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J. Anderson, S. Tang, and C. Blue

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by

J. Anderson, S. Tang and C. Blue

Correspondence to:
Dr. J. Anderson
e-mail: jandersn@unixg.ubc.ca

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Abstract

Health care delivery systems in western nations have undergone major restructuring to increase efficiency and contain health care costs, concurrent with widespread migration from one part of the globe to another. The call for health care to be more culturally responsive to diverse client populations has come from different sectors, including governments and researchers, and has led to policies to address perceived deficiencies in health care services.

We draw on our current research at health care institutions in a city in Western Canada to probe, first of all, how the concept of culture is interpreted within organizations; and second, how culture is 'written into health systems' as they undergo restructuring. We argue that meanings and interpretations of culture are not transparent; health care practitioners may have different interpretations of the concept of culture. Furthermore, 'writing in culture' is not simply a matter of health care providers learning about their clients' 'belief systems' (a commonly held notion of 'what culture is'), and being sensitive to these beliefs. Belief systems and people's experiences of the care they receive are negotiated within highly complex 'organizational cultures' that are located within broader macroeconomic and political structures and discourses that shape how health care systems are organized. We conclude by calling for a closer look at the goals of restructuring, and question whether current discourses on cost containment are in competition with providing equitable health care services to diverse client populations.

1. Background

Health care delivery systems in Canada have undergone major restructuring during the past decade. In 1993 Evans noted that, “[i]n the last five years, every province of Canada has established a Royal Commission or other major inquiry into its health care system” (p. 35). Restructuring of health care systems is not unique to Canada, Evans tells us. In fact, Andrew Creese (1994), in discussing global trends in health care reform, has argued that “[r]eform is in progress in countries at all levels of development” (p. 317). He suggests that underlying pressures for reform in most countries are concerns with the scale of government spending on health. These reforms are taking place at the same time as widespread immigration. In countries such as Canada, the source countries from which people come have changed in the past few decades. “European countries used to be the leading source of Canada's immigrants but, beginning in the 1970s, the picture changed. Asia, Central and South America, the Caribbean, and Africa now account for the majority of immigrants” (Chui and Devereaux 1995, 19).

Health reform is often part of a much wider process of social and political restructuring. Fundamental questions are being asked about the role and responsibility of governments, health care providers, and consumers of care. Questions such as these were addressed in the report, *Closer to home: The report of the British Columbia Royal Commission on health care and costs* (British Columbia 1991). This commission, conducted over a period of eighteen months in the province of British Columbia, involved extensive consultation with consumers and providers of care. The commissioners concluded that although British Columbia has one of the best health care systems in the

world, not all people are equally served. The system is littered with barriers that reinforce inequities, and “many people of minority ethnic background are not using existing services because those services are not culturally responsive or *accessible* to them” (p. C-36).

Recommendations from this report laid the groundwork for policy documents, such as, *New Directions for a Healthy British Columbia* (British Columbia 1993). One of the priority actions of *New Directions* was to develop policy frameworks to deal with obstacles to equitable service and equitable health status. Multicultural populations, women, seniors, children and adolescents were among the groups identified as having poorer health, or experiencing barriers to health care. The subsequent report, *Policy Frameworks on Designated Populations* (British Columbia 1995), was developed for the purpose of offering guidance to those responsible for the governance and management of health services. Documents such as these provided the impetus for initiatives to make health care more accessible to underserved groups. One initiative, *The Multicultural Change in Health Services Delivery Project* (1995-7), aimed to create partnerships among health care agencies to foster organizational change and minimize barriers to accessible health care. A systematic attempt was made to integrate concepts pertinent to the care of people from different cultural and linguistic backgrounds into the services offered in different health care institutions. Efforts are underway to make these changes sustainable within the participating organizations.

The above issues, coupled with changing demographics in Canada, and the findings from our earlier research (see, for example, Anderson 1985, 1986, 1987a, b, 1990, 1991a, b, 1996, 1998; Anderson and Lynam 1987; Anderson, Elfert, and Lai 1989; Anderson, Blue, and Lau 1991; Anderson, Blue, Holbrook, and Ng 1993; Anderson, Wiggins,

Rajwani, Holbrook, Blue, and Ng 1995; Anderson, Dyck, and Lynam 1997) on the topic of culture, gender and health, provided the impetus for the present research project. This study was designed to examine how cultural plurality is negotiated in health care institutions. Our study is still in progress.

In this paper we discuss how the study is being carried out, and we share the questions that have arisen from our observations and discussions with study participants. We stress that it would be premature to treat this discussion as decisive ‘research findings.’ The issues discussed are based on a preliminary analysis of the data, and the questions raised provide direction for further exploration.

In the section that follows (Section 2), we begin by briefly discussing population changes in Canada that have brought to the forefront the discourse of ‘culture’ and ‘culturally sensitive health care,’ and that have led to research studies such as the present one. In Section 3, we proceed to examine questions from the field, that prompt us to hold up for examination assumptions about ‘culture.’ Based on our analysis in Section 3, we conclude (Section 4) by arguing for the need to recognize the context in which cultural meanings are constructed, and the social and political processes that organize the experiences of health professionals and patients alike. In responding to the call for culturally responsive health care, we suggest that this cannot be addressed by focusing solely on the attributes of health professionals. The complex interweaving of social and cultural meanings within the context of health care organizations, and structural constraints within the wider societal system must also be acknowledged and addressed.

2. Migration and the Discourse on Culture and Health Care

Immigration and Naming the Issues in Health Care Delivery

With migration being a widespread phenomenon in the 20th century, there is heightened attentiveness to *perceived* ‘cultural differences’ in areas such as health care delivery, where health care provider and client quite likely are from different countries.

