walks in looking tired and 'oh my toddler kept me up' – 'oh that must be hard.' We support each other.

In addition to the team's discussion on how gender roles in the domestic sphere impact their professional roles, this interviewee suggested also that the team had talks about gender issues and their impact on patients' lives. The interviewee's recollections of these conversations suggest that the team has multidimensional discussions about gender issues and patient care. During a discussion about one patient's care, the team discussed how gender roles placed care-giving responsibility of the patient onto the patient's mother and sister. The team noted that the mother and sister's care-giving roles were complicated by the lack of health services, and deep poverty characteristic of the northern native reserve that the patient came from.

Interestingly, another interviewee remarked that her team did not talk about how gender issues impacted team members' lives. On occasion, however, the team talked about how gender impacted patient care. Again, the team discussions about gender were

also described as multidimensional in that team members considered how race, class, and gender all intersected together, and thus making gender issues more complex.

Race

Team discussions about race were also inconsistent and varied. Teams were seen to relate race and ethnicity to their own lives during discussions more frequently than they related gender or class back to themselves. One interviewee talked about how world sports events initiated conversations about team members' racial and ethnic backgrounds. During these conversations, team members compared differences and similarities about their European roots, and curiously explored each other's backgrounds,

> I guess there was a lot of talk about where we came from and our family backgrounds when the Euro Cup was on.... I happen to have grown-up in France.... and as it happens, some of them [coworkers] happen to have grown-up in Germany and they're right beside each other.... I guess that's where ethnicity comes into play.

Another interviewee suggested that the diverse racial and ethnic backgrounds of the team, which in turn stirred the team's curiosity about each other, necessitated conversations between team members regarding their racial and ethnic backgrounds. The interviewee stated that team members frequently engaged in conversations about their racial and ethnic backgrounds in an effort to educate their colleagues about their culture and diminish false stereotypes. In fact, the team regularly attended training sessions that gave the team the opportunity to talk about their cultural backgrounds, and to ask questions about others.

> I made some comment about racism and in a way people don't understand. And he [a man of a visible minority] started to laugh and he talked about some of the racist experiences he's had and they [other team members] were like [shocked] (interviewee makes shocked face).

The interviewee understood this form of peer education to be extremely fruitful because it increased understanding and communication between team members. The interviewee also commented on how the team has increased cultural awareness transferred into their practice. The interviewee remarked that after she provided a training session on a certain ethnic group, she observed how over the period of 12 months her coworkers began to incorporate considerations specific to that ethnic group when planning a patient's care. The interviewee observed a notable difference in a coworker's attitude towards and considerations about patient's ethnic backgrounds. The interviewee suggested that,

> [T]his was totally something different from her – like I wouldn't have expected it
> ..., and I just wanted to say 'YES! Got it!' .... Her lack of awareness was changed
> and so when something came across her desk that was a possible resource she
> thought of them.

The interviewee further noted that her coworker's adoption of cultural awareness is not automatic; however, she feels that progress has been made at a reasonable pace.

In contrast, another interviewee who also identified her workplace as multicultural thought that her coworkers' uptake of cultural competency skills were slow and sometimes nil. She noted that only a few team members made referrals to an ethnic specific support group. In a disappointed voice, the interviewee stated, "even the doctors that referred to the social workers – they all seemed to be the same ones...." Additionally, the interviewee noted that there was resistance from her team in regards to initiatives concerning race and ethnicity issues. Forms of resistance included disinterest in diversity initiatives, and subtly criticizing initiatives in informal settings. For example, while there was no formal discussion regarding the teams' attitudes and opinions regarding diversity

initiatives, there were, "rumblings [and] mutterings. It wasn't looked at as a discussion – it was never really held."

A fourth interviewee also noted animosity in her team's discussions about race and ethnicity. The interviewee recalled how conversations about patient's race and ethnicity sometimes created conflict because, "race I think it's a lack of education. You just need more education right. Because they [coworkers] come from a perspective of my way is the right way or the only way." It appeared from this standpoint that team members did not have a shared understanding of how a patient's race or ethnicity informed their behavior, nor did they have a common vision of what behaviors should be considered acceptable or tolerated. The interviewee recalls

> Because of their [patient's] background, the wife in that background actually caters to the husband and helps him bath. And really, that was OK with him. But it wasn't OK necessarily with some of the team members because some of the team member's vision is this doesn't help this person to become independent.

In effect, the team often disputed the patient's care. Indeed, the interviewee remarked, "I did advocate – I think it's only fair that people have the right to do what they wanna do you know. So everyone has the same rights."

Interestingly, the interviewee also commented that conversations about patient's race and ethnicity were easier for team members to talk about than conversations about their own race and ethnicity. "When you talk about class it's usually a little bit easier [because] people don't pick sides." The interviewee noted, however, that when team members were from the same racial or ethnic background as the client, they would frequently explain their culture and try to help their colleagues understand better the patient's behaviour from a cultural perspective. Outside of discussions on patient's care,

the interviewee suggested that the team rarely discussed race and ethnicity with each

other because,

> [W]hen you're talking amongst the team and the differences about their
> backgrounds you don't want to offend anybody. But when you're talking about
> patients it is easier to talk about it [class] – I mean there are more judgments that
> are made.

Class

One noteworthy observation was the strikingly similar accounts interviewees gave

in regards to how class was discussed on their interdisciplinary teams. While one

interviewee did not comment on this topic, three interviewees reported that their team

members never discussed each other's class. Two interviewees suggested that the team

was aware of each other's differences in income, but these observations never developed

into discussions. Curiously, the three interviewees suggested that class was discussed

regularly on the teams in regards to how patients' class status impacted their plans of

care. During these discussions, interviewees suggested that the team talked about, for

instance, a patient's poverty and how it impacted their ability to afford private medical

services. Interviewees described these conversations as multidimensional in that

discussions about class also took into consideration how race, gender, disability, and

geographic location intersected with a patient's class. One interviewee suggested that

conversations about class evoked harmony on the team because everyone seemed to have

a shared agreement and understanding about patients' class, unlike discussions about

gender or race and ethnicity. The interviewee insinuated that the effects of class, unlike

gender and race and ethnicity, are more concrete or factual. The interviewee suggested

that the effects of class cannot be disputed because they have a real and direct impact on

the patient's care, while gender, race, and ethnicity can be disputed. That is because they are framed as opinions as their impacts are harder to detect and see directly.

iii.   How Teams Manage Diversity

When asked about how interdisciplinary teams manage diversity, interviewees gave several insightful responses. One interviewee did not perceive diversity to have any impact on the team's dynamics, and indicated that cultural diversity was not actively managed on the team. Noteworthy, however, is that the team acknowledged how a professional hierarchy impacted the team's dynamics. Consequently, the team actively attempted to compensate for these differences in power. For example, the interviewee stated that "I think I'm very inclusive in my practice. I ask for their feedback. I ask for their suggestions." When the interviewee was asked how gender, race, and class created differences in power the interviewee responded, "I don't notice it, to be honest with you. I'm not sure if it's in the background and I'm not aware of it."

