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# Health Care Communications with Diverse Ethnic Groups

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The concept of respect is rooted in the core value of human relations, and interpersonal relationships with others. The notion of respect in these relationships is entrenched in the broader context of the processes of relationships between professionals and clients in general, along with the philosophical and ethical foundations of respect. Although nursing principles and values, such as autonomy and dignity have built their foundation of care on the concept of respect, these concepts (ie. autonomy and dignity) are still different from respect. Respect within health professional-client relationships, indicates that respect is a fundamental concept within nursing, permeating a number of other concepts that provide purposeful nursing care within the process of nurse-client relationships and respect has been discussed as an ethical and moral concept of care that addresses the values of human dignity in the nursing discipline, however research examining the client's perspectives of respect as an ethical principle of care, especially within Canada's diverse population is non-existent. There is limited research from the client's perspective addressing challenges communicating the concept of respect in relationships between health professionals and clients, specifically research directed at immigrant or the vulnerable population.

**Key Words:** Communication, Culture, Respect

## INTRODUCTION

As part of the health care system, nurses constantly face challenges working with ethnic populations. Challenges include finding ways of communicating effectively; building and maintaining respectful relationships with patients, and providing care and support to individuals with differences that might be unique to them. Health care encounters and the dynamics that constitute and shape these relationships are significant, as they reflect, influence, and construct social, political, institutional, and ideological relations (Browne & Fiske, 2001). The current health care system, socio-political milieu, and institutional settings have created remarkable restructuring, downsizing, and change in the past decade, which have influenced interactions between nurses and female patients (Browne & Fiske, 2001; Kirkham, 2003). The conceptual basis of much research undertaken in the past with the immigrant population to examine the links between culture and health is problematic, because it does not analyze institutional practices and policies or their ideological underpinnings and premises (Ahmad, 1993). These institutional, socio-political and biomedical ideologies cannot be labelled cultural barriers but instead need to be examined as the intersectionalities of social conditions within the institutional setting. Lynam et al. (2003) identified that nurses face great challenges in settings where "organizational supports are not in place to facilitate the prompt mobilization of resources to respond to changing patient conditions" and to meet the patients' needs within the current health care system (p. 119). This is an illustration of how nurses in these contexts are continuously absorbing the consequences of delivering respectful health care to the increasingly diverse Canadian population (Kirkham, 2003; Lynam et al., 2003). In light of these complexities, this paper will examine how multiple institutional, socio-political, and ideological contexts will have an impact on the exploration of respect within nurse-patient relationships, especially those with immigrant women patients.

Although most Canadian women will confront various challenges related to feeling respected within nurse-patient relationships, these challenges are usually heightened for immigrant women. Immigrant women might be

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struggling with migration and resettlement issues, which include challenges of maintaining lifelong beliefs and practices, leaving their extended family behind in their country of origin, and fulfilling the responsibility of caring for other family members while learning new ways of establishing a stable life in the new country (Bhachu, 1996; Choudhry, 2001; Kirkham, 2003). The ability to negotiate successful intergroup nurse-patient relationships that foster respectful relationships is further compromised within the current institutional and clinical settings by diminished resources, workplace restructuring, increased demands on nurses' time, and a lack of coherent organizational support for their work (Lynam et al., 2003). These cannot be glossed over as lifestyle, behavioural, or cultural issues; rather, they are manifestations of the complex interplay of social, political, economic, institutional, and ideological contexts that will influence how interactions between nurses and immigrant women are structured and constructed. Furthermore, Browne (1993, 1995, 1997) asserted that understanding the range of social, historical, and political factors that affect health care interactions is vital if health care providers are to prevent the discrimination and dehumanization that marginalized patients can encounter when entering the mainstream health care system. Because the concept of respect is rooted in the core value of human relations and a key principle and value within nurse-patient relationship, this paper will present an overview of respect as a concept with a view to demonstrating how it is discussed and presented within the healthcare literature.

## 1. Respect

Webster's dictionary definition of respect is "to be held in regard, honoured, or being esteemed as a formal expression or gesture of greeting" (Costello, 1996. p. 196). Kant's idea of respect within the larger aspect of humanity contains the notion that respect is something more than Just moral ideals or material benefits, more than even benefits that might be offered in a charitable spirit or through recognition; it is something that is owed within relationships (Hill, 2000). Other philosophers have also viewed that the provision of respect is characterized by the principle of respect for human nature in one's own person or in that of another. For moral reasons, we should respect everyone's humanity, because respect is clearly different from honour, self-esteem, and admiration, accolades that are generally credited to those who have performed some feat or deserve respect because they have earned it (Dillon, 1992; Downie & Telfer, 1969; Lawrence-Lightfoot, 2000; Peters, 1961). Lawrence-Lightfoot (2000) asserted that "respect is not a given in certain relationships; rather, it is an expression of circumstance, temperament or culture" (p. 10). The author further indicated that it is impossible to do the work that health professionals do without offering respect: creating a relationship with respect at the centre.