In 1996, the top five source countries (by last permanent residence) of immigrants to Canada were Hong Kong, India, China, Taiwan, and the Philippines (Canada 1997a).

“British Columbia also attracts a significant inflow of recent immigrants via other provinces” (British Columbia 1995, 35). Although females make up approximately 50% of all those who immigrate to Canada — a figure that has not changed over the past 30 years (Canada 1995) — there were striking imbalances in the sex structure of some population groups (Mitchell 1998). For instance, the 1996 census shows that there were over 30% more Filipino women than men in Canada (Canada 1998).

Closer to Home (British Columbia 1991) was not the first document to address the health issues of immigrants. Similar issues were addressed in earlier documents such as the Epp report (Canada 1986). It was argued then that “[t]here is disturbing evidence which shows that, despite Canada's superior health services system, people's health remains directly related to their economic status. . . Within the low-income bracket, certain groups have a higher chance of experiencing poor health than others. Older people, the unemployed, welfare recipients, single women supporting children and minorities such as natives and immigrants all fall into this category” (p. 4). More recent reports (Canada 1997b) continue to document that some groups, including people from ethnic minority groups, are at risk for poor health, thereby requiring them to seek out health care. However, when they seek help there are barriers to equitable health care that

include language, lack of cultural knowledge on the part of health professionals, and racism both in staff-to-staff relationships, staff-to-client relationships, and vice versa (see, for example, British Columbia 1991 C-37).

These reports provide evidence that ethnic minority groups are at risk for poor health. Our own studies with women who have migrated to Canada from South and South East Asia have highlighted the circumstances under which women experienced difficulties in accessing and utilizing health care. When adequate interpreter services were lacking, when health care professionals did not fully understand how cultural meanings organize experience, or how the mediating circumstances of a woman's life structure her ability to manage an illness, and when health care services were geared towards middle-class mainstream life, women usually experienced difficulty getting the help they needed to manage their illness. These difficulties were mitigated when the health care provider was responsive to cultural plurality, and when resources were in place to facilitate the negotiation of acceptable care (Anderson, 1991a,b, 1996, 1998; Anderson, Blue, and Lau 1991; Anderson, Blue, Holbrook, and Ng 1993; Anderson, Wiggins, Rajwani, Holbrook, Blue, and Ng 1995; Anderson, Dyck, and Lynam 1997). These studies and others have documented the experiences of people from different ethnocultural groups as they seek health care. For example, Tang (1996) in her study of Chinese families caring for a dying family member found that families and health care providers in her study held different expectations about the care of a dying family member. The families felt that they had no choice about care, even when they found caring for a family member excessively stressful. Furthermore, discriminatory practices have also been found to be an issue for patients seeking health care. Struser (1985), in her research with Indo-Canadian women, found that they perceived hospital nurses as discriminating against them and they believed this

affected the nursing care they received. The women in her study talked of feelings of unhappiness and/or anger at this discrimination. Nurses — frequently ethnically diverse themselves — may be well aware of the issue of racism as Reimer (1995) found in her research with nurses. Although some nurses were committed to anti-racist practice, they identified racist practices among colleagues and in the institution itself.

The above studies point to the complex issues that underscore relationships between health care providers and patients. These issues and the different cultural meanings that patients and health care providers bring to the health care encounter, have been addressed (see for example, Waxler-Morrison, Anderson, and Richardson 1990), as attempts are made to provide more accessible health care to people of different ethnocultural backgrounds. It is generally believed that the difficulties people of ethnic minority groups encounter in getting access to health care is due to their ‘cultural differences,’ and cultural insensitivity to these differences on the part of health care providers (see, for example, British Columbia 1991, 1995). But ‘culture’ is not a transparent concept; it, too, needs to be problematized as we speak of writing culture into health care. Otherwise we risk essentializing and marginalizing those whom we see as having ‘distinct’ cultures. We turn, now, to this issue.

Culture and Health: Making Sense of ‘Difference’

Margaret Lock (1993), drawing on Raymond Williams, reiterates that ‘culture’ is “one of the two or three most complicated words in the English language” (p. 144). She traces the evolution of the concept, pointing out that we

have done a complete about-face over the past one hundred years. . . From claiming that only the educated elite are cultivated, we have moved to an unexamined assumption that only poorly educated peasants are completely

immersed in culture, while the rest of us, have moved beyond culture into a rational, post- or supra-cultural world, which is grounded in science and hence is value free. (p. 144)

She goes on to say,

There is a real danger, then, of jumping into a culturally sensitive approach to health education [and, we would add, health care delivery] without first examining what we mean by culture *and, even more important what our own values are with respect to the culture of the Other* (italics added). (p. 145)

Unexamined assumptions about ‘culture’ and values about the ‘Other,’ underpin one conceptualization of culture that has been drawn upon by health professionals. ‘Culture’ is often conflated with ‘ethnicity’; ‘distinct’ ethnic groups are seen to carry distinct cultures encompassing values and beliefs passed on from one generation to the next, and held up in contrast with the ‘mainstream norm.’ There is a call for health professionals (assumed to be of European descent) to learn about the cultures of different ethnic groups, to enable them to provide culturally sensitive health care.

