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Diversity, Racism and Eurocentric- Normative Practice in Healthcare

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ABSTRACT

This paper contributes to scholarship focused on promoting ethno-cultural diversity in Canada's health care workforce. In order to care for Canada's diverse population appropriately visible minorities must be better represented among both nursing staff and administration. Evidence links increased ethno- cultural diversity within organizations to a decrease in experienced microaggressions related to race. However, these studies do not address the potential role of assimilation and appeasement on the part of Minorities in easing intercultural tensions. This paper interrogates ethno-cultural 'diversity' in the nursing workforce, concerned that advancing visible diversity does not go far enough to challenge invisible uniformity.

Keywords: Diversity, Racism, Micro-aggressions, Minority Nurses, Healthcare, Assimilation.

INTRODUCTION

The need for greater ethno-cultural diversity within health care organizations is an issue of increasing international concern. As national populations become less homogeneous, public expectations for health care practice include greater sensitivity to cultural and personal experiences of sickness and health. Encouraging diversity within the healthcare professions is seen as a way to increase cultural sensitivity within healthcare establishments, both internationally and within Canada (Bleich et al, 2014; Kunic& Jackson, 2013; Badger et al, 2012; Choiniere, MacDonnell & Shamonda 2010).

Canada's population has grown more and more diverse throughout its history, from the 25 distinct ethnic groups identified in 1900, to over 200 identified in the 2006 census. As of 2006 (the most recent figures available), 16.2% of Canada's population identify as visible minority (5,068,100 people). There are also one million Aboriginal people in Canada (Statistics Canada, 2006).

Exposure to diverse cultures empowers people. It offers each of us an expanded repertoire of communication skills and enhances our ability to navigate our multicultural reality (American College of Physicians, 2004; Dunn, 2002; Gurin, 2001; Salimbene, 1999). The relationships we build, and the creativity and flexibility we gain from cross-cultural interactions are significant assets. Light (2001) found that students in an ethno-culturally mixed university learned things they would not otherwise have encountered. Similarly, Bowen and Bok (1998) found that students in 'mixed' institutions were better able to understand and consider multiple perspectives and resolve conflict than those at schools with homogeneous student bodies. Gurin (2001) showed that students who experienced the greatest racial and ethnic diversity in their post-secondary study environment showed the greatest capacity for critical thinking.

The benefits of exposure to diversity are well documented. Nonetheless, even while touting the value of encouraging diversity in Canada's healthcare workforce, this paper calls attention to the potential harm of achieving visible diversity without challenging invisible norms of thought and practice. The possibility that inclusion too readily becomes assimilation poses a particular challenge to Canada's healthcare and health research communities. We must reflect on what individuals learn from their professional training and how that training constrains or enriches healthcare in Canada (Leonard, 2006). We need to make better use of existing diversity to make healthcare workplaces more inclusive, and healthcare practice more culturally aware.

Diversity issues in health care are not limited to ethno-cultural differences. They include questions of gender, lifestyle, and the age/stage of individuals (Davidhizar, Dowd, and Giger 1999). They exist within ethno-cultural groups and are complicated by intersecting and crosscutting cultures and identities. This paper draws on a study describing the work-life experiences of Black nurses in one of Canada's eastern provinces to illustrate the troubling relationship between inclusion and assimilation. We are concerned to highlight the reality that encouraging visible diversity does not automatically address the homogenizing presence of invisible Eurocentric norms.

Background: African Canadians are under-represented in the health professions, including nursing. In Nova Scotia specifically it is possible for a Black person to spend time in a health care setting without meeting a single Black health care provider (Premji and Etowa, 2014). Enang (2002) found that women of African descent feel unwelcome within a predominantly white health care system. Given that situation, the under-representation of minority groups in the health professions is an urgent problem.

The Canadian Federation of Nurses Unions (2014) and the Canadian Nurses Association (2009) highlight the need for a culturally diverse nursing workforce. Research shows that the under-representation of Black healthcare professionals, especially in leadership positions, is a barrier to effective, inclusive health care in Canada (Premji& Etowa, 2014; Hyman, 2009; Mc Gibbon & Etowa, 2009).

