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Transcultural Nursing Theory From a Critical Cultural Perspective

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This critical cultural discourse analysis explores the internal logic of Transcultural Nursing Theory and interrogates the underlying assumptions, goals, and strategies of this approach to race and other human and social differences. Drawing on examples from nursing textbooks and policy documents, I assert that Transcultural Nursing Theory operates from a liberal standpoint that focuses attention on a broadly defined, but narrowly applied, concept of culture. The goal of providing culturally competent care and the processes used to achieve that outcome reinforce, rather than transform, the social practices and relations that institutionalize the dominant approach to social and human differences. **Key words:** *critical theory*, *cultural diversity*, *cultural sensitivity*, *discourse analysis*, *racism*, *Transcultural Nursing*

SINCE its conception more than 4 decades ago, Transcultural Nursing (TCN) Theory has gained acceptance in the United States and Canada as the way of promoting culturally competent healthcare to individuals from diverse cultures. Leininger, the nurse anthropologist who established the subdiscipline of *Transcultural Nursing*, first defined it as "the humanistic and scientific study of all people from different cultures in the world with thought to the ways the nurse can assist people with their daily health and living needs."[1(p8)] The widespread acceptance of TCN Theory is reflected in the burgeoning literature on the topic that necessitated the entry of TCN as a subject heading in CINAHL in 1981. Acceptance of TCN Theory is also reflected in North American nursing literature, textbooks, educational curricula, and practice policies that use TCN Theory as a way of thinking through issues of race and other categories of social and human difference. As clinical nurses, nursing faculty and students, nursing researchers, managers, and policymakers, we call upon these texts to guide our learning about what it means to perform in culturally competent ways.

Cultural competence is represented as a quantifiable set of individual attitudes and communication and practice skills that enables the nurse to work effectively within the cultural context of individuals and families from diverse backgrounds.[2] A culturally competent nurse performs a nursing assessment, using her or his knowledge and communication skills to identify the client's cultural similarities and differences, and to establish mutual goals for care. If the nurse finds that her or his cultural beliefs conflict with

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those of the client or family, she or he may integrate the client's wishes into the plan of care. If that is not possible because of potential harm to the client or anyone else, the nurse helps the client adopt new patterns of behavior. If the nurse finds that her or his individual biases get in the way of implementing culturally sensitive practices, she or he is encouraged to participate in educational programs and consciousness raising to remediate deficits in culturally specific knowledge, skills, and attitudes. Thus, culture care is located within the space of the nurse-client relationship.

TCN Theory offers a theoretical and practical approach to nurse-client relations that centers culture as a way of understanding individuals and their responses to health and disease.[1,3] *Culture* is defined as a composite of multiple differences producing individual identity. This apparently commonsensical approach to social and human diversity has easy appeal to nurses because it is consistent with the liberal ideology that is deeply rooted in our professional value system and in the everyday discourse of the dominant North American society in which we live and work.[4] Our profession values and promotes individual responsibility for health and well-being, informed choice, self-awareness, tolerance, and the ethic of care. It is no surprise, therefore, that TCN Theory with its liberal, humanistic focus on the individual would be embraced by those of us concerned about what is often characterized as the problem of increasing cultural diversity in our client population and our local communities.

The purpose of this article is to deconstruct TCN Theory as a framework for thinking through, talking about, valuing, and engaging with human and social differences. This means systematically taking apart and interrogating from a critical cultural perspective the underlying assumptions, goals, and strategies of TCN Theory as articulated in nursing research, policy, and educational reference texts. This discourse analysis emerges from a larger project that examines the interdependence and cross-pollination of text-based nursing knowledges.* The larger project analyzes the culture care standard of practice[5] issued by the College of Nurses of Ontario (CNO),† the educational curricula and textbooks relating to cultural sensitivity used by one Canadian school of nursing, and the nursing research literature that supported the development of both sets of texts.

The following discussion is framed using 4 broad but interrelated conceptual elements: standpoint, focus, goals, and process.‡ Drawing on nursing textbooks, policy documents, and other TCN literature, I assert that TCN Theory operates from a liberal *standpoint* that *focuses* attention on a broadly defined, but narrowly applied, concept of culture. The knowledge, beliefs, and values that underpin TCN Theory organize the *goal* of providing culturally competent care and the *process* or strategies used to achieve that outcome. These goals and strategies reinforce, rather than transform, the social practices and relations that are embedded in, and mediated by, the hierarchically ranked social order both within and beyond nursing. The outcome is a broadly based, dynamically interconnected, and depoliticizing project of knowledge production that reinscribes the dominant liberal approach to social and human differences.

A CRITICAL CULTURAL PERSPECTIVE

A critical cultural discourse analysis is unlike most critiques of TCN Theory that accept

*In some disciplines, the interconnectedness of texts is referred to as intertextuality. Intertextuality is a hallmark of academic texts that routinely cite and cross-reference other texts as a way of demonstrating the reliability and validity of truth claims.