The notion of ‘difference,’ embedded in the assumption that some people's beliefs are located in their ‘ethnic heritage,’ solidifies ethnic boundaries and treats beliefs as frozen in time and history. But Lock (1990) provides another lens through which we can make sense of the concept of ethnicity. She tells us that:

A person is many different things, and ethnic identity is only part of a multidimensional, multifaceted concept of self, subject to continual reshaping and at the same time reconfirmation in light of shifting contexts and new experiences. . . The creation of an ethnic identity for immigrants and refugees through the imposition of artificial rigid boundary markers such as nation states is. . . perverse. This can only lead to jingoistic cultivation of difference or, at best, to paternalism. In the case of many immigrant women, it masks, I believe, perhaps half deliberately, the economic exploitation and oppression which the majority experience. It also glosses over the ambivalences and contradictions involved in cultivating traditional values for coherence, but which often actually

promote anxiety and physical distress when practiced out of their original context. (p.251)

Lock would have us see ethnicity not as immutable categories, but as constructed within a web of class and gender relationships. In a similar vein, Allen (1996) argues that culture is constructed through discursive acts which arise from different perspectives and have different purposes. “Consequently,” he argues, “the representation of the culture varies” (p. 96). In elaborating on what this means, Allen suggests that:

A frequent goal of the process is creating cultural identity as a means to a political end (e.g., unifying divergent perspectives; clarifying who has access to certain resources; creating a positive identity for group members). . . Other goals include creating generalizations that facilitate talking or working across ‘differences.’ (p. 96)

Allen warns of the pitfalls of analyses of ‘difference’; such analyses are essentialist, “in that they tend to portray each cultural position as a homogeneous set of relatively fixed characteristics” (p. 96). Allen makes the point that a description of culture is always based on perspective; “what is described depends on the position from which it is viewed” (p. 96). How health care providers speak about the culture of those viewed as ‘Other’ or as ‘different’ must be understood from the framework of interpretation of the health professional who speaks. This framework refers not only to the Western scientific perspective upon which professional practice is based, but also, to the personal meanings and values of the health professional. Neither the culture of Western science nor the personal meanings of the health professional that are used as the norm against which the ‘Other’ is evaluated and assessed, are made explicit, but are taken as ‘natural,’ and are, for the most part, uncontested.

This being the case, the cultural construction of the ‘Other’ is never neutral; there are no pre-given facts about another person's culture that can be described in a

neutral way. Discourses of culture and ethnicity are embedded in the histories of both those who are constructed as ‘Other’ and those whose cultures are taken as the norm and the relations of power that accrue from histories, and the background knowledge and understanding that each brings to an encounter. Furthermore, interactions between health care provider and patient occur within the social and political milieu of health care institutions and are shaped by contextual features often not made explicit. What does this mean for ‘writing culture’ into health care delivery systems? We turn to the research that forms the basis for this exploration.

3. The research: Questions from the field

The Study

The study is being conducted in three institutions in succession, this number determined in part by the resources available for the research. The health care institutions selected will allow us to make comparisons on the basis of size, organizational structure, and the demographic characteristics of the populations served. The study is occurring at the same time as the restructuring process of health care delivery services, which means that a number of changes have occurred, and continue to occur, in relation to the governance structure of institutions and institutional policies.

From Theory to Method

We begin with the premise that individual experience needs to be interpreted and understood within the context of broader social relations. What does this mean for the discourse on ‘culture’ within health care institutions? In the preceding discussion we argued that while ‘culture’ has often been used to describe, in neutral terms, people’s

beliefs, we conceptualize culture not as static beliefs frozen in time but rather as being constructed through discursive acts. In speaking of culture, we examine how certain practices are maintained through hegemonic discourses and relations of power, how some groups are excluded, and the impact this has on people's health. In examining, for example, the policy implementation process in health care institutions, we recognize the competing priorities that contextualize this process. Priorities are usually established not only within the institutional culture of health, and the culture of biomedicine — cultures that are often unexamined — but also by decisions that filter down to staff and patients from different levels of government through local governing bodies.

Method of Inquiry: Central ideas from Dorothy Smith's work on 'standpoint perspective' inform our method of inquiry. Standpoint perspective attempts to create a method of inquiry that begins in the realities of people's experience, and aims to explain the actual social processes and practices organizing everyday experience (Smith 1986; 1987;1992). These social processes are seen as mediated by power relations, and are historically constituted, and ideologically inscribed. The formulation of this method of inquiry, Smith points out, "works to make a space into which anyone's experience, however various, could become a beginning place inquiry" (1992: 90). Smith tells us that the notion of standpoint doesn't privilege a knower. "The knowing subject is always located in a particular spatial and temporal site . . . Inquiry is directed towards exploring and explicating what she does not know — the social relations and organization pervading her world but invisible to it" (p.91). From different sites of experience, "different social relations or different aspects of the same complex are brought into view and their organization is explicated" (p. 91).

The issue, for Smith, is not qualitative versus quantitative methods; any of these methods can be used. The issue, instead, is drawing a contrast between beginning in the standpoint of actual individuals and standpoints constituted in the text-mediated discourse. By starting with the standpoint of actual individuals we can explore how actual activities are “organized as a complex of social relations beyond the scope of any one individual’s experience” (Smith 1986, p.6). This method of inquiry discloses the set of social processes which are usually not knowable to us. For example, by beginning with the daily realities of patients who use hospital services, we are able to give a detailed explanation of the social relations that organize their everyday experiences. We may begin with the patient who must interact with a health care professional without the assistance of adequate interpreter services, and may have to negotiate issues such as informed consent for surgery. By taking this as the starting point, we can begin to analyze how decisions are made within the institutions to allocate resources, how priorities are established, and what the ideologies are that form the basis of decisions. Starting with individual actions and experience, we are able to examine the ways in which people can take action and exert control in their own lives; we can also examine the structural constraints over which they have no control. The standpoint perspective therefore allows us to examine micro-processes of interaction and the macro-social processes that organize everyday experience. An underlying assumption is that realities are located within an historical context, shaped by social, economic, and political processes. The aim of inquiry is to unmask these processes.