Conversely, two interviewees found that their teams did not manage diversity so much as react to it. These interviewees described how differences and dissent was only tolerated to a certain extent on their teams, and after a certain threshold, team members exercised overt and discreet forms of pressure to force their colleagues to conform to the status quo. Discreet pressure was exercised when team members ignored and disregarded certain kinds of contributions or certain team members. In the interviewee's accounts, the team members who were ignored and cut off were always of a minority status. It seemed that the types of contributions not being valued strayed from traditional medical jargon and frequently highlighted diversity issues. One interviewee described her uncertainty

about whether or not her teammates were inclusive and accepting when unconventional

views were voiced.

> People, it seems, they just sort of silently accept but then may go and discuss it
> among certain groups behind your back. On the surface everybody is smiley and
> happy. But the sort of the team dynamics underneath [long pause].... present as if
> they are accepting but it's hard to know if it's real.

Overt pressure to conform to a particular way of doing things involved team members

openly criticizing certain styles of practice and particular kinds of contributions. One

interviewee recounted how her coworkers made "snide comments.... It's like oh there

she goes again. So it's like they wanna turn off or belittle you or be critical of you or

they'll find something else that they can be critical of."

Sometimes it appeared that criticism looked more like discrimination. During one

interview, an interviewee recalled how a female colleague was told to brush up on her

physical appearance because she looked like an absent-minded professor. While

providing this account, the interviewee spoke about the discrepancy between her

workplace's desires to have a multicultural image, but its failure to uphold multicultural

and pluralistic values, because it only recognized one right way of doing and being.

> In all other ways anything I saw at the clinic, well not in all other ways, but so
> professional. Like we are [John Hopkins]. We are great. We are leaders. Like, we
> know more is expected of us. Like we value this [cultural diversity]. We want to
> be this [culturally diverse]. It was just weird.

Alternatively, another interviewee proudly described the progressive and proactive

steps her workplace took to manage diversity in a healthy and inclusive manner. From

her standpoint, the team proactively managed diversity by providing educational training

around cultural awareness. Her team effectively managed discrimination, which she

believed stemmed from cultural misunderstandings, by confronting false belief systems

when they surfaced. Indeed, the interviewee recounted how she has personally confronted false stereotypes on numerous occasions, and how her coworkers were beginning to identify and confront false stereotypes more frequently. This interviewee highlighted,

> [W]hen I was not in this group and when I came in someone said 'yeah, so and so made a joke - you wouldn't have liked it.' I said I'm glad I wasn't here then. My hunch was it was a homophobic joke. I don't know what it was but someone called him on it even when I wasn't in the room. So I'm not there but it still didn't wash.

Outcomes of Diversity Management

For the above interviewee, diversity management in her workplace was like an upwards spiral, where education on cultural awareness enabled the team to become more culturally competent, and as the team's cultural competency skills improved, they were able to identify and confront more stereotypes and become more accepting and inclusive of difference. The interviewee found that diversity in her workplace was effectively managed and resulted in the creation of a safe and culturally inclusive space.

For the two interviewees who understood their teams to be reacting to diversity rather than managing it, these interdisciplinary teams became unwelcoming and unsafe spaces with little room for difference and dissent from the medical model. One interviewee recalled how it was exhausting to be continuously at odds with other team members, and revealed that she sometimes chose to be passive and silent on issues. This insight presents concerns about the ability of social workers to contribute fully to a patient's care when the work environment is exclusive and exhausting.

On a lighter note, the fourth interviewee who did not perceive diversity to be impacting her team's dynamics told me that her team was supportive and inclusive because they did not recognize gender, race, and class differences.

> The team doesn't operate any differently. The day doesn't go any differently. Communication doesn't change whenever they're [black coworkers] on.... [Everyone has] the same opportunity to voice and to express yourself and your concerns.

The interviewee's account suggests that the team's colour-blind approach to difference has allowed the team to foster equality and inclusion in the work environment.

B. Discrimination & Resistance

A second major topic interviewees tended to focus on was discrimination and resistance to difference and diversity. While interviewees provided many accounts of resistance and discrimination, three interviewees stressed that discrimination did not occur on a daily basis, and when discrimination did happen, it felt like an exception to the normal, daily interactions. Two interviewees described resistance to alternative practices and ideologies as a more common and frequent practice. In fact, one interviewee inferred that the resistance she faced from her team was a weekly ordeal that sometimes exhausted her. One interviewee knew of zero incidents of discrimination or resistance on her team.

As stated earlier, interviewees described overt and discreet forms of resistance and discrimination. Resistance was often to diversity initiatives or education around gender, race, and ethnicity. Resistance was discreet when coworkers ignored or were disinterested in certain contributions or contributions made by certain colleagues. Indeed, three interviewees mentioned that they often had to have repeat conversations about the same issue or concern. One interviewee mentioned how having to repeat herself over the same topics wore her out. Resistance was overt when coworkers voiced objections about initiatives. Another recalled how resistance to one diversity initiative eventually undermined the entire project.

It was like, you know the same tune – I'm sick of it. Originally we had planned to have it [bake sales to help purchase medical services for an ethnic group] every Wednesday and then we moved it to every other Wednesday and then just depending on if we are going to have any residences here today. So it started to become less and less often and just more random.

Accounts of discrimination included sexism, racism, homophobia, and class-based discrimination. Discrimination was described as harmful utterances and false judgments and stereotypes. Interviewees suggested that sometimes the discrimination was intentionally targeted at a specific person, while other times the offenders were not aware of the harm they had caused. As one interviewee reflected, "one staff made a [homophobic] comment and they didn't have a clue how I experienced what they said." Undoubtedly, many accounts of discrimination suggested that offenders were not aware of the effects of their actions. Interviewees suggested that their coworkers drew negative conclusions about patients and coworkers because they had bought into false stereotypes. Here, one interviewee stated that some of her coworkers had negative opinions about patients who access Ontario Works – a program that provides unemployed residences of Ontario with a small monthly allowance. The interviewee felt that coworkers had bought into the false myth that people who use Ontario Works are too lazy to get a job.

Team members of all different professional statuses exercised resistance and discrimination. When discriminatory incidents occurred, interviewees recalled how sometimes team members confronted the individual who issued the utterance while the rest of the team remained silent. Other times, interviewees recalled how their teams appeared to be in shock, and did not say anything to address the utterance, or the team reacted passively and did not say anything. In fact, one interviewee recalled how everyone had been so shocked by a sexist remark that was made during a presentation

that even "the leader [director who] looked at it, didn't say anything, didn't comment at all." Based on the interviewees' accounts, it seems that the most common reactions to discrimination in interdisciplinary health teams are shock, passivity, and silence.