In light of this definition of respect, what are the conditions under which nurse-patient relationships are occurring for immigrant women who enter the institutional setting? Furthermore, how do the current ideological underpinnings and premises of the institutional settings influence or structure nurses' ability to practice efficient health care delivery for their immigrant and non-immigrant patients? These illustrations identify gaps where vulnerable patients' needs for interpretation services could not be readily accommodated within the existing organizational structures because of critical shortages for such resources (Kirkham, 2003; Lynam et al., 2003).

## 2. Respect in the Nurse-patient Relationship

The ideal perspective we would all strive for within a relationship would be for each human being to have equal worth independent of social standing and individual merits. However, imperialistic notions of dominant and non-dominant groups which give the illusion of hierarchical statuses have created discussions about basic respect as it is related to concepts such as diversity and multiculturalism within society. Previous governments have clearly articulated policy objectives related to equity and health for their culturally diverse populations at the national, provincial, and regional levels (Canada Health, 1997, 2001; British Columbia, 1995; Vancouver-Richmond Health Board, 2000). Health care literature has addressed this ideal imperialistic notion of cultural diversity and multiculturalism as referring to the provision of respectful health care to immigrant populations and First Nation's women (Bottorff, Johnson et al., 1998; Choudhry, 2001; Kirkham, 2003). These researchers have discussed the need for health care providers to give respectful care by taking individuals' differences into consideration and by providing culturally sensitive care. However, evidence from previous research confirms that it is not a woman's "culture" per se but, rather, the mediating circumstances of her life experiences and the relationship with health professionals at the social setting in the institutional setting that organize the ways in which illness is experienced and managed (Anderson & Reimer Kirkham, 1998; Browne & Fiske, 2001). How, then, do we go

beyond the hypocrisy of oppressors such as the multiple institutional, socio-political, and ideological conditions who dominate others in the name of high moral ideals and take the extreme relativistic position but still endorse the basic notion of respect for persons under the guise of cultural diversity and multiculturalism (Hill, 2000; Lawrence-Lightfoot, 2000)? Evidence from health care-related research with immigrant populations indicates that we would need to move beyond the notion of cultural diversity and critique the context of current and historical socio-political relations, and the institutional settings that structure and influence interactions between nurses and immigrant women patients (Browne, 1995; Kirkham, 2003).

A review of the literature indicates that respect is a fundamental concept both in nursing (Browne, 1993, 1995; Kelly, 1990; McGee, 1994; Stephen, 1994) and, more generally, within health professional-client relationships. Nurse researchers indicate that the limited research on respect might be due to the fact that the fundamental notion of respect might be difficult to define (Stephen, 1994). Stephen (1994), who viewed respect and caring to be the ethics and essence of "nursing," provided several propositions that delineate the relationships between the concepts of respect, caring, and nursing. Kelly further supported three propositions for respect within nursing: (a) "respect precedes caring in the nurse- client relationship; (b) in the absence of respect, caring cannot take place; (b) in the absence of caring, nursing cannot take place" (p. 73). Browne (1993), who has made several contributions toward clarifying the meaning of respect within the context of nursing practice, conceded, "initially, the effort of defining respect may seem rhetorical: because its meaning is often implicitly assumed" (p. 77). Browne (1995) and McGee (1994) concurred that respect emerges as a fundamental and essential aspect of nursing practice; however there are no instruments or criteria for measuring or evaluating respect. Lawrence-Lightfoot (2000) stated that the traditional view of respect, though rarely expressed in its pure form, might tend to be relatively static and impersonal and can usually be seen as involving some sort of debt due to people because of their attained or inherent position, age, gender, class, professional status, or accomplishments.

### 3. Immigrant Women and the Contexts of Health Care

Health professionals often attribute the difficulties people encounter in accessing health care and in managing health and illness to their cultures and to their differences from "mainstream society", rather than attempting to understand the complex factors influencing their experiences or acknowledging the diverse experiences within ethno-cultural groups (Anderson & Reimer Kirkham, 1998). It can be argued that when particular groups are labelled as "ethnic" or "multicultural", we expect these individuals to have common cultural beliefs and values hindering them from accessing health care as readily as the dominant group. This is probably true to an extent; however, researchers exploring people's experiences should also acknowledge the influence of social class, gender, and social environment, along with the macro and micro organizational structuring of the health care system (Browne & Fiske, 2001; Kirkham, 2003; Lynam et al., 2003). Kirkham (2003) illustrated that negotiations of visiting hours and incorporation of alternative therapies stood out as struggles for patients, with nurses being placed in the middle of intergroup relations because of institutional policies deemed to attend to "diversity" within the population. A participant in Kirkham's study voiced, "We have all these noble statements about diversity. But how does this translate into action?" (p. 770). Daily life experiences, ways of communicating, ways of constructing meanings from negative or positive occupational experiences, and struggles with financial exigencies and existing family situations all influence the experiences of health and illness of women from ethnic and cultural minorities (Anderson & Reimer Kirkham, 1998; Lipson & Meleis, 1985). This complexity was evidenced when nurses made referrals for home care for patients who had neither family nor finances to support themselves at home on discharge from the institutional setting (Lynam et al., 2003). Lynam and colleagues stated, "[The] system is premised upon the assumption that 'family' will be available upon discharge" (p. 124).

A number of studies exploring immigrant women's health care encounters indicate that women are often marginalized by the mainstream health care structures, increasing their difficulty in accessing health care. Results from studies that have examined health care providers' experiences and their perceptions of working with South Asian women, as well as women from other ethnocultural groups, suggest that stereotypes and assumptions might exist when health care providers care for women from various ethnic groups (Browne & Fiske, 2001; Bottorff, Balneaves, Sent, Grewal, & Browne, 2001). Existing stereotypes and assumptions regarding immigrant families' relying on their extended family members to care for their ill can become troublesome when proper discharge assessments are not done by health care

providers (Browne & Fiske, 2001; Lynam et al., 2003). Participants in Choudhry's (2001) study regretted that the sudden change in environment and the transition from a traditional society to a modern one does not allow for the informal daily social interactions that helped lessen the burden of daily stresses. Besides, they viewed that in Canada, "family members are busy focusing on their own resettlement process and are not always available to respond. They miss the company of extended family members and friends they had to leave behind in their country of origin" (p. 385).

However, to respond to the influx of new immigrants, health care providers and policy makers have espoused the concept of multiculturalism, thereby infusing this concept into the health care system to try to understand the notion of culture and its relatedness to difference and diversity (Hall, Stevens, & Meleis, 1994; Harding, 2003). In discussions of the micro-politics of belonging, Kirkham (2003) found that under ideal conditions, intergroup encounters illustrated connected care marked by respectful interpersonal connections and an understanding of the illness experience from the patient's perspective; however, the lack of organizational resources, such as adequate language services, especially for those patients who did not speak English, compromised connected care.

There is a paucity of studies exploring either respect as a component of care in nursing practice or respect within health professional-client relationships with immigrant women (Singh-Carlson, Neufeld, & Olson, 2010). Given the evidence that most immigrant women will face challenges compounded by migration and transition experiences, it is important to further explore immigrant women's experience of respect within the contexts of the socio-political and institutional settings.

### 4. Contexts of Health Care

An examination of multiple cultural, societal, personal, and institutional factors provides a lens through which to view the complexities of nurse-patient relationships within the much broader notion of human relations. This helps to illustrate how these are orchestrated within an institutional setting, when professionals and recipients enter the relationship. There might be predetermined assumptions made by nurses, physicians, and other health professionals that immigrant women expect different dimensions of respect from those of the dominant group. The key will be to go beyond simply describing pictorially a situation in nurses' and immigrant women's everyday world to problematizing and reflecting not Just on the power relations of social Justice and structuring but on the socio-political, institutionalized setting and ideologies of the health care system (Smith, 1994). Researchers who have studied immigrant women's access to health care within the context of socio-political, institutional, and biomedical ideologies profess that our theories will have to leave room for the intersectionalities within the constantly shifting, evolving, and contradictory nature of intergroup relations under existing social conditions (Browne, 1995; Browne & Fiske, 2001; Kirkham, 2003; Lynam et al., 2003).

Under ideal conditions, all nurse-patient relationships, including those with immigrant or non-immigrant women, would illustrate respect marked by satisfied interpersonal relationships and an understanding of the illness experience from the patients' perspective and their health care needs (Kirkham, 2003). However, as we live in the real world, where we constantly have to hold the health care system up for scrutiny at both macro and micro levels, researchers must be critical in their approach to the shifting, contradictory, and ambivalent nature of nurse-patient relationships within the constantly shifting institutional and socio-political realm of the health care system.

## CONCLUSION

The experiences of migrating and resettling to a different country and adjusting to a new way of life affect people of all ages, backgrounds, and genders. Understanding of immigrant women's experiences of respect within nurse-patient relationships might help to alleviate these women's distress during illness experiences and might promote health and well-being for immigrant women and their families (Deeny & McGuigan, 1999; Moyle, 2003). Given that we live in a world where health care relations are influenced by institutional settings, current and historical socio-political situations, and interpersonal relational contexts, nurse scholars and researchers need to shift to being more critical by drawing on all the factors that will have an impact on nurse-patient relationships within a clinical setting.

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