Black nurses in Canada continue to face discrimination. It is evident in hiring practices, underemployment, and promotion processes. It is seen in their relationships with White colleagues, especially supervisors and managers (Calliste, 2000; das Gupta, 1996; Keddy, 1997; 1996; 1995). Participants in our study reported incidents of 'subtle racism'. Meertens and Pettigrew (1997) describe subtle racism as a "cool, distant and indirect" answer to social norms that proscribe blatant expressions of prejudice and discrimination.

'Subtle' racism exemplifies the shift from publicly acceptable prejudice based on colour alone to a more complex socially condoned prejudice against those who fail in the liberal meritocracy (Anderson et al, 2014). This form of racism has been conceptualized under various names: micro-stressors (Harrell, 2000), everyday racism (Essed, 1991), and everyday inequalities (Beagan, 2001). Beagan (2003) uses the concept of everyday racism to describe the micro level processes that perpetuate inequities of power based on racialized differences.

According to Ceci (2003), nursing systematically privileges "Whiteness". Hezekiah (2001) points to the "colonial relationship" still visible in nursing. It is evident, for example, at conferences where minority presenters or minority issues are often deferred until the end of the proceedings when all the "important" topics have been addressed, and the crowd is beginning to thin.

Racialized health disparities have multiple root causes interwoven in complex ways. They include differential health care access (Kington &Nickens, 2001), and interconnected factors related to economic, environmental, psycho-social and iatrogenic conditions (Krieger, 2003). Links between race and socioeconomic status are so well documented that research examining the association between race and health routinely adjust for this variable (Krieger 2003; Williams 1999).

Increasing the representation of minorities within the health professions has become the strategy of choice to improve access to appropriate health care for minority patients. Kington, Tisnado, and Carlisle (2001) found that minority health care providers improved communication and patient satisfaction with care as well as increasing the use of preventive services by minority patients. A Canadian study found that minority physicians were more apt to treat disadvantaged patients, and to work in rural areas (Dhalla et al, 2002). The 'difference' that prompts these behaviors is a tremendous asset to Canada's healthcare system.

Increasing cultural diversity in healthcare organizations is seen as a panacea with the power to advance a broad spectrum of changes. Our caution is that this is only true if institutions make room for different worldviews along with the diverse faces.

MATERIALS AND METHODS

Research Methodology

The current work is based on a study designed to explicate the work-life experiences of Black nurses working in one of Canada's eastern provinces using the grounded theory research approach. The data were collected using informal interviews, observations, field notes and focus group meetings. Data collection and analysis occurred simultaneously allowing the researcher to conceptualize and articulate emerging theory.

Seventy percent (14 of 20) of the study participants were multi-generation African Canadians. Three of the six first-generation nurses were from the African continent, two from the Caribbean and one from the United States. Nineteen of the nurses held Canadian citizenship while one nurse had a work permit. The participants had worked in various areas of the province. The study sample included both rural and urban participants; however the majority lived and worked in Halifax when the interviews were conducted. There were 17 females and 3 males in the study sample. The participants ranged in age from 27 to 72, with a mean age of 51. Their years of nursing experience in Nova Scotia ranged from two to forty, with an average of twenty years of work experience. The participants were deliberately selected to ensure a representative sample.

RESULTS

Findings: Participants in the study clearly expressed the particular difficulties inherent in being a Black health care professional in a predominantly white health care system. They described a range of subtle but frequently occurring actions and inactions that render them visible against an invisible norm. The theme of racism is discussed under the following sub-headings: 1) Experienced Racism; 2) Responding to Racism; 3) The Impact of Racism/Micro-aggression.

Experienced Racism: According to the study sample being Black is so fundamental that it overwhelms other issues to become the defining factor in the work-life experience of Black nurses. Race matters, as this nurse clearly expresses:

> In the real world...people have perceptions about who Black people are. Whether you're a nurse, whether you're a physician, doesn't matter. What, what walk of life, or

> what professions you find yourself in, people have perceptions about Black people. And, what they will do, rather than look at your profession first, they will look at your face.