Conducting Fieldwork

Participant observation, in-depth interviewing, and the review of documents are the methods being used to obtain data since November 1996. As well as gaining access to policy documents and reviewing these documents, we have had extensive discussions with administrators to apprise us of the institutional policies pertinent to the care of people from different ethnocultural backgrounds, and also to keep us informed about the ongoing restructuring processes. We have met with front-line health care workers on the patient units, observed them in their interactions with patients, and discussed issues they encountered while working with patients from different ethnocultural groups. In addition, we have participated in different meetings, such as discharge planning meetings, so as to have a sense of the kinds of issues that are being addressed. We have also conducted interviews with patients and their families to learn from them their experiences surrounding hospitalization and their perceptions of the ongoing changes in the health care system.

The process of fieldwork is inseparable from the process of restructuring that is taking place in health care agencies in British Columbia. We are observing that organizational changes have created uncertainties at different levels of organizations. Not only are front-line workers wondering "what health care regionalization is going to do to us," but also senior administrators have similar questions. Constant changes in the organizational structure have a direct impact on the dynamics of the health care context in any institution.

The changing context in the front line of health care has shaped the process of negotiating entry in our study in significant ways. Early in the study, the lack of continuity in the persons who facilitated our fieldwork meant that the research assistants

often had to renegotiate entry into a ward and establish linkages with individual nurses on the day of fieldwork. It could be argued that the restructuring process also influenced how nurses responded to our research. In the words of one nurse, “the goal these days is to get the patient out of the hospital as soon as possible.” Often feeling ‘rushed’ and faced with pressure to manage a heavy workload, the nurse might be reluctant to participate in extra activities such as research. Because of the tight working schedules of nurses and the priority to provide care, it was not uncommon for the research assistants to spend a few hours waiting in order to negotiate initial access to potential patient participants through the nurse.

The process of negotiating entry can even be more complex when the nurse cannot communicate with the patient in the same language. Even though we have prepared a short letter describing the study in both English and Chinese, it is sometimes difficult for the nurse to find out from the non-English speaking Chinese patient if s/he is actually willing to talk to the Cantonese-speaking research assistant about the study to ascertain whether the patient is willing to participate. In those situations where the research assistants have to depend on the only Chinese-speaking nurse on duty to approach potential Chinese patient participants and to clarify for them the intent of the study, the research assistants might have to spend even more time waiting for the nurse until she can spare a few moments from her own working assignment.

The (un)availability of bi-lingual nurses to facilitate recruitment of non-English speaking patients for the study points to the complexity of delivering health care to patients of diverse linguistic and ethnocultural backgrounds. In fact, the experience of the research assistants in asking staff interpreters to inform potential participants about the study probably reflects the average experience of non-English speaking patients and their

families, who might also need to wait for a substantial period of time for a staff member or interpreter to become available for interpretation pertaining to their care.

Theorizing about Culture: Making Sense of the Field

Contested discourses: 'Reading culture,' 'writing culture': Culture is not an unproblematic concept. The inclusion and exclusion criteria we use in the recruitment of participants to a study such as this, state, in profound ways, how 'culture' is conceptualized by the researcher. For the most part, exclusion and inclusion criteria are usually premised on the assumption that there are cultures 'out there' that can be identified, and that we can formulate criteria that will tell us about people's 'acculturation' into the 'mainstream' culture, so that we can make decisions as to whether the participant meets the criteria for inclusion in a study. Practical guidelines such as length of time in the host country, or fluency in the language of the host country, are usually constructed as providing insights into how conversant people might be with the 'host culture.' Yet we know from past experience in conducting research, as well as from this study, that such criteria can be misleading. Some participants in our study who have lived in Canada for up to 35 years did not speak English; others who have lived in Canada for a much shorter period of time spoke fluent English and were conversant with what is usually construed as Western health care practices. These were the issues we grappled with as we attempted to recruit people who might help us to address the issues being raised in this research study.

We opted, initially, to speak with first-generation Indo- and Chinese-Canadians who were hospitalized long enough — usually for about a week — to allow us to speak with them. Family members, agreeable to participating in the research study, are also

being recruited. Since one of us is bilingual in English and Cantonese, we are able to recruit people who speak only Cantonese. Given the linguistic limitations of the research team however, the Indo-Canadian people whom we are recruiting are English speaking. Our decision to include Indo-Canadian and Chinese-Canadian participants was **not** to study ‘ethnic differences’; rather, we believed that by engaging with these two groups, we might begin to understand how cultural plurality is negotiated in the clinical setting. This is not to say that other groups would not enable us to address this phenomenon, but practical issues, in particular the language competencies of the research team, guided our decision about inclusion criteria. Health care professionals of different ethnocultural backgrounds are also participating in the study.

As we analyzed the data during the first year of the study, it became apparent that in order to more fully interrogate the concept of ‘culture,’ Anglo-Canadian participants would also need to be included in our interviews. We stress that the inclusion of Anglo-Canadians is not to provide a ‘control group’ as this is understood in biomedical research. Instead, the inclusion of Anglo-Canadians is enabling us to detect how ‘culture’ is constructed and played out in the clinical field, and to unmask the ways in which ‘culture’ may be drawn upon to make sense of people’s behaviour. For example, we can begin to explain how ‘culture’ is ‘read’ by health professionals, and drawn upon to make a distinction between ‘some ethnic groups’ and, in the words of one health professional, “our own people.” From what some health professionals had to say, it was evident that some people are seen as possessing ‘cultural’ characteristics that organize their expectations of health care. In the words of one health professional:

There's a cultural thing there too. We have a lot of immigrants that have come to Canada, and I'm thinking of some of the . . . families, their expectation from where I sit is unrealistic. . . We often have families who

just cannot accept the fact that they have some responsibility for caring for this patient at home. . . that could still be cared for.