†The CNO is a Canadian provincial self-regulating body that has the government mandate to protect the public right to quality nursing services. Two strategies for achieving this goal are establishing minimum educational requirements and setting standards of practice with which the members must comply.

‡These elements are drawn from a framework originally intended to facilitate the systematic analysis of a large body of feminist literature and described in Gustafson.[6]

the underlying assumptions of TCN Theory and are concerned with fine-tuning or expanding the theory[3,7,8] or the tools for measuring nurses' cultural competence[9,10] or implementing culture care in various practice settings.[11–13] Instead, this critique contributes to an emerging feminist postcolonialist dialogue in nursing.[14–20] Although the fundamental concepts I apply here will be familiar to those of us who read cultural studies or antiracism literature,[21–32] the concepts may be unsettling to those of us who do not. Whatever your entry point, I invite you to reflect on the contributions that a critical cultural perspective offers.

One distinguishing feature of a critical cultural perspective* is the way of thinking about diversity and categories of social and human difference. Critical theorists challenge categories of difference that are held up as distinct, bounded, and static biological facts or essentialized categories of human identities.[28–31] Instead, race, religion, gender, and sexuality (to name a few) are regarded as deeply interconnected social, political, and ideological categories to which positive and negative meanings are attached. Dei[28] asserts that there is no scientific validity to support the practice of classifying individuals and groups by race for instance. Yet, the continuing reiteration in nursing texts of racialized differences—as if race difference were a biological fact—has material consequences for nurses and clients as individuals and collectives. These consequences are experienced as differential access to power, privilege, wealth, opportunity, and resources.[31,32] Those of us who are white, middle-class women tend to be positioned as nurse managers, researchers, and educators whereas those of us who are black, Caribbean, or Filipino, for example, tend to be concentrated in less prestigious, less autonomous nursing positions.[33–35] Thus, cultural diversity is not the problem but rather how institutional discourses articulate difference that results in the material consequences that play out in everyday engagement.

Although categories of difference are "coercive and resilient" social and political facts that organize how we think and act, Dei cautions that these structures do not necessarily "define the limits of social action."[28(p59)] This caveat brings me to a second distinguishing feature of a critical cultural perspective. Change is an explicitly political project. Rather than attending to the individual and ways of changing individual behavior, critical theorists look for connections between social practices and social identities, representations, and identifications.[28] Material practices in local social networks that structure and organize everyday experiences and unequal power relations are the focus of change. Situating social relations within a dynamic, social hierarchy at a given moment in time and space moves the critical theorist "beyond questions about *who we are* to discussions about *what we do*" (italic in original).[28(p60)] The overt attention to discourses of difference and change as political acts are the 2 features of a critical cultural perspective that underpin the analysis of TCN Theory that is offered here.

ESTABLISHING THE LIBERAL STANDPOINT OF TCN THEORY

Every *standpoint* or worldview shapes what is possible to see and what is obscured. Each standpoint is based on a set of assumptions that structures how one sees and interprets the world. A given set of beliefs and assumptions about social phenomena forms the basis of a *theory* or set of organized ideas that helps us make sense of the particularities of everyday experiences. In this way, we all make meaning of the world and theorize about human interaction from a particular standpoint. The standpoint we embrace as

*I am not suggesting that all knowledges produced by critical theorists or TCN theorists are consolidated and harmonious. Both bodies of literature reflect multiple and divergent perspectives. Given the limits of this article, I focus greater attention on shared assumptions and internal consistencies in each. For a lucid and readable discussion of the many features of a critical cultural or integrated antiracism perspective, see Henry et al.[31]

nurses is dynamically connected to the text-based and experiential knowledges that organize individual and group identities, and structure social relations and prescribed practices with clients and each other.

TCN Theory operates from a *liberal standpoint* that stresses the individual, and individual rights, freedoms, responsibilities, and action. The assumption is that we live in a society that is fundamentally egalitarian and equitable and strives toward maximum individual freedom and autonomy.[4] Scheurich observes that the liberal discourse about the individual and individual choice is so dominant as to be regarded as a "naturally occurring, transhistorical, transcultural condition to which all humans naturally aspire."[26(p6)] Social standing and personal achievement are believed to be earned through merit and individual effort and disconnected from group social membership. For those of us who are white, our "socially learned investment in individualism eclipses our awareness of our racial positionality" as well as the power of liberal individualism to assert our dominance in relation to the racialized Other.[26(p5)]

This investment is revealed in TCN literature that is regarded as rational and objective and emerging from a politically neutral space. This investment is also evident in the way that TCN Theory conceives of nurse-client relations as the interaction of individuals rather than social engagement that is embedded in, and constituted by and through, institutional and structural processes. Thus, macroprocesses that shape individual and collective experience tend to be obscured by the discourses of individualism and meritocracy. These discourses hide the ways that race and other categories of social difference accord some of us undeserved power and privilege at the expense of others of us who are regarded as less deserving.