C. Social Worker's Understanding of Self

A third major topic that came up in interviews was the interviewees' perceptions of themselves in relation to the teams' dynamics. During the interviews participants referred to themselves as allies and advocates of patients and the oppressed. Interviewees described their positions on their respective teams as twofold: they provided advocacy for patients especially around race, class, and gender issues that impacted the patient's care, and they educated and confronted their team members about race, class, and gender issues. Indeed, interviewees tended to talk about themselves as being different from the rest of their team members. They frequently mentioned or inferred that they worked from a very different ideology, and considered diversity issues more often than other team members. Sadly, one interviewee commented on the distance she felt between herself and other coworkers stating that, "sometimes you're sort of that lone wolf."

When asked how interdisciplinary teams responded to these activities, interviewees reported a wide range of reactions. Teams were accepting, indifferent, uninterested, disagreeing, and critical of the interviewees' contributions to the team. Based on the interviewees' accounts, it seems that interdisciplinary health teams are for the most part accepting or indifferent towards social worker contributions on gender, race, and class issues. One interviewee felt that her contributions were greatly valued by her team, and highlighted how the teams lead physician routinely made inquires for her input. Another interviewee also felt that she generally had her team's support on gender,

race, and class issues and that the team's interest and understanding of these issues grew over time. A third interviewee questioned whether her team's agreeable attitudes were genuine, and suggested that deep down some coworkers actually disagreed with her but did not say anything. This interviewee also recalled how at other times her team has voiced their disagreement and criticisms. A fourth interviewee noticed that social workers were valued on the team when they used medical jargon, but when they used more holistic terminology they tended to be ignored and shut down by the rest of team.

When interviewees were asked how they responded to resistance and discrimination, interviewees gave an array of responses that included education, confrontation, shock, passiveness, and silence. When interviewees heard their colleagues use false stereotypes or draw false judgments, interviewees suggested that they often used these moments as opportunities to provide education around cultural awareness. Three interviewees recalled how they sometimes had to have repeated conversations around gender, race, and class issues. One interviewee stated that having repeated conversations made her feel exhausted, and consequently she sometimes chose to be passive and silent around these issues, rather than repeat herself again. "You know if I just listen and don't say anything I think it's just – you don't want to deal with it at this point (laughs). You know, it can get annoying sometimes."

During another interview, the participant described how she became immobilized by shock that came over her when colleagues made racist, homophobic, and sexist comments. Curiously, the interviewee also gave accounts about times where she confronted her colleagues about their discriminatory comments. When asked why she was able to confront her colleagues in some moments but not in others, the interviewee

stated that she was able to confront colleagues with whom she had developed friendships. The interviewee also noted that she was unsure about confronting other coworkers with whom she did not have a more intimate relationship, due to her employee status. She recalled that "my role, I'm a [temporary employee]. I'm not going to be there forever. I didn't know how to respond to it [homophobic comments]."

Another interviewee also stated that she chose not to become involved in matters that she understood to be discriminatory and inappropriate when she perceived the issue to be none of her business. "It's not happening directly to me. But if it were happening to me, I would speak up. Because in another work situation I did." The interviewee's response suggests that her decision to remain silent and passive or to confront matters is guided by social norms about what constitutes public and private business. The interviewee also added in a bleak tone that she chose not to say anything about the issue, "because I don't think it will go anywhere." Indeed, it seems that hope and the possibility for change is a crucial consideration for this interviewee, when deciding on whether or not to expend energies that are already low and exhausted from having to repeat herself on other issues.

SECTION II: DISCOURSE ANALYSIS

A. Intention of Analysis

During interviews, as participants shared their thoughts on gender, race, and class, I did not perceive there to be anything unnatural or inconsistent in their reasoning, and in fact, I frequently found a shared understanding or agreement with their line of thinking. Their perceptions seemed logical enough – with nothing out of the ordinary. It is in the ordinary, however, that Smith (1987, p. 94) asserts that we need to see as "problematic". These attitudes and perceptions are anything but natural. According to Smith, the ordinary is organized by hidden sets of social relations in such a way as to benefit dominant groups of society.

Like a fish out of water, I initially failed to observe some of the more extraordinary aspects of the interviews. It was not until I was deep in analysis, comparing the different accounts of gender, race, and class, that I started to become aware of the particular ways in which language was fashioned around these topics, and in the large gaps and discrepancies in some of the reasoning and perceptions. I want to explain that while the following two sections may come across as being critical of the interviewees, my intention is to make explicit the silences, gaps, and discrepancies in the everyday discourse on interdisciplinary health teams. It is my hope that by illuminating how our everyday speech maintains relations of dominance and subordination, individuals will become more critically conscious of their everyday speech, and will therefore be able to exercise more control over their own participation in relations of oppression. My hope is that the following reflections will serve as critical self-reflection tools, and thus will be used to evoke social change in our individual lives.

B. Difficulties Talking About Gender, Race & Class

Noticeable throughout the discussions was that it seemed like a strenuous effort for interviewees to talk about diversity issues in their workplaces. While interviewees spoke fluidly about gender, race, and class issues that impacted their patients, it appeared as if interviewees were less prepared to talk about the ways that diversity issues impacted their own lives. Uttered throughout the interviews were phrases such as, "Oh that's a hard one, ummmm, can I think of something", "I can't think of one off the top of my head", or "ahhhhhh (sigh) – I'm trying to think."

In comparing the discussions about patients versus themselves, interviewees paused more often to reflect on questions, had trouble finding words, and informed me that they had never considered their work relations from a gender, race, and class analysis. In fact, the first thing one interviewee did in an interview was express concern about her ability to contribute to the study.

> I'm not sure how much I'm going to be able to speak to that [race, class, and gender issues] because I'm sort of part of a really good functioning team. But certainly, I was intrigued by the subject matter. You know race, class, and gender issues in interdisciplinary teams. It's not something you think about a lot because you're so focused on your clients and addressing the race, class, and gender issues that affect them.

It appears easier for social work practitioners to talk about diversity issues that concern their clients, but not issues that affect themselves. Baines (2003) observed that when social workers talk about diversity issues they tend to focus on the oppression of their clients, and generally, they do not talk about their own privilege and oppression associated with their social location.

C. Absences of Self & Focus on Others

Interviewees regularly gave examples without placing themselves within the narratives, and at times, spoke in third person about *the social worker*. Indeed, interviewees rarely commented on their own social status or the ways their social status related to others in the workplace. This observation is somewhat surprising and curious considering that critical self-reflection is a primary cornerstone of social work education. Indeed, two interviewees mentioned that they worked from an anti-oppressive practice paradigm; a paradigm that fosters self-reflection and identifying your social location and understanding how your social location interacts with others (Heron, 2005). While interviewees certainly demonstrated a wealth of information and critical reflection about the gender, race, and class of their client base, it seemed to be more difficult for interviewees to use this framework to understand their coworkers and work environments.

Absence of self was particularly evident in accounts about class, race, and ethnicity where interviewees tended to talk about incidents that happened to others, particularly patients and racial minorities. An interviewee briefly noted that her and her coworkers were middle or upper class, and then extensively spoke to the poverty faced by her clients, and the financial programs her workplace offered to assist poor clients. The focus of the interviewee's response suggested that it was easier to hold a discussion about her client's class than to talk about her own class. Another participant began her interview by listing off the ethnic racial backgrounds of her colleagues in an effort to illustrate the clinic's multi-cultural atmosphere. In this way, race and ethnicity were presented as just differences: mutually exclusive categories to be slotted into one another.