Yet, participants in our study from both Indo- and Chinese-Canadian backgrounds who had immigrated to Canada, spoke of the ways in which they looked after their loved ones. As one woman who cares for her husband at home said: “I am the one who looks after him.” She proceeded to tell us about the economic hardships she faces and the economic support that she must accept from her children in order to make ends meet. We came to question, then, whether what may be perceived as a reluctance to take on the responsibility of caretaking by some people may be due, not to their ‘culture,’ as the health care professional suggested, but to the economic circumstances of their lives. We asked, “What might lead health professionals to see the behaviour of such people as unrealistic? Might the expectations of some Anglo-Canadians be seen as unrealistic?” Mr. Sam, an Anglo-Canadian patient, for example, in speaking about the effects of cutbacks in health care spending, told us:

The meals. . . I mean before you used to get a menu and you can pick and choose things that you really wanted. I really think that when they stopped the menu bit. . . I think that's bad. I really think that was bad.

Should we understand Mr. Sam’s comment as a ‘cultural thing’? Should we interpret it as a statement about ‘Anglo-Canadian culture’ — that Anglo-Canadians expect menus, and that they want to be able to pick and choose what they want to eat? Should this be read as an unrealistic ‘cultural’ expectation? Or, do we hear it, instead, as a reasonable expectation? Would this statement be heard as a ‘cultural thing’ if uttered by an Indo-Canadian or a Chinese-Canadian person? The issue then becomes how ‘culture’ is interpreted, and whether the patient’s ‘culture’ might be perceived as a barrier to cooperating with health professionals. How the ‘patient’s culture’ is interpreted depends on

the interpretive lens through which the health professional constructs the patient and the notions of 'Other' that might be held.

Age was also constructed as 'a culture', and the following statement by a nurse reflects how she constructs this culture:

Cultural perspective. . . um, there are some where the elderly might be less than willing to make an effort to show that they are capable because they seem to enjoy the sympathy and extra attention they are receiving from their families or friends, and they like to be waited on, they like to be pampered. I'm old now, so this is great, I can just take it easy and someone is going to come and take care of me.

The questions that have arisen in our fieldwork bring forward issues that need to be brought to light if we are to make sense of 'reading culture' and 'writing culture' into health care delivery systems. These issues are not solely theoretical, but rather are germane to the practical ways in which health care is provided in the clinical context. We need to understand the ways in which conceptualizations of culture inform how health care providers interact with patients, and how patients 'read' their interactions with health professionals. An Indo-Canadian woman, whose father was not able to communicate with the interviewer due to his illness, consented to participate in the study and shared some of her perceptions with us.

He seems to be getting better care here. It is quieter and he can rest peacefully. I think the nurses here were culturally sensitive because he has many visitors, especially family, so they gave him a private room. It's nice and quiet here.

Later,

Nursing profession is very challenging. They do all the front-line work. I don't have any complaints about the nursing care. The doctor, however. . . he comes in and shakes his leg and arm and sees how he responds and just tells us the only thing we can do is pray. You think that they can do more but all they can say is pray. I'd really like to see [a specialist].

We pondered whether telling the daughter to pray may have been based on some notion about the woman's culture and her spirituality, and questioned whether an Anglo-Canadian family member would have been instructed likewise.

In drawing on our conversations with patients, their families, and health care professionals, we stress that they are not meant as research findings that would give us the 'facts' as to whether health care professionals are, indeed, culturally sensitive. This is not the issue being addressed here. Rather, these data provide a window into a central problem in health care delivery as we attempt to make health care services more culturally responsive to people of 'minority' ethnic backgrounds. If we are unclear about what we mean by the concept of 'culture,' it seems reasonable that we will be equally unclear as to what constitutes culturally responsive care.

As we have conducted interviews and observed practitioners performing their everyday duties, it has become apparent that *how* policies are implemented to improve access to health care by immigrant populations is filtered through the interpretive lenses of the health care provider. Furthermore, interactions with clients are contextualized within broader *macro-institutional cultural systems*. We turn now to some of the areas that are being highlighted in our fieldwork in the attempt to interrogate what 'writing in culture' might mean as health care institutions are restructured to become more efficient, and as health care moves *closer to home*.

The Language of Health Care: Standardizing the Care Process and Early Discharge of Patients from Hospital

Standardization of policies and procedures across institutions is part and parcel of the process of making health care more efficient and cost-effective. As health care agencies

amalgamated under regional health boards throughout the province of British Columbia, programs and services were integrated and administration was streamlined. On the one hand, regional health boards were believed to have great potential to “achieve significant cost savings through consolidation and rationalization of services and economies of scale” (British Columbia 1996). On the other hand, it was expected that health care regionalization would enable “a continuum of care for patients through better integration of community and institutional services in major urban regions” (British Columbia, 1996).

In our fieldwork, standardization of care protocols, and early discharge of patients from the hospital have surfaced as one focus of the professional discourse, and we have been led to question what this means within the organizational culture. Standardization of care, as we were told by one health professional, is not a new phenomenon, but is a way of drawing on research as a basis for practice. In her words:

Acute care is standardizing certain activities, and in continuing care, they are also standardizing activities. So we take all our policies and procedures that provide care, pull this together to what they do over there (at other institutions within the region). [We] look at the commonalities, what does the research tell us and then develop a new one that is combined.

In this time of health care restructuring, standardization of care may also be interpreted as a way of balancing biomedically safe treatments with organizational efficiency. That is, as treatment protocols are standardized, health professionals can ‘do things the same’ by following an algorithm that leads down a path of intervention, based on research. Patients can therefore expect to have similar care in different institutions within a health region. Ms. R., a nurse, interprets how protocols work to promote efficiency in one clinical setting:

They come in, we have a certain assessment protocol, we check things off now, very brief, short, to the point, that's it. Don't go overboard more than you need to. You know. It's all being tailor made.