Proponents of TCN Theory may disagree with my assertion that the TCN focuses on the individual, claiming instead that the focus is on the family and community. Leininger, for example, writes that "from the beginning, transcultural nursing has maintained a strong and deliberate focus on discovering comparative nursing knowledge."[7(p39)] Although it is true that some research compares the beliefs of diverse cultural groups,[36,37] such comparisons are underpinned by the appeal to individualism that locates responsibility for appropriate care within the nurse-client relationship.

The appeal to individualism frames Canadian and American nursing policy. A Position Statement on Cultural Diversity in Nursing Practice issued by the American Nurses Association refers to culture as the "central organizing concept upon which nursing is based and defined."[38(p1)] This assertion plays on the liberal theme of international equality and civil rights highly visible in the American media in the 1980s and early 1990s. The following year, the American Academy of Nurses (AAN)[39] published 10 recommendations promoting culturally competent care. In 1999, the CNO issued a policymaking culturally sensitive care an expectation for competent nursing practice wherein personal autonomy and freedom of choice were said to be "strongly valued" by nurses.[5(p4)] The official position taken by these professional bodies lends considerable authority to the centering of a broadly defined, but narrowly applied, concept of culture—an assertion I discuss more fully in the next section.

Research is cited to support the development of policy statements and educational curricula. Similarly, policy statements are frequently cited in journal articles and textbooks to support cultural competence in nursing education and practice. Collectively, these interdependent resources form the text-based knowledges that nurses use in developing what we are told is a rational and objective approach to individualized care.[2] Claiming objectivity is consistent with a liberal standpoint[4] and facilitates a continuing and detached way of thinking, talking about, and performing social practices associated with social and human differences.

TCN Theory emerges from, and is implicated in, the reproduction of individualism as a core value in nursing. Although TCN Theory

is not overtly political, the appeal to individualism and objectivity is inherently political. Cultural care competencies are advanced as a set of well-intentioned, commonsense solutions for organizing the activities of the individual nurse. Appealing to universal subjectivity reasserts the view that we are all *just people* negotiating interpersonal relations while simultaneously obscuring the power of the very social processes used to organize those engagements. The liberal discourse of individualism in TCN Theory renders less visible and, therefore, less eligible for discussion, the derivative social practices that perpetuate racism, sexism, and other systemic oppressions.

THE PROBLEMATIC FOCUS ON CULTURE

Depending on one's standpoint, attention is focussed in particular ways on some issues whereas other issues are viewed less clearly or not at all. Any given *focus* limits the observations it is possible to make, the problems identified, and the goals for addressing those problems. Culture is defined broadly in the TCN literature as a composite of multiple differences that produce individual identity. The CNO culture care standard explains that culture as a set of learned beliefs, values, and biases that affect "the way people view and respond to their world and other people in it."[5(p4)] From the liberal TCN perspective, unequal valuing and respect for different cultures leads to problems with preserving and incorporating cultural beliefs and practices into safe and effective healthcare.[3] The TCN focus on a broadly defined, but narrowly applied, concept of culture (1) is a depoliticizing point of entry into the discussion of race and other social differences; (2) emphasizes individual identity and the commonality of the experience of difference; and (3) blurs attention to power relations, systemic oppressions, and a history of exploitation, violence, and colonialism.

Depoliticizing point of entry

The TCN focus on culture is the depoliticizing point of entry into the discussion of race, ethnicity, and other social differences. Speaking of a depoliticiz*ing*, rather than a depoliticiz*ed*, point of entry more accurately reflects the active stance required to respond to, and regulate, conflict when the liberal standpoint is contested.* When the CNO culture care standard was showcased at an international conference, an electronic media release quoted a nurse administrator as saying, "Ethnicity is by no means the only component of a person's culture, but this diversity is indicative of the challenges Ontario nurses face in delivering therapeutic care to patients whose culture may be significantly different from their own."[40] Although the speaker acknowledges that culture is a combination of individual attributes, she advances ethnicity as the significant difference. Moreover, she constructs an implicitly homogeneous group of Ontario nurses challenged by working with the ethnic Other. My intention here is not to indict the individual speaker but rather to illustrate how racialized subtexts are communicated in everyday talk and penetrate our ways of understanding human and social differences.