Again, it is easier for social workers or white people in general to talk about race

and ethnicity as though it is something that only affects the lives of racial minorities and

not mention their own whiteness (Baines, 2003; Henry et al., 2000; Macalpine & Marsh,

2005; Razack, 1999). Baines also notes that social workers commonly envision class, as

something that is only a characteristic of the poor and working classes and not an

attribute of the affluent.

Razack (1999, p. 14) suggests that,

> In focusing on our subordination, and not on our privilege, and in failing to see
> the connections between them, we perform what Mary Louise Fellows and I call
> 'the race of innocence,' a belief that we are uninvolved in subordinating others.

Perhaps the interviewees' focus on the subordination and oppression of others is

an example of Razack and Fellows' race of innocence. A few interviewees self identified

as middle or upper class and then immediately commented on the poor and working class

status of their client base. In this way, the classes were presented as being different,

mutually exclusive categories. By not commenting on the relations of power and

exploitation that tie the classes together, this discourse, unbeknownst to the interviewees,

works to reinforce the status quo. Indeed, upper and lower classes make two sides of the

same coin – one class cannot exist without the other. In not acknowledging the relations

of power between upper and lower classes, interviewees do not have to confront their

own privilege that is made possible by the flip side of the coin – the subordination and

oppression of lower classes. Consequently, the status quo is not held accountable for their

compliance in the subordination of others.

D. Homogenous Discourse

Descriptions of gender, race, and class affect interdisciplinary team dynamics were frequently homogenous and flat in that they were referred to as though there was a universal experience of gender, race, and class. Different experiences of gender or different experiences of race and class are not considered in this regard. There also was little mention of how these social statuses intersected with each other. When interviewees concluded that the high proportion of female employees on the team negated gender dynamics, interviewees were in effect not acknowledging any differences between and amongst female employees in areas such as race, class, disability, or sexual orientation. Similar descriptions were also made about class, race, and ethnicity. One interviewee stated, "the majority of us [on the team], as you have probably noticed, are white or at least pure white." Here, whiteness is described in homogenous terms. No consideration in how other social statuses may result in different experiences of being white.

Razack (1999) argues that when white and/or privileged women refer to themselves as a homogenous, universal group, they conveniently although subconsciously, rule out in-group relations of domination and subordination. In effect, white and/or privileged women do not have to confront their own participation in subordinating other women. The same concept about homogenous, universal discourse can be applied to race and class; insiders do have to take responsibility for their compliance in oppression.

It is important to note, however, that interviewee's homogenous responses were likely influenced by the way the interview questions were framed. While interviews began more broadly, asking interviewees how they thought gender, race, and class influenced team dynamics, questions later in the interviewees tended to be directed at

only one category at a time. It was reasonable for interviewees to provide homogenous responses initially. Nonetheless, interviewees did have a desire to split the categories and talk about them separately. As one interviewee responded to the broad opening question, "Oh that's a hard one – all three at the same time?"

E. Essentialist Discourse

Curiously, interviewees talked about gender, race, and class and how it affected their client base a multidimensional way. However, when differences within the gender, race, and class areas were observed, interviewees tended to essentialize the differences, in that the differences were presented as mutually exclusive categories that had no bearing on each other. Differences were described as simply differences with no recognition of the power relations between them. One interviewee acknowledged that there are multiple experiences of being white or multiple experiences of being a woman when she said, "I'm telling you a white women's perspective." While gender and race are recognized as being multidimensional, the differences are seen as self-evident rather than socially constructed. Razack (1999, p. 12) suggests, "When difference is thought to reside in the person rather than in the social context, we are able to ignore our role in producing it."

When interviewees name differences without acknowledging relations of domination and subordination between the differences, they miss the opportunity to take accountability for their privilege and their complicity in subordination. Such silences, although we are not consciously aware of them, make relations of power invisible and present privilege as an innocent, static state of being rather than active networks of social relations and exchanges of power that are detrimental to many lives.

SECTION III: MAPPING THE SOCIAL ORGANIZATION OF KNOWLEDGE IN INTERDISCIPLINARY TEAMS: SILENCES, GAPS & DISCREPANCIES

A. CONTRADICTING INTERPRETATIONS OF WORKPLACE DIVERSITY

While reviewing the data to better understand how relations of domination and subordination were reinforced by the social organization of knowledge and discourse on interdisciplinary health teams, several major discrepancies quickly became apparent. Conceptualizations of workplace diversity were various and even contradicting. Interviewees felt that having an interdisciplinary team made up entirely of women was problematic. To be certain, one interviewee recalled how during a hiring process "there was a strong male applicant and someone said it's important that they get in because we're so short of men." Notable, is that the hiring team independently found it problematic that the team was dominated by women. Conversely, the team did not independently observe nor find it problematic that the team was almost exclusively white. In fact, the social worker had to initialize a conversation about the racial and ethnic diversity of the team before another team member agreed, "Yeah, we're too Wonder Bread aren't we."

In a similar vein, interviewees maintained a casual attitude when they spoke about how their entire team belonged to the same class, giving the impression that this shared status was perceived to be natural and not problematic. However, having a team made up exclusively of the same gender was deemed undesirable and concerning. Indeed, as one interviewee suggested, "What's happening is family medicine is getting ghettoized as the place where women become doctors.... You don't want a ghetto of women." Interestingly, interviewees did not express the same quandaries about class.

The discrepancies between the different ways that gender, race, and class are deemed problematic and not problematic may suggest that healthcare continues to be imagined as a space rightfully occupied by white, middle-class males. Women and non-white people, however, "still do not have an undisputed right to occupy the space" (Puwar, 2004, p. 1). From this framework, female dominance in the health professions is perhaps seen as problematic because it does not match the schema that healthcare is a space naturally occupied by men. Likewise, whiteness and having membership to the middle-class may not have been questioned because they nicely complement preexisting schemas of who is expected to occupy the space. As a result, the ideology and discourse used by the hiring team can be understood as working for the interests of the dominant group - an effort was made to reserve positions of power and authority for white, middle-class men in a way that was not made for anyone else. While such practices do not ensure that white, middle-class men will indeed be awarded these positions, they are setup for better success.

B. MAKING VISIBLE/INVISIBLE RACE & ETHNICITY IN RACISM & SEXISM

Another discrepancy in how gender, race and class on interdisciplinary teams is imagined and understood is exemplified in interviewees' accounts of racism and sexism and the ways race and ethnicity are made visible and invisible throughout these discussions. Most notable was how the offender's race and ethnicity was only mentioned if the person was a racial or ethnic minority. Undeniably, several accounts of racism and sexism were directly attributed to the offender's racial or ethnic minority status. The comments of one interviewee perhaps offer insight into the discrepancy. "If there's difficulty it might get attributed to the fact that he's [from a foreign country]... he needs,

you know, a bit of a tune up in terms of Canadian culture." Difficulties or faults are automatically associated to race and ethnicity if the person has a minority background. What the interviewee infers but does not say is that difficulties and faults are not attributed to a white person's skin colour or cultural background.