This is one nurse's interpretation of how protocols work; quite likely there are different viewpoints. Suffice to say, however, that the phenomena of efficiency and early discharge from hospital are not unique to the settings in which we are conducting research, but are now the language of health care services across Canada (see, for example, Reamy 1995; McDaniel 1997). Battin (1992) argues that efficiency, or cost-effectiveness, is a predictable goal for a national health system which is required to provide care for everybody under limited resources. With the emphasis on efficiency and cost containment, moving health care closer to home has been interpreted as off-loading of responsibility from the state to the individual and family. An issue that has arisen is whether decisions to discharge patients from hospital are in the interest of the patient, or whether they serve the goals of the organization such as budget controls and efficiency (Bull & Kane 1996; Iglehart 1990). In her investigation of the process of decision-making concerning the discharge of elderly patients from hospital, for example, Wells (1995) concluded that decisions to discharge patients from hospital were "mediated largely by systemic forces" (p. 52).

Yet there are competing discourses around the phenomenon of early discharge that challenge these perspectives. Instead, the early discharge of patients from hospital is also constructed as resulting from scientific advances, and as promoting patient safety. Clearly, there are different perspectives on the issues within health care and, as we have listened to them, we have been pondering how the discourses on standardization, biomedical safety, efficiency, and early discharge, interface with the discourse on making

health care more accessible to immigrant populations. All of these discourses are mediated within institutional contexts with explicit guidelines on the provision of different services and the care of patients. These include guidelines for interpreter services, ethical decision making, and informed consent of patients to treatment. These guidelines are meant to direct the provision of care, yet, guidelines are interpreted and managed within the ongoing exigencies of a hospital setting, and also, through the knowledge that health care providers draw upon in their interactions with patients. In implementing guidelines for interpreter services, for example, the health care provider must judge when interpreter services are needed as a requirement for adequate patient care, and whom to approach to obtain these services. The understanding (or lack thereof) that the health professional has of the interpretation process will guide how she seeks help and from whom. As Ms. R. told us:

You mentioned the interpretive support. . . and so that's one of the first measures we do take. . . we try and find somebody who can speak their language, and often we look in other department areas like housekeeping or food services, or pharmacy, or what have you, whoever is available within the hospital. And we do have a list of names compiled and areas that they work in, so that's readily available to us. . . Sometimes we are successful and sometimes we are not. If not, then we wait for family members to come during visiting hours. . . Italians . . . are such a cohesive group of people, that there are always young people within the family who are readily available.

This nurse discussed issues, as she perceived them, in providing care to people with whom the nurse cannot communicate mentioning, specifically, difficulties in the assessment of pain. Cues can be missed. In one situation, it was assumed that a patient was having 'a good night'; communication with the patient revealed otherwise.

As Ms. R put it,

And so there you go, there is a big difference there. And so one nurse will chart one thing, whatever she can see and perceive; whereas [another]

comes along and gets the more in-depth ideas as to what is going on with her. . . Sometimes what we do is establish a sort of code system, so that signals or certain whatever will mean something. So this we communicate with the staff.

To make up for the issues of lack of adequate interpretation she felt that: “Assessment skills have to be really acute, sharper, for those who we cannot communicate effectively with and who cannot communicate with us.”

Health care providers had different notions about how they could communicate with people. Ms. R., for example, suggested that:

Language of the heart I think is the key. If you want to get yourself understood, and you want someone to understand you, I think you will be able to communicate that to them. It doesn't have to be verbal all the time.

Nonetheless, the everyday issues that health care providers confronted were real and had consequences for patient care. As Ms. R. told us:

Sometimes you are rushed. You find yourself rushed. On a busy day, if there was. . . this lady who speaks only Punjabi, and no one else can speak Punjabi with her, she would probably get the most minimal assessment. Just simply going in and checking out that she is not in any acute distress. . . Do you have time to find an interpreter? Is an interpreter available? Will the interpreter be available when you do need them? Like, there is a whole bunch of questions that come up. And it bothers me then because people who don't speak English, perhaps don't get the care that is deserving to them, you know, and maybe they end up lying in the bed a longer period of time, before someone, before anything actually gets done. So it's a little bit of a concern that way, when you are on a fast paced unit like this one, and you don't have the time to take to talk to them.

However well meaning the staff members are, there were practical issues, and the availability of interpreters from the community or from within the institution may not always meet the needs of patients. One bilingual patient observed:

Like when they want, at least when they want to get a bedpan [referring to patients], and don't know how to say it. Sometimes they couldn't hold it. I said it for her, like by the time I could say it for her, it's a bit too late.

It is not only the availability of interpreter services that is at issue, but also, how these services are used. A health care provider's knowledge, and the ability to recognize the central nature of adequate interpretation to the care of patients will determine how interpretation is viewed and utilized. An understanding of how cultural meanings are negotiated within the context of interpretation, which can be laden with disparate power relations between patient and interpreter even when both come from the same ethnic background and speak the same language, issues of confidentiality, issues around using family members to interpret, are all pivotal to the process of interpretation, but may not be obvious to everyone. In fact, when one of us was asked to interpret, and hesitated out of concern for confidentiality for the patient, the staff member replied that interpretation was just about 'speaking'. This statement underscores the fact that the critical nature of interpretation and the complex issues surrounding it can be missed. Further, when language differences are singled out as the major barrier to the immediate clinical encounter between the patient and health care provider, issues such as gender, class, and age differences between the interpreter, health care provider and patient could be rendered irrelevant or unimportant in the process of negotiating health care.