Not only does the TCN concept of culture stand in for and operate as a code word for race and ethnic differences, a broad definition simultaneously realigns our focus on more comfortable, celebratory aspects of social difference. This realignment helps us avoid naming race and other categories of difference as social facts. Indeed, the word *racism* seldom appears in TCN literature. One exception is the AAN report that defines its mandate as identifying "issues affecting the provision of sensitive/competent nursing care, such as racism, heterosexism, sexism, ethnocentrism, lack of cultural understanding, and stereotyping."[39p(277)] More commonly, *racism* is used as a synonym for discrimination. One text labels descriptions of overt racism as "not so-subtle insensitivity to ethnic diversity."[41]

As van Dijk[27] points out, prejudices such as racism are considered socially undesirable,

*I thank Rebecca Hagey for this insight.

and expressions and denials of racism have their own etiquette. She argues convincingly that avoiding provocative talk about race and racism is part of a discursive white etiquette. The same, I would add, could be said of avoiding provocative talk about other aspects of social difference. Not seeing racism, sexism, or homophobia, or seeing expressions of social oppression as the behavior of a few misguided individuals arises from a liberal emphasis on the individual.[31] Denial of systemic oppressions is an integral part of the identity formation of the dominant subject. More specifically, denial or evasion of race difference is an integral part of white identity formation.[25]

With few exceptions,[42,43] nursing texts do not problematize race or other discourses of difference. This failure grants continuing credence to the use of racial categorization as a valid tool for classifying people. As mentioned previously, race has no validity as a biological fact. Migration and so-called interracial mixing makes it impossible to classify individuals and groups according to physical, genetic, and other discrete biological characteristics. The concept of race as a biological category is being replaced with the concept of race as "an essential category of human identities and bodies."[28(p41)] No less problematic, this revised concept is used in some medical and social scientific research to advance ideas about the nature and ability of various racialized groups. J. Philippe Rushton's controversial bell curve research is one example of how text-based knowledge adds power to racializing discourses. Moreover, some critical theorists report that the political and social production of racialized groupings reinforces differential access to quality healthcare. For example, Hammonds'[44] study of people living with AIDS reports that some groups receive healthcare qualitatively different from what others receive, and, more interestingly, that the very definitions of *health* and *disease* themselves vary by race, class, and gender.

Similarly, TCN Theory is implicated in the reproduction of racialized categorizations. Literature and textbooks are heavily peppered with a cookbook approach to cultural diversity.[36,45–47] Peoples are clumped together on the basis of a shared language or heritage of a language, a shared historical experience, or shared cultural traditions and practices. For example, Kozier et al[45] offer a 2-page matrix entitled "Selected American Cultures," which compares the health-related beliefs and characteristics of the 4 groups. Highlighted are the Navajo (explicitly representing Native Americans), Mexican Americans (explicitly representing Latino or Hispanic Americans), African Americans (implicitly representing blacks), and Chinese Americans (implicitly representing Asian Americans).* The text rationalizes the use of these categories claiming that biology plays an important role in defining *race*, *ethnicity*, and *culture*. "Ethnicity and race can overlap because cultural practices are reinforced by physical characteristics."[45(p292)] However, the imposed homogeneity evident in these texts ignores the many differences *among* group members such as gender, sexuality, religion, class and economic differences, and rural or urban living conditions.[28,31] Furthermore, reductionist categories emerging from research conducted by and through the dominant lens do not reflect the multiple aspects of self-definition between and among group members.[27,28,31,32]

Individual identity and the commonality of difference

The second problem with the TCN focus on a broadly defined concept of culture is the way it emphasizes individual identity and the commonality of the experience of difference. Culture is alleged to be an individual characteristic that shapes every person's subjectivity

*Recent editions (Kozier et al[2] and Potter and Perry[48]) of earlier texts (Kozier et al[49] and Potter and Perry[46]) have eliminated charts with cryptic bullets in favor of more detailed prose. The assertions about biological variations, time, space, and social organization across racialized groups remain.

and experience. Every person and every situation is regarded as "unique."[5(p3)] The responsibility is placed on the nurse, herself a unique person, to establish a therapeutically effective interaction with a client who is similarly regarded as having a unique identity shaped by multiple factors such as gender, sexuality, race, religion, and country of origin.

According to TCN Theory, everyone holds stereotypical beliefs about other individuals and groups, and everyone, at one time or another, is the subject of discrimination.[3] The CNO standard claims that responses to cultural differences are "automatic, often subconscious."[5(p3)] Individual prejudice, bias, and discrimination stand in for, and obscure attention to, racism and other forms of oppression, exclusion, and marginalization. Isolated from the institutional relations that make them explicable, racist, homophobic, and sexist ideology and action become treatable like a disease with educational programs and consciousness-raising proffered as treatments for individuals who demonstrate aberrant behaviors. Thus, a broadly defined concept of culture located in individual identity and practices fails to connect explicitly discourses of race difference with racism, sexuality with homophobia, sex/gender with sexism, and more important, collective social identities with institutionalized knowledges, social practices, and experiences.