In fact, not a single account of racism, sexism, or any other mentioned discrimination was attributed to a person's white skin colour, European, or Canadian background! When the race and ethnicity of the offender were not provided, discrimination was described as isolated individual acts – they were not deemed to be expressive of a group's inner essence. Curiously, these accounts provided hardly any identifying information about the offender – it was as though they were ghosts. An interviewee remarked, "It was a voice in a crowd" that had shouted a sexist comment at the presenter during a presentation.

Another interviewee, who suspected coworkers were racially prejudiced against a black colleague mused that "people are very critical of this person in many ways." While much is known about the victim, her skin colour being particularly highlighted, her perpetrators are described anonymously as people. Similarly, in a third interview a participant told me that during a Native health training session "there were people who made comments like, 'I didn't take land from anyone.'" The people making the racist comments are spoken about generically.

Race and ethnicity was woven in and out scripts about racism and sexism in ways that rendered whiteness invisible. Whiteness was unseen and unnamed. Although the interviewees' selective discourses are unconscious and unintentional, the discourse nonetheless portrays a pristine image of white people; white people were not connected

to racist and sexist acts. Whiteness remained largely unnamed. Interestingly, whiteness was identified in examples of how coworkers were becoming more culturally competent.

Meanwhile, racial and ethnic minorities were portrayed with very negative and tarnished images; they were the only racial and ethnic groups identified as perpetrators of racism and sexism in the workplace. Although it is possible that all of the perceived offenders were of a racial or ethnic minority, including the offenders whose race and ethnicity were not named, it is worth nothing that racial and ethnic minority statuses were not used to illustrate examples of progress in cultural competency. Taken together, the discourse on racism and sexism in the workplace makes whiteness invisible and shines the headlights on the negative actions of racial and ethnic minorities.

C. THE SHOCKING (WHITE) PROFESSIONAL

What happens when professionals go against our imagined Canadian customs and conventions by making racist and sexist slurs? One interviewee described these moments as car crashes – a perfect metaphor to describe the unexpected and unimaginable. In the interviews, comments and facial expressions of shock routinely accompanied accounts of discrimination. While reflecting on a professional conference where a doctor shouted a sexist comment at the presenter, an interviewee stated, "The general reaction was like, 'Oh I can't believe it was said.'" Another interviewee mimicked the shock on her coworkers' faces after two of their colleagues recounted their experiences of racism.

When asked why these instances were so unexpected and shocking, one interviewee responded that they did not coincide with the image of healthcare as professional and progressive. The notion of professional was a common theme through

all of the interviews. Indeed, one interviewee concluded that the reason why there were no incidents of discrimination on her team because "we're very professional here."

According to Fusco (in Razack, 1999, p. 11), incidents are profoundly shocking "because they upset the dominant group's notion of self." It seems that when members of interdisciplinary teams make discriminatory comments, not only do they break the imagined social norms of Canadian culture, but they also violate the imagined qualities and characteristics professionals are thought to espouse. According to Puwar (2004, p. 154), "professionals think of themselves as being neutral, meritocratic and objective." In affect, we are completely thrown when a health professional makes racist or sexist comments because it smashes our imaged image of the characteristics of a professional.

After incidents of blatant discrimination, how is it that we are still able to imagine a professional image of healthcare? How do we interpret these metaphorical car crashes? Interestingly, not every offence was understood with the same reasoning. Sometimes incidences were understood to be rare and abrupt occurrences that came as a shock because, as one interviewee said, "they're a doctor." Apparently, the prestigious and professional status of the physician did not coincide with schemas about what a racist or sexist person looks like.

In other instances, interviewees were not surprised when discriminating comments and judgments were made. One interviewee concluded that "given the culture he [the perceived offender] was trained in that [patriarchy] might not be totally surprising." Similarly, another interviewee seemed unwavered by her colleagues' continuous discriminating judgments as she suggested that their behaviours were the result of their cultural backgrounds and lack of education around race, class, and gender

matters. It seems that racial and ethnic minorities are very much connected to dominant

ideas about who is a racist or sexist. Therefore, these professionals do not disrupt the

professional image, and witnesses do not go into shock because their discriminatory

actions can be explained by their race and ethnicity.

Depending on which social status the interviewees observed as the primary social

status, either professional status or racial and ethic status, discrimination either came as a

surprise or it did not. When only the professional status of the offender was observed, the

incident came as a shock, but when the cultural background of the offender was observed,

the incident did not always come as a surprise.

Consequently, when anonymous professionals made derogatory comments they

were viewed as bad apples. Their judgments and actions were not viewed as a reflection

of something deeply wrong with the entire group. However, when the offender's racial or

ethnic status was observed, their judgments and actions were understood to be reflective

of a group trait – a group that is not deemed to authentically belong in that space. In

effect, these car crashes are not traced back to the social relationships operating in the

space. They are interpreted as something that is brought in from outside the space –

whether it is unique individual biases not shared by the rest of the group, or biases

understood to belong to an alien group that has made its way into the space like Trojan

horses.

The resulting effect is a preserved professional image of healthcare: one that is

unbiased, neutral, and objective despite occurrences of discrimination. Additionally, the

authentic occupants of the space, those anonymous people with bodies unmarked by race

and ethnicity (white people) are again left with a pristine image and no cause to improve their social relations with racialized others.

D. DOUBLE STANDARDS WITH EDUCATION

Another instance where dominant discourse maintains and reinforces the status quo on interdisciplinary health teams is seen in discussions on diversity education. Interviewees reported that they frequently took it upon themselves to initiate discussion and provide education around diversity issues in the hopes of decreasing false stereotypes in their workplaces. Several interviewees commented that people from *different* cultural backgrounds would help with this initiative by educating their coworkers about their cultures. At one interviewee's workplace,

> People had questions – just questions they didn't know about. You know, we hear this, is this true? And he's [the different team member] very comfortable – he's made it clear, I'm quite comfortable [with people] ask[ing] me questions. And I think he has very much challenged the stereotype and educated them [the other employees] and taken that role on.

Similarly, another interviewee suggested that, "team member's of the same ethnic background understand [patients of the same ethnic background], and so they help explain and educate. So that's often a good thing."

It is these accounts that are deemed socially acceptable for persons of *different* ethnic and racial backgrounds to educate their coworkers to become more culturally sensitive. Sometimes employees of *different* ethnic and racial backgrounds specifically outline to their coworkers how to make the workplace more inclusive. One interviewee mentioned that an employee from a different ethnic background "wanted to be able to pray a bunch of times on Friday so they adjusted his schedule so that could happen." The

employee's schedule had to get adjusted because the employee's cultural beliefs and needs were not taken into consideration prior to the issue being raised.