Study participants reported racially-based discrimination as an everyday reality in their workplaces. They described alienation and isolation, as well as blatant incidents of marginalization and exclusion. Some of them pointed to the tendency of White patients to treat Black nurses as if they were invisible, or to assume they are orderlies or cleaners rather than health care professionals. Many reported that even healthcare colleagues routinely deferred to White staff. The accounts below document specific experiences involving both patients and colleagues. In the first excerpt the Black nurse is especially frustrated that her uniform is overshadowed by the colour of her face:

> A patient signal went on… and when I went in, the patient said, “Oh, I would like to see a nurse”. And I said, “Well I am a nurse”. You know, wearing a white hat with a Black band, which meant that I was a registered nurse. She said, “No, I would like to see a proper nurse”…

In the incident below, the nurse’s hurt is soothed by her colleague, but the patient’s action goes unchallenged:

> I went to help her cut up her food, she was a neuro patient, and she needed assistance to eat. And she said, “Please don't touch my food”. I was shocked… So, I told my co-worker who herself expressed some surprise, and she said, “Don't worry, I will take over for you”, and she took over the patient for me. So she was quite understanding of the situation…I thought, what did she think I was going to do with the food? Did she think I, my hands, were going to contaminate it? What was she thinking of…I think deep down inside, there's still the perception that we came from slavery and that we're second-class citizens.

The excerpt below describes the actions of a doctor. His blatant racism goes unacknowledged.

> I remember an experience of being a black nurse in the hospital. I was in this room by myself … just standing by the bedside, so this doctor came into the room and, I think he was looking for a nurse, or somebody to talk to. So as he saw me, he came straight to me and said, “Are you the cleaner?” I looked at him and said, “Excuse me, I'm not a cleaner, I'm a nurse, I'm looking after your patient actually, if you have any questions”. He didn’t even apologize…he walked right out to look for the charge nurse. I don't know if it was his own way of making up, he came back and said, “Okay, I don't need to talk to the nurse, I need the clinical leader, whoever is in charge”.

Study participants stressed that the most painful aspect of this kind of nurse-patient and/or nurse-colleague encounter is too often the action, or inaction, of management. In their experience managers were insensitive to the hurt caused and dismissed such situations as trivial, or were actively un-supportive participating in the negative behavior. In the following excerpt management appears to confirm the patient’s lack of confidence rather than support the professionalism of the nurse.

> I was an RN, and I went in the house as an LPN, and he still refused to let me go in and take care of the patient, as an LPN! He told me that he didn't trust me. And he actually told the agency, and they pulled me out of the house…The manager at the agency

> actually told me that this client, this is the first time he has come across a Black person going into his house, and he's not used to, and he's never seen a Black nurse in his life… He didn't even give me the opportunity to prove myself.

By allowing the patient's negative view of the nurse's abilities to stand unchallenged the agency compounds the blow the nurse must work through. Doubt, particularly self-doubt, is contagious. Management's failure to respond in a sensitive manner not only adds to the nurse's demoralization in immediate terms, but also creates an environment in which minority nurses are easily overlooked and have difficulty advancing. Some nurses described their colleagues as very supportive, but the lack of support from leadership was a negative experience in the work-life environment of Black nurses.

Responding to Racism:

All of the study participants described navigating a "proving ground", a metaphor for the experience of feeling tested. In the following excerpts nurses variously describe the proving ground experience as demoralizing, lonely, and anxious:

> As a Black nurse, I felt I was always on the proving ground. There were times that I felt I was barely surviving but through self-determination continued until retirement''.

The need to prove oneself competent never ends. It cannot be done once and for all. The nurse cited below clearly feels that she is working against the weight of negative assumptions;

> I was the only Black nurse on the floor…I felt like I had to prove myself to everyone…that Black nurses are as good as White nurses…that we work hard, that we have knowledge, and that we can get somewhere. Being the only one meant a lot of pressure… in terms of proving myself, trying to make sure that everybody likes me, and that I'm not the big bad wolf on the block.

It is not enough just to be competent; perfection is called for:

> I have to be perfect, I have to be perfect, and so you go that extra striving. Oh, I have to do this and you're checking things, double-checking things… Actually, it's your responsibility to be perfect…

It is clear that the Black nurses feel tested and measured. It is also clear that the metric of worth is in the hands of others. Although invited to become part of a 'diverse' work place, these nurses feel compelled to make themselves 'likable' and 'non-threatening' to those who better fit the normative standard. Strategies to fit themselves to that norm include showing exaggerated commitment to their role, striving to be "a perfect nurse" or "a super nurse" and seeking constantly to "prove" themselves to those holding the measuring stick. Black nurses live with an ideological construct of the "perfect nurse" from which they are excluded by their Blackness. Most of the Black nurses in the study reported constantly striving to prove themselves to colleagues, patients and administrators. They described feeling compelled to be better than "good", to be "the best" or the "perfect" nurse. This involved setting higher expectations for themselves and performing above and beyond their assigned workload. The following excerpt describes the effort involved in not "being singled out":

> I wouldn't let my guard down, I always make sure I'm on time for work…and my work is done completely, timely, professionally, everything neat and organized and I'm able to communicate effectively with the other nurses… because there is that other pressure of being singled out.

The excerpt below points to the tensions inherent in such exaggerated diligence:

> I find that you have to be better than everybody else. You have to really think about what you're doing and… lay it out and make sure that you check and double check, and make sure that you're knowledgeable…and if you have an opinion, that you can back your opinion up with data…

The Impact of Racism/Micro-Aggressions: Pressure to overcome the 'otherness' that separates them from the norm leads some Black nurses to separate themselves instead from their minority identity. Given the constant pressure to assess themselves against a standard that is inherently unattainable to non-majority others, it becomes practical to simply claim membership in the mainstream, majority, group. In this excerpt, a Black nurse firmly locates herself outside the Black community,

> I'm not from a Black community so I'm not used to, you know, I'm not from a Black community. So I mean, that's not a Black community, so I'm quite familiar with… when I went to church on Sundays…I wasn't going to the Black church, and so I wasn't involved in a lot of those kinds of traditional things… we didn't go to a Black church, we didn't live in a Black community. So you functioned quite differently.

Distancing allows those who have achieved integration to seal themselves off from the struggles of people still on the margin. This form of avoidance or denial varies from complete withdrawal to role playing according to circumstances. Simpson and Yinger (1965) found the behavior more common among middle and upper class individuals who, having achieved some success, safeguard their attained status by aligning themselves with the mainstream. The nurse cited below expresses her opinion of this response to 'success' quite eloquently:

> How can I explain it? A lot of Black people, I think they want to be recognized but they don't want too many people up there because then it takes away from them… You know how they say "It's lonely at the top". Well, it seems Black people want to be lonely, they want to get to the top, but they don't want to bring too many Blacks along with them. And I find that very sad.

In contrast, other nurses take on the burden of representing the entire "Black race". In so doing they become cultural-awareness educators and advocates within the healthcare system. Those who took up this mantle found themselves constantly called on to explain their own' difference', or mediate another's minority position. Most of the nurses in the study took on advocacy roles just as the nurse in the excerpt below describes:

> So I kind of took it upon myself to be an advocate for some of these people… we've given in-services and talked about...our communities and what we needed, and not in a...confrontational way, but just to allow people to know that there are people who are not necessarily...on the same wavelength as mainstream and this is why people were having problems.

Some found themselves advocating for minority patients' needs and becoming *defacto* cultural liaison workers like the nurse cited below:

> In the unit I find being the only Black person in the unit… whenever we have a minority patient, I try my very best to look after that patient because my colleagues know the patient care, but there are certain things I feel that they don't really teach in nursing school so… especially me being African...and African parents coming in, there are certain things

> that people take for granted, and I wish there would be a couple more Black nurses in my unit that I could talk to and we can relate to, as to what the parent, being a Black parent in the unit, goes through.

The role of educator and cultural interpreter puts tremendous pressure on some individuals. It can be morally exhausting:

> I've always been the one that's been having to educate people about saying the wrong things, about doing the wrong things, about behaving the wrong way, you know. And it's so tiring... Every time we [Black nurses] turn around, I'm having to explain why this is, why that is, why don't we do this, and why don't you do that, you know. It just becomes so exhausting sometimes, over and above my work.

The lack of policy facilitating and guiding cultural accommodation in many healthcare institutions creates challenges for Black nurses and ultimately impacts on minority patients' access to culturally appropriate health care (Choiniereet al, 2010). There are too few educational resources equipping nurses to work effectively across cultural boundaries. The following interview excerpt points to the reality that the growth and learning inherent in 'diversity' is often one-sided:

> In the last 10 years, the hospital changed their outlook to be more diverse and... to serve the community better…And I was given an opportunity at that time to...be part of that strategic planning, which allowed me to look at budgets, how you run a unit, resources, making links......which was...an immense education for me on that level….However, at the same time, you...felt that. .sometimes when you were speaking, that you weren't always...listened to.

The nurses in this study identified a problem with the level of cultural knowledge and sensitivity demonstrated by many nurses, especially those in leadership positions. They reported that many health care professionals are not very skilled or comfortable working with people who are different from themselves. One nurse stated clearly that in her work place "the managing director…didn't have any experience about diversity."Other Black nurses described the lack of cross-cultural sensitivity in equally stark terms:

> Well, it may be abuse in one sense... Their ignorance, their treatment of Black people was less than... much less than appropriate, but less than ideal, much less than ideal. Because they just didn't have the knowledge. Just like you have to have knowledge to put an IV in. I believe that nurses, mainstream nurses need to be... lack cultural awareness and they need to be trained.

Similarly, another nurse noted that:

> The White people also need to be trained, or at least required to understand how these people coming from a different background and different cultural experiences feel, and not just try and dismiss whatever it is, because if that's what they believe in, then don't tell them that it's not important.

DISCUSSION

The study findings reveal the on-going presence of a single, Euro-centric ideal of "the Nurse". At its most stark, the starched white archetype is so prominent that it can make the real Black nurse standing by the bedside invisible to the patient, and even more problematically, to his or her healthcare colleagues, as in the examples above. This failure of

recognition carries a weight of doubt and distrust. It speaks of lingering misgivings about the 'other' on the one hand, and feeds internalized race-based insecurities on the other (Horowitz et al, 2011. P.31)). It also confirms the existence of a problematic 'norm' in healthcare (Spitzer, 2004). Whether that norm is a definable prototype or a less definable sense of what-it-is-not hardly matters. The norm is definite enough to make nurses who do not resemble it invisible to those who cannot see past it. It is clear enough to put nurses who do not see themselves identified within it on edge. As evidenced above, Black nurses feel tested by, and seek to prove themselves against, a normative standard that stands outside of them.

The Black nurses who participated in the Halifax study described two opposite responses to finding themselves on what they called a "proving ground". One was to exceed even the highest expectations placed on them; accepting the responsibility to be "perfect". Yee (2003) called this behavior "the dedicated display of a functional role". Yee observed that members of a marginalized group might display an exaggerated commitment to a given social role, including tolerating and enduring particular slights, and being prepared to prove their competence time and again, in the hope of gaining acceptance by the majority power holders. In our study the Black nurses acquiesced to the need to prove themselves, working to be perfect in order to overcome their "handicap" (Anderson *et al.,* 2012).

The alternative response the Black nurses reported was to down-play or deny the existence of difference. Again, the goal was to minimize visibility; in this case by distancing themselves from more visible others and adopting as far as possible the behavioral markers of the dominant group. Simpson and Yinger (1965) point out that denying difference is positive from the perspective of the mainstream. In fact both behaviors, exaggerated commitment and the denial of minority group membership, play directly into liberal ideology. Both reactions privilege individual choice and the idea of self-improvement through immersion in Western scientific knowledge. In liberal ideology success is an individual achievement, not a collective endeavor. Framing systemic problems of exclusion and marginalization as individual failures negates the need to re-evaluate the appropriateness of Euro-centric norms.

Efforts on the part of minority nurses to out-perform expectations and/or deny the existence of 'difference 'point to the authoritative hold of a benchmark which must be adapted to rather than counted on to bend. Both behaviors also suggest a benchmark which is not a comfortable fit. Easing the difficult fit of a singular, Euro-centric benchmark might be managed by opening the existing normative standard to alternative calibrations. A non-standard measure-of-worth would need to recognize the value of diverse skills and gifts. For example, the Black nurses who participated in this study had extensive nursing experience and a wealth of educational experiences spanning national and cultural boundaries. Without a tick-box on an assessment form or designated points to assign, non-standard assets are too often and too easily overlooked. It is difficult to see or value skills and gifts that are not represented within the norm. Consequently, many of the Black nurses reported feeling under-valued. They felt that their ability to practice nursing to their full potential had been unfairly limited (Kunic& Jackson, 2013).

There is often limited knowledge about alternative worldviews among people who identify with the majority culture and its norms and standards (Carter et al, 2015; p.101). In contrast, people who identify with those "other" worldviews must be knowledgeable about the majority culture in order to successfully navigate

any sphere beyond their own homes. The implications of living in a world designed according to a logic that is not yours are explored by post-colonial writers drawing on Fanon's notion of "dual consciousness" (2004 [1961]). According to Fanon, every member of a minority group acquires a sort of 'double mastery' in order to live out of his or her own socio-cultural worldview within a world designed by the dominant or majority group.

The person holding the minority view point must be able to present her or his own position framed in terms that are intelligible within the dominant worldview. There is no reason that this sort of cultural competence cannot go both ways. Douglas *et al*. (2011), for example, propose a universal standard for culturally competent nursing care rooted in social justice and critical self-reflection. It is workable, they insist, because nursing begins with caring compassion and cultural awareness with self-consciousness. Horowitz *et al*. (2011) advocate diversity training focused on communication skills and conflict resolution. Their study insists that real change in cross-cultural care needs "an infrastructure that creates synergism" (p.37). Communication is key.

Cross-cultural communication is not unlike communication across disciplines in the academy. Interdisciplinary scholars are reassuringly optimistic that competent communication across cultural (disciplinary) boundaries can be taught. Patton (2002b), for example, writes that differing expectations do not need to be insurmountable obstacles to communicating between cultures (disciplines). We can anticipate the criteria others will use to interpret our words and actions. Most importantly, we can make an accurate interpretation more likely by establishing common reference points. Cross-cultural communication assumes reciprocal effort. If the adaptation is all on the minority side, diversity will inevitably be lost in assimilation.

Peeters and Oerlemans (2009) distinguish between assimilation (in which employees learn and adhere to mainstream 'norms') and integration (in which mainstream norms make room for cultural interpretation). According to their findings, integration is a more constructive goal in terms of employee well-being. Our own findings suggest that integration is also a better goal for a healthcare system struggling to gain cultural competence, and to recruit and retain minority healthcare professionals.

Implications: Diversity is an asset to healthcare institutions because it creates a context in which multiple "lives" become accessible and thus imaginable. It is assumed that if health care professionals interact across racial and ethnic boundaries in formal and informal encounters with colleagues, cultural enrichment will occur. Our contention is that cultural sensitivity is not so easily caught. It is communicable only through two-way communication.

Canada's current reality calls for the equitable integration of diverse views into the socio-cultural and professional spheres of Canadian society. David Pratt, while he was Canada's Minister of National Defense described Canada as a country with no single culture, language or history (Tolley, 2004). As a composite country it should be well equipped to live comfortably with diversity.

Culturally inclusive policies will be vital to the success of recruiting efforts targeted at minority health care professionals. Building an infrastructure of trustworthy health care professionals and institutions has great potential to increase the health and well being of individuals and communities across Canada's cultural mosaic. Canadian nursing needs to cultivate an environment that fosters the professional growth of all nurses, keeping in mind that those who practice nursing on the margin of the profession, like all

marginalized groups, will require targeted efforts to make the best use of their potential (Silvestre, Arrowood, I very, and Barksdale, 2002).

Move beyond rhetoric will mean challenging the systemic structures that perpetuate marginalization by supporting an invisible normative standard.

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