The TCN catch-all concept of culture ascribes multiple differences to everyone and to everyone equally. Every person is regarded as differently different creating an essential commonality of identity across human experience. The result is a curious mix of "universal sameness overlaid with individual difference."[25(p148)] Furthermore, the notion that "everyone is struggling against something" blots out the operation of difference as a social mechanism of domination and subordination.[30(p294)] From a critical perspective, a broadly defined concept of culture is problematic as it makes less eligible for discussion of those instances when "difference make[s] a difference."[30(p294)]

Another aspect of the problematic focus on individual identity is the way it entrenches the assumption that we all begin from a similar social location. Erasing the significance of the social hierarchy allows whiteness to be bounded in the same way that other racialized groups are bounded.[29] Heterosexuality can be bounded in the same way as homosexuality, bisexuality, and transgendered sexuality. And similarly, Christianity can be bounded in the same way as Judaism, Hinduism, Buddhism, and so on. When membership in a group is advanced as different from, but equal to, all other groups, the negative social meanings attached to some categories of difference are hidden. The lived experiences of those of us who are members of a minoritized group are ignored; the social significance of being regarded as inferior to or "less than" is erased.[42] Consequently, the straight, white, Christian nurse can see herself or himself as having a nuanced cultural identity without recognizing how her or his dominant relationship to the social order legitimates the liberal discourse,[29] and how her or his experiences are qualitatively different from those of a differently located nurse.[17,20,33] By extension, those of us who located at the top of the hierarchical heap may regard ourselves as innocent or unimplicated and, therefore, less responsible for making fundamental systemic changes. The outcome bolsters the power of the dominant subject without impacting the system. Moreover, focusing on the individual, and the nurse-client relationship in its particularity, makes seeing the big picture difficult.[22] This brings me to the third point.

History, geography, and systemic oppressions

The focus on culture broadly defined blurs attention to power relations and the interconnectedness of systemic oppressions and, in particular, the connection between systemic oppressions and the history, geography, and the capitalist relations of exploitation and colonialism.[29] TCN Theory lacks an

explicit discussion about the impact of systemic oppressions in organizing people's experiences of social difference. The microscopic attention to individual cultural identity and common experience of difference makes it difficult to recognize racism and other social oppressions as systems of exclusion and privilege.[28] Thus, systems are cleansed of their political and historical significance as mechanisms of power.[29] The significance of history in producing contemporary realities for marginalized nurses in nursing education are avoided.[17,34] The same can be said of marginalized populations in healthcare delivery.[19,33,44]

TCN texts implicitly legitimate whiteness as a politically neutral identity position from which to interpret race difference[29] and construct theoretical and material responses to race difference in nurse-client relations. From a liberal standpoint where equality of opportunity is assumed,[4] inequality can be attributed to individual inferiority or inability to integrate into the dominant society. Nurses as individuals and a profession can avoid the discomfort and "messy context" of history, politics, and systemic oppressions.[29(p311)] The practical and material questions about access to power, wealth, and privilege are displaced by questions about how to assist nurses in becoming culturally sensitive by reflecting on their own values and responses to the cultural Other.[5] To borrow Dei's words, TCN Theory exemplifies the failure of traditional disciplines "to address with intellectual honesty the complex histories and social relations of colonized and marginalized peoples."[28(p249)]

A critical cultural approach to diversity does not erase the uniqueness of individual cultural self-representation or self-identification. Rather the social practices of individuals and collectives are located within the social context and discourses that shape social identities, representations, and identifications.[28] Group identification is not equated with group homogeneity but acknowledges the considerable diversity within groups as well as the commonalities across groups.[28] A critical cultural perspective does not rank order social differences attaching more social significance to one category than to another[30] because the complexity and totality of people's lived experiences emerge from the ways that relational categories are dependent upon, and articulated through, each other. Kirkham's[20] ethnographic study of intergroup healthcare encounters illustrates the explanatory power of locating the micropolitics of the nurse-patient relationship within the institutional context that organizes the macropolitics of belonging.

TCN GOAL OF PROVIDING CULTURALLY COMPETENT CARE

According to TCN Theory, addressing cultural diversity is an important challenge facing nurses. The *goal* or intended outcome of TCN is to meet clients' health needs in ways that are consistent with their cultural beliefs. A systematic review of selected TCN literature suggests that responding to cultural diversity is a challenge that nursing faces with ambivalence. Cultural diversity is regarded as an exciting challenge that appeals to our liberal sensibilities as a profession. At the same time, cultural diversity is perceived as a threat to the concept of nation and the integrity of a racialized order in and beyond nursing.

The so-called problem of increasing cultural diversity is the starting point for many TCN texts.[1,3,5,11,12,36,45,46] These sources assert that the changing face of the North American population is impacting the interpersonal relations among nurses, and between nurses and their clients. The dramatic rate at which newcomers are "pouring into this country from all the nations of the world" supports the push for cultural competence.[36(pix)] One text describes the transformation of the healthcare system as an "ongoing healthquake" of global proportions.[12(p330)] The "smaller world" brought together by communication technology, "the potency of television," and global travel is said to have serious implications for nurses and nursing practice, education, and research.[12(p330)] The smaller world

concept is based on the erroneous notion that a multicultural society is a recent phenomenon that began with increased migration in the 1900s into North America.