Interestingly, when it comes to gender issues, it is deemed inappropriate and wrong that women should have to provide education around gender issues in the workplace. One interviewee was livid that her female colleagues instructed some of their male coworkers about appropriate interactions between males and females in the workplace. In an irritated tone the interviewee recalled that "they ended up actually speaking up at some point and saying this is not acceptable what you're doing. And the fact is that you had to actually say it."

Cultural incompetence is dismissed as merely a lack of education, while ignorance about gender issues is considered an insult, unacceptable, unprofessional, and at times even suggestive of sexism. The double-standard not only devalues and dismisses cultural competence, but allowances are given for ignorance of cultural incompetency, unlike ignorance around gender issues, because people are presumed innocent for their lack of knowledge. In other words, white people are not expected to be culturally competent. Cultural incompetency does not suggest biased or prejudiced attitudes or a lack of professionalism as it does with those who fail to be attuned to gender issues.

The interviewee who was appalled at her coworkers, for asking Malaysians if they still lived in trees, concluded that the doctors required more education on cultural awareness. Professional and pristine images are not tarnished or challenged when people and workplaces are culturally incompetent because such mistakes, as they are called, are deemed to be innocent questions not intentional of any harm. Innocence takes the heat off cultural incompetency allowing the status quo to prevail.

E. HEROIC ADVOCATES AND ALLIES

Dominant culture is also preserved in the ways that social workers talk about themselves. Interestingly, interviewees frequently referred to themselves as advocates or allies in their professional roles as social workers and in this way, they inadvertently inferred their positions of power and privilege. However, without directly stating their power and privilege, their roles as advocates and allies present as selfless, benevolent, and heroic acts (Razack, 1999). In this way innocence is maintained and interviewees do not have to confront the ways that their privileged social status is directly linked to the subordination of those they advocate for. Social work advocates and allies do not have to address their compliance in subordination, be accountable for the ways that they benefit from these relations of power imbalances, or dismantle these exploitative social arrangements. Thus, the status quo predominantly benefits white European Canadians under the façade of altruism.

CHAPTER 5: CONCLUSION, DISCUSSION & RECOMMENDATIONS

CONCLUSION

Taken together, this study presents many useful findings. The varying responses suggest that there can be multiple experiences of interdisciplinary teams that depend not only on a person's professional status but also their social location. In addition, the discourse analysis and mapping of the social organization of knowledge and power suggest that ideologies and discourses about interdisciplinary teams work in ways beyond our intentions. They reproduce and maintain relations of dominance and subordination.

The finding suggests that interdisciplinary team members need to take a more reflective approach in interpreting their work relationships, and in the ways, their discourse works to preserve oppressive relations of power. Such considerations are not only important for giving interdisciplinary teams a more inclusive atmosphere, but the findings suggest that cultural awareness and inclusiveness have important and significant effects. They affect how team members contributions, what they contribute, and which contributions are regarded and valued. Indeed, as exemplified in the interviews, an atmosphere that excludes and certainly compromises the social worker's ability to perform her team role. Consequently, it is reasonable to assume that exclusive team environments can also have undesirable impacts on patient care and outcome.

DISCUSSION & RECOMMENDATIONS

This study raises several important questions about how to transform interdisciplinary teams into culturally inclusive spaces. While scholars maintain that a shared vision is necessary to have successful interdisciplinary teamwork, we need to ask whose visions are included in the shared vision and whose visions are being disregarded. While

interdisciplinary teams offer a structure for everyone to voice their opinions, presently not all opinions are being valued and heard. Indeed, this has certainly been the case with holistic, feminine discourse that is being disregarded for the more preferred medical, rational, and masculine discourse.

Producing a culturally inclusive environment will require more than just the efforts of individual team members. More research is needed on how the business culture currently being espoused by healthcare, not only impacts the culture of care (Chapman et al., 1995), but also on how the business culture stifles cultural diversity and compromises cultural competence initiatives.

It is important to ask if education on diversity and difference is enough to create a culturally inclusive atmosphere. It is also questionable whether increased exposure to difference and diversity, and increased education about difference and diversity can effectively dismantle the deep and often unconscious ideologies that, as the third analysis reveals, reproduce unequal relations of power. This question is raised because several interviewees drew the conclusion that discrimination in their workplace was the result of a lack of education or exposure of difference and diversity. As one interviewee remarked, "I think because of the number of not-white people that we work with on a day-to-day basis that after a while you can beat it [cultural competency] into our stupid heads."

The benefits that are likely to derive from increased education and exposure of diversity are not in dispute; however, it is questionable whether these initiatives alone are enough to tackle deep, underlying belief systems. Several participants mentioned their frustration at having to repeat discussions about gender, race, and class issues regarding clients. This observation may suggest that education and increased exposure to diversity

does not effectively challenge rigid belief systems. In recounting her experiences of

educating her colleagues about race and class issues one interviewee said,

> I think the team is accepting of most cases, but it's like you have to repeat it because there's that judgment that always is there and they've already judged right from the beginning.

Noticeable that this interviewee sees an underlying belief system as the barrier

preventing her colleagues from ever fully adopting a culturally competent outlook.

Finally, the important question must be asked about what will actually be

achieved through critical reflection of interdisciplinary health teams, and taking

accountability for participation in relations of dominance and subordination. Razack

(1999) warns that naming differences has become a current trend in academia and the

public sphere. It is on everyone's lips, and has become politically correct. In turn, there is

the risk of making critical reflection of diversity and difference a shallow practice,

because differences are essentialized and the social construction of difference is ignored.

In this way, naming differences does not dismantle relations of power because the

relations of power are not perceived in the first place. Thus, the status quo prevails.

To avoid making difference-naming shallow, Razack (1999) argues that we need

to become accountable for our complicity in oppressive relations. Razack states that we

need to critically self-reflect and identify our own power and privilege. Ahmed (2004)

disagrees. She blatantly says that such utterances are non-performative. The act of

naming one's own participation in oppression does not dismantle relations of power. In

fact, Ahmed suggests that the act of declaring ourselves as compliant in oppression

instantly transforms your negative identity as an oppressor into the ultimate positive

identity: altruistic. Such utterances are non-performative because they do not alter the relations of power, but conversely, they restore the oppressor's innocence.

Despite Ahmed's (2004) disclaimer, naming our compliance in the oppression of others should not be entirely dismissed. Perhaps the reason why uttering accountability has previously been ineffective at redistributing power is that it only looks at the ways power is cognitively reproduced. Razack (1999) states that the status of a person is dependent on the subordination of another. "These sources of her status are not merely in representation, that is, in how she is likely to be perceived. They are also material. The houses of the middle class *are* cleaned by working-class women" (1999, p. 158). In other words, it is a combination of both material and ideological arrangements that structure relations of power.

The practice of uttering accountability of compliance in subordination may yet prove to be effective in redistributing power if it is complemented by shifts in material arrangements. Shifts in material power that in turn create shifts in cognitive power are already being imagined and implemented at Toronto's Mount Sinai Hospital (Sulman, et al., 2007). Several years ago the hospital created an office of Diversity and Human Rights that is staffed by a social worker. The goal is to create an equitable and culturally inclusive environment by providing three services: education, conflict management, and policy development. A hospital-wide committee was also struck to plan and advice a procedure to create institutional change regarding diversity and human rights. A study produced by this office suggests that the program is effectively increasing cultural competency among the hospital's staff and management.

Indeed, uttering accountability seems a most important practice to help everyone realize Smith's goal – seeing the every day world as problematic (1987). Without this understanding, we will do what one interdisciplinary team did during hiring: unconsciously, we will continue to imagine privileged spaces as rightfully embodied by white, affluent men. Unconsciously, we will continue to reserve positions of power for white, affluent men. Unconsciously, we will continually fail to make the same effort for the oppressed. Consequently, our efforts to rearrange material power will be significantly undermined.

Acknowledging multiple and complex identities and the power relationships that are a part of and shape identities "allows us to see how less obvious and more nuanced exclusion operates within institutions via the tacit reservation of privileged positions for the somatic norm" (Puwar, 2004, p. 10). This is perhaps the pedagogy of the privileged: to clear the path of resistance for the oppressed, to raise themselves out of oppression.[3] Most certainly, practicing accountability and altering material power arrangements cannot be a one-time deal that Ahmed (2004) perhaps envisioned. It must be a continuous, reflective process. It does not imagine an end state when all the work is done. It must always imagine what a socially just world can look like.

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[3] Pedagogy of the privileged is in response to Paulo Freire's meditation, Pedagogy of the Oppressed (2000). It asserts that the only way oppression can be eradicated is if the oppressed raise themselves out of oppression. The dominant group will always look after its own interests – maintaining its dominance, even when it attempts to become allies of the oppressed. Indeed, this research project verifies Freire's

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APPENDIX A

McMaster
University

Interview Schedule

The following themes and/or questions represent an overarching agenda for a semi-structured interview with a small number of participants. The themes and/or questions will be pursued flexibly, utilizing an open-ended in-depth qualitative interview methodology.

OPENING: I'm interested in learning more about how race, class, and gender issues impact interdisciplinary team dynamics in the hopes of identifying those factors that amplify or reduce healthy team relations.

1. Re: INTEREST IN STUDY
   - I was wondering if you could tell me about why you are interested in participating in this study.
   - So you think there is value in learning/discussing more about gender, race, class?

2. Re: PREVIOUS DISCUSSIONS ABOUT INTERDISCIPLINARY TEAMS
   - Have you previously ever had a conversation about the race, class, or gender dynamics of interdisciplinary teams?
     - What was talked about?
     - (if not) why might that be?
   - How are interdisciplinary team dynamics generally talked about? ·
     - Who starts these conversations? / Who participates in these conversations?
     - What is done? / Is there any action taken?
     - Who decides what action is taken?
     - Are there certain topics/issues that get revisited over and over again?
     - What attitudes do team members have towards the revisited topic/issue?

3. Re: EXPERIENCE OF RACE, CLASS, OR GENDER
   - Could you tell me a time that race, class, or gender influenced team dynamics?
     - What happened? / Tell me more about how that happened?
     - Who was involved – how?
     - Was there anyone who was not involved whom you expected to be involved? What role would they have played?

4. Re: TEAM'S REACTION / BEHAVIOR
   - Did everyone on the team see it that way? / How did other members of team respond?
     - What was the majority or dominant opinion?
     - How did team members respond to each other?
     - If (the other opinion) was used, what would have been the outcome? / What team practices would have to change?

5. Re: RESPONSE / ACTION TAKEN
    - What was the response? / was there any action taken?
      - Was the response following any formal policies?
      - (if yes) what policies?
      - (if no) are there any policies or guidelines to deal with these kinds of matters?
        - Why do you think they weren't used?
    - Did (the action) resolve the issue?
      - (if yes) why do you think it worked?
      - (if no) why did (action) not work?
    - Who decided what action would be taken?
      - Did everyone think this response was appropriate?
    - Was the team's response to this situation similar to how it normally responds to issues?
      - (if yes) Is this response generally effective in resolving the issue?
      - (if no) How was it different?
    - Have there been similar instances when team members responded differently?
      - Why do you think that was?
      - What was different in that situation?

6. Re: PERCEPTION /INTERPRETATION OF EXPERIENCE
    - For the sake of recording all the details, tell me about what makes you understand this instance as a race, class, or gender issue.
      - So, *** singles to you that (race, class, gender) is influencing team dynamics?
        - oppression/discrimination
        - conflict/disagreement
        - difference
        - differing consequences for (women/men, white/non-white, affluent/middle class/working class/poor/everyone else)

7. Re: GETTING ALONG / RUNNING SMOOTHLY
    - If everyone on the team is getting along / If everything is running smoothly, does that mean that race, class, and gender are NOT influencing team dynamics?
      - (if no/kind of) can you give me an example?
        - Does the team ever discuss this issue?
        - Why not/Why is that?
        - Was anything done to try to address this issue?
        - Who is involved?
        - How did that work out?
      - (if yes) is there greater equality between team members in these moments?
        - Tell me about what the equality looks like?
        - Are there specific policies or practices that facilitate equal relations between team members?

- Are there discussions about team dynamics when everything is running smoothly?
  - o (if yes) What is talked about?
    - How / Where do the conversations take place
    - Does everyone participate?
  - o (if no) Why is that?
    - Do time and resources influence this decision?

8. Re: <u>RESEARCHER OBSERVATIONS OF SILENCES & GAPS</u>
   - I've that your stories tend to focus on [gender/insert category] ...
     - o I wonder is there a reason why gender issues are more prevalent than race and class?
     - o Are [gender] issues more prevalent or do you think there are other reasons why you choose to talk about gender?
     - o Are [race and class] perhaps harder issues to talk about?
       - (if yes) what makes it difficult to talk about?
       - (if no) ... what do you think are other reasons that [race, class] dynamics of interdisciplinary teams are not talked about as much?
     - o How do you feel about talking about [race, class]?
       - [eg/ uneasy, uncomfortable, no problem]
       - Are there different times when it is easier or harder to talk about [race, class]?
         - Why do you think that is?
         - What makes it harder to talk about [race, class] issues?
         - What makes it easier to talk about [race, class] issues? (context)
     - o Do you have any additional comments about team discussions or silences of race, class, and gender issues?

Conclusion

Please add any other thoughts, perceptions, and experiences, which come to mind in regarding race, class, and gender dynamics of interdisciplinary teams.

Please add any observations, clarifications, or second thoughts, which come to mind concerning any of the topics, which we have covered in this interview.

Are there important issues, which you feel have not been raised in the course of this interview? Please elaborate.

Thank you very much for your time and thoughtful comments.

APPENDIX B

McMaster University

CONSENT TO PARTICIPATE IN RESEARCH

Beyond Professional Affiliation: Race, Class, and Gender Dynamics in Interdisciplinary Teams

From Researcher: Alex Johnstone
Date: Spring, 2008

Dear Social Worker;

I am currently conducting a research study to explore how race, class, and gender affect interdisciplinary team dynamics, and to explore policies, practices, and processes that reinforce and/or reduce race, class, and gender inequalities between members on interdisciplinary teams.

Your part in the research, if you agree, is to participate in one face-to-face tape-recorded in-depth interview of approximately one to one and one half hours with me (Alex Johnstone). The interview will be arranged at a mutually convenient time and location. In addition, you may also receive a summary report of the research findings.

You are free to withdraw from the study at any time without reprisal, and the entire transcript of your interview will be destroyed. Upon your request, the transcript will not be destroyed and will be included in the research findings. Additionally, you may choose not to answer any questions but remain in the study.

Potential limitations in my ability to guarantee anonymity are minimal. Only you, the researcher, and Dr. Roy Cain will be privy to the data that is collected from you. All the raw data will be kept in confidence and I will delete or change any identifying information that they provide, and you will not be identified by name in the study, nor will any associated institutions or worksites be identified. The data will be used for the sole purpose of this research study, and all raw data will be destroyed after successful completion of the project. Information obtained will be kept confidential to the full extent of the law, meaning that in the event that child abuse is revealed, or if you pose a potential harm to yourself or to others your identity may be revealed. There will be four to six participants in the study. This sample size creates the possibility that participants might be identified in direct quotes that may be used in the summary report and/or if my study is published in a professional journal.

While the potential risks of this study are small, some people may feel discomfort, embarrassment, frustration, anger, sadness, or concern when reflecting on difficult team dynamics. Although the findings of this research may not benefit participants directly, participants will have the opportunity to critically reflect on their interdisciplinary team relations, and the factors that influence interdisciplinary team dynamics in a dialectic relationship with the researcher. Participants will contribute to the production of new and potentially illuminating knowledge about interdisciplinary team dynamics and factors that foster the reduction of inequalities among and in between team members, which is important to anti-oppressive social work practice.

If you have any inquiries regarding participation in this study please feel free to contact McMaster Research Ethics Board at (905) 525-9140 ext. 23142 or email: ethicsoffice@mcmaster.ca

I hope that this study will reflect a wide range of perspectives that will be reflective of the social work experience on interdisciplinary teams in the Hamilton community and that based upon our shared experiences we can identify strategies for improving our working relations and conditions thereby enhancing our service to clients and our own well-being.

I encourage you to participate and should you have any questions about this project or if you would like to participate please contact the researcher, Alex Johnstone at (289) 244-3438 or email: johnsaj2@mcmaster.ca.

I looking forward to meeting you soon.

Sincerely,

Alex Johnstone
Researcher

Spring 2008   <u>**APPENDIX C**</u>

CONSENT TO PARTICIPATE IN RESEARCH

Beyond Professional Affiliation: Race, Class, and Gender Dynamics in Interdisciplinary Teams

Dear Participant;

Thank you for considering participating in my research project. I am currently enrolled in a graduate program at McMaster University in Hamilton. As such, the results of this research project will be submitted of the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Master of Social Work.

The purpose of this letter is to provide you with information that you will need to understand what I am doing, and to decide whether or not to choose to participate. Participation is completely voluntary, and, should you decide to participate, you are free to withdraw at any time. Should you have any concerns about the research, you may at any time contact Dr. Roy Cain at (905) 525-9140 ext. 27960 or email: <u>cainr@mcmaster.ca</u> or the researcher (Alex Johnstone) at johnsaj2@mcmaster.ca or at (289) 244-3438.

PURPOSE OF THE STUDY

At present, literature on interdisciplinary teams provides a very limited discussion on how race, class, and gender influences interdisciplinary team dynamics. This research study is intended to address this identified gap in the literature, and to initiate discussion and further research in this area. This study will explore how race, class, and gender affect interdisciplinary team dynamics, and to explore policies, practices, and processes that reinforce and/or reduce race, class, and gender inequalities between members on interdisciplinary teams.

PROCEDURES

Your part in the research, if you agree, is to participate in one face-to-face tape-recorded in-depth interview. The interview will last approximately one to one and one half hours with me (Alex Johnstone). The interview will be arranged at a mutually convenient time and location. We will be doing a semi-structured interview. During the study, I will ask you questions about a time when you understood race, class, or gender to be influencing team dynamics. I will inquire about the responses to race, class, and gender issues, and I will inquire about the kinds of teamwork related issues that are commonly discussed by the team. For the purposes of ensuring confidentiality, your name and any other information associated with your identity will be deleted or changed in the transcripts, final research document, and any subsequent publication(s).

The time frame for this study is between January and August 2008. The early stages of the research began in January. The goal would be to have your interview completed by the end of May or early June. The research will conclude by August.

POTENTIAL HARMS AND BENEFITS

While the potential risks of this study are small, some people may feel discomfort, embarrassment, frustration, anger, sadness, or concern when reflecting on difficult team dynamics. Although the findings of this research may not benefit participants directly, participants will have the opportunity to critically reflect on their interdisciplinary team relations, and the factors that influence interdisciplinary team dynamics in a dialectic relationship with the researcher. Participants will contribute to the production of new and potentially illuminating knowledge about interdisciplinary team dynamics and factors that foster the reduction of inequalities among and in between team members, which is important to anti-oppressive social work practice.

CONFIDENTIALITY

Be aware that I cannot guarantee absolute anonymity. There will be four to six participants in the study. This sample size creates the possibility that participants might be identified in direct quotes that may be used in the summary report and/or if my study is published in a professional journal. To minimize the loss of anonymity, I will delete or change any identifying information that you provide and I will not identify by name any associated institutions or worksites. Only you, the researcher, and Dr. Roy Cain will be privy to the data that is collected from you. The data will be used for the sole purpose of this research study, and all raw data will be destroyed after successful completion of the project. Information obtained will be kept confidential to the full extent of the law, meaning that in the event that child abuse is revealed, or if you pose a potential harm to yourself or to others your identity may be revealed.

PARTICIPATION AND WITHDRAWAL

Participation in this study is completely voluntary. You are free to withdraw from the study at any time without reprisal, and you may request that the entire transcript of your interview be destroyed. Additionally, you may choose not to answer any questions but remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so. As interviewee, you may also receive a copy of the summary report of the research findings.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the McMaster Research Ethics Board (MREB). If you have any questions regarding your rights as a research participant, contact:

CONSENT

To be Completed by Participants

I have read through this document and any enclosed documents. I understand what is being asked and the accompanying conditions and promises. I understand the nature and limitations of the
research.

I agree to participate in the ways described. If I am making any exceptions or stipulations, these are

I understand that I am free to withdraw my participation at any time.

_____ (Signature)

_____ (Printed Name)

_____ (Date)

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

BEYOND PROFESSIONAL AFFILIATION:
RACE, CLASS & GENDER DYNAMICS IN INTERDISCIPLINARY TEAMS

ALEX JANELLE JOHNSTONE