The issues that have become apparent in this exploration of 'interpreter services' raise further questions about how 'culturally responsive care' might be understood, and whether 'words' might be seen as distinct from 'action'. Within hospital settings, medical treatments (read 'action') and the patient's biomedical safety may take priority over 'psycho- social- cultural safety' (construed as 'words') when time is limited.

In the foregoing discussion we have pointed to the complex context in which policies are played out within institutional settings, and the interweaving of the knowledge health professionals bring to the clinical encounter, with the mediating

circumstances of the institutional context. We proceed now to examine how the wider 'cultural system' organizes the construction of local cultural meanings, and 'writing culture' into health care delivery systems.

Locating Experience in the 'System'

Patients and practitioners alike located their everyday experiences in the broader issues in health care delivery today. In comparing past experiences of hospitalization with the present, some patients attributed these experiences to 'government cutbacks', and drew upon what they saw as a decline in standards of housekeeping in hospitals, having to provide their own costly medications while in the hospital (i.e., medications purchased for home use), the quality of hospital food, and the like, as examples to substantiate their claims. As participants spoke of their experiences, they spoke not only of their present hospitalization, but also of other experiences in obtaining health care services as a way of illustrating that their expectations were, or were not being met. This first generation Chinese-Canadian man who has lived in Canada for well over thirty years had this to say:

At least when you come to emergency, they give you a bed, not like it's under a lot of lighting, and shines right into your eyes, don't even allow you to open your eyes. When the doctor comes and asks you questions, you have to talk to him/her with the eyes closed. That is, at least have an appropriate position/place for you. . . [The doctor] had to tell the emergency nurses, "OK, you can push that bed away because I have to push Mr. P. in to examine him." Only then was there room for the doctor to pull the curtain up and examine me. Because there were no curtains along the corridor, it's open. So I felt very inconvenient, very uncomfortable; there were people walking up and down. It's very bothersome for me, since you are already a sick person.

In comparing his hospitalization experiences of some years ago with the present, he felt that health care "has been deteriorating gradually."

How can we make sense of such accounts, and what do they tell us about ‘writing culture’ into health care services? How are we to understand this ‘deterioration’?

According to this man, he has had no problem communicating with nurses, or physicians:

I don't have any problem in communicating with them [the nurses]. They are quite nice. Basically speaking, the nurses are very smart, know a few words of Chinese. Sometimes talk to those (who don't know English), “toi” (pain), “em toi” (no pain), “orr” (hungry), “em orr” (not hungry), they do know.

The following vignette provides some insights into his reading of ‘culture’ and ‘inter-cultural’ relations:

Interviewer : In your experience, if the health care provider came from another culture, speaking a different language, even though you can communicate very well in English, do you feel that might influence the care that you get?

Mr. P.: It shouldn't be the case. They have recommended me to see another doctor who is Caucasian. A lot of times, the specialists that I see are Caucasians. That's not a problem. They are the same, treating everybody the same. I also treat them the same.

What then is meant by ‘deterioration’? We tried to find this out by asking Mr. P. what improvements he would like to see in the health care system; this is what he had to say:

Like to go and see a specialist, it'd be good to have arrangement so that people can see [the specialist] within a week. Sometimes people can't wait for that long. Like screening for cancer and things like that, if it can be detected earlier then can be treated earlier, don't keep people waiting for that long, early treatment can cure people earlier. Right? If you have to wait for three weeks in order to go for examination, after being diagnosed, have to wait again for treatment. . . I saw that with my own eyes, with a few of my friends, they have died. . . They've all lived very normal lives, all my friends neither smoke nor drink. . . he had to wait for a long time before being examined. After diagnosis had to wait for a long time before arrangements could be made for him to go to the hospital for treatment. He also said that he felt very helpless.

Similar concerns about health care delivery services were raised by Mr. Sam, whom we mentioned earlier. When asked if he had noticed any changes in the Canadian health care system in the past little while, he replied:

I mean you can't count on anything. Like where I think changes could be made, like in regards to even admittance. For example, when I phoned, and I was supposed to be booked. . . I feel that I shouldn't have had to keep phoning back. . . Because when you have been told to phone in and then you can't get a bed, the stress of waiting. I'll tell you, the last two days I was really, really upset. Because you are just waiting around for the phone to ring. And anybody phones you, you have to hang up and say "well, I'm waiting for a call," and you wait for hours. And this shouldn't be. . . You shouldn't have to phone back to see if there is one [bed].

Mr. X., of Chinese-Canadian descent, and a family member who consented to participate in the study, shared similar concerns to Mr. Sam. In his words:

The government cut, cut, cut. Lots of cut. The government doesn't care about health care anymore. The government doesn't want to spend more money. . . before they could keep longer [meaning longer in hospital], now they can't keep long. As soon as OK then we go home.

That's not the hospital's fault. It's the government. They are the one who are tightening the purse. So, what can the hospital do? They have to budget everything so it's not their fault. They are shutting down all the bed and everything so what can you do.

One woman went on to say that her husband receives home care services, and she is responsible for the care of her husband outside of the home care visits. She feeds him, does the laundry, and makes sure he is comfortable.

Mr. Y., the son of a hospitalized man of Chinese-Canadian background, emphasized that "all the nurses and doctors were very good, and they worked very hard." He felt, however, that staffing was insufficient. Furthermore, he had first hand experience with the shortage of hospital beds; a sick relative who had cancer and also contracted pneumonia, had to be taken to the hospital every day for treatment of

pneumonia. Although the treatment took only fifteen minutes, on one occasion he had to wait for three hours. Mr. Y. felt that it was very hard on the patient.