The deceptively neutral viewpoint presented in this example ignores the shifting nature of racialized categories.[29] At the same time, the small world concept erases the historical and contemporary presence of Aboriginal peoples in North America as well as the historical and present-day threat that the colonizing and dominant societies pose to Aboriginal communities. Attending to demographic shifts, while downplaying the impact of other fundamental political, social, economic, and familial trends on the healthcare system, adds potency to conceptualizing cultural diversity as a problem. Together, these ideas imply that those who are culturally different are a threat to a supposedly homogeneous society.

This threat is articulated in several ways. Some sources cite statistics whereas others provide graphs depicting demographic changes[9,46] Although figures and pie charts are purportedly objective and politically benign, visual representations lend power to text that in one case forewarns that by the 21st century "the collective of minorities will become the majority in the United States."[9(p292)]

International visitors, exchange students, and recent newcomers are said to be straining the American healthcare system.[9,12] An enlarged and emboldened insert in one journal article pronounces, "The worldwide epidemic of AIDS has reminded us that disease knows no boundaries."[12(p331)] The accompanying text continues, "It is not possible for nurses to ignore the health problems that exist in other countries because international travel makes those health problems the health problems of the world."[12(p331)] The alleged burden this demographic shift poses for a healthcare system widely regarded as being in crisis is linked with the threat to individual well-being.

Elsewhere, nurses who immigrate to North America to find work are mistakenly regarded as another threat to nurse-nurse and nurse-client relations.[33] One nurse researcher writes, "Many of us have worked in the United States with foreign-trained nurses, and therefore understand the difficulties encountered when nurses from different cultures who are educated under different systems of nursing education work together."[12(p331)] As the text subsequently refers to American and Canadian nurses as if we were a homogeneous collective of professionals, it is safe to assume that "foreign-trained nurses" are not white nurses crossing the Canada-US border but nurses of color emigrating from the so-called Third World countries.

References to the increase in "foreign-trained nurses" working in the United States are followed by comments about the shrinking job market facing American nurses and the departure of many to work outside the country.[12] Juxtaposing these 2 trends conveys the unspoken message that American nurses (read white) are losing their jobs to nurses immigrating to the United States. This linguistic trick is more subtle than are other sorts of coded language signifiers that attach racist ideas to racialized groups.

Claims about a shrinking job market for nurses and the rising incidence of life-threatening disease imply that demographic shifts are a threat to (white) America. These claims take on even greater potency since the events of 9/11 in New York. At the same time, demographic shifts are characterized as an *opportunity* for American nurses to work in the so-called developing countries. American nurses working beyond their national borders are not characterized as foreign-trained nurses but rather as "ambassadors for world health."[12(p331)] The text continues with a reference to Florence Nightingale, who left England to work in Germany and "who influenced the health of populations throughout the world."[12(p331)]

Looking critically at the images created in these texts reveals how people, structures, and geographies are racialized in TCN literature. Some traveling nurses are portrayed as health ambassadors whereas others are

labelled foreigners or foreign-trained. The same geographies that are imagined as needy and referred to as foreign lands are simultaneously regarded as desirable sites for learning and research. Canadian and American national identities and geographies are constructed as homogeneous, white, and inherently superior, whereas the newcomer or non-Canadian/American nurse is constructed as inferior, Other, and a threat. This way of thinking advances an us/them, superior/inferior binary typical of racializing discourse.

Moreover, these images exemplify what Rosaldo calls "imperialist nostalgia."[21(p107)] The reference to Nightingale, who conceived of nursing as a calling conjures up images of today's nurses following in her footsteps, taking supposedly superior knowledge and skills to a sick and needy world. These "innocent yearnings" conceal the historical complicity of nursing "with often brutal domination."[21(p108)] Advocating that American nurses serve as health ambassadors is reminiscent of the imperialism that motivated some British women in the late 19th century to spread Christian civilization throughout the empire in order to save the "the heathen" from their "backward" cultures.[24(p160)] This colonialist agenda is documented with disturbing and unreflective clarity in Gibbon and Mathewson's[50] history of Canadian nursing that describes how the British and French nursing sisterhoods willingly participated in the so-called salvation and civilization of the Canadian indigenous peoples.

References to the perceived threat posed by immigrants, international travelers, foreign-trained nurses, and those who are culturally different are expressions of systemic racism. These expressions appear in nursing texts alongside expressions of disapproval for various socially unacceptable racist attitudes and behaviors. The simultaneous acknowledgment and denial of racism in TCN Theory adheres to the liberal etiquette of race discourse. That is to say, bias, discrimination, and prejudice are situated in the individual psyche or condemned as aberrant behavior whereas systemic racism is unreflectively expressed and unnamed.

TCN PROCESSES FOR CHANGE

Processes or strategies for action may take the form of individual responses, social behavior, or institutional practice. TCN Theory frames the development of 2 types of processes that focus on the individual: (1) those that assist the nurse in assessing clients and implementing their culturally specific health preferences into a care plan and (2) those that measure a nurse's growth toward cultural competence. This section begins with a discussion of the latter.

Becoming culturally competent

Understood as an ongoing process, a nurse's personal growth toward cultural competence is said to be measurable,[13,51] using such tools as the Borkan and Neher Developmental Model of Ethnosensitivity.[9] Implicit in this model is the focus on the individual nurse who is responsible for addressing cultural diversity. One benefit of locating the process with the individual is the space it creates for individual agency and change. This strategy grounds the work in the actual interaction between 2 individuals in a real place and time. It enables the nurse to start from where she or he is. There are, however, several problems with this and similar models for developing cultural competence.

Some concepts associated with cultural competence actually reinforce the very beliefs they purport to resist. The Borkan and Neher Model[9] identifies *ethnocentrism* as one end of the continuum where the nurse displays fear and mistrust of the client who is culturally Other. *Ethnocentrism* is defined as "the belief that one's own culture is superior to all others."[9(p293)] TCN Theory teaches us that the culturally competent nurse is aware of the tendency to use her or his own social location as a bench mark against which to assess the health-related beliefs and behaviors of others. The nursing subject who

holds his or her health beliefs and practices superior may label this ethnocentrism. However, this definition allows the dominant subject to regard a client subject who holds Traditional Chinese Medicine as superior to be similarly ethnocentric. If we are aware of our ethnocentrism, the logic goes, then nurses can learn to value equally all culturally specific beliefs and practices.

The problem is that the operationalization of this concept attends to individual behavior rather than systemic practices that organize that behavior. Those of us who are dominant subjects can ignore the legitimacy accorded to our dominant beliefs and practices while simultaneously espousing and performing cultural competence. Those of us (nurses and clients alike) with less social power and, therefore, with less ability to retain and perform our health-related beliefs and practices, must define our *marginalization* as the result of ethnocentric practices by individual practitioners rather than as a deeply entrenched systemic problem.

Moreover, critical theorists resist the assumption that fear and mistrust responses emerge from a lack of knowledge about the Other. Frankenberg asserts that fear and mistrust of the Other "must be understood as an element of racist discourse crucially linked to essentialist racism, or the idea that people of colour are fundamentally Other than white people."[25(pp60,61)] hooks also asks us to consider the "terrorizing imposition" of whiteness in the lives of blacks and I would add other racialized groups.[23(p341).] From a critical cultural stance, dominant discourses of superiority and privilege rather than lack of knowledge are the issue.

In her or his quest for cultural competence, the nurse moves along the Borkan and Neher Model,[9] from ethnocentrism through a stage of *denial* marked by cultural blindness and overgeneralization, to *superiority*, then to *minimization* characterized by reductionism, later to *relativism* marked by acceptance, and finally to the desired goal of *pluralism* recognized as empathy and integration. Respect, empathy, sensitivity, and tolerance are values with deep roots in European culture and Christian morality, which in turn strongly influenced the development of nursing.[52] Moreover, sensitivity is one of those virtues so naturalized in the subjugation of girls and women that one scholar asks, "If we are found insensitive, we may fear we have no redeeming traits at all and perhaps are not real women."[22(p38)] In a white, female-dominated profession, demonstrations of tolerance, sensitivity, understanding, and empathy can stand in for being fair and being fairly represented.[32] Those of us in positions of power have the luxury of expressing tolerance and sensitivity for nondominant beliefs and practices. Those of us who are marginalized are expected to be satisfied with being tolerated or having our diversity celebrated rather than being able to expect fair treatment as professionals[33–35] and equitable access to healthcare as clients.[19,20]

Underpinning this expectation to become culturally competent is the push to acquire cultural knowledge. As described earlier, fundamental nursing textbooks and the research these texts draw upon is replete with reductionist information about the cultural Other. Although most TCN texts[5,36] warn against faulty overgeneralizations, acquiring specific knowledge about minoritized groups has historically been regarded as an essential research and educational strategy.[1,3,36,37] The manufactured need to know about and construct categories of difference justifies the reproduction of the white liberal imaginings about the beliefs and practices of nondominant groups.

Providing culturally competent care

TCN Theory also frames the development of strategies that assist the nurse in assessing clients' health beliefs and practices. Leininger's Acculturation Health Assessment Tool is cited in many nursing reference texts[9,46] and in the CNO culture care

standard.[5] The nurse uses the tool when assessing the level of risk associated with incorporating a client's cultural preferences into the care plan. The first mode of intervention, *culture care preservation*, involves integrating the client's wishes into care when there is no risk of harm. Accepting key elements of client choice while minimizing risk of harm is called *culture care accommodation*. The third mode, *culture care repatterning*, involves assisting the client in adopting new patterns of behavior when instituting a given cultural practice would bring harm to the client or anyone else.

Moving toward inclusivity and social justice in healthcare is a goal I share with many TCN scholars. Incorporating a client's preferences into a plan of care indicates a desire to be inclusive—to recognize and value health knowledge and practices outside biomedicine. However, this particular way of understanding and promoting inclusivity may not result in that outcome and is problematic for 2 reasons: First, TCN Theory reinscribes the nurse-client relationship as a private event. The institutionalized power of nursing regulates the activities of individual nurses who are expected to authorize or invalidate other legitimate healing practices under the rubric of doing no harm. Western ways of thinking about and performing health practices are the norm against which all other practices are measured. When there is insufficient evidence to support the use of an alternative health practice, the nurse is expected to err on the safe side and encourage cultural assimilation allegedly in the interests of the client. Inclusivity is supposedly enacted by bringing culture-specific knowledge and practices into the existing boundaries of Western healthcare.

The TCN gesture of reaching out from the center to embrace the margins[28] mirrors the tension that exists in the wider healthcare community. Practitioners embrace those aspects of indigenous healthcare knowledges that biomedicine needs but lacks while at the same time keeping these systems positioned as Other with terms such as alternative medicine and complementary medicine. Common to TCN and the wider healthcare community is the inherent valuing of the Western ways as scientific, objective, advanced, and therefore, superior.

Second, decision making is ideally negotiated between equal partners and the culturally competent nurse is expected to facilitate that negotiation. The client is imbued with the power to make decisions about whether to retain his or her health practices or to assimilate. The problem is that institutional relations organize the range of decision-making options available to clients. On one hand, the client who is culturally Other has considerably less power than it appears to make a genuine choice about his or her care. Failure on the part of the cultural Other to conform is constituted as a problem related to lack of knowledge about the superiority of Western practices. On the other hand, dominant nursing practices advanced in reference texts, and learned and practiced over time take on the power of ritual and create the context for marginalizing those who do not conform to or choose not to follow what is allegedly sensible advice. Nursing practices articulated in hospital policy, for example, limit the power of the most competent nurse to act on behalf of her or his client. Although this approach appears to respect the client's agency, the strategies for incorporating cultural preferences may actually accord the nurse (and the biomedical model) greater control.

To be effective, strategies for inclusivity must examine how and under what conditions inclusion and exclusion occur. This means making explicit the centrality of the dominant, liberal approach to healthcare in the construction of nursing knowledges and institutional practices. Specifically, creating space for the expression of difference demands that the nurse-client relationship is located within the larger institutional and systemic contexts that shape and constrain social practices, identities, representations, and identifications.[18,19]

SUMMARY

TCN Theory is a dynamically interconnected project of knowledge production that reinscribes the dominant liberal discourse and regulates the activities of the nurse, the client, their relationship, and the context in which that relationship is enacted. TCN Theory is advanced in the nursing literature. It shapes nursing curricula. It structures nursing and institutional policy. It penetrates the actual locations where nursing practice takes place and as such constitutes one of the structural processes that reinforces rather than challenges the hierarchically ranked social order.

A careful deconstruction of the standpoint, focus, goals, and process of TCN Theory reveals 2 fundamental problems: First, giving primacy to a broadly defined, but narrowly applied, concept of culture when articulating appropriate nursing care obscures the social and political contexts that underlie the TCN conceptualization of culture and shape the human experience of being regarded as culturally different. Second, TCN Theory is flawed, not because it lacks internal logic, but because it emerges from a liberal and depoliticizing standpoint that perpetuates, rather than interrupts, the dominant ways of interpreting and addressing human and social differences. These dominant ways of thinking are deeply embedded in and structure hierarchical social relations within and beyond nursing.

Using TCN Theory as the framework for research, education, policy development, and clinical practice has implications for how well our profession addresses social and human differences. The reiteration of TCN Theory in educational curricula and policies such as the CNO culture care standard puts social differences on the political agenda. Issues of race, religion, sexuality, ethnicity, and other social categories of difference are more eligible for discussion. Creating spaces for voices to be heard and bodies to be represented creates yet more opportunities for resistance and social change. As individual nurses reflecting critically on issues of difference, we begin the important process of transforming our thinking and practices. As such, TCN Theory may facilitate slow incremental change. This should not be interpreted as support for TCN Theory. Using or revising a framework that is deeply flawed will not transform the social practices and relations that institutionalize the dominant approach to social and human differences.

A critical cultural perspective embraces an overtly political agenda that supports sweeping social change. The preceding discussion constitutes a challenge to the liberal, individualistic discourse that is central to the construction and reproduction of nursing knowledge and institutional practices. Nursing as a profession must take seriously the invitation to dialogue about alternative ways of thinking about and interpreting social reality. From a critical cultural standpoint, we can envision an alternative future achieved through innovative strategies for change that will unsettle power inequalities and effect meaningful changes in our local and translocal social networks.

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