Health professionals might have a different interpretation of the issues raised by these people. For example, one health professional explained to us how treatment for pneumonia had changed. At one time, patients were required to be hospitalized, now they can be treated without having to come into the hospital.

Patients and health professionals may, therefore, have different interpretations of the changes in health care delivery. What patients may explain as deterioration in services, health professionals might see as resulting from advances in biomedical science and more efficient use of resources.

These vignettes draw attention to the many layers of contexts in which health care is mediated, and to the many levels at which ‘culturally responsive care’, as advocated by governments, is interpreted and negotiated. While acknowledging the everyday realities in patient-practitioner encounters that make health care inaccessible to some groups, we argue that ‘writing in culture’ needs to be conceptualized within the discourses and institutionalized practices of global socio-cultural-economic systems. Not only do macro level processes filter down and shape the restructuring processes at the local level, and organize everyday human interactions, but also, decisions about the allocation of resources will profoundly influence the services that people have access to. We turn to this in the next section.

4. 'Writing culture' into a renewed health care system

“We don't get a chance to assimilate the change, to get used to it, before something else happens.”

Health care restructuring, which entails ongoing changes within institutional settings, is not just a Canadian phenomenon; Creese (1994) tells us that in most countries health reform is driven by the concern that the scale of government spending on health care is not sustainable. In countries such as North America, he points out, the emphasis on policy change has been “less on shifting the boundary between public and private financing, and more on improving performance under what in most cases is a predominantly public system” (p. 321).

The overhaul of the health care system and the emphasis on a more efficient system is taking place at a time of major population movement. Issues of access to health care services are being raised by users of health care services, policy makers and governments, and the discourse on cultural meanings and health has come to the forefront as health care providers attempt to provide health care to people with experiences and interpretations of health and illness that may differ from their own.

In the foregoing discussion on ‘writing culture’ into health care delivery systems, we have posed questions that have arisen from our research as we examine how policies aimed at making health care more accessible are negotiated in the everyday realities of hospital settings. We have grappled with what we mean by ‘culture.’ The word is not as transparent as it seems, and health care providers bring varying interpretations of the concept to their interactions with patients. Policies that are in place to foster the inclusion of culturally responsive care to patients are therefore interpreted and negotiated within

the context of complex personal meanings, and within institutional contexts influenced by broader structural forces.

In light of this, a pressing question at this time is whether there is a disjuncture between the discourse on making health care more accessible to groups that have been underserved, and the ways in which the attempt to contain health care costs is being approached. The seeming tension between organizational restructuring and provision of accessible and acceptable care is felt in the everyday reality in the health care context. While patients perceive that they are receiving competent care from health care providers, patients and practitioners alike are telling us that recent restructuring has led to what they perceive as a decline in resources for health care. Yet, not everyone agrees with this. One administrator said, “We are taking the money that used to be given to the big hospitals, and it is being put into different places.” It might be argued, then, that the issue is not a decline in resources, but rather a redistribution of resources.

While the current restructuring might be perceived, on the one hand, as a move towards greater efficiency, and as fostering the emergence of new leadership styles, on the other hand, what is being experienced by consumers and front line health care workers is a growing scarcity of resources — e.g., hospital beds, and personnel, such as nurses — the very resources that might be needed if health care is to be made accessible to populations that have been underserved.

What does all this tell us about policy implementation and organizational change to make health care more accessible to underserved groups? Policies are implemented within complex organizational structures, and the knowledge of health professionals and availability of resources influence how a policy can be implemented, and how ‘culture is written into’ the health care system. Implementing a policy on interpreter services that

would facilitate the negotiation and construction of cultural meanings between staff and patient, for example, means, first of all, that such services will be available when needed, and that staff members have the time to procure them, and know how to use them effectively. When time is an issue, staff members may see biomedical safety as taking precedence, even though the lack of negotiation of cultural meanings can lead to unsafe biomedical care.

While there are competing discourses in the field, our observations are suggesting that 'writing in culture' cannot be addressed apart from the structural constraints in health care and decision making about resource allocation for health care services. 'Writing in culture' is not just a competency issue on the part of health care providers that can be addressed by better education. While we stress the need for knowledge that enables health care professionals to provide appropriate health care to diverse client populations, the issues extend beyond the individual competencies of practitioners to the broader economic, social and political processes that determine how health care services are organized. From what people are telling us, some of them perceive that the bare minimum is not always available (for example, people wait in emergencies when no bed is available, there are extended waits for surgical procedures and for admission to hospital). Patients from all ethnocultural backgrounds are experiencing these issues; those who cannot communicate in English and who are less conversant with the health care system may face added difficulties. They may not be able to negotiate for privacy in a crowded emergency, nor may they be able to negotiate getting a hospital bed when this is urgently needed.

Our observations and what we are hearing have led us to question whether the outcomes from the current restructuring will, in fact, achieve the goal of making health

care more accessible and culturally responsive to people of minority ethnic backgrounds -
- an issue raised in the *Closer to Home Report*. Long waits for surgical procedures,
premature discharge from hospital — if indeed this is the case — lack of adequate
understanding of treatment processes because adequate interpreter services may not be
available or used appropriately may, in fact, lead to a decline in health and, in the long
run, to more expensive health care interventions.

We recognize that the discourse on cost containment in health care is a complex
one. The ‘culture of science’ continues to be preeminent, and access to costly
technological procedures is an expectation of consumers and health professionals alike —
both groups expect the best that science has to offer; life is often prolonged with costly
technological intervention raising issues that are now widely discussed by clinicians and
health care ethicists. Resources allocated to technology will not be available to other
sectors of health care, but decisions are not easily made as to how resources should be
parceled out and often raise ethical and moral concerns. We continue to explore such
issues in our